From: (b)(6) (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=E90EF156ED05483F959D8C4039D9B906-LORDEN, SUS (b)(6)>

To: Romero-Escobar, Beatriz (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user8a7a5326 <Beatriz.Romero@HHS.GOV>; Stampul, Barbara (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aba3e5fc28844f3399581d12fbec4fcb-Stampul, Ba <Barbara.Stampul@hhs.gov>

CC: (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-Dekervor, D (b)(6)>; (b)(6) OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user5d5a5775 <(b)(6)

Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Date: 2022/10/21 12:11:31

Priority: Normal

Type: Note

Thank you both for the update. Beatriz, since (b)(6) are back in the office, would you mind (b)(5)
(b)(5) Thanks! (b)(6)

From: Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Sent: Friday, October 21, 2022 12:08 PM
To: (b)(6) (HHS/OCR) <(b)(6) >; Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Cc: (b)(6) (HHS/OCR) <(b)(6) >; (b)(6) (OS/OCR) &lt(b)(6) >
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)
Hi,
(b)(5)
Thanks.

From: (b)(6) (HHS/OCR) <(b)(6) >
Sent: Friday, October 21, 2022 11:44 AM
To: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>; Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Cc: (b)(6) HHS/OCR) &lt(b)(6) >; (b)(6) (OS/OCR) &lt(b)(6) >
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)
Hi Barbara and Beatriz,
Hope you’re having a good Friday so far. Could you give us a status on the (b)(5) Medicaid cases per below?
We appreciate you! Thanks, (b)(6)

From: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Sent: Friday, September 30, 2022 8:44 AM
To: (b)(6) HHS/OCR) <(b)(6) >; Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>

Cc: (b)(6) (HHS/OCR) <(b)(6) >; (b)(6) (OS/OCR) &lt(b)(6) >
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)
Thanks Susie! Sounds like a plan!

From: (b)(6) (HHS/OCR) <(b)(6) >
Sent: Thursday, September 29, 2022 10:10 PM
To: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>; Chirila, Robert (HHS/OCR) <Robert.Chirila@hhs.gov>; Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Cc: (b)(6) (HHS/OCR) <(b)(6) >; (b)(6) (OS/OCR) &lt(b)(6) >
Subject: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)
Hello Southeast colleagues,
Thanks for sending over a draft DRL in the South Carolina Medicaid cases. We have a couple of recommendations:

(b)(5)

I hope this sounds like a plan.(b)(6)
Please let us know if you have any questions, and we’ll address when we get back.
Thanks for all your work on these cases.
(b)(6)

From: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Sent: Monday, September 26, 2022 12:31 PM
To: (b)(6) (HHS/OCR) &lt(b)(6) >

Cc: (b)(6) (HHS/OCR) <(b)(6) >; Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Subject: Gender Affirming Care (GAC) State Medicaid and MCO cases DRL Draft
<< File: (b)(5)
>> Hi (b)(6)
(b)(5)
(b)(5) Thank you!

Sender: (b)(6) (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=E90EF156ED05483F959D8C4039D9B906-LORDEN, SUS (b)(6)

Recipient: Romero-Escobar, Beatriz (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user8a7a5326 <Beatriz.Romero@HHS.GOV>; Stampul, Barbara (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aba3e5fc28844f3399581d12fbec4fcb-Stampul, Ba <Barbara.Stampul@hhs.gov>; (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) ; (b)(6) (b)(6) OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user5d5a5775(b)(6)

Sent Date: 2022/10/21 12:11:29

Delivered Date: 2022/10/21 12:11:31

From: Rahn Ballay, Jamie (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=A890960EDA2B40988EA0FD5DE7F7770A-RAHN, JAMIE <Jamie.Rahn@hhs.gov>

To: (b)(6) HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=e90ef156ed05483f959d8c4039d9b906-Lorden, Sus
(b)(6)
Welch, Alisha (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=c4f04c6ecc4a48358e8bb05b44dc4eb7-Welch, Alis <Alisha.Welch@hhs.gov>

CC: Stampul, Barbara (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aba3e5fc28844f3399581d12fbec4fcb-Stampul, Ba <Barbara.Stampul@hhs.gov>;
Romero-Escobar, Beatriz (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user8a7a5326 <Beatriz.Romero@HHS.GOV>;
(b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-Dekervor, D
(b)(6)
(b)(6) OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user5d5a5775 <(b)(6)

Subject: RE: State Medicaid MCO DRL template

Date: 2022/11/08 08:08:05

Priority: Normal

Type: Note

Good Morning and thank you Susie for sharing this with us. (b)(5)
(b)(5)
(b)(5) Thanks again and have a nice day.

Jamie

From: (b)(6) (HHS/OCR) <(b)(6)
Sent: Monday, November 7, 2022 6:36 PM
To: Rahn Ballay, Jamie (HHS/OCR) <Jamie.Rahn@hhs.gov>; Welch, Alisha (HHS/OCR) <Alisha.Welch@hhs.gov>
Cc: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>; Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>; (b)(6) (HHS/OCR) <(b)(6) ;(b)(6)
(OS/OCR) <(b)(6)
Subject: State Medicaid MCO DRL template

Hi Jamie and Alisha,

(b)(5)

Thanks so much, (b)(6)

From: (b)(6) (HHS/OCR) <(b)(6)>
Sent: Thursday, September 29, 2022 10:24 PM
To: Rahn Ballay, Jamie (HHS/OCR) <Jamie.Rahn@hhs.gov>; Welch, Alisha (HHS/OCR) <Alisha.Welch@hhs.gov>
Cc: (b)(6) (HHS/OCR) <(b)(6)>; (b)(6) (OS/OCR) <(b)(6)>
Subject: South Carolina Medicaid GAC complaints (b)(5)

Hi Jamie and Alisha,

(b)(5)

(b)(5) I'm just giving you a heads-up. Please let us know if you have any questions, though Dylan and I are out next week.

Thank you, (b)(6)

From: (b)(6) (HHS/OCR) <(b)(6)>
Sent: Thursday, September 29, 2022 10:10 PM
To: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>; Chirila, Robert (HHS/OCR) <Robert.Chirila@hhs.gov>; Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Cc: (b)(6) (HHS/OCR) <(b)(6)>; (b)(6) (OS/OCR) <(b)(6)>
Subject: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Hello Southeast colleagues,

Thanks for sending over a draft DRL in the (b)(5) We have a couple of recommendations:

(b)(5)

(b)(5)

I hope this sounds like a plan. (b)(6) Please let us know if you have any questions, and we'll address when we get back.

Thanks for all your work on these cases.

(b)(6)

From: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Sent: Monday, September 26, 2022 12:31 PM
To: (b)(6) (HHS/OCR) <(b)(6)
Cc: (b)(6) (HHS/OCR) <(b)(6); Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Subject: Gender Affirming Care (GAC) State Medicaid and MCO cases DRL Draft

<< File: (b)(5) > Hi (b)(6)

(b)(5)

(b)(5) Thank you!

Sender:	Rahn Ballay, Jamie (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=A890960EDA2B40988EA0FD5DE7F7770A-RAHN, JAMIE <Jamie.Rahn@hhs.gov>
Recipient:	(b)(6) HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=e90ef156ed05483f959d8c4039d9b906-Lorden, Sus (b)(6) Welch, Alisha (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=c4f04c6ecc4a48358e8bb05b44dc4eb7-Welch, Alis <Alisha.Welch@hhs.gov>; Stampul, Barbara (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aba3e5fc28844f3399581d12fbec4fcb-Stampul, Ba <Barbara.Stampul@hhs.gov>; Romero-Escobar, Beatriz (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user8a7a5326 <Beatriz.Romero@HHS.GOV>; (b)(6) HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-Dekervor, D (b)(6) (b)(6) OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user5d5a5775 (b)(6)
Sent Date:	2022/11/08 08:08:01
Delivered Date:	2022/11/08 08:08:05

From: (b)(6) HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=E90EF156ED05483F959D8C4039D9B906-LORDEN, SUS (b)(6)

To: Romero-Escobar, Beatriz (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user8a7a5326 <Beatriz.Romero@HHS.GOV>; Stampul, Barbara (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aba3e5fc28844f3399581d12fbec4fcb-Stampul, Ba <Barbara.Stampul@hhs.gov>

CC: (b)(6) HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-Dekervor, D (b)(6)
Roman, David (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user5d5a5775 <David.Roman@hhs.gov>

Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Date: 2022/11/08 10:02:42

Priority: Normal

Type: Note

Good morning,

FYI, Jamie said the data request looks great and the MidAtlantic Region has no edits on it.

Thanks, (b)(6)

From: (b)(6) HHS/OCR) <(b)(6)
Sent: Monday, November 7, 2022 6:16 PM
To: Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>; Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Cc: (b)(6) (HHS/OCR) <(b)(6) ; (b)(6) (OS/OCR) (b)(6)
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Hi Beatriz and Barbara,

Please find attached our minor edits to the data request for the (b)(5)

(b)(5)

Appreciate your great work on these cases. On ALL your cases….!

Thanks, (b)(6)

From: Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Sent: Tuesday, October 25, 2022 11:03 AM
To: (b)(6) (HHS/OCR) <(b)(6)>; Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Cc: (b)(6) (HHS/OCR) <(b)(6)>; Roman, David (OS/OCR) <David.Roman@hhs.gov>
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Hi (b)(6)

Please note that we sent you the updated DR via collaboration in PIMS.

Let me know if you have any questions.

Regards,

From: Romero-Escobar, Beatriz (HHS/OCR)
Sent: Friday, October 21, 2022 12:20 PM
To: (b)(6) (HHS/OCR) <(b)(6)>; Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Cc: (b)(6) HHS/OCR) <(b)(6)>; (b)(6) (OS/OCR) (b)(6)
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Will do, enjoy yours too.

From: (b)(6) HHS/OCR) <(b)(6)>
Sent: Friday, October 21, 2022 12:14 PM
To: Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>; Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Cc: (b)(6) (HHS/OCR) <(b)(6)>; (b)(6) (OS/OCR) (b)(6)
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

That's perfect! But please send me an email that you've uploaded it in PIMS because I don't get an alert that it's in there. Thanks so much – have a great weekend all.

From: Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Sent: Friday, October 21, 2022 12:12 PM
To: (b)(6) (HHS/OCR) <(b)(6)>; Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Cc: (b)(6) (HHS/OCR) <(b)(6)>; (b)(6) (OS/OCR) (b)(6)
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Absolutely, via PIMS?

From: (b)(6) (HHS/OCR) <(b)(6)>
Sent: Friday, October 21, 2022 12:11 PM
To: Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>; Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Cc: (b)(6) (HHS/OCR) <(b)(6)>; (b)(6) (OS/OCR) <(b)(6)>
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Thank you both for the update. Beatriz, since (b)(6) are back in the office, would you mind sending the DRL to us first so we can review, and then we'll send our revised version back to both you and MA? Thanks! (b)(6)

From: Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Sent: Friday, October 21, 2022 12:08 PM
To (b)(6) (HHS/OCR) <(b)(6)>; Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Cc: (b)(6) (HHS/OCR) <(b)(6)>; (b)(6) (OS/OCR) <(b)(6)>
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Hi,

Dt still on the works. We plan to send the DR to MA region sometime next week.

Thanks.

From: (b)(6) (HHS/OCR) <(b)(6)>
Sent: Friday, October 21, 2022 11:44 AM
To: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>; Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Cc: (b)(6) (HHS/OCR) <(b)(6)>; (b)(6) (OS/OCR) <(b)(6)>
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Hi Barbara and Beatriz,

Hope you're having a good Friday so far. Could you give us a status on the (b)(5) per below?

We appreciate you! Thanks (b)(6)

From: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>
Sent: Friday, September 30, 2022 8:44 AM
To: (b)(6) HHS/OCR) <(b)(6)>; Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>

Cc: (b)(6) (HHS/OCR) <(b)(6)>; (b)(6) (OS/OCR) (b)(6)
Subject: RE: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Thanks (b)(6) Sounds like a plan!

From: (b)(6) (HHS/OCR) <(b)(6)>
Sent: Thursday, September 29, 2022 10:10 PM
To: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>; Chirila, Robert (HHS/OCR) <Robert.Chirila@hhs.gov>; Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Cc: (b)(6) (HHS/OCR) <(b)(6)>; (b)(6) (OS/OCR) (b)(6)
Subject: SC Medicaid GAC complaints: DRL + Next Steps (b)(5)

Hello Southeast colleagues,

Thanks for sending over a draft DRL in the South Carolina Medicaid cases. We have a couple of recommendations:

(b)(5)

I hope this sounds like a plan. (b)(6) Please let us know if you have any questions, and we'll address when we get back.

Thanks for all your work on these cases.

(b)(6)

From: Stampul, Barbara (HHS/OCR) <Barbara.Stampul@hhs.gov>

Sent: Monday, September 26, 2022 12:31 PM
To: (b)(6) (HHS/OCR) (b)(6)
Cc: (b)(6) (HHS/OCR) <(b)(6); Romero-Escobar, Beatriz (HHS/OCR) <Beatriz.Romero@HHS.GOV>
Subject: Gender Affirming Care (GAC) State Medicaid and MCO cases DRL Draft

<< File: (b)(5) docx >> Hi (b)(6)

(b)(5)
(b)(5) Thank you!

Sender: (b)(6) HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=E90EF156ED05483F959D8C4039D9B906-LORDEN, SUS (b)(6)

Recipient: Romero-Escobar, Beatriz (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user8a7a5326 <Beatriz.Romero@HHS.GOV>; Stampul, Barbara (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aba3e5fc28844f3399581d12fbec4fcb-Stampul, Ba <Barbara.Stampul@hhs.gov>; (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-Dekervor, D (b)(6); (b)(6) OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user5d5a5775 (b)(6)

Sent Date: 2022/11/08 10:02:39

Delivered Date: 2022/11/08 10:02:42

Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria

Ron DeSantis, Governor
Simone Marstiller, Secretary

Contents

Introductory Remarks and Abstract

Generally Accepted Professional Medical Standards

The Secretary of the Florida Agency for Health Care Administration requested that the Division of Florida Medicaid review the treatment of gender dysphoria for a coverage determination pursuant to Rule 59G-1.035, Florida Administrative Code (F.A.C.) (See Attachment A for the Secretary's Letter to Deputy Secretary Tom Wallace). The treatment reviewed within this report included "sex reassignment treatment," which refers to medical services used to obtain the primary and/or secondary physical sexual characteristics of a male or female. As a condition of coverage, sex reassignment treatment must be "consistent with generally accepted professional medical standards (GAPMS) and not experimental or investigational" (Rule 59G-1.035, F.A.C., see Attachment B for the complete rule text).

The determination process requires that "the Deputy Secretary for Medicaid will make the final determination as to whether the health service is consistent with GAPMS and not experimental or investigational" (Rule 59G-1.035, F.A.C.). In making that determination, Rule 59G-1.035, F.A.C., identifies several factors for consideration. Among other things, the rule contemplates the consideration of "recommendations or assessments by clinical or technical experts on the subject or field" (Rule 59G-1.035(4)(f), F.A.C.). Accordingly, this report attaches five assessments from subject-matter experts:

- **Attachment C:** Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence*. 16 May 2022.
- **Attachment D:** James Cantor, PhD: *Science of Gender Dysphoria and Transsexualism*. 17 May 2022.
- **Attachment E:** Quentin Van Meter, MD: *Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent*. 17 May 2022.
- **Attachment F:** Patrick Lappert, MD: *Surgical Procedures and Gender Dysphoria*. 17 May 2022.
- **Attachment G:** G. Kevin Donovan, MD: *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. 16 May 2022.

Abstract

Available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased. Rather, the available evidence demonstrates that these treatments cause irreversible physical changes and side effects that can affect long-term health.

Five clinical and technical expert assessments attached to this report recommend against the use of such interventions to treat what is categorized as a mental health disorder (See attachments):

- **Health Care Research:** Brignardello-Petersen and Wiercioch performed a systematic review that graded a multitude of studies. They conclude

that evidence supporting sex reassignment treatments is low or very low quality.

- **Clinical Psychology:** Cantor provided a review of literature on all aspects of the subject, covering therapies, lack of research on suicidality, practice guidelines, and Western European coverage requirements.
- **Plastic Surgery:** Lappert provided an evaluation explaining how surgical interventions are cosmetic with little to no supporting evidence to improve mental health, particularly those altering the chest.
- **Pediatric Endocrinology:** Van Meter explains how children and adolescent brains are in continuous phases of development and how puberty suppression and cross-sex hormones can potentially affect appropriate neural maturation.
- **Bioethics:** Donovan provides additional insight on the bioethics of administering these treatments, asserting that children and adolescents cannot provide truly informed consent.

Following a review of available literature, clinical guidelines, and coverage by other insurers and nations, Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety. In addition, numerous studies, including the reports provided by the clinical and technical experts listed above, identify poor methods and the certainty of irreversible physical changes. Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to the stronger research demonstrating the permanent effects they cause, these treatments do not conform to GAPMS and are experimental and investigational.

Health Service Summary

Gender Dysphoria

Frequently used to describe individuals whose gender identity conflicts with their natural-born sex, the term gender dysphoria has a history of evolving definitions during the past decades (Note: This report uses the term "gender" in reference to the construct of male and female identities and the term "sex" when regarding biological characteristics). Prior to the publication of the *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), the American Psychiatric Association (APA) used the diagnosis of gender identity disorder (GID) to describe individuals who sought to transition to the opposite gender. However, behavioral health clinicians sought a revision after determining that using GID created stigma for those who received the diagnosis. This is despite the APA having adopted GID to replace the previous diagnosis of transsexualism for the exact same reason (APA, 2017).[1]

When crafting its new definition and terminology, the APA sought to remove the stigma of classifying as a disorder the questioning of one's gender identity by focusing instead on the psychological distress that such questioning can evoke. This approach argues that individuals seeking behavioral health and transition services are doing so due to experiencing distress and that gender non-conformity by itself is not a mental health issue. This led to the adoption of gender dysphoria in 2013 when the APA released the DSM-V. In addition to using a new term, the APA also differentiated the diagnosis between children and adolescents and adults, listing different characteristics for the two age groups (APA, 2017).

According to the DSM-V, gender dysphoria is defined as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender." As for the criteria to receive the diagnosis, the APA issued stricter criteria for children than adolescents and adults. For the former, the APA states that a child must meet six out of eight behavioral characteristics such as having "a strong desire to be of the other gender or an insistence that one is the other gender" or "a strong preference for cross-gender roles in make-believe or fantasy play." The criteria for adults and adolescents are less stringent with individuals only having to meet two out of six characteristics that include "a strong desire to be the other gender" or "a strong desire to be rid of one's primary and/or secondary sexual characteristics." The APA further notes that these criteria can also apply to young adolescents (DSM-V, 2013).

In 2021, the Merck Manual released a slightly different definition for gender dysphoria, citing that the condition "is characterized by a strong, persistent cross-gender identification associated with anxiety, depression, irritability, and often a wish to live as a gender different from the one associated with the

[1] The concept of gender being part of identity and disconnected from biological sex originated during the mid-twentieth century and was publicized by psychologist John W. Money. His research asserted that gender was a complete social construct and separate from biology, meaning that parents and/or caregivers could imprint on a young child (under three years) the identity of a boy or girl. In 1967, Money's theories led to a failed experiment on twin boys where physicians surgically transitioned one to appear as a girl. The twin that underwent sex reassignment never fully identified as a female. However, Money never publicly acknowledged this and reported the experiment as a success. Furthermore, he promoted his conclusions across the scientific community, concealing what actually unfolded. As a result, Money's ideas on gender fluidity served as a basis for performing procedures on children with hermaphroditic features or genital abnormalities. The case reveals how the understanding of a concept (e.g., gender) at any given time can lead to incorrect medical decisions with irreversible consequences (Gaetano, 2015).

sex assigned at birth." Additionally, the Merck Manual further states that "gender dysphoria is a diagnosis requiring specific criteria but is sometimes used more loosely for people in whom symptoms do not reach a clinical threshold" (Merck Manual, 2021). This definition is largely consistent with the DSM-V but does not emphasize the distress component to the same extent.[2]

Like other behavioral health diagnoses classified in the DSM-V, gender dysphoria has the following subtypes:

- **Early-Onset Gender Dysphoria:** This subtype begins during childhood and persists through adolescence into adulthood. It can be interrupted by periods where the individual does not experience gender dysphoria signs and may classify as homosexual (DSM-V, 2013).
- **Late-Onset Gender Dysphoria:** Occurring after puberty or during adulthood, this subtype does not begin until late adolescence and can emerge following no previous signs of gender dysphoria. The APA attributes this partially to individuals who did not want to verbalize their desires to transition (DSM-V, 2013).

Further studies have identified additional subtypes of gender dysphoria. In 2018, Lisa Littman introduced the concept of a rapid-onset subtype. Classified as rapid-onset gender dysphoria (ROGD), it features characteristics such as sudden beginnings during or following puberty. However, it differs from the DSM-V definitions because ROGD is associated with other causes such as social influences (e.g., peer groups, authority figures, and media). In other words, adolescents who had no history of displaying typical gender dysphoria characteristics go through a sudden change in identity following intense exposure to peers and/or media that heavily promotes transgender lifestyles (Littman, 2018). While more long-term studies are needed to confirm whether ROGD is a temporary or long-term condition, Littman's study has initiated discussions regarding potential causes of gender dysphoria as well as introduced a potential subtype.

Additionally, the frequent use of gender dysphoria in clinical and lay discourse has led to a fracturing of the definition. Studies on the topic frequently do not apply the DSM-V's criteria for the diagnosis and overlook certain key features such as distress. In a 2018 review by Zowie Davy and Michael Toze, the authors evaluated 387 articles that examine gender dysphoria and noted stark departures from the APA's definition. They further asserted that the APA intended to "reduce pathologization" by establishing a new definition for gender dysphoria in the DSM-V. This in turn would reduce diagnoses, although as Davy and Toze note, the tendency for the literature to diverge from the APA's definition may result in increased numbers of individuals classified as having gender dysphoria when they do not meet the DSM-V's criteria (Davy and Toze, 2018). This further raises the question of whether individuals are receiving potentially irreversible treatments for the condition when they might not actually have it.

The current usage of gender dysphoria is the result of discussions spanning across decades as demonstrated in the past editions of the DSM. Until 2013, the APA considered having gender identity issues a mental disorder by itself regardless of the presence of psychological distress. That perspective has since shifted to only consider the adverse psychological effects of questioning one's gender as a disorder. In addition, the APA considers gender as part of one's identity, which is not subject to a diagnosis. Whether the APA has shifted its terminology and criteria for gender identity issues due to

[2] Following the release of the Florida Department of Health's guidelines for treating gender dysphoria, Merck removed its definition for "gender dysphoria" from the Merck Manual (Fox News, 2022).

emerging clinical data or cultural changes is another question. In 1994, the APA replaced transsexualism with gender identity disorder as part of the "effort to reduce stigma" (APA, 2017). This raises questions about what influences decisions to revise definitions and criteria; is it social trends or medical evidence?

Behavioral Health Issues Co-Occurring with Gender Dysphoria

Because gender dysphoria pertains directly to the distress experienced by an individual who desires to change gender identities, secondary behavioral health issues can co-occur such as depression and anxiety. If left untreated, these conditions can lead to the inability to function in daily activities, social isolation, and even suicidal ideation. Studies do confirm that adolescents and adults with gender dysphoria report higher levels of anxiety, depression, and poor peer relationships than the general population (Kuper et al, 2019). Other associated conditions include substance abuse, eating disorders, and compulsivity. A significant proportion of individuals with gender dysphoria also have autism spectrum disorder (ASD) (Saleem and Rizvi, 2017). Although the number reporting secondary issues is increased, individuals diagnosed with gender dysphoria do not necessarily constitute the entire population that is gender non-conforming (i.e., does not identify with natal sex), and no information is available breaking down the percentage of those who are non-conforming with gender dysphoria and those who are non-conforming with no distress. Additionally, available research raises questions as to whether the distress is secondary to pre-existing behavioral health disorders and not gender dysphoria. This is evident in the number of adolescents who reported anxiety and depression diagnoses prior to transitioning (Saleem and Rizvi, 2017).

Furthermore, conventional treatments for secondary behavioral health issues are available. These include cognitive behavioral therapy, medication, and inpatient services. The APA reports that treatments for these are highly effective with 80% to 90% of individuals diagnosed with depression responding positively (APA, 2020). In addition, a high percentage of adolescents diagnosed with gender dysphoria had received psychiatric treatment for a prior or co-occurring mental health issue. A 2015 study from Finland by Kaltiala-Heino et al noted that 75% of children seeking sex reassignment services had been treated by a behavioral health professional (Kaltiala-Heino et al, 2015).

Diagnosing Gender Dysphoria

Prior to the publication of the DSM-V, diagnosing individuals experiencing gender identity issues followed a different process. Behavioral health clinicians could assign the diagnosis based on gender non-conformance alone. That has changed since 2013. Today, non-conforming to one's gender is part of personal identity and not a disorder requiring treatment. This change has led professional associations to shift the diagnostic criteria for gender dysphoria to focus on the distress caused by shifting identities (DSM-V, 2013).

For adolescents, the APA identifies "a marked incongruence between one's experienced/expressed gender and natal sex, of at least 6 months' duration" as the core component of gender dysphoria (DSM-V, 2013). What the APA does not elucidate is the threshold for "marked." This raises questions as to whether practitioners exercise uniformity when applying the diagnostic criteria or if they do so subjectively. For example, the WPATH's *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People* provides guidance on the processes mental health practitioners should use when assessing for gender dysphoria but offers no benchmarks for meeting diagnostic criteria (WPATH, 2012).

Such processes include evaluating for gender non-conforming behaviors and other co-existing mental disorders like anxiety or depression. This involves not only interviewing the adolescent but also the family in addition to reviewing medical histories. WPATH also asserts that gender dysphoria assessments need to account for peer relationships, academic performance, and provide information of potential treatments. This last component is necessary because it might affect an individual's choices regarding transitioning, particularly if the information does not correspond to the desired outcome (WPATH, 2012).

The diagnosis of gender dysphoria is a relatively recent concept in mental health, being the product of decades of discussion and building upon previous definitions. Instead of treating gender non-conformity as a disorder, behavioral health professionals acknowledge it as part of one's identity and focus on addressing the associated distress. Considering the new criteria, this changes the dynamics of the population who would have qualified for a diagnosis before 2013 and those who would today. Given that desiring to transition into a gender different from natal sex no longer qualifies as a disorder, behavioral health professionals are treating distress and referring adolescents and adults to therapies that are used off-label and pose irreversible effects.

Current Available Treatments for Gender Dysphoria

At present, proposed treatment for gender dysphoria occurs in four stages, beginning with psychological services and ending with sex reassignment surgery. As an individual progresses through each stage, the treatments gradually become more irreversible with surgical changes being permanent. Because of the increasing effects, individuals must have attempted treatment at the previous stage before pursuing the next one (Note: late adolescents and adults have already completed puberty and do not require puberty blockers). Listed in order, the four stages are as follows:

- **Behavioral Health Services:** Psychologists and other mental health professionals are likely the first practitioners individuals with gender dysphoria will encounter. In accordance with clinical guidelines established by the World Professional Association for Transgender Health (WPATH)[3], behavioral health professionals are supposed to "find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment." WPATH further discourages services for attempting to change someone's gender identity. Instead, it instructs practitioners to assess for the condition and readiness for puberty blockers or cross-sex hormones while offering guidance to function in a chosen gender. WPATH does assert that the clinicians do need to treat any other underlying mental health issues secondary or co-occurring with gender dysphoria (WPATH, 2012). However, the organization provides conflicting guidance because it also advises practitioners to prescribe cross-sex hormones on demand (Levine, 2018).
- **Puberty Suppression:** Used only on individuals in the earliest stages of puberty (Tanner stage 2), preventing pubertal onset provides additional time to explore gender identities before the physical characteristics of biological sex develop. This treatment is intended to reduce distress and anxiety related to the appearance of adult sexual physical features. To suppress puberty, pediatric endocrinologists inject gonadotropin releasing hormone (Gn-RH) at specific intervals (e.g., 4 weeks or 12 weeks). The Gn-RH suppresses gonadotropin receptors that allow for the

[3] The World Professional Association for Transgender Health asserts that it is a professional organization. However, it functions like an advocacy group by allowing open membership to non-clinicians (WPATH, 2022).

development of primary and secondary adult sexual characteristics. Prior to receiving puberty suppression therapy, individuals must have received a diagnosis of gender dysphoria and have undergone a mental health evaluation (Kyriakou et al, 2020).

- **Cross-Sex Hormones:** For adults and late adolescents (16 years or older), the next treatment phase recommended is taking cross-sex hormones (e.g., testosterone or estrogen) to create secondary sex characteristics. In men transitioning into women, these include breast development and widening around the pelvis. Women who transition into men experience deeper voices, redistribution of fat deposits, and growing facial hair. According to the Endocrine Society, late adolescents who qualify for cross-sex hormones must have a confirmed diagnosis of gender dysphoria from a mental health practitioner with experience treating that population. Some physical changes induced by these hormones are irreversible (Endocrine Society, 2017).
- **Sex Reassignment Surgery:** Sometimes referred to as "gender affirming" surgery, this treatment does not consist of just one procedure but several, depending on the desires of the transitioning individual. Primarily, sex reassignment procedures alter the primary and secondary sexual characteristics. Men transitioning into women (trans-females) undergo a penectomy (removal of the penis), orchiectomy (removal of the testes), and vulvoplasty (creation of female genitals). Other procedures trans-females may undergo include breast augmentation and facial feminization. For women that transition into men (trans-males), procedures include mastectomy (removal of the breasts), hysterectomy (removal of the uterus), oophorectomy (removal of the ovaries), and phalloplasty (creation of male genitals). Because of the complexities involved in phalloplasty, many trans-males do not opt for this procedure and limit themselves to mastectomies. Additionally, the effects of sex reassignment surgery, such as infertility, are permanent (WPATH, 2012).

While some clinical organizations assert that they are the standard of care for gender dysphoria, the U.S. Food and Drug Administration (FDA) currently has not approved any medication as clinically indicated for this condition (Unger, 2018). Although puberty blockers and cross-sex hormones are FDA approved, the FDA did not approve them for treating gender dysphoria, meaning that their use for anything other than the clinical indications listed is off-label (American Academy of Pediatrics, 2014). As for surgical procedures, the FDA does not evaluate or approve them, but it does review all surgical devices (FDA, 2021). In addition, the Endocrine Society concedes that its practice guidelines for sex reassignment treatment does *not* constitute a "standard of care" and that its grades for available services are low or very low (Endocrine Society, 2017).[4]

[4] Disagreement over how to treat gender dysphoria, gender identity disorder, and transsexualism has persisted since sex reassignment surgery first became available in the 1960s. In a 2006 counterargument, Paul McHugh highlights how individuals seeking surgery had other reasons that extended beyond gender identity, including sexual arousal and guilt over homosexuality. In addition, he asserts that undergoing sex reassignment procedures did not improve a patient's overall behavioral health and that providing a "surgical alteration to the body of these unfortunate people was to collaborate with a mental disorder rather than to treat it" (McHugh, 2006).

Literature Review: Introduction

Currently, an abundance of literature and studies on gender dysphoria is available through academic journals, clinical guidelines, and news articles. Similar to other mental health issues, the material addresses a broad range of topics consisting of available treatments, etiology (i.e., causes), risks, benefits, and side effects. Although most stories reported by the media indicate that treatments such as cross-sex hormones and sex reassignment surgery are the most effective, research reveals that numerous questions still exist. These include what are the long-term health effects of taking cross-sex hormones, what are the real causes of gender dysphoria, and how many individuals that transition will eventually want to revert to their natal sex. Additionally, much of the available research is inconclusive regarding the effectiveness of sex reassignment treatments with multiple studies lacking adequate sample sizes and relying on subjective questionnaires. While much of the scientific literature leans in favor of cross-sex hormones and surgery as options for improving the mental health of individuals with gender dysphoria, it does not conclusively demonstrate that the benefits outweigh the risks involved, either short or long-term. What studies do reveal with certainty is that sex reassignment surgery and cross-sex hormones pose permanent effects that can result in infertility, cardiovascular disease, and disfigurement. All of this indicates that further research is necessary to validate available treatments for gender dysphoria. Thus, physicians, who recommend sex reassignment treatment, are not adhering to an evidence-based medicine approach and are following an eminence-based model.

The following literature review addresses the multiple facets of this condition and presents areas of ongoing debate and persisting questions. Beginning with the condition's etiology and continuing with evaluations of puberty blockers, cross-sex hormones, and surgery, the review explains each area separately and in context of gender dysphoria at large. Additionally, the review provides an analysis on available research on mental health outcomes as well as the condition's persistence into adulthood. Taken as a whole, the available studies demonstrate that existing gender dysphoria research is inconclusive and that current treatments are used to achieve cosmetic benefits while posing risky side effects as well as irreversible changes.

Literature Review: Etiology of Gender Dysphoria

What causes gender dysphoria is an ongoing debate among experts in the scientific and behavioral health fields. Currently, the research indicates that diagnosed individuals have higher proportions of autism spectrum disorder (ASD), history of trauma or abuse, fetal hormone imbalances, and co-existing mental illnesses. Also, experts acknowledge that genetics may factor into gender dysphoria. Another potential cause is social factors such as peer and online media influence. At the moment, none of the studies provides a definite cause and offer only correlations and weakly supported hypotheses. In addition, evidence favoring a biological explanation is highly speculative. However, the research does raise questions about whether treatments with permanent effects are warranted in a population with disproportionately high percentages of ASD, behavioral health problems, and trauma.

In a 2017 literature review by Fatima Saleem and Syed Rizvi, the authors examine gender dysphoria's numerous potential causes and the remaining questions requiring further research. In conclusion, the pair indicate that associations exist between the condition and ASD, schizophrenia, childhood abuse, genetics, and endocrine disruption chemicals but that more research is needed to improve understanding of how these underlying issues factor into a diagnosis. Throughout the review, Saleem and Rizvi identify the following as potential contributing elements to the etiology of gender dysphoria:

- **Neuroanatomical Etiology:** During fetal development, the genitals and brain develop during different periods of a pregnancy, the first and second trimesters respectively. Because the processes are separate, misaligned development is possible where the brain may have features belonging to the opposite sex. The authors identify one study where trans-females presented with a "female-like putamen" (structure at the base of the brain) when undergoing magnetic resonance imaging (MRI) scans.[5]
- **Psychiatric Associations:** Saleem and Rizvi identify multiple studies reporting that individuals with gender dysphoria have high rates of anxiety and depressive disorders with results ranging as high as 70% having a mental health diagnosis. In addition, the pair note that schizophrenia may also influence desires to transition. However, the review does not assess whether the mental health conditions are secondary to gender dysphoria.
- **Autism Spectrum Disorder:** Evidence suggests a significant percentage of individuals diagnosed with gender dysphoria also have ASD. The authors note that the available studies only establish a correlation and do not identify mechanisms for causation.
- **Childhood Abuse:** Like the above causes, Saleem and Rizvi note that those with gender dysphoria tended to experience higher rates of child abuse across all categories, including neglect, emotional, physical, and sexual.
- **Endocrine Disruptors:** Although this cause still requires substantial research, it is a valid hypothesis regarding how phthalates found in plastics can create an imbalance of testosterone in fetuses during gestation, which can potentially lead to gender dysphoria. The authors point to one study that makes this suggestion.

[5] Research on neuroanatomical etiology for gender dysphoria remains highly speculative due to limitations of brain imaging (Mayer and McHugh, 2016). In addition, neuroscience demonstrates that exposures to certain environments and stimuli as well as behaviors can affect brain changes (Gu, 2014). Furthermore, available research indicates that male and female brains have different physical characteristics but cannot be placed in separate categories due to extensive overlap of white/grey matter and neural connections (Joel et al, 2015).

Saleem and Rizvi's review reveal that gender dysphoria's etiology can have multiple factors, most of which require treatments and therapies not consisting of cross-sex hormones or surgery. (Saleem and Rizvi, 2017).

Out of the research on the condition's etiology, a large portion focuses on the correlation with ASD. One of the more substantial studies by Van der Miesen et al published in 2018 evaluates 573 adolescents and 807 adults diagnosed with ASD and compares them to 1016 adolescents and 846 adults from the general population. The authors' findings note that adolescents and adults with ASD were approximately 2.5 times more likely to indicate a desire of becoming the opposite sex. Although the methodology used to reach this conclusion consisted of surveys where respondents had a choice of answering "never," "sometimes," or "often," the results correspond with those of similar studies. Van der Miesen et al also indicate that most responses favoring a change in gender responded with "sometimes." Additionally, the authors do not state how many in their sample group actually had a gender dysphoria diagnosis. (Van der Miesen et al, 2018).

Another study by Shumer et al from 2016 utilizes a smaller sample size (39 adolescents) referred to an American hospital's gender clinic. Unlike Van der Miesen et al's research, Shumer et al evaluate subjects with a diagnosis of gender dysphoria for possible signs of ASD or Asperger's syndrome. Their findings revealed that 23% of patients presenting at the clinic would likely have one of the two conditions. Possible explanations for the high percentage are the methods used to gather the data. Shumer et al requested a clinical psychologist to administer the Asperger Syndrome Diagnostic Scale to the parents of the sample patients, four of whom already had an ASD diagnosis. The authors conclude that the evidence to support high incidence of gender dysphoria in individuals with ASD is growing and that further research is needed to determine the specific cause (Shumer et al, 2016).

Research indicating a strong correlation between ASD and gender dysphoria is not the only area where new studies are emerging. Discussions about the effects of prenatal testosterone levels are also becoming more prevalent. One such example is Sadr et al's 2020 study that looks at the lengths of the index and ring fingers (2D:4D) of both left and right hands of 203 individuals diagnosed with gender dysphoria. The authors used this method because prenatal testosterone levels can affect the length ratios of 2D:4D. By comparing the ratios of a group with gender dysphoria to a cohort from the general population, Sadr et al could assess for any significant difference. Their results indicated a difference in trans-females who presented with more feminized hands. For trans-males, the difference was less pronounced. The results for both groups were slight, and the meta-analysis that accompanies the study notes no statistically significant differences in multiple groups from across cultures. However, Sadr et al further assert that the evidence strongly suggests elevated prenatal testosterone levels in girls and reduced amounts in boys may contribute to gender dysphoria, requiring additional research (Sadr et al, 2020).

In addition to biological factors and correlations with ASD, researchers are exploring psychological and social factors to assess their role in gender dysphoria etiology. This literature examines a range of potential causative agents, including child abuse, trauma, and peer group influences. One such study by Kozlowska et al from 2021 explores patterns in children with high-risk attachment issues who also had gender dysphoria. The authors wanted to assess whether past incidents of abuse, loss, or trauma are associated with higher rates of persons desiring to transition. As a basis, Kozlowska et al cite John Bowlby's research on childhood brain development, noting that the process is not linear and depends

heavily on lived experiences. The study further acknowledges that biological factors combined with life events serve as the foundation for the next developmental phase and that early poor-quality attachment issues increase the risk for psychological disorders in adolescence and adulthood. Such disorders include mood and affective disorders, suicidal ideations, and self-harm. Kozlowska et al also cite other studies that indicate a high correlation between gender dysphoria and "adverse childhood events" and further assert that the condition "needs to be conceptualized in the context of the child's lived experience, and the many different ways in which lived experience is biologically embedded to shape the developing brain and to steer each child along their developmental pathway" (Kozlowska et al, 2021).

For their study, Kozlowska et al recruited 70 children diagnosed with gender dysphoria and completed family assessments going back three generations. This in-depth level was necessary to ascertain any and all events that could affect a child's developmental phases. Additionally, the researchers individually assessed the diagnosed children. To establish comparisons, Kozlowska et al performed assessments on a non-clinical group and a mixed-psychiatric group. Their results demonstrate that children with gender dysphoria have significantly higher rates of attachment issues as well as increased reports of "adverse childhood events" such as trauma (e.g., domestic violence and physical abuse). Furthermore, the authors indicate that a high proportion of families reported "instability, conflict, parental psychiatric disorder, financial stress, maltreatment events, and relational ruptures." These results led Kozlowska et al to conclude that gender dysphoria can be "associated with developmental pathways – reflected in at-risk patterns of attachment and high rates of unresolved loss and trauma – that are shaped by disruptions to family stability and cohesion." The study also cites that treatment requires "a comprehensive biopsychosocial assessment with the child and family, followed by therapeutic interventions that address, insofar as possible, the breadth of factors that are interconnected with each particular child's presentation" (Kozlowska et al, 2021).

This recent study raises questions regarding the medical necessity of gender dysphoria treatments such as puberty blockers and cross-sex hormones for adolescents. If high percentages of children diagnosed with gender dysphoria also have histories of trauma and attachment issues, should conventional behavioral health services be utilized without proposing treatments that pose irreversible effects? Would that approach not provide additional time to address underlying issues before introducing therapies that pose permanent effects (i.e., the watchful waiting approach)?

Aside from the notion that childhood abuse and adversity can potentially cause gender dysphoria, other possible explanations such as social factors (e.g., peer influences and media) may be contributing factors. Research on rapid onset gender dysphoria (ROGD) links this phenomenon to peer and social elements. In an analysis utilizing parent surveys, Lisa Littman asserts that the rapid rise of ROGD is not associated with the traditional patterns of gender dysphoria onset (i.e., evidence of an individual's gravitation to the opposite sex documented over multiple years) but rather exposure to "social and peer contagion." Littman uses this term in the context of definitions cited in academic literature, stating that "social contagion is the spread of affect or behaviors through a population" and that "peer contagion is the process where an individual and peer mutually influence each other in a way that promotes emotions and behaviors that can potentially undermine their own development or harm others." Examples of the latter's negative effects include depression, eating disorders, and substance abuse. What prompted this study is a sudden increase of parents reporting their daughters declaring themselves to be transgender without any previous signs of gender dysphoria. Littman also indicates

that these parents cite that their daughters became immersed in peer groups and social media that emphasized transgender lifestyles (Littman, 2018).

In addition to identifying characteristics of ROGD, the study examines social media content that provides information to adolescents regarding how to obtain cross-sex hormones through deception of physicians, parents, and behavioral health professionals. Such guidance includes coaching on how to fit a description to correspond to the DSM-V and pressures to implement treatment during youth to avoid a potential lifetime of unhappiness in an undesirable body. Littman further states that "online content may encourage vulnerable individuals to believe that non-specific symptoms and vague feelings should be interpreted as gender dysphoria." The study also notes that none of the individuals assessed using the parental surveys qualified for a formal diagnosis using the DSM-V criteria (Littman, 2018).

The survey responses revealed similar data to Kozlowska et al's study with 62.5% of the adolescents having a mental health or neurodevelopmental disorder. Furthermore, the responses indicate a rapid desire to bypass behavioral health options and pursue cross-sex hormones. 28.1% of parents surveyed stated that their adolescents did not want psychiatric treatments. One parent even reported that their daughter stopped taking prescribed anti-depressants and sought advice only from a gender therapist. Littman's research further reveals that 21.2% of parents responded that their adolescent received a prescription for puberty blockers or cross-sex hormones at their first visit (Littman, 2018). These responses indicate that practitioners do not uniformly follow clinical guidelines when making diagnoses or prescribing treatment.

In the discussion, Littman proposes two hypotheses for the appearance of ROGD. The first states that social and peer contagion is one of the primary causes, and the second asserts that ROGD is a "maladaptive coping mechanism" for adolescents dealing with emotional and social issues. While the surveyed parents did not report early signs of gender dysphoria, a majority noted that their daughters had difficulty in handling negative emotions. Littman concludes that ROGD is distinct from gender dysphoria as described in the DSM-V and that further research is needed to assess whether the condition is short or long-term (Littman, 2018). What the study does not explore, but raises the question, is what proportion of those being treated for gender dysphoria are adolescents with ROGD.

Littman's study along with the others reveal that the causes of gender dysphoria are still a mystery and could have multiple biological and social elements. Because of this ongoing uncertainty, treatments that pose irreversible effects should not be utilized to address what is still categorized as a mental health issue. That allows adequate opportunity for individuals to receive treatment for co-existing mental disorders, establish their gender dysphoria diagnoses, and understand how cross-sex hormones and surgery will alter the appearance of their bodies as well as long-term health.

Literature Review: Desistance of Gender Dysphoria and Puberty Suppression

The World Professional Association for Transgender Health (WPATH) and the Endocrine Society both endorse the use of gonadotropin releasing hormones (Gn-RH) to suppress puberty in young adolescents who have gender dysphoria. Both organizations state that the treatment is safe and fully reversible. In addition, they state that delaying pubertal onset can provide extra time for adolescents to explore the gender in which they choose to live. The associations further state that puberty suppression is necessary to prevent the development of primary and secondary sexual characteristics that can inhibit successful transitions into adulthood (WPATH, 2012; Endocrine Society, 2017). Of the two groups, WPATH offers clinical criteria an individual should meet to qualify for puberty suppression such as addressing psychological co-morbidities and assessing whether gender dysphoria has intensified (WPATH, 2012).

Neither organization explains that the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex and that the puberty suppression can have side effects. Both organizations neglect to mention that using Gn-RH for gender dysphoria by altering the appearance is not an FDA-approved clinical indication. Furthermore, the research used to justify puberty suppression is low or very-low quality and little information is available on long-term effects (Hruz, 2019). Additionally, in his assessment, Quentin Van Meter explained that physical differences between central precocious puberty and natural onset puberty demonstrate that Gn-RH does not have permanent adverse effects for those treated for the former but can for the latter such as insufficient bone-mineral density and neural development (Van Meter, 2022). Also, as recently as May 17, 2022, during a U.S. Senate Committee on Appropriations hearing, Lawrence Tabak, acting director of the National Institutes of Health, responded to Senator Marco Rubio, acknowledging that no long-term studies are available evaluating the effects of puberty blockers when used for gender dysphoria (U.S. Senate Committee on Appropriations, 2022).

Currently, some studies provide weak support for this treatment but leave too many questions as to its effectiveness and medical necessity, especially considering how many children decide against transitioning. In addition, puberty blockers halt development of primary and secondary sexual characteristics and deny opportunities for adolescents to adapt and become comfortable with their natal sex. Instead, puberty blockers can serve as a potential "gateway drug" for cross-sex hormones by denying them the experience of physically maturing (Laidlaw et al, 2018).

A 2013 study by Steensma et al offers data on the percentage of children who opt not to transition after experiencing gender dysphoria. The authors follow 127 adolescents (mean age of 15 during the evaluation period) for four years who had been referred to a Dutch gender dysphoria clinic. Out of this cohort, 47 (37%; 23 boys and 24 girls) continued experiencing the condition and applied for sex reassignment treatment. The other 80 adolescents never returned to the clinic. Because this clinic was the only one that treated gender dysphoria in the Netherlands, Steensma et al assumed that those who did not return no longer desired transitioning. The study indicates one of the key predictors for persisting gender dysphoria was the age of first presentation. Older adolescents that started going to the clinic were more likely to persist, while younger adolescents tended not to follow through. Steensma et al provide further insight into other predicting factors, particularly on how each individual views his or her gender identity. The authors note that adolescents who "wished they were the other sex" were more likely to become desisters and that those who "believed that they were the other sex" persisted

and later sought sex reassignment treatment (Steensma et al, 2013). While the study focuses on factors that contribute to the condition's persistence or desistance, it raises the question as to whether puberty suppression is necessary when age plays such an important role regarding the decision to transition.

WPATH and the Endocrine Society state that the primary reason for initiating pubertal suppression is not to treat a physical condition but to improve the mental health of adolescents with gender dysphoria. However, available research does not yield definitive results that this method is effective at addressing a mental health issue. The "gold standard" for medical studies is the randomized-controlled trial (RCT). Because RCTs utilize large sample sizes, have blind testing groups (i.e, placebos), and use objective controls, they can offer concrete conclusions and shape the array of established treatments. In addition, RCTs require comparisons between cohort outcomes and ensure that participants are randomly assigned to each group. These measures further reduce the potential for bias and subjectivity (Hariton and Locascio, 2018).

Presently, no RCTs that evaluate puberty suppression as a method to treat gender dysphoria are available. Instead, the limited number of published studies on the topic utilize small sample sizes and subjective methods (Hruz, 2019). A 2015 article by Costa et al is one such example. The study asserts that "psychological support and puberty suppression were both associated with an improved global psychological functioning in gender dysphoric adolescents." To reach this conclusion, the authors selected 201 children diagnosed with the condition and divided them into two groups, one to receive psychological support only and the other to get puberty blockers in addition to psychological support. Costa et al did not create a third group that lacked a gender dysphoria diagnosis to serve as a control. To assess whether puberty suppression is an effective treatment, the authors administered two self-assessments (Utrect Gender Dysphoria Scale and Children's Global Assessment Scale)[6] to the groups at 6-month intervals during a 12-month period. Because the study relies heavily on self-assessments, the conclusions are likely biased and invalid. Another problem that is also present and common throughout articles supporting puberty suppression is the short-term period of the study. Costa et al's conclusions may not be the same if additional follow-ups occurred three or five years later (Costa et al, 2015). This further raises the question whether low-quality studies like Costa et al's should serve as the basis for clinical guidelines advising clinicians to prescribe drugs for off-label purposes.

Aside from questionable research, information regarding the full physical effects of puberty suppression is incomplete. In a 2020 consensus parameter prepared by Chen et al, 44 experts in neurodevelopment, gender development, and puberty/adolescence reached a conclusion stating that "the effects of pubertal suppression warrant further study." The basis for this was that the "full consequences (both beneficial and adverse) of suppressing endogenous puberty are not yet understood." The participating experts emphasized that the treatment's impact on neurodevelopment in adolescents remains unknown. Chen et al explain that puberty-related hormones play a role in brain development as documented in animal studies and that stopping these hormones also prevents neurodevelopment in addition to sexual maturation. The authors further raise the question whether normal brain development resumes as if it had not been interrupted when puberty suppression ceases. Because this

[6] Behavioral health practitioners use the Children's Global Assessment Scale (CGAS) to measure child functioning during the evaluation process to determine diagnoses. Available evidence indicates that the CGAS is not effective for evaluating children who experienced trauma and presented with mental health symptoms (Blake et al, 2006).

question remains unanswered, it casts doubt on the veracity of organizations' assertions that puberty suppression is "fully reversible" (Chen et al, 2020).

In addition to the unanswered questions and low-quality research, puberty suppression causes side effects, some of which have the potential to be permanent. According to a 2019 literature review by De Sanctis et al, most side effects associated with Gn-RH are mild, consisting mostly of irritation around injection sites. However, clinicians have linked the drug to long-term conditions such as polycystic ovarian syndrome, obesity, hypertension, and reduced bone mineral density. While reports of these events are low and the authors indicate that Gn-RH is safe for treating central precocious puberty (Note: De Sanctis et al do not consider gender dysphoria in their analysis), the review raises questions about whether off-label use to treat a psychological condition is worth the risks (De Sanctis et al, 2019).

Furthermore, De Sanctis et al cite studies noting increased obesity rates in girls who take Gn-RH but that more research is needed to gauge the consistency. Additionally, the authors note that evidence is strong regarding reduced bone mineral density during puberty suppression but indicate that the literature suggests it is reversible following treatment (De Sanctis et al, 2019). While research leans toward the reversibility of effects on bone mineral density, the quantity of studies available on this subject are limited. Also, no long-term research has been completed on how puberty suppression affects bone growth. This is significant because puberty is when bone mass accumulates the most (Kyriakou et al, 2020). One example of a complication involving bone growth and Gn-RH is slipped capital femoral epiphysis. This condition occurs when the head of the femur (i.e., thighbone) can slip out of the pelvis, which can eventually lead to osteonecrosis (i.e., bone death) of the femoral head. Although the complication is rare, its link to puberty suppression indicates that the "lack of adequate sex hormone exposure" could be a cause (De Sanctis et al, 2019).

The current literature on puberty suppression indicates that using it to treat gender dysphoria is off-label, poses potentially permanent side effects, and has questionable mental health benefits. The limited research and lack of FDA approval for that clinical indication prompt questions about whether medications with physically altering effects should be used to treat a problem that most adolescents who experience it will later overcome by conforming to their natal sex. Additional evidence is required to establish puberty suppression as a standard treatment for gender dysphoria.

Literature Review: Cross-Sex Hormones as a Treatment for Gender Dysphoria

Currently, the debate surrounding the use of cross-sex hormones to treat gender dysphoria revolves around their ability to improve mental health without causing irreversible effects. It is not about whether taking cross-sex hormones can alter someone's appearance. The evidence demonstrating the effectiveness of cross-sex hormones in achieving the secondary sexual characteristics of the opposite sex is abundant. Also, the overall scientific consensus concludes that individuals who take cross-sex hormones will reduce the primary sexual function of his or her natal sex organs. What researchers continue evaluating are the short and long-term effects on mental health, impacts on overall physical health, and how the changes affect the ability to detransition. Of these, benefits to mental health overshadow the other discussions. Prescribers of cross-sex hormones focus so heavily on behavioral health outcomes that they de-emphasize that these drugs cause permanent physical changes and side effects that can lead to premature death (Hruz, 2020). Some clinical guidelines such as WPATH's do not even indicate that some of the changes are irreversible.

Like puberty suppression, the Endocrine Society and WPATH provide guidance on administering cross-sex hormones to individuals with gender dysphoria. Both organizations state that this treatment should not be administered without a confirmed diagnosis of gender dysphoria and only after a full psychosocial assessment. In addition, behavioral health practitioners must ensure that any mental comorbidities are not affecting the individual's desire to transition. WPATH and the Endocrine Society further state that clinicians should administer hormone replacements such as testosterone and Estradiol (estrogen) in gradual phases, where the dose increases over several months. For trans-females, the organizations state that progesterone (anti-androgen) is also necessary to block the effects of naturally produced testosterone (WPATH, 2012; Endocrine Society, 2017). When taking cross-sex hormones, trans-males need increased doses for the first six months. After that, the testosterone's effects are the same on lower doses. Once started, individuals cannot stop taking hormones unless they desire to detransition (Unger, 2016).

Although the two groups provide similar guidance, they vary on statements that can have significant impact on long-term outcomes, particularly regarding age. According to WPATH's standards, 16 years is the general age for initiating cross-sex hormones, but the organization acknowledges that the treatment can occur for younger individuals depending on circumstances (WPATH, 2012). This differs from the Endocrine Society, which states no specific age for appropriateness and explains the disagreements in assigning a number. The group highlights that most adolescents have attained sufficient competence by age 16 but may not have developed adequate abilities to assess risk (Endocrine Society, 2017). This raises the question whether adolescents can make sound decisions regarding their long-term health. Additionally, the varying guidance raises an issue with WPATH not only using age 16 as a standard but also indicating that younger adolescents are capable of making that choice.

WPATH's guidance also does not stress the irreversible nature of cross-sex hormones, citing the treatment as "partially reversible" and not indicating which changes are permanent. Furthermore, parts of WPATH's information are misleading and directly conflict with guidance issued by clinics and other sources. One such example consists of WPATH stating that "hormone therapy *may* (emphasis added) lead to irreversible changes." This statement is misleading in light of existing research, which indicates that multiple physical changes are permanent. In addition, WPATH claims that certain effects of cross-

sex hormones such as clitoral enlargement can last one to two years when it is actually irreversible (UCSF, 2020). WPATH also does not explain the risks to male fertility, noting that lowered sperm count or sterility is "variable." The University of California at San Francisco (UCSF) provides starkly different information by stating that trans-females should expect to become sterile within a few months of starting cross-sex hormones. UCSF also advises trans-females to consult a sperm bank if they may want to father children after transitioning (WPATH, 2012; UCSF, 2020). Below is a chart that outlines the effects of cross-sex hormones and identifies which ones are reversible or permanent.

Physical Changes Effectuated by Cross-Sex Hormones	
Physical Changes in Trans-Males (Female-to-Male Transitions)	
Physical Change	**Reversible or Irreversible**
Oily Skin or Acne	Reversible
Facial and Body Hair Growth	Irreversible
Male-Pattern Baldness	Irreversible
Increased Muscle Mass	Reversible
Body Fat Redistribution	Reversible
Ceasing of Menstruation	Reversible
Enlarged Clitoris	Irreversible
Vaginal Atrophy	Reversible
Deepening of Voice	Irreversible
Physical Changes in Trans-Females (Male-to-Female Transitions)	
Body Fat Redistribution	Reversible
Decreased Muscle Mass	Reversible
Skin Softening or Decrease in Oiliness	Reversible
Lower Libido	Reversible
Fewer Spontaneous Erections	Reversible
Male Sexual Dysfunction	Possibly Irreversible
Breast Growth	Irreversible
Decrease in Testicular Size	Reversible
Decrease in Sperm Production or Infertility	Likely Irreversible
Slower Facial and Body Hair Growth	Reversible

Sources: UCSF, 2020; WPATH, 2012; Endocrine Society, 2017[7]

The above chart demonstrates that trans-males and trans-females experience different effects from cross-sex hormones that can cause myriad issues in later life. For example, trans-males who opt to detransition may face challenges related to permanent disfigurement (e.g., facial hair and deepened voices). Trans-females, on the other hand, may not endure the same issues pertaining to visible physical changes but might become despondent over being unable to reproduce. This can occur regardless of whether the transitioning individual is satisfied with sex reassignment. Given that the clinical guidelines do not provide uniform information on the permanent effects of cross-sex hormones, clinicians are unable to make sound recommendations to patients. This treatment can supposedly alleviate symptoms

[7] This chart consists of conclusions regarding physical changes made by three different clinical organizations. If one organization determined that a physical change was irreversible, that was sufficient to meet the criteria to be listed as "irreversible" in the chart.

of distress. However, cross-sex hormones' permanent effects also have the potential to cause psychological issues.

Arguments favoring cross-sex hormones assert that the desired physical changes can alleviate mental health issues in individuals with gender dysphoria but do not consider that hormones used in this manner, like puberty blockers, are off-label. While the FDA has approved estrogen and testosterone for specific clinical indications (e.g., hypogonadism), it has not cleared these drugs for treating gender dysphoria. Additionally, these arguments do not acknowledge that the U.S. Drug Enforcement Administration (DEA) lists testosterone as a Schedule III controlled substance, meaning that it has a high probability of abuse (DEA, 2022). Furthermore, evidence of psychological benefit from cross-sex hormones is low-quality and relies heavily on self-assessments taken from small sample groups (Hruz, 2020).

A 2019 study by Kuper et al seeks to demonstrate that adolescents desiring cross-sex hormones have elevated rates of depression, anxiety, and challenges with peer relationships. To make their findings, the authors provided questionnaires to 149 adolescents who presented at a gender clinic in Dallas, Texas and concluded that half of the sample group experienced increased psychological issues. One problem with the study is that it relies on parent or self-assessments such as the Youth-Self Report, Body-Image Scale, and the Child Behavior Checklist. While these assessments have strong reliability, the sample is cross-sectional, consisting of gender dysphoric individuals who presented for an initial visit at the clinic. Also, Kuper et al do not directly link these psychological symptoms to gender dysphoria but rather insinuate a strong connection. Without an analysis of the longitudinal histories of the participants, the study cannot demonstrate whether gender dysphoria was a direct cause of the psychological issues, which could possibly result from trauma, abuse, or family dysfunction. Kuper et al's study only presents weak correlation between adolescents who report symptoms of distress and gender dysphoria. While the authors do not claim that the participants' psychological problems caused the condition, they fail to explicitly state that no demonstrable relationship exists and explain that their findings are "broadly consistent with the previous literature" (Kuper et al, 2019).

Additionally, a more comprehensive literature review from 2019 by Nguyen et al evaluates the effect of cross-sex hormones on mental health outcomes. Although the authors argue that the evidence supports the treatment, they do note that available studies use "uncontrolled observational methods" and "rely on self-report." The review also asserts that "future research should focus on applying more robust study designs with large sample sizes, such as controlled prospective cohort studies using clinician-administered ratings and longitudinal designs with appropriately matched control groups." All of these are characteristics of RCTs. While Nguyen et al highlight flaws in the studies in their conclusion, they do not emphasize them in their analysis, opting to focus primarily on results. Another problem with the studies selected for the review is the short-term periods for evaluation. Out of 11 studies Nguyen et al discuss, only one tracks its participants for 24 months. The others only follow their cohorts for 6 or 12 months (Nguyen et al, 2019). Without long-term data to support assertions that cross-sex hormones substantially improve the mental health of individuals with gender dysphoria, the review cannot make definitive conclusions on the treatment's benefits.

Basing their stances on this low-quality evidence, clinical associations such as the American Academy of Pediatrics (AAP) and the American Psychology Association endorse the use of cross-sex hormones as treatments for gender dysphoria. In particular, the AAP discourages use of the term "transition" and

asserts that medical treatments used to obtain secondary characteristics of the opposite sex are "gender affirming." This decision mirrors the DSM-V's interpretation of gender being part of identity. The AAP further states that taking cross-sex hormones is an "affirmation and acceptance of who they (i.e., patient) have always been" (AAP, 2018). The American Psychological Association also takes a similar stance in its *Resolution on Gender Identity Change Efforts* by asserting that medical treatments such as puberty suppression, cross-sex hormones, and surgery improve mental health and quality of life and reinforce the notion that transitioning and seeking sex reassignment therapies do not constitute a psychological disorder (American Psychological Association, 2021). Stances like these can substantially influence practitioners and their treatment recommendations. Given that low-quality evidence serves as the basis for supportive positions, this raises questions about whether clinicians can make informed decisions for their patients that will promote the best outcomes.

James Cantor published a critique in 2020 of the AAP's endorsement of "gender affirming" treatments, arguing that the organization did not base its recommendations on established medical evidence. He asserts that the AAP's position is based on research that does not support intervention but rather supports "watchful waiting" because most transgender youths desist and identify as their natal sex during puberty. Cantor further argues that the AAP not only disregards evidence but also cites "gender affirming" interventions as the only effective method. To conclude, he states the organization is "advocating for something far in excess of mainstream practice and medical consensus" (Cantor, 2020).

Given those evidentiary problems, those who rely on the AAP's endorsement as a basis for "gender affirming" treatments are practicing eminence-based medicine as opposed to evidence-based medicine. Eminence-based medicine refers to clinical decisions made by relying on the opinions of prominent health organizations rather than relying on critical appraisals of scientific evidence (Nhi Le, 2016). While it is true that the AAP has more knowledge than a lay person and a degree of credibility in the medical community, the opinions of such organizations are not valid unless they are based on quality evidence.

Research on sex reassignment also does not adequately address the reasons for and prevalence of detransitioning. Although no definite numbers are available regarding the percentage of transgender people who decide to detransition, research indicates that roughly 8% decide to return to their natal sex. The reasons range from treatment side effects to more self-exploration that provided insight on individuals' gender dysphoria. In a 2020 study by Lisa Littman, 101 people who had detransitioned provided their basis for doing so. Out of the sample group, 96% had taken cross-sex hormones and 33% had sex reassignment surgery. The average age for transitioning was 22 years, and the mean duration for the transition was 4 years. This indicates that even allowing additional time beyond the recommended age of 16 years can still lead to regrets. The study also raises the question as to whether individuals who transitioned at 16 or younger wanted to detransition in greater numbers. The author further offers reasons why these individuals sought cross-sex hormones and surgery, which include having endured trauma (mental or sexual), homophobia (challenged to accept oneself as a homosexual), peer and media influences, and misogyny (applicable only to trans-males). To obtain the results, the participants responded to a survey that asked about their backgrounds (e.g., reasons for transitioning, mental health comorbidities), and motivations for detransitioning. Littman noted that half of the women (former trans-males) had a mental health disorder and/or had experienced trauma within a year of deciding to transition. Men (former trans-females) reported much lower numbers of behavioral health issues and trauma after de-transitioning. Additionally, 77% of men surveyed identified as the opposite gender prior to transition, whereas just 58% of women had (Littman, 2020).

Of the reasons cited for detransitioning, the majority (60%) noted that they became more comfortable with their natal sex. Other reasons included concerns over complications from the treatments, primarily cross-sex hormones, and lack of improved mental health. Other less-cited explanations include concerns about workplace discrimination and worsening physical health. The study also notes that approximately 36% of participants experienced worse mental health symptoms. Based on the findings, Littman concludes that more research is needed in tracking the transgender population to obtain accurate percentages of those who decide to detransition and that men and women reported varying reasons for deciding to transition and later return to their natal sex. The author notes that higher rates of trauma and peer group influences might have contributed to women's decisions, which Littman attributes partially to rapid onset gender dysphoria (Littman, 2020). What the study also indicates is that cross-sex hormones are not a validated treatment for gender dysphoria. Nearly all of the participants had taken them and decided against maintaining the physical changes. Given that the majority of surveyed detransitioners cited that they were comfortable with their biological sex, the study indicates that gender dysphoria is not necessarily a lifelong issue. This necessarily raises doubts about whether cross-hormones, which cause permanent physical damage, is justified.

In addition to the psychological factors, cross-sex hormones pose significant long-term health risks to transitioning individuals. Currently, little information is available given that researchers have not had adequate time to study the effects in this population. However, use of hormones for other conditions has yielded data on how these drugs can affect the body and the cardiovascular system in particular. Because of the high dosages required to achieve physical change and the need to continuously take the drugs, cross-sex hormones can potentially harm quality of life and reduce life expectancy for transitioning individuals. According to Dutra et al, trans-females are three times more likely to die from a cardiovascular event than the general population. In their 2019 literature review, Dutra et al examined the results of over 50 studies evaluating the effects of cross-sex hormones on not only transgender individuals but those with menopause and other endocrine disorders, all of which indicate that use of estrogen or testosterone can increase risks for cardiovascular disease. Throughout their review, Dutra et al cite examples of trans-females having higher triglyceride levels after 24 months of cross-sex hormones and how researchers halted a study on estrogen due to an increase in heart attacks among participants. Another article the authors reference indicates a higher risk for thromboembolisms (i.e., blood clots) in trans-females. For trans-males, Dutra et al explain that research shows significant increased risk for hypertension, high cholesterol, obesity, and heart attacks. One study noted that trans-males have a four times greater risk of heart attack compared to women identifying as their natal sex. Dutra et al conclude that most transgender individuals are younger than 50 and that more studies are needed as this population ages. They do note that available studies indicate that cross-sex hormones pose dangers to long-term cardiovascular health (Dutra et al, 2019).

In sum, the literature reveals that the evidence for cross-sex hormones as a treatment for gender dysphoria is weak and insufficient. Between the permanent effects, off-label use, and consequences to long-term health, cross-sex hormones are a risky option that does not promise a cure but does guarantee irreversible changes to both male and female bodies. Additionally, the inadequate studies serving as the basis for recommendations by clinical associations can lead to providers making poorly informed decisions for their patients. Research asserting that taking cross-sex hormones improves mental health is subjective and short-term. More studies that utilize large sample sizes and appropriate

methods is required before the medical profession should consider cross-sex hormones as one of gender dysphoria's standard treatments.

Literature Review: Sex Reassignment Surgery

The final phase of treatment for gender dysphoria is sex reassignment surgery. This method consists of multiple procedures to alter the appearance of the body to resemble an individual's desired gender. Some procedures apply to the genitals (genital procedures) while others affect facial features and vocal cords (non-genital procedures). While the surgery creates aesthetical aspects, it does not fully transform someone into the opposite biological sex. Transgender persons who undergo the procedures must continue taking cross-sex hormones to maintain secondary sexual characteristics. Additionally, all physical changes are irreversible, and the success rate of a surgery varies depending on the procedure and the population. For example, surgeries for trans-females have much better results than those for trans-males. Complications such as post-operative infections can also arise with the urinary tract system. However, sex reassignment surgery supposedly can provide drastic, if not complete, relief from gender dysphoria (Endocrine Society, 2017). The following is a list of procedures (both genital and non-genital) for trans-females and trans-males that create physical features of the desired sex.

Procedures for Trans-Females

- **Genital Surgeries:** These consist of penectomy (removal of the penis), orchiectomy (removal of the testicles), vaginoplasty (construction of a neo-vagina), clitoroplasty (construction of a clitoris), and vulvoplasty (construction of a vulva and labia). To perform, a surgeon begins by deconstructing the penis and removing the testicles. The penile shaft and glans are repurposed to serve as a neo-vagina and artificial clitoris (Note: These are not actual female genitalia but tissue constructed to resemble female anatomy). If the shaft tissue is insufficient, the surgeon may opt to use a portion of intestine to build a neo-vagina. The scrotum serves as material for fashioning a vulva and labia. In addition to constructing female genitalia, the surgeon reroutes the urethra to align with the neo-vagina. Genital surgeries for trans-females result in permanent sterility (Bizic et al, 2014).
- **Chest Surgery:** To attain full breasts, trans-females can undergo enlargement. The procedure is similar to breast augmentation for women where a surgeon places implants underneath breast tissue. Prior to surgery, trans-females need to take cross-sex hormones for roughly 24 months to increase breast size to get maximum benefit from the procedure (Endocrine Society, 2017).
- **Cosmetic and Voice Surgeries:** Designed to create feminine facial features, fat deposits, and vocal sounds, these procedures are secondary to genital procedures and intended to alter trans-females' appearances to better integrate into society as a member of the desired gender (WPATH, 2012).

Procedures for Trans-Males

- **Mastectomy:** This is the most performed sex reassignment surgery on trans-males because cross-sex hormones and chest-binding garments are often insufficient at diminishing breasts. To remove this secondary sexual characteristic, trans-males can undergo a mastectomy where a surgeon removes breast tissue subcutaneously (i.e., under the skin) and reconstructs the nipples to appear masculine. The procedure can result in significant scarring (Monstrey et al, 2011).
- **Genital Surgeries:** Unlike the procedures for trans-females, genital surgeries for trans-males are more complex and have lower success rates. Consisting of hysterectomy, oophorectomy

(removal of the ovaries), vaginectomy (removal of the vagina), phalloplasty (construction of a penis), and scrotoplasty (construction of prosthetic testicles), a team of surgeons must manufacture a penis using skin from the patient (taken from an appendage) while removing the vagina and creating an extended urethra. The functionality of the artificial penis can vary based on how extensive the construction was. Attaining erections requires additional surgery to implant a prosthesis, and the ability to urinate while standing is often not achieved. Genital procedures for trans-males result in irreversible sterility (Monstrey et al, 2011).

- **Cosmetic Surgeries:** Similar to trans-females, these procedures create masculine facial features, fat deposits, and artificial pectoral muscles. They aid trans-males with socially integrating as their desired gender. Surgery to deepen voices is also available but rarely performed (WPATH, 2012).

Because sex reassignment surgery is irreversible, the criteria for receiving these procedures is the strictest of all gender dysphoria treatments. WPATH and the Endocrine Society suggest rigorous reviews of patient history and prior use of other therapies before approving. Furthermore, the two organizations recommend that only adults (18 years old) undergo sex reassignment surgery.[8] WPATH and the Endocrine Society also recommend ensuring a strongly documented diagnosis of gender dysphoria, addressing all medical and mental health issues, and at least 12 months of cross-sex hormones for genital surgeries. Although the organizations agree on most criteria, they differ on whether hormones should be taken prior to mastectomies. WPATH asserts that hormones should not be a requirement, whereas the Endocrine Society advises up to 2 years of cross-sex hormones before undergoing the procedure (WPATH, 2012; Endocrine Society, 2017). What this indicates is that trans-males might undergo breast removal without having first pursued all options if their clinician adheres to WPATH's guidelines, which can lead to possible regret over irreversible effects.

As with cross-sex hormones, sex reassignment surgery's irreversible physical changes can potentially show marked mental health improvements and prevent suicidality in people diagnosed with gender dysphoria. In April 2022, the chair of the University of Florida's pediatric endocrinology department, Dr. Michael Haller, advocated for the benefits of "gender affirming" treatments (WUSF, 2020). However, the available evidence calls such statements into question. Recent research assessing both cross-sex hormones and sex reassignment surgery indicate that the effects on "long-term mental health are largely unknown." In studies regarding the benefits of surgery, the results have the same weaknesses as the research for the effectiveness of cross-sex hormones. These include small sample sizes, self-report surveys, and short evaluation periods, all of which are insufficient to justify recommendations for irreversible treatments (Bränström et al, 2020).

Two studies conducted in Sweden provide insight on the effectiveness of sex reassignment surgery in improving the behavioral health of transgender persons. Because Sweden has a nationalized health system that collects data on all residents, this country can serve as a resource to assess service utilization and inpatient admissions. Both studies, one by Dhejne et al from 2011 and another by Bränström et al published in 2020, assessed individuals who had received sex reassignment surgery and examined outcomes over several decades. Dhejne et al's findings indicate that sex reassignment

[8] Although practice guidelines indicate the minimum age to undergo sex reassignment surgery is 18, available evidence demonstrates that mastectomies have been performed on adolescent girls as young as 13 who experience "chest dysphoria" (Olson-Kennedy et al, 2018).

procedures do not reduce suicidality. The authors explained that individuals who underwent sex reassignment surgery were still more likely to attempt or commit suicide than those in the general population. This study is unique because it monitored the subjects over a long period of time. Dhejne et al note that the transgender persons tracked for the study did not show an elevated suicide risk until ten years after surgery (Dhejne et al, 2011). Given that a high proportion of research follows sex reassignment patients for much shorter timeframes, this evidence indicates that surgery might have little to no effect in preventing suicides in gender dysphoric individuals over the long run.

In addition to having an increased suicide risk, Dhejne et al discuss how individuals who underwent sex reassignment procedures also had higher mortality due to cardiovascular disease. The authors do not list the specific causes but establish the correlation. Given that cross-sex hormones can damage the heart, the increased risk could be related to the drugs and not the surgery. Furthermore, the study explains that the tracked population had higher rates of psychiatric inpatient admissions following sex reassignment. Dhejne et al established this by examining the rates of psychiatric hospitalizations in these individuals prior to surgery and noted higher utilization in the years following the procedures. These results are in comparison to the Swedish population at large. While the study contradicts other research emphasizing improvements in mental health issues, it has its limitations. For example, the sample size is small. Dhejne et al identified only 324 individuals who had undergone sex reassignment surgery between 1973 and 2003. In addition, the authors noted that while the tracked population had increased suicide risks when compared to individuals identifying as their natal sex, the rates could have been much higher if the procedures were not available (Dhejne et al 2011). What this study postulates is that sex reassignment surgery does not necessarily serve as a "cure" to the distress resulting from gender dysphoria and that ongoing behavioral health care may still be required even after a complete transition.

Bränström et al's study evaluating the Swedish population used a larger sample (1,018 individuals who had received sex reassignment surgery) but tracked them for just a ten-year period (2005 to 2015).[9] Unlike Dhejne et al, the authors did not track suicides and focused primarily on mood or anxiety disorder treatment utilization. Their results indicate that transgender persons who had undergone surgery utilized psychiatric outpatient services at lower rates and were prescribed medications for behavioral health issues at an annual decrease rate of 8%. Bränström et al also did not limit comparisons to Sweden's overall population and factored in transgender persons who take cross-sex hormones but have not elected to have surgery. Those results still presented a decrease in outpatient mental health services. However, Bränström et al note that individuals only on cross-sex hormones showed no significant reduction in that category, which calls into question claims regarding effectiveness of cross-sex hormones in ameliorating behavioral issues.

The Bränström et al study prompted numerous responses questioning its methodology. The study lacked a prospective cohort or RCT design, and it did not track all participants for a full ten-year period (Van Mol et al, 2020). These criticisms resulted in a retraction, asserting that Bränström et al's conclusions were "too strong" and that further analysis by the authors revealed that the new "results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related

[9] Although Bränström et al claim to follow individuals for a ten-year period, peer reviews of the research revealed that this was not the case, noting the authors had varying periods of tracking, ranging from one to ten years (Van Mol et al, 2020).

health care visits or prescriptions or hospitalizations following suicide attempts in that comparison" (Kalin, 2020).

There are multiple explanations for why the Bränström et al study reached different results than the Dhejne et al study. For starters, Bränström et al tracked a larger sample group over a later period (2005 to 2015 as opposed to 1973 to 2003) during which gender dysphoria underwent a dramatic shift in definition. Also, Dhejne et al did not see elevated suicides until after ten years, raising the question as to whether sex reassignment surgery has temporary benefits on mental health rather than long-term or permanent benefits. Like the other Swedish study, Bränström et al's findings are a correlation and do not specifically state that the procedures cause reduced psychiatric service utilization (Bränström et al, 2020).

A 2014 study by Hess et al in Germany evaluated satisfaction with sex reassignment procedures by attempting to survey 254 trans-females on their quality of life, appearance, and functionality as women. Out of the participants selected, only 119 (47%) returned completed questionnaires, which Hess et al indicate is problematic because dissatisfied trans-females might not have wanted to provide input. The results from the collected responses noted that 65.7% of participants reported satisfaction with their lives following surgery and that 90.2% indicated that the procedures fulfilled their expectations for life as women. While these results led Hess et al to conclude that sex reassignment surgery generally benefits individuals with gender dysphoria, the information is limited and raises questions (Hess et al, 2014). Such questions include whether the participants had mental health issues before or after surgery and did their satisfaction wane over time. Hess et al only sent out one questionnaire and not several to ascertain consistency over multiple years. Questions like these raise doubts about the validity of the study. Although Hess et al's research is just one study, numerous others utilize the same subjective methods to reach their conclusions (Hruz, 2018).

In his assessment, Patrick Lappert contributes additional insight on the appropriate clinical indications for mastectomies, noting that removal of breast tissue is necessary following the diagnosis of breast cancer or as a prophylactic against that disease. He cites that this basis is verifiable through definitive laboratory testing and imaging, making it an objective diagnosis, whereas gender dysphoria has no such empirical methods to assess and depends heavily on the patient's perspective. Also, Lappert notes that trans-males who make such decisions are doing so on the idea that the procedure will reduce their dysphoria and suicide risk. However, they are making an irreversible choice based on anticipated outcomes supported only by weak evidence, and thus cannot provide informed consent (Lappert, 2022).

The literature is inconclusive on whether sex reassignment surgery can improve mental health for gender dysphoric individuals. Higher quality research is needed to validate this method as an effective treatment. This includes studies that obtain detailed participant histories (e.g., behavioral diagnoses) and track participants for longer periods of time. These are necessary to evaluate the full effects of treatments that cause irreversible physical changes. In addition, sex reassignment procedures can result in severe complications such as infections in trans-females and urethral blockage in trans-males. Health issues related to natal sex can also persist. For example, trans-males who undergo mastectomy can still develop breast cancer and should receive the same recommended screenings (Trum et al, 2015). Until more definitive evidence becomes available, sex reassignment surgery should not qualify as a standard treatment for gender dysphoria.

Literature Review: Quality of Available Evidence and Bioethical Questions

Quality of Available Evidence

Clinical organizations that have endorsed puberty suppression, cross-sex hormones, and sex reassignment surgery frequently state that these treatments have the potential to save lives by preventing suicide and suicidal ideation. The evidence, however, does not support these conclusions. James Cantor notes that actual suicides (defined as killing oneself) are low, occur at higher rates for men, and that interpretations of available research indicate a blurring of numbers between those with gender dysphoria and homosexuals (Cantor, 2022). Although information exists that contradicts certain arguments, media outlets continue to report stories emphasizing the "lifesaving" potential of sex reassignment treatment. A May 2022 story by NBC announced survey results under the headline "Almost half of LGBTQ youths 'seriously considered suicide in the past year'" (NBC, 2022). This is a significant claim that can have a sensational effect on patients and providers alike, but how strong is the evidence supporting it? Almost all of the data backing this assertion are based on surveys and cross-studies, which tend to yield low-quality results (Hruz, 2018). In addition, how many gender dysphoric individuals are seeing stories in the media and not questioning the narrative? Because research on the effectiveness of treatments is ongoing, a debate persists regarding their use in the adolescent and young-adult populations, and much of it is due to the low-quality studies serving as evidence.

In their assessment, Romina Brignardello-Petersen and Wojtek Wiercioch examined the quality of 61 articles published between 2020 and 2022 (Note: See Attachment A for the full study). They identified research on the effectiveness of puberty blockers, cross-sex hormones, and sex reassignment surgery and assigned a grade (high, moderate, low, or very low) in accordance with the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach. Out of the articles reviewed, all with a few exceptions received grades of low or very low quality when demonstrating outcomes regarding improvements in mental health and overall satisfaction with transitioning. For puberty blockers, Brignardello-Petersen and Wiercioch identified low quality evidence for alleviating gender dysphoria and very low quality for reducing suicidal ideation. The authors also had nearly identical findings for cross-sex hormones. However, they noted moderate quality evidence for the likelihood of cardiovascular side effects. Regarding surgery, Brignardello-Petersen and Wiercioch graded articles that examined overall satisfaction and complication rates. None of the studies received grades higher than low quality. These findings led the authors to conclude that "there is great uncertainty about the effects" of sex reassignment treatments and that the "evidence alone is not sufficient to support" using such treatments. Among the studies graded was one the U.S. Department of Health and Human Services cited in its information on "gender affirming" treatments. The authors noted this research had a "critical risk of bias" and was of low quality (Brignardello-Petersen and Wiercioch, 2022).

For his part, James Cantor provided a review of available literature, which addresses studies on etiology, desistance, effectiveness of puberty blockers and cross-sex hormones, suicidal behaviors, and clinical association and international guidelines. Throughout his analysis, Cantor cites weak evidence, poor methodologies (e.g., retrospective versus prospective studies), and lack of professional endorsements in research that indicates the benefits of sex reassignment treatment. Additionally, he notes that improvements in the behavioral health of adolescents who take cross-sex hormones can be attributed to the counseling they receive concurrently and that suicidality is not likely to result from gender

dysphoria but from co-occurring mental disorders. The reasoning behind the third point is based on the blending of suicide and suicidality, which are two distinct concepts. The former refers specifically to killing oneself, and the second regards ideation and threats in attempts to receive help. Cantor specifically notes that actual suicides are highly unlikely among gender dysphoric individuals, particularly trans-males. His other conclusions indicate that young children who experience gender identity issues will most likely desist by puberty, that multiple phenomena can cause the condition, and that Western European health services are not recommending medical intervention for minors. The basis for these statements is the paucity of high to moderate quality evidence on the effectiveness of sex reassignment treatments and numerous studies demonstrating desistance (Cantor, 2022).

Despite the need for stronger studies that provide definitive conclusions, many practitioners stand by the recommendations of the AAP, Endocrine Society, and WPATH. This is evident in a letter submitted to the *Tampa Bay Times*, which was a rebuttal to the Florida Department of Health's (DOH) guidance on treatment for gender dysphoria (Note: The guidance recommends against using puberty blockers, cross-sex hormones, or surgery for minors) (DOH, 2022). The authors, led by six professors at the University of Florida's College of Medicine, state that recommendations by clinical organizations are based on "careful deliberation and examination of the evidence by experts." However, evaluations of these studies show otherwise. Not only does the available research use cross-sectional methods such as surveys, but it provides insufficient evidence based on momentary snapshots regarding mental health benefits. These weak studies are the foundation for the clinical organizations' guidelines that the University of Florida professors tout as a gold standard. In addition, the letter's authors state that DOH's guidance is based on a "non-representative sample of small studies and reviews, editorials, opinion pieces, and commentary" (Tampa Bay Times, 2022). That statement misses the point when it comes to evidence demonstrating whether treatments with irreversible effects are beneficial because the burden of proof is on those advocating for this treatment, not on those acknowledging the need for further research. This raises the question concerning how much academic rigor these professors are applying to practice guidelines released by clinical organizations and whether they also apply the same level of rigor to novel treatments for other conditions (e.g., drugs, medical devices).

Another example of a lack of rigor is a 2019 article by Herman et al from the University of California at Los Angeles (UCLA) that evaluated responses to a 2015 national survey on transgender individuals and suicide. Unlike other studies, this one utilized a large cohort with 28,000 participants from across the U.S. responding. However, the researchers used no screening criteria and did not randomly select individuals. In addition, responses consisted entirely of self-reports with no supporting evidence to even prove a diagnosis of gender dysphoria. Although Herman et al conclude that the U.S. transgender population is at higher risk for suicidal behaviors, the authors' supporting evidence is subjective and serves as a weak basis. Additionally, the survey results do not establish gender dysphoria as a direct cause of suicide or suicidal ideation. The questions required participants to respond about their overall physical and mental health. Out of those that indicated "poor" health, 77.7% reported suicidal thoughts or attempts during the previous year, whereas just 29.1% of participants in "excellent" health had. These percentages indicate that causes beyond gender dysphoria could be affecting suicidal behaviors. Other reasons cited include rejection by family or religious organizations and discrimination. The authors also acknowledge that their findings are broad, not nationally representative, and should serve as a basis for pursuing future research (Herman et al, 2019).

Yet another example is a study published in 2022 by Olson et al tracks 300 young children that identify as transgender over a 5-year period, and asserts low probabilities for detransitioning, while supporting interventions such as puberty blockers. The authors found that children (median age of 8 years) who identified as a gender that differed from their natal sex were unlikely to desist at a rate of 94% and conclude that "transgender youth who socially transitioned at early ages" will continue "to identify that way." While this appears to contradict earlier studies that demonstrate most young adolescents who change gender identities return to their "assigned gender at birth," the authors note differences and limitations with the results. For example, Olson et al notes that they did not verify whether the participants met the DSM-V's diagnostic criteria for gender dysphoria and that the children's families supported the decisions to transition. Instead, the authors relied on a child's chosen pronouns to classify as transgender. Also, Olson et al acknowledged that roughly 66% of the sample was biologically male. This is particularly significant considering that the majority of transitioning adolescents in recent years were natal females. Another issue with the study includes the median age at the end of follow-up (13 years), which is when boys begin puberty. Furthermore, the authors cite that the participants received strong parental support regarding the transitions, which constitutes positive reinforcement (Olson et al, 2022). Other research demonstrates that such feedback on social transitioning from parents and peers can prevent desistance following pubertal onset (Zucker, 2019). Despite these limitations, the New York Times announced the study's publication under the headline "Few Transgender Children Change Their Minds After 5 Years" (New York Times, 2022). Such a title can add to the public's perception that gender dysphoria requires early medical intervention to address.

Bioethical Questions

The irreversible physical changes and potential side effects of sex reassignment treatment raise significant ethical questions. These questions concern multiple bioethical principles including patient autonomy, informed consent, and beneficence. In a 2019 article, Michael Laidlaw, Michelle Cretella, and Kevin Donovan argue that prescribing puberty blockers or cross-sex hormones on the basis that they will alleviate psychological symptoms should not be the standard of care for children with gender dysphoria. Additionally, the three authors assert that such treatments "constitute an unmonitored, experimental intervention in children without sufficient evidence of efficacy or safety." The primary ethical question Laidlaw, Cretella, and Donovan pose is whether pushing physical transitioning, particularly without parental consent, violates fully informed consent (Laidlaw et al, 2019).

In accordance with principles of bioethics, several factors must be present to obtain informed consent from a patient. These consist of being able to understand and comprehend the service and potential risks, receiving complete disclosure from the physician, and voluntarily providing consent. Bioethicists generally do not afford the ability of giving informed consent to children who lack the competence to make decisions that pose permanent consequences (Varkey, 2021). Laidlaw, Cretella, and Donovan reinforce this point regarding sex reassignment treatment when they state that "children and adolescents have neither the cognitive nor the emotional maturity to comprehend the consequences of receiving a treatment for which the end result is sterility and organs devoid of sexual function" (Laidlaw et al, 2019). This further raises the question whether clinicians who make such treatment recommendations are providing full disclosure about the irreversible effects and truly obtaining informed consent.

Another issue is the conflict between consumerism and the practitioner's ability to provide appropriate care. Consumerism refers to patients learning about treatments through media/marketing and requesting their health care provider to prescribe it, regardless of medical necessity. Considering that social media is rife with individuals promoting "gender affirmative" drugs and surgeries, children are making self-assessments based on feelings they may not understand and that can lead to deep regret in the future (Littman, 2018). This can contribute to patients applying pressure on their doctors to prescribe medications not proven safe or effective for the condition. Consumerism can also affect bioethical compliance because it constrains clinicians from using their full "knowledge and skills to benefit the patient," which is "tantamount to a form of patient abandonment and therefore is ethically indefensible" (Varkey, 2021).

In his assessment, G. Kevin Donovan explains the bioethical challenges related to sex reassignment treatment, emphasizing the lack of informed consent when administering these services. He asserts that gender dysphoria is largely a self-diagnosis practitioners cannot verify with empirical tests (e.g., labs and imaging) and that providing such treatments is experimental. Because of the lack of consent and off-label use of puberty blockers and cross-sex hormones, Donovan raises the question as to how "experienced and ethical physicians so mislead others or be so misled themselves?" He further attributes this phenomenon to societal and peer pressures that influence self-diagnosis and confirm decisions to transition. As a result, these pressures lead to individuals wanting puberty blockers, cross-sex hormones, and surgery. Donovan goes on to identify several news stories where embracing sex reassignment treatment is a "cult-like" behavior. To conclude, he links these factors back to the failure to obtain informed consent from transgender patients and how that violates basic bioethical principles (Donovan, 2022).

Coverage Policies of the U.S. and Western Europe

U.S. Federal Level Coverage Policies

Medicare: In 2016, the Centers for Medicare and Medicaid Services (CMS) published a decision memo announcing that Medicare Administrative Contractors (MACs) can evaluate sex reassignment surgery coverage on a "case-by-case" basis. [10] CMS specifically noted that the decision memo is not a National Coverage Determination and that "no national policy will be put in place for the Medicare program" (CMS, 2016). This memo was the result of CMS reviewing over 500 studies, reports, and articles to the validity of the procedures. Following its evaluation, CMS determined that "the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding . . . small sample sizes, lack of validated assessment tools, and considerable (number of participants in the studies) lost to follow up." In 2017, CMS reinforced this position with a policy transmittal that repeated the 2016 memo's criteria (CMS, 2017).

The basis for Medicare's decision is that the "clinical evidence is inconclusive" and that "robust" studies are "needed to ensure that patients achieve improved health outcomes." In its review of available literature, CMS sought to answer whether there is "sufficient evidence to conclude that gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria." After evaluating 33 studies that met inclusion criteria, CMS's review concludes that "not enough high-quality evidence" is available "to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively." Additionally, out of the 33 studies, just 6 provided "useful information" on the procedures' effectiveness, revealing that their authors "assessed quality of life before and after surgery using validated (albeit non-specific) psychometric studies" that "did not demonstrate clinically significant changes or differences in psychometric test results" following sex reassignment surgery (CMS, 2016).

U.S. Department of Defense – Tricare: Tricare does not cover sex reassignment surgery, but it will cover psychological services such as counseling for individuals diagnosed with gender dysphoria and cross-sex hormones when medically necessary (Tricare, 2022).[11]

U.S. Department of Veterans Affairs: The U.S. Department of Veterans Affairs (VA) does not cover sex reassignment surgery, although it will reimburse for cross-sex hormones and pre- and post-operative care related to transitioning. Because the VA only provides services to veterans of the U.S. armed forces, it cannot offer sex reassignment treatment to children (VA, 2020).[12]

---

[10] The Centers for Medicare and Medicaid Services is part of the U.S. Department of Health and Human Services. Its primary functions are to administer the entire Medicare system and oversee federal compliance of state Medicaid programs. In addition, CMS sets reimbursement rates and coverage criteria for the Medicare program.
[11] Tricare is the insurance program that covers members of the U.S. armed forces and their families. This includes children of all ages.
[12] The U.S. Department of Veterans Affairs oversees the Veterans Health Administration (VHA), which consists of over 1,000 hospitals, clinics, and long-term care facilities. As the largest health care network in the U.S., the VHA provides services to veterans of the U.S. armed forces.

State-Level Coverage Policies

Florida: In April 2022, DOH issued guidance for the treatment of gender dysphoria, recommending that minors not receive puberty blockers, cross-sex hormones, or sex reassignment surgery. [13] The justification offered for recommending against these treatments is that available evidence is low-quality and that European countries also have similar guidelines. Accordingly, DOH provided the following guidelines:

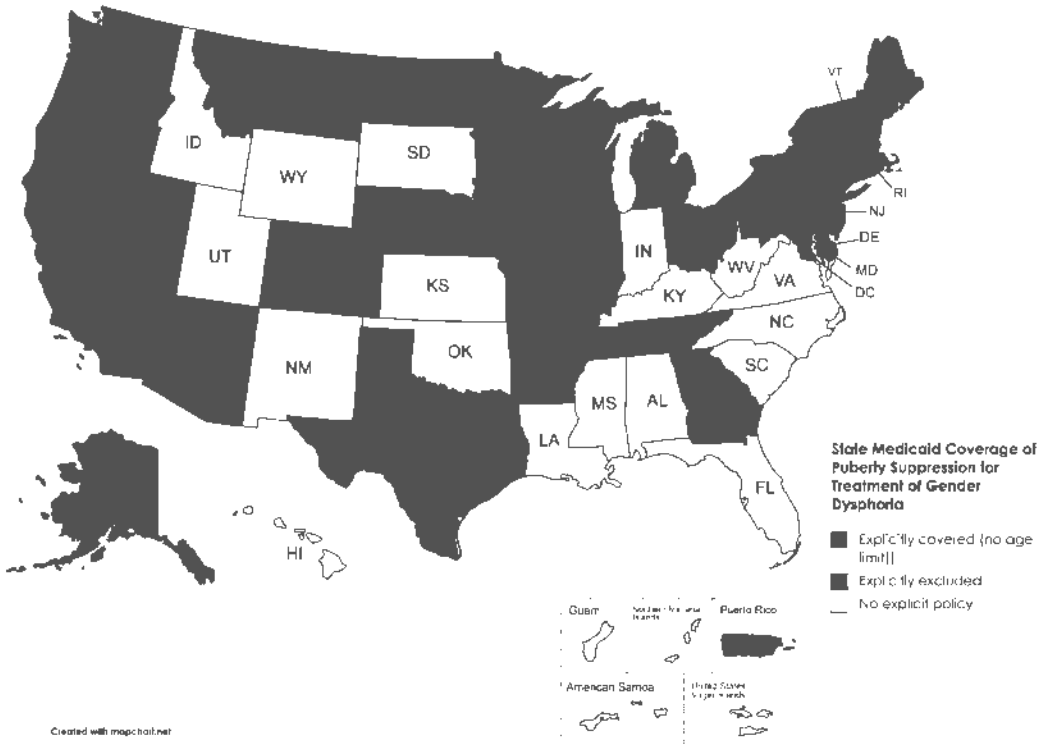
- "Social gender transition should not be a treatment option for children or adolescents."
- "Anyone under 18 should not be prescribed puberty blockers or hormone therapy."
- "Gender reassignment surgery should not be a treatment option for children or adolescents."
- "Children and adolescents should be provided social support by peers and family and seek counseling from a licensed provider."

In a separate fact sheet released simultaneously with the guidance, DOH further asserts that the evidence cited by the federal government cannot establish sex reassignment treatment's ability to improve mental health (DOH, 2022).

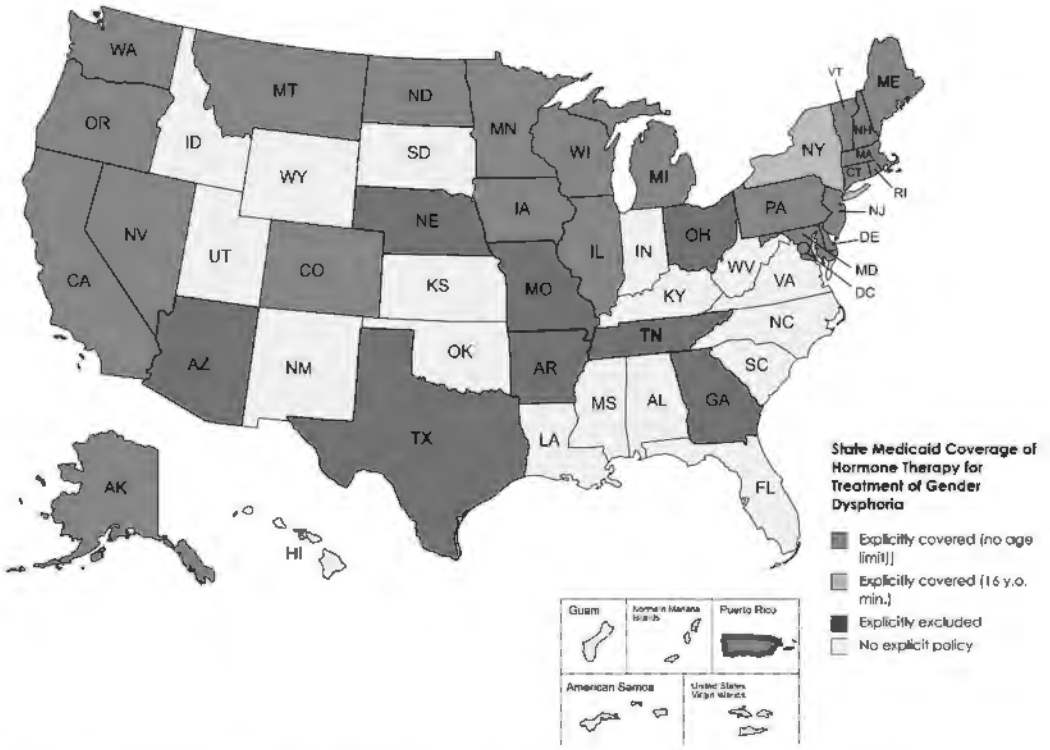
State Medicaid Programs: Because individual states differ in health services offered, Medicaid programs vary in their coverage of sex reassignment treatments. The following maps identify states that cover sex reassignment treatments, states that have no policy, and states that do not cover such treatments.

[13] Unlike the federal government, the State of Florida delegates responsibilities for Medicaid and health care services to five separate agencies (Agency for Health Care Administration, Department of Health, Department of Children and Families, Department of Elder Affairs, and Agency for Persons with Disabilities). Each agency has its own separate head (secretary or surgeon general), which reports directly to the Executive Office of the Governor. As Florida's public health agency, DOH oversees all county health departments, medical professional boards, and numerous health and welfare programs (e.g., Early Steps and Women, Infants, and Children). Because it oversees the boards, DOH has authority to release practice guidelines.

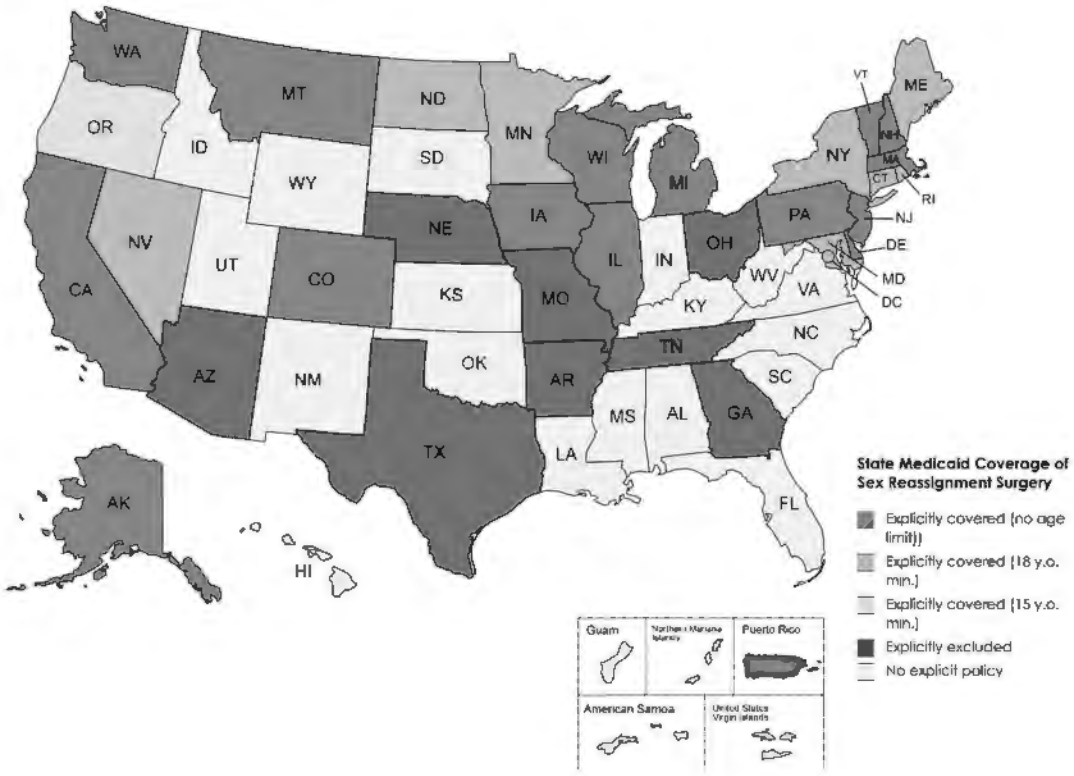
State Medicaid programs with coverage decisions regarding puberty blockers:



State Medicaid programs with coverage decisions regarding cross-sex hormones:



State Medicaid programs with coverage decisions regarding sex reassignment surgery:



Western Europe

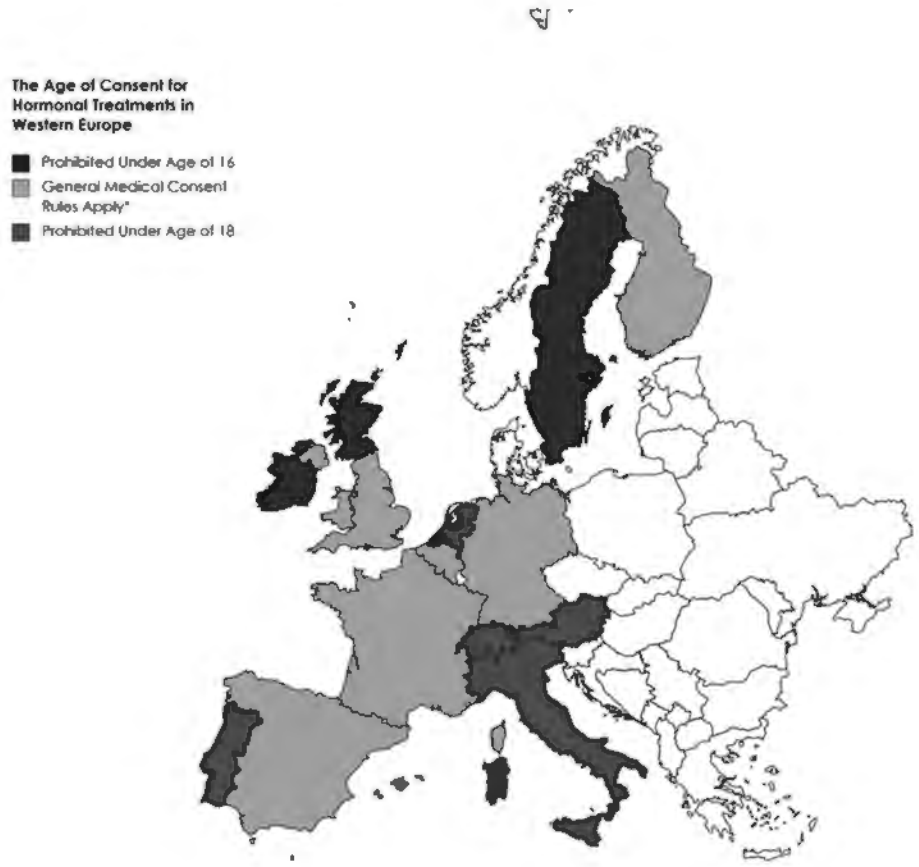
Scandinavian countries such as Sweden and Finland have released new guidelines on sex reassignment treatment for children. In 2022, the Swedish National Board of Health stated that "the risks of hormonal interventions for gender dysphoric youth outweigh the potential benefits." With the exception of youths who exhibited "classic" signs of gender identity issues, adolescents who present with the condition will receive behavioral health services and gender-exploratory therapy (Society for Evidence Based Gender Medicine, 2022).

In Finland, the Palveluvalikoima issued guidelines in 2020 stating that sex reassignment in minors "is an experimental practice" and that "no irreversible treatment should be initiated." The guidelines further assert that youths diagnosed with gender dysphoria often have co-occurring psychiatric disorders that must be stabilized prior to prescribing any cross-sex hormones or undergoing sex reassignment surgery (Palveluvalikoima, 2020).

The United Kingdom (U.K.) is also reassessing the use of irreversible treatments for gender dysphoria due the long-term effects on mental and physical health. In 2022, an independent interim report commissioned by the U.K.'s National Health Service (NHS) indicates that additional research and systematic changes are necessary to ensure the safe treatment of gender dysphoric youths. These include reinforcing the diagnosis process to assess all areas of physical and behavioral health, additional training for pediatric endocrinologists, and informing parents about the uncertainties regarding puberty blockers. The interim report is serving as a benchmark until the research is completed for final guidelines (The Cass Report, 2022).

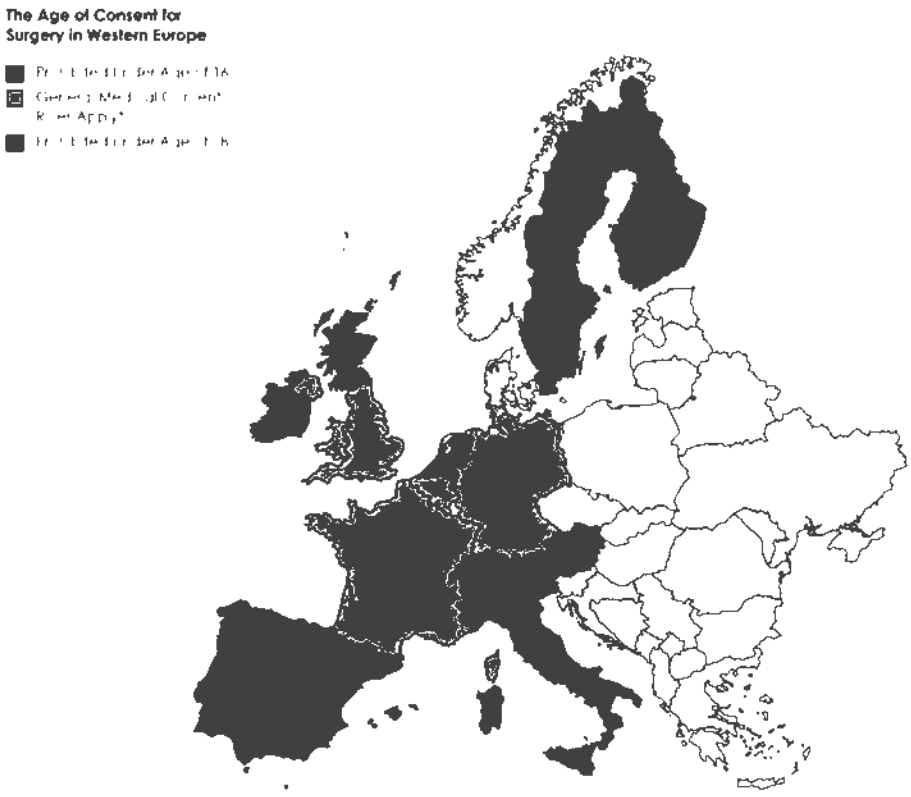
Like state Medicaid programs, health systems across Western Europe also vary in their coverage of sex reassignment treatment.

Western European nations' requirements for cross-sex hormones:



In this context, the age requirement for access to any medical treatment without consent of parents or of a public authority. This age may range from 16 to 18 years depending on each country's laws.

Western European nations' requirements for sex reassignment surgery:



In this context, the oge requirement for access to ony medical treotment without consent of parents or of a public authority. This age may range from 16 to 18 yeors depending on each country's laws.

Generally Accepted Professional Medical Standards Recommendation

This report does not recommend sex reassignment treatment as a health service that is consistent with generally accepted professional medical standards. Available evidence indicates that the services are not proven safe or effective treatments for gender dysphoria.

Rationale

The available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. As this report demonstrates, the evidence favoring "gender affirming" treatments, including evidence regarding suicidality, is either low or very low quality:

- **Puberty Blockers:** Evidence does not prove that puberty blockers are safe for treatment of gender dysphoria. Evidence that they improve mental health and reduce suicidality is low or very low quality.
- **Cross-Sex Hormones:** Evidence suggesting that cross-sex hormones provide benefits to mental health and prevents suicidality is low or very low quality. Rather, evidence shows that cross-sex hormones cause multiple irreversible physical consequences as well as infertility.
- **Sex Reassignment Surgery:** Evidence of improvement in mental health and reduction in suicidality is low or very low quality. Sex reassignment surgery results in irreversible physical changes, including sterility.

While clinical organizations like the AAP endorse the above treatments, none of those organizations relies on high quality evidence. Their eminence in the medical community alone does not validate their views in the absence of quality, supporting evidence. To the contrary, the evidence shows that the above treatments pose irreversible consequences, exacerbate or fail to alleviate existing mental health conditions, and cause infertility or sterility. Given the current state of the evidence, the above treatments do not conform to GAPMS and are experimental and investigational.

✓ **Concur** ____ **Do not Concur**

Comments:

_____

_____

_____

Tom Wilkes
Deputy Secretary for Medicaid (or designee)

6/2/22
Date

Works Cited

Almost Half of LGBTQ Youths 'Seriously Considered' Suicide in Past Year, Survey Says. *NBC News*. 4 May 2022.

American Academy of Pediatrics. Policy Statement: Off-Label Use of Drugs in Children. *Pediatrics*. 2014. 133(3).

American Psychiatric Association. *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders*. 2013.

American Psychiatric Association. *Gender Dyspharia Diagnosis*. 2017.

American Psychiatric Association. *What Is Depression*. 2020.

American Psychological Association. *APA Resolution on Gender Identity Change Efforts*. 2021.

Baker GM, Guzman-Arocho YD, Bret-Mounet VC, Torous VF, Schnitt SJ, Tobias AM, Bartlett RA, Fein-Zachary VJ, Collins LC, Wulf GM, Heng YJ. Testosterone Therapy and Breast Histopathological Features in Transgender Individuals. *Mod Pathol*. 2021. 34(1).

Blake K, Cangelosi S, Johnson-Brooks S, Belcher HME. Reliability of the GAF and CGAS with Children Exposed to Trauma. *Child Abuse and Neglect*. 2007. 31: 909-915.

Bizic MR, Jeftovic M, Pusica S, Stojanovic B, Duisin D, Vujovic S, Rakic V, Djordjevic ML. Gender Dysphoria: Bioethical Aspects of Medical Treatment. *BioMed Research International*. 2018: 9652305.

Bizic M, Kojovic V, Duisin D, Stanojevic D, Vujovic S, Milosevic A, Korac G, Djordjevic ML. An Overview of Neovaginal Reconstruction Options in Male to Female Transsexuals. *The Scientific World Journal*. 2014. 638919.

Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. *American Journal of Psychiatry*. 2020. 177(8).

Brignardello-Petersen R, Wiercioch W. Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence. Unpublished: Commissioned by the Florida Agency for Health Care Administration. 2022.

Bruggeman BS, Dayton K, Diaz A, Evans J, Haller MJ, Hudak ML, Mathews CA, Shapiro M. We 300 Florida Health Care Professionals Say the State Gets Transgender Guidance Wrong. *Tampa Bay Times*. 27 April 2022.

Cantor J. Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. *Journal of Sex and Marital Therapy*. 46(4).

Cantor J. *Science of Gender Dysphoria and Transsexualism*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Cass H. *The Cass Review: Independent Review of Gender Identity Services for Children and Young People, Interim Report*. 2022.

The Centers for Medicare and Medicaid Services. Decision Memo: Gender Dysphoria and Gender Reassignment Surgery. 30 August 2016.

The Centers for Medicare and Medicaid Services. Pub 100-03 Medicare National Coverage Determinations. 3 March 2017.

Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, Steinberg L, Sisk CL, Roth J, Paus T, Mueller SC, McCarthy MM, Micevych PE, Martin CL, Kreukels BPC, Kenworthy L, Herting MM, Herlitz A, Heraldsen RJH, Dahl R, Crone EA, Chelune GJ, Burke SM, Berenbaum SA, Beltz AM, Bakker J, Eliot L, Vilain E, Wallace GL, Nelson EE, Garofalo R. Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth. *Transgender Health*. 2020. 5(4).

Claahsen-van der Grinten H, Verhaak C, Steensma T, Middelberg T, Roeffen J, Klink D. Gender Incongruence and Gender Dysphoria in Childhood and Adolescence – Current Insights in Diagnostics, Management, and Follow-Up. *European Journal of Pediatrics*. 2020. 180: 1349-1357.

Costa R, Colizzi M. The Effect of Cross-Sex Hormonal Treatment on Gender Dysphoria Individuals' Mental Health: A Systematic Review. *Neuropsychiatric Disease and Treatment*. 2016. 12: 1953-1966.

Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *Journal of Sexual Medicine*. 2015. 12(11).

Davy Z, Toze M. What Is Gender Dysphoria? A Critical Systematic Narrative Review. *Transgender Health*. 2018. 3(1).

De Sanctis V, Soliman AT, Di Maio S, Soliman N, Elsedfy H. Long-Term Effects and Significant Adverse Drug Reactions (ADRs) Associated with the Use of Gonadotropin-Releasing Hormone Analogs (GnRHa) for Central Precocious Puberty: A Brief Review of Literature. *Acta Biomed*. 2019. 90(3).

De Vries ALC, McGuire JK, Steensma TD, Wagenaar ECF, Doreleijers TAH, Cohen-Kettenis PT. Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment. *Pediatrics*. 2014. 134(4).

Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Langstrom N, Landen M. Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLoS One*. 6(2).

Donovan GK. *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Dutra E, Lee J, Torbati T, Garcia M, Merz CNB, Shufelt C. Cardiovascular Implications of Gender-Affirming Hormone Treatment in the Transgender Population. *Maturitas*. 2019. 129: 45-49.

Few Transgender Children Change Their Minds After 5 Years, Study Finds. *New York Times*. 4 May 2022.

Gaetano P. David Reimer and John Money Gender Reassignment Controversy: The John/Joan Case. *The Embryo Project Encyclopedia*. 2017.

Geffen S, Horn T, Smith KJ, Cahill S. Advocacy for Gender Affirming Care: Learning from the Injectable Estrogen Shortage. *Tronsgender Heolth*. 2018. 3(1).

Go JJ. Should Gender Reassignment Surgery Be Publicly Funded? *Bioethical Inquiry*. 2018. 15: 527-534.

Gu J, Kanai, R. What contributes to individual differences in brain structure. *Front Hum Neurosci*. 2014. 8:262.

Hariton E, Locascio JJ. Randomised Controlled Trials – The Gold Standard for Effectiveness Research. *BJOG: An International Journal of Obstetrics and Gynecology*. 2018. 125(13).

Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GG. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinological Metabolism*. 2017. 102(11).

Herman JL, Brown TNT, Haas AP. *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey*. University of California at Los Angeles School of Law Williams Institute. 2019.

Hess J, Neto RR, Panic L, Rubben H, Senf W. Satisfaction with Male-to-Female Gender Reassignment Surgery. *Deutsches Arzteblatt International*. 2014. 111: 795-801.

Hruz PW. Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. *Catholic Medical Association*. 2020. 87(1).

James HA, Chang AY, Imhof RL, Sahoo A, Montenegro MM, Imhof NR, Gonzalez CA, Lteif AN, Nippoldt TB, Davidge-Pitts CJ. A Community-Bases Study of Demographics, Medical and Psychiatric Conditions, and Gender Dysphoria/Incongruence Treatment in Transgender/Gender Diverse Individuals. *Biology of Sex Differences*. 2020. 11(55).

Jensen RK, Jensen JK, Simons LK, Chen D, Rosoklija I, Finlayson C. Effect of Concurrent Gonadotropin-Releasing Hormone Against Treatment on Dose and Side Effects of Gender-Affirming Hormone Therapy in Adolescent Transgender Patients. *Transgender Health*. 2019. 4(1).

Joel D., Berman Z., Tavor L. Sex beyond the Genitalia: The Human Brain Mosaic. *Proceedings of the National Academy of Sciences of the United States of America*. 2015. 112(50).

Kalin NH. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals after Gender-Affirming Surgeries: A Comment by the Editor on the Process (Letter). *American Journal of Psychiatry*. 2020. 177:765.

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

Kozlowska K, Chudleigh C, McClure G, Maguire AM, Ambler GR. Attachment Patterns in Children and Adolescents with Gender Dysphoria. *Frontiers in Psychology*. 2021. 11: 582688.

Kuper LE, Mathews S, Lau M. Baseline Mental Health and Psychosocial Functioning of Transgender Adolescents Seeking Gender-Affirming Hormone Therapy. *Journal of Developmental Behavior Pediatrics*. 2019. 40(8).

Kyriakou A, Nicolaides NC, Skordis N. Current Approach to the Clinical Care of Adolescents with Gender Dysphoria. *Acta Biomed*. 2020. 91(1).

Laidlaw M, Cretella M, Donovan K. The Right to Best Care for Children Does Not Include the Right to Medical Transition. *The American Journal of Bioethics*. 2019. 19(2).

Laidlaw M, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: Endocrine Treatment of Gender-Dsyphoria/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *Journal of Clinical Endocrinological Metabolism*. 2018.

Lappert P. *Surgical Procedures and Gender Dysphoria*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Lee JY, Finlayson C, Olson-Kennedy J, Garofalo R, Chan YM, Glidden DV, Rosenthal SM. Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings from the Trans Youth Care Study. *Journal of the Endocrine Society*. 2020. 4(9).

Levine SB. Informed Consent for Transgendered Patients. *Journal of Sex & Marital Therapy*. 2018. 10:1080.

Littman L. Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Archives of Sexual Behavior*. 2021. 50: 3353-3369.

Littman L. Rapid-Onset Gender Dysphoria in Adolescents and Young Adults: A Study of Parental Reports. *PLOS One*. 2018. 13(8).

Mayer L, McHugh PR. Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences. *The New Atlantis*. 2016. Fall Edition. 103.

McHugh PR. *The Mind Has Mountains: Reflections on Society and Psychiatry*. The Johns Hopkins University Press. 2006.

Medical Textbook Strips Gender Dysphoria Definition after Being Cited by Florida. *Fox News*. 8 May 2022.

Merck Pharmaceuticals. *Merck Manual: Professional Version*. 2021.

Monstrey SJ, Ceulemans P, Hoebeke P. Sex Reassignment Surgery in the Female-to-Male Transsexual. *Seminars in Plastic Surgery*. 2011. 25(3).

Nguyen HB, Chavez AM, Lipner E, Hantsoo L, Kornfield SL, Davies RD, Epperson CN. Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition. *Curr Psychiatry Rep*. 2019. 20(12).

Nhi Le HP. *Eminence-Based Medicine vs. Evidence-Based Medicine*. Students 4 Best Evidence. 12 January 2016. https://s4be.cochrane.org/blog/2016/01/12/eminence-based-medicine-vs-evidence-based-medicine/#:~:text=What%20is%20eminence-based%20medicine,appraisal%20of%20scientific%20evidence%20available

Olson KR, Durwood L, DeMeules M, McLaughlin KL. Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics*. 2015. 137(3).

Olson KR, Durwood L, Horton R, Gallagher NM, Devor A. Gender Identity 5 Years After Social Transition. *Pediatrics*. 2022; doi: 10.1542/peds.2021-056082.

Olson-Kennedy J, Warus J, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA Pediatrics*. 2018. 172(5).

Palveluvalikoima of Finland. Recommendation of the Council for Choices in Health Care in Finland (Palko/Cohere Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. 2020.

Rafferty J, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*. 2018. 142(4).

Sadr M, Korashad BS, Talaei A, Fazeli N, Honekopp J. 2D:4D Suggests a Role of Prenatal Testosterone in Gender Dysphoria. *Archives of Sexuol Behavior*. 2020. 49: 421-432.

Saleem F, Rizvi SW. Transgender Associations and Possible Etiology: A Literature Review. *Cureus*. 9(12).

Shumer DE, Reisner SL, Edwards-Leeper L, Tishelman A. Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic. *LGBT Health*. 2016. 3(5).

Society for Evidence Based Gender Medicine. Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW). 2022.

Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT. Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2013. 52(6).

Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Open Network*. 2022; 59(2).

Trum H, Hoebeke P, Gooren L. Sex Reassignment of Transsexual People from a Gynecologist's and Urologist's Perspective. *Acto Obstetrica et Gynecologica*. 2016. 94: 563-567.

Turban JL, Loo SS, Almazan AN, Keuroghlian AS. Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Method Analysis *LGBT Health*. 2021. 8(4).

UF Doctor Says Gender-Affirming Care Works for Kids Who Need It, and Can Even Save Lives. *Health News Florida*. 26 April 2022.

Unger CA. Hormone Therapy for Transgender Patients. *Translationol Andrology and Urology*. 2016. 5(6).

University of California at San Francisco Health System. *Overview of Feminizing Hormone Therapy*. 2020.

University of California at San Francisco Health System. *Overview of Masculinizing Hormone Therapy*. 2020.

U.S. Department of Defense, Tricare. *Gender Dysphoria Services*. 2022.

U.S. Department of Health and Human Services: Office for Civil Rights. HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy. 2 March 2022.

U.S. Drug Enforcement Administration. *Drug Fact Sheet: Steroids*. 2020.

A Review of the President's FY 2023 Funding Request and Budget Justification for the National Institutes of Health. U.S. Senate Committee on Appropriations. Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. 17 May 2022. https://www.appropriations.senate.gov/hearings/a-review-of-the-presidents-fy-2023-funding-request-and-budget-justification-for-the-national-institutes-of-health

Van Meter QL. Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Van der Miesen AIR, Hurley H, Bal AM, de Vries ALC. Prevalence of the Wish to Be of the Opposite Gender in Adolescents and Adults with Autism Spectrum Disorder. *Archives of Sexual Behavior*. 2018. 47: 2307-2317.

Van Mol A, Laidlaw MK, Grossman M, McHugh PR. Gender-Affirmation Surgery Conclusion Lacks Evidence. *American Journal of Psychiatry*. 2020. 177:765.

Varkey B. Principles of Clinical Ethics and Their Application to Practice. *Medical Principles and Practice*. 2021. 30: 17-28.

World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. 2012.

Zhao JJ, Marchaim D, Palla MB, Bogan CW, Hayakawa K, Tansek R, Moshos J, Muthusamy A, Kotra H, Lephart PR, Wilson AN, Kaye KS. Surgical Site Infections in Genital Reconstruction Surgery for Gender Reassignment, Detroit: 1984-2008. *Surgical Infections*. 2014. 15(2).

Zucker K. Debate: Different strokes for different folks. *Child and Adolescent Mental Health*. 2019. doi.org/10.1111/camh.12330.

Attachments

Attachment A: Secretary for the Florida Agency for Health Care Administration's Letter to Deputy Secretary Thomas Wallace. 20 April 2022.

Attachment B: Complete text of Rule 59G-1.035, F.A.C.

Attachment C: Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluatian of the Best Available Evidence*. 16 May 2022.

Attachment D: James Cantor, PhD: *Science of Gender Dysphoria and Transsexualism*. 17 May 2022.

Attachment E: Quentin Van Meter, MD: *Cancerns about Affirmation af an Incangruent Gender in a Child or Adolescent*. 17 May 2022.

Attachment F: Patrick Lappert, MD: *Surgical Pracedures and Gender Dyspharia*. 17 May 2022.

Attachment G: G. Kevin Donovan, MD: *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. 16 May 2022.

Noble, Amy N (CHFS)

From: (b)(6)
Sent: Tuesday, June 7, 2022 9:16 AM
To: Noble, Amy N (CHFS)
Subject: (b)(6)
Attachments: IMG_20220607_091420981.jpg; IMG_20220607_091432770.jpg; IMG_20220607_091442734.jpg

Hi! Here's my letter, please let me know if I need to change anything!

Hello, to whom it may concern, I am a transgender male who is in process of transitioning. I have my name in process of legally switching my name. I have a court order, I'm just switching other documents.

My name is (b)(6) on my insurance documents.
My name is (b)(6) on my state ID.
My name is (b)(6) on my court order.
My DOB is (b)(6)
My social security number is (b)(6)

I am writing to request a state fair hearing. I am requesting this on this grounds of Wellcare's blanket exclusion on gender affirming surgeries, and the denial of my appeal for top surgery.

My plan's exclusion of coverage of transgender-related care should not govern this decision as such an exclusion is prohibited by the Affordable Care Act - instead, WellCare must evaluate this decision on the basis of medical necessity. Wellcare should approve my request for precertification of code (b)(6) on the basis of the medical necessity documented by my medical providers and duly provided in my initial request, and appeal.

I. My plan's current exclusion of coverage of transgender-related care, which dictated WellCares denial of my precertification request, and appeal request is prohibited by the Affordable Care Act.

WellCare based its denial of my request on a blanket exclusion in my health insurance plan. This exclusion violates section 1557 of the Affordable Care Act.

Section 1557 of the Affordable Care Act (42 U.S.C. 18116) sets forth the requirement for non-discrimination in health care coverage, requiring that:

> "[A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection."

Title IX of the Education Amendments of 1972 provides, in pertinent part:

"No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance [...]"

Further guidance on Section 1557 of the Affordable Care Act is provided in the rule on Nondiscrimination in Health Programs and Activities, which expands upon the definition of sex discrimination:

> *"On the basis of sex* includes, but is not limited to, on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or **gender identity**. [...]
>
> We noted that like other Federal agencies, HHS has previously interpreted sex discrimination to include discrimination on the basis of gender identity. We also noted that courts, including in the context of Section 1557, have recognized that sex discrimination includes discrimination based on gender identity. Thus, we proposed to adopt formally this well-accepted interpretation of discrimination "on the basis of sex.""

The rule goes on to explain:

> "OCR proposed to apply basic nondiscrimination principles in evaluating whether a covered entity's denial of a claim for coverage for transition-related care is the product of discrimination. We noted that based on these principles, **an explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to gender transition is unlawful** on its face under paragraph (b)(4); in singling out the entire category of gender transition services, **such an exclusion or limitation systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex.**
>
> Moreover, we proposed in § 92.207(b)(5) to bar a covered entity from denying or limiting coverage, or denying a claim for coverage, for specific health services related to gender transition where such a denial or limitation results in discrimination against a transgender individual. **In evaluating whether it is discriminatory to deny or limit a request for coverage for a particular service for an individual seeking the service as part of transition-related care, we provided that OCR will start by inquiring whether and to what extent coverage is available when the same service is not related to gender transition.** If, for example, an issuer or State Medicaid agency denies a claim for coverage for a hysterectomy that a patient's provider says is medically necessary to treat gender dysphoria, OCR will evaluate the extent of the covered entity's coverage policy for hysterectomies under other circumstances. We noted that OCR will also carefully scrutinize whether the covered entity's explanation for the

denial or limitation of coverage for transition-related care is legitimate and not a pretext for discrimination."

WellCare routinely covers mastectomies and breast reconstructive surgeries deemed to be medically necessary, including areolar reconstruction, when not related to gender transition. To exclude identical procedures for transgender individuals based merely on their medical necessity being due to gender dysphoria as opposed to other diagnoses, "systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex" in violation of Section 1557.

II. Because WellCares blanket exclusion of transition-related healthcare is unlawful under the Affordable Care Act, WellCare must evaluate my request for precertification on the basis of medical necessity.

I meet criteria for medical necessity both generally and as it pertains to gender reassignment surgery (GRS). I meet and exceed the criteria as set forth by the World Professional Association for Transgender Health (WPATH) as well as for a diagnosis of Gender Dysphoria as set forth by the DSM 5. Further, it is the clinical opinion of my therapist, a M.S., LPCC., who possesses all of the characteristics of a Qualified Mental Health Professional defined by WPATH, that surgery is the appropriate treatment for my long-standing Gender Dysphoria and that my mental health and overall well-being would greatly benefit from this procedure.

I would like for Wellcare to reevaluate their decision, and approve my request for "top surgery," as well as reevaluate their policy against GRS, as it's discriminatory against transgender individuals and is unlawful.

Sincerely,

(b)(6)

(b)(6)

Noble, Amy N (CHFS)

From: Dienst, Richard D (CHFS)
Sent: Monday, June 6, 2022 2:29 PM
To: CHFS OMB Constituent Services
Cc: Noble, Amy N (CHFS)
Subject: RE: Wellcare: Appeal

We can follow up and see if they want to submit a state fair hearing request...which is the next step after the denial of the internal MCO appeal.

Rick

From: CHFS OMB Constituent Services <ConstituentServices@ky.gov>
Sent: Monday, June 6, 2022 2:24 PM
To: Dienst, Richard D (CHFS) <Richard.Dienst@ky.gov>
Subject: Wellcare: Appeal

Hi Rick,
This constituent is saying she wants to appeal the decision on the CPT code for Wellcare. Is this something you can look into?
Thanks,

Emy Pastrano
Executive Advisor
Constituent Services
Office of the Ombudsman and Administrative Review
Cabinet for Health and Family Services
275 East Main St. 2E-O
Frankfort, KY 40621
Office: (502) 564-5497
Cell #: (b)(6)

From: Hockensmith Pane, Angela D (Gov Office) <Angela.HockensmithPane@ky.gov>
Sent: Monday, June 6, 2022 10:55 AM
To: CHFS OMB Constituent Services <ConstituentServices@ky.gov>
Subject: FW: Angela shared a message with you

Please send to appropriate staff to address. Thanks!

From: iConstituent notifications <governor@ky.gov>
Sent: Monday, June 6, 2022 9:02 AM
To: Hockensmith Pane, Angela D (Gov Office) <Angela.HockensmithPane@ky.gov>
Subject: Angela shared a message with you

iConstituent

Angela shared a message

Angela

AH

(b)(6) said:

Subject: Illegal Medicaid actions. Hi! In writing to inform you that Wellcare of Kentucky is not following federal regulations for protected class, which includes gender. I am a transgender male. I was denied coverage for my top surgery. My appeal letter was as follows.

05/06/2022

WellCare of Kentucky
2480 Fortune Dr Ste 200
Lexington, KY 40509

Member Name:
(b)(6)
Member Number ID:
(b)(6)
Provider Name:
(b)(6)
Payer:
(b)(6)

Plan name:
Medicaid

Contact Name:
(b)(6)
Contact Email:
(b)(6)
Contact Phone Number:
(b)(6)
Contact Address:

(b)(6)

Subject: Request for [LEVEL 2 Appeal]

To Whom It May Concern:

I am writing to request a LEVEL 2 appeal. I wish to appeal the decision relating to CPT code (b)(6) for Authorization (b)(6) CaseID# (b)(6)

My plan's exclusion of coverage of transgender-related care should not govern this decision as such an exclusion is prohibited by the Affordable Care Act - instead, WellCare must evaluate this decision on the basis of medical necessity. Wellcare should approve my request for precertification of code (b)(6) on the basis of the medical necessity documented by my medical providers and duly provided in my initial request.

My plan's current exclusion of coverage of transgender-related care, which dictated WellCares denial of my precertification request, is prohibited by the Affordable Care Act.

WellCare based its denial of my request on a blanket exclusion in my health insurance plan. This exclusion violates section 1557 of the Affordable Care Act.

Section 1557 of the Affordable Care Act (42 U.S.C. 18116) sets forth the requirement for non-discrimination in health care coverage, requiring that:

"[A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection."

Title IX of the Education Amendments of 1972 provides, in pertinent part:

"No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance [...]"

Further guidance on Section 1S57 of the Affordable Care Act is provided in the rule on Nondiscrimination in Health Programs and Activities, which expands upon the definition of sex discrimination:

"On the basis of sex includes, but is not limited to, on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or gender identity. [...]

We noted that like other Federal agencies, HHS has previously interpreted sex discrimination to include discrimination on the basis of gender identity. We also noted that courts, including in the context of Section 1557, have recognized that sex
discrimination includes discrimination based on gender identity. Thus, we proposed

to adopt formally this well-accepted interpretation of discrimination "on the basis of sex.""

The rule goes on to explain:

"OCR proposed to apply basic nondiscrimination principles in evaluating whether a covered entity's denial of a claim for coverage for transition-related care is the product of discrimination. We noted that based on these principles, an explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to gender transition is unlawful on its face under paragraph (b)(4); in singling out the entire category of gender transition services, such an exclusion or limitation systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex.

Moreover, we proposed in § 92.207(b)(5) to bar a covered entity from denying or limiting coverage, or denying a claim for coverage, for specific health services related to gender transition where such a denial or limitation results in discrimination against a transgender individual. In evaluating whether it is discriminatory to deny or limit a request for coverage for a particular service for an individual seeking the service as part of transition-related care, we provided that OCR will start by inquiring whether and to what extent coverage is available when the same service is not related to gender transition. If, for example, an issuer or State Medicaid agency denies a claim for coverage for a hysterectomy that a patient's provider says is medically necessary to treat gender dysphoria, OCR will evaluate the extent of the covered entity's coverage policy for hysterectomies under other circumstances. We noted that OCR will also carefully scrutinize whether the covered entity's explanation for the denial or limitation of coverage for transition-related care is legitimate and not a pretext for discrimination."

WellCare routinely covers mastectomies and breast reconstructive surgeries deemed to be medically necessary, including areolar reconstruction, when not related to gender transition. To exclude identical procedures for transgender individuals based merely on their medical necessity being due to gender dysphoria as opposed to other diagnoses, "systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex" in violation of Section 1557.

Because WellCares blanket exclusion of transition-related healthcare is unlawful

under the Affordable Care Act, WellCare must evaluate my request for precertification on the basis of medical necessity.

I meet criteria for medical necessity both generally and as it pertains to gender reassignment surgery (GRS. I meet and exceed the criteria as set forth by the World Professional Association for Transgender Health (WPATH) as well as for a diagnosis of Gender Dysphoria as set forth by the DSM 5. Further, it is the clinical opinion of my therapist, a M.S., LPCC., who possesses all of the characteristics of a Qualified Mental Health Professional defined by WPATH, that surgery is the appropriate treatment for my long-standing Gender Dysphoria and that my mental health and overall well-being would greatly benefit from this procedure (see attached letter of referral from Sydney King).

I request that WellCare, in recognizing its blanket exclusion of transition related healthcare coverage as unlawful, approve my request for precertification for codes on the basis of medical necessity as described in WellCares Enrollee Handbook and specifically confirmed by my medical providers in accordance with the general requirements for medical necessity defined by WellCare.
WellCares Enrollee Handbook states, "We approve care that is medically needed or necessary. This means the care, services, or supplies give you the treatment you need. The care, services, or supplies must:
• Be right for your medical condition • Be care accepted by most doctors • Not be for convenience • Be in the right amount, at the right place, and at the right time • Be safe for you

Clinically Appropriate We approve care that is clinically right or appropriate. This just means the services or supplies you get are standard. Standards are set by national guidelines, such as InterQual®."

The requested procedure meets WellCares criteria for medically needed.

Sincerely,
(b)(6)

Wellcares member handbook states specifically that transgender surgeries are excluded, which goes against the protections afforded to me by the ACA.

I would like help with protecting my rights as a Kentucky citizen, and a transgender individual. I would like for Wellcare to be made to seriously look at, and correct how illegal their blanket exclusion of transgender healthcare is, and remedy it.

Thank you so much.

I prefer to be contacted VIA telephone. My phone number is (b)(6) Thank you again.

(b)(6)

View message

WellCare
Beyond Healthcare. A Better You.

PO Box 31370
Tampa, FL 33631-3370

KRISTEN MURPHY
432 16TH ST
ASHLAND, KY 41101

05/04/2022

Notice of Adverse Benefit Determination

Name: (b)(6)
Member ID: (b)(6)
Reference #: (b)(6)
DOB: (b)(6)
DOS: (b)(6)

Dear Provider:

We have taken the following action on your service request regarding the member noted above:

The request for female to male breast reduction surgery-a surgery to remove a breast is not approved. The service is not covered by your Plan. Please follow up with your doctor for a new referral for a covered service.
Criteria Referenced: Kentucky Enrollee Handbook, Section: Services Not Covered by WellCare of Kentucky

You may request a copy of the clinical criteria, benefit provision or other information used to make this decision by calling Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7 a.m. to 7 p.m. EST.

This does not mean that you cannot provide the service(s) you requested. It means you may not be reimbursed for the service(s).

YOU HAVE THE RIGHT TO ASK FOR AN APPEAL OF THIS DECISION.

If you do not agree with this decision, you may appeal. Your request must be submitted within sixty (60) calendar days of the date of this notice. We will issue an appeal decision in writing within thirty (30) calendar days of receiving the appeal request, unless we need a fourteen (14) calendar day extension. If we need an extension, we will request it from you.

WellCare
Beyond Healthcare. A Better You.
PO Box 31370
Tampa, FL 33631-3370

To appeal this decision, please fax or mail your request to:

WellCare of Kentucky Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253
Fax: 1-866-201-0657

For assistance in filing an appeal call Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7:00 a.m. to 7:00 p.m. EST.

Sincerely,

Utilization Management Department

Printout

Friday, May 27, 2022 2:40 PM

WellCare
Beyond Healthcare. A Better You.

PO Box 31370
Tampa, FL 33631-3370

LEXINGTON SURGERY CENTER LTD
2115 HARRODSBURG RD
LEXINGTON, KY 40504

05/04/2022

Notice of Adverse Benefit Determination

Name: (b)(6)
Member ID: (b)(6)
Reference #: (b)(6)
DOB: (b)(6)
DOS:

Dear Provider:

We have taken the following action on your service request regarding the member noted above:

The request for female to male breast reduction surgery-a surgery to remove a breast is not approved. The service is not covered by your Plan. Please follow up with your doctor for a new referral for a covered service.
Criteria Referenced: Kentucky Enrollee Handbook, Section: Services Not Covered by WellCare of Kentucky

You may request a copy of the clinical criteria, benefit provision or other information used to make this decision by calling Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7 a.m. to 7 p.m. EST.

This does not mean that you cannot provide the service(s) you requested. It means you may not be reimbursed for the service(s).

YOU HAVE THE RIGHT TO ASK FOR AN APPEAL OF THIS DECISION.

If you do not agree with this decision, you may appeal. Your request must be submitted within sixty (60) calendar days of the date of this notice. We will issue an appeal decision in writing within thirty (30) calendar days of receiving the appeal request, unless we need a fourteen (14) calendar day extension. If we need an extension, we will request it from you.

WellCare
Beyond Healthcare. A Better You.
PO Box 31370
Tampa, FL 33631-3370

To appeal this decision, please fax or mail your request to:

WellCare of Kentucky Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253
Fax: 1-866-201-0657

For assistance in filing an appeal call Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7:00 a.m. to 7:00 p.m. EST.

Sincerely,

Utilization Management Department

Printout

Friday, May 27, 2022 2:41 PM

WellCare
Beyond Healthcare. A Better You.

PO Box 31370
Tampa, FL 33631-3370

DAVID DRAKE
2195 HARRODSBURG RD 2ND FLOOR
LEXINGTON, KY 40504

05/04/2022

Notice of Adverse Benefit Determination

Name: (b)(6)
Member ID: (b)(6)
Reference #: (b)(6)
DOB: (b)(6)
DOS:

Dear Provider:

We have taken the following action on your service request regarding the member noted above:

The request for female to male breast reduction surgery-a surgery to remove a breast is not approved. The service is not covered by your Plan. Please follow up with your doctor for a new referral for a covered service.
Criteria Referenced: Kentucky Enrollee Handbook, Section: Services Not Covered by WellCare of Kentucky

You may request a copy of the clinical criteria, benefit provision or other information used to make this decision by calling Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7 a.m. to 7 p.m. EST.

This does not mean that you cannot provide the service(s) you requested. It means you may not be reimbursed for the service(s).

YOU HAVE THE RIGHT TO ASK FOR AN APPEAL OF THIS DECISION.

If you do not agree with this decision, you may appeal. Your request must be submitted within sixty (60) calendar days of the date of this notice. We will issue an appeal decision in writing within thirty (30) calendar days of receiving the appeal request, unless we need a fourteen (14) calendar day extension. If we need an extension, we will request it from you.

WellCare
Beyond Healthcare. A Better You.
PO Box 31370
Tampa, FL 33631-3370

To appeal this decision, please fax or mail your request to:

WellCare of Kentucky Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253
Fax: 1-866-201-0657

For assistance in filing an appeal call Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7:00 a.m. to 7:00 p.m. EST.

Sincerely,

Utilization Management Department

WellCare
Beyond Healthcare. A Better You.
P.O. Box 436000
Louisville, KY 40253

Notice of Appeal Decision

(b)(6)

June 2, 2022

Re (b)(6)
ID#: (b)(6)
File #: (b)(6)
Request: Reduction Mammoplasty CPT 19318

Dear (b)(6)

On May 4, 2022, we received your appeal. This appeal was about: Reduction Mammoplasty.

An Appeals Review Nurse looked at your request.

We reached this decision: The procedure to make your breasts smaller is not approved.

We made this decision because the notes say you want smaller breasts so you will look like a male. The health plan does not cover this kind of procedure. The reasons for the denial are based on a set of benefits/criteria, which include Kentucky Enrollee Handbook 2022 Section: Services Not Covered by WellCare of Kentucky

Kentucky law says we cover services that are "medically necessary." Per *907 KAR 17:020 and 907 KAR 3:130,* "medically necessary" means:

- Care or supplies required to meet an enrollee's medical needs
- The care or supplies must:

- Be right for the enrollee's medical condition;
- Be care accepted by most doctors;
- Not be for convenience;
- Be in the right amount, at the right place and at the right time; and
- Be safe for the enrollee.

This decision will not affect the services or supplies you may need in the future.

You, your doctor, or someone you choose can get a copy of any paperwork used to make this decision. You can get this at no charge. Call **1-877-389-9457** or write to:

WellCare of Kentucky
Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253

We also want to let you know that, per *907 KAR 17:035*, if your provider gets an adverse final decision of a denial, in whole or in part, of a health service or claim for reimbursement related to this service, he or she may ask for an external, independent third-party review. Your provider must first complete an internal appeal with WellCare of Kentucky. Provider requests for external review will only be considered for dates of service on or after December 1, 2016.

If an external, independent third-party review is held, your provider and WellCare of Kentucky may, depending on the outcome of this review, ask for an administrative hearing. This is per *907 KAR 17:040*.

You do not have to take action if your provider files for an external, independent third-party review or administrative hearing. This does not affect your appeal rights or right to ask for a State Fair Hearing.

You Have the Right to Ask for a State Fair Hearing

You have the right to ask for a State Fair Hearing if you do not agree with the decision. A hearing officer from the Kentucky Cabinet for Health and Family Services will review our decision. You, a friend, a relative, lawyer, or someone you choose may ask for a hearing for you. You must give this person permission in writing to act for you.

You must ask for a State Fair Hearing within **120** days from the date of this letter. See *907 KAR 17:010*.

If you ask for a hearing to appeal our decision, you may continue to receive these services. But you must ask for the hearing within 10 days of receiving this notice. You may have to pay for these services if the hearing officer agrees with WellCare that the services are not needed.

You may request a State Fair Hearing at this address:

Office of the Ombudsman
Office of the Ombudsman and Administrative Review
Attn: Medical Appeals and Reconsiderations
275 East Main Street, 2E-O
Frankfort, KY 40621
Phone: 502-564-5497 (TTY **711**)
Fax: 502-564-9523

Contact us or the Kentucky Department for Medicaid Services if:

- You want to know if you can ask for a State Fair Hearing on the denial.
- You want to know if you can still get the care you asked for.
- You want to learn more.

Other things to know:

- You do not have to pay for the State Fair Hearing.
- You have the right to name someone you trust to file a State Fair Hearing for you. You must give the person permission in writing to do so.

Questions? Just call Customer Service at **1-877-389-9457**. TTY users may call **711**. We are here to help you. You can call Monday–Friday, 7 a.m. to 7 p.m.

Sincerely,

Appeals Department
mbsharp

Cc: Dr. David Drake

Discrimination is Against the Law

WellCare of Kentucky complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WellCare of Kentucky does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WellCare of Kentucky provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

WellCare of Kentucky also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call us toll-free at **1-877-389-9457** (TTY: **711**). We're here for your Monday–Friday from 7 a.m. to 7 p.m.

If you believe that WellCare of Kentucky has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

EEO/Civil Rights Compliance Branch
Cabinet for Health and Family Services
Office of Human Resource Management
275 E. Main St, Mail Stop 5C-D
Frankfort, KY 40621
Telephone: **1-502-564-7770**
Fax: **1-502-564-3129**
Email/Web: **https://chfs.ky.gov/Pages/civil-rights.aspx**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the EEO/Civil Rights Compliance Branch is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F
HHH Building
Washington, D.C. 20201
Telephone: **1-800-368-1019**, **1-800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-389-9457** (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-389-9457** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-389-9457** (TTY: **711**)。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-389-9457** (TTY: **711**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-389-9457** (TTY: **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-389-9457** (TTY: **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-389-9457** (TTY: **711**).

주의: 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-389-9457** (TTY: **711**)번으로 전화해 주십시오 .

Opmierksamkeet: Wann du Deitsch (Pennsylvania German/ Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff **1-877-389-9457** (TTY: **711**).

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-877-389-9457** (TTY: **711**)।

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-877-389-9457** (TTY: **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-389-9457** (TTY: **711**).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-389-9457** (TTY: **711**).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona **1-877-389-9457** (TTY: **711**).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-877-389-9457** (TTY: **711**).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-389-9457** (TTY: **711**) まで、お電話にてご連絡ください。

WellCare
Beyond Healthcare. A Better You.
P.O. Box 436000
Louisville, KY 40253

Notice of Appeal Decision

Dr. David Drake
2195 Harrodsburg Road, 2nd Floor
Lexington, KY 40504

June 2, 2022

Re: (b)(6)
ID# (b)(6)
File #: (b)(6)
Request: Reduction Mammoplasty CPT 19318

Dear (b)(6):

On May 4, 2022, we received your appeal. This appeal was about: Reduction Mammoplasty.

An Appeals Review Nurse looked at your request.

We reached this decision: The procedure to make your breasts smaller is not approved.

We made this decision because the notes say you want smaller breasts so you will look like a male. The health plan does not cover this kind of procedure. The reasons for the denial are based on a set of benefits/criteria, which include Kentucky Enrollee Handbook 2022 Section: Services Not Covered by WellCare of Kentucky

Kentucky law says we cover services that are "medically necessary." Per *907 KAR 17:020 and 907 KAR 3:130,* "medically necessary" means:

- Care or supplies required to meet an enrollee's medical needs
- The care or supplies must:

- Be right for the enrollee's medical condition;
- Be care accepted by most doctors;
- Not be for convenience;
- Be in the right amount, at the right place and at the right time; and
- Be safe for the enrollee.

This decision will not affect the services or supplies you may need in the future.

You, your doctor, or someone you choose can get a copy of any paperwork used to make this decision. You can get this at no charge. Call **1-877-389-9457** or write to:

WellCare of Kentucky
Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253

We also want to let you know that, per *907 KAR 17:035*, if your provider gets an adverse final decision of a denial, in whole or in part, of a health service or claim for reimbursement related to this service, he or she may ask for an external, independent third-party review. Your provider must first complete an internal appeal with WellCare of Kentucky. Provider requests for external review will only be considered for dates of service on or after December 1, 2016.

If an external, independent third-party review is held, your provider and WellCare of Kentucky may, depending on the outcome of this review, ask for an administrative hearing. This is per *907 KAR 17:040*.

You do not have to take action if your provider files for an external, independent third-party review or administrative hearing. This does not affect your appeal rights or right to ask for a State Fair Hearing.

You Have the Right to Ask for a State Fair Hearing

You have the right to ask for a State Fair Hearing if you do not agree with the decision. A hearing officer from the Kentucky Cabinet for Health and Family Services will review our decision. You, a friend, a relative, lawyer, or someone you choose may ask for a hearing for you. You must give this person permission in writing to act for you.

You must ask for a State Fair Hearing within **120** days from the date of this letter. See *907 KAR 17:010*.

If you ask for a hearing to appeal our decision, you may continue to receive these services. But you must ask for the hearing within 10 days of receiving this notice. You may have to pay for these services if the hearing officer agrees with WellCare that the services are not needed.

You may request a State Fair Hearing at this address:

Office of the Ombudsman
Office of the Ombudsman and Administrative Review
Attn: Medical Appeals and Reconsiderations
275 East Main Street, 2E-O
Frankfort, KY 40621
Phone: 502-564-5497 (TTY **711**)
Fax: 502-564-9523

Contact us or the Kentucky Department for Medicaid Services if:

- You want to know if you can ask for a State Fair Hearing on the denial.
- You want to know if you can still get the care you asked for.
- You want to learn more.

Other things to know:

- You do not have to pay for the State Fair Hearing.
- You have the right to name someone you trust to file a State Fair Hearing for you. You must give the person permission in writing to do so.

Questions? Just call Customer Service at **1-877-389-9457**. TTY users may call **711**. We are here to help you. You can call Monday–Friday, 7 a.m. to 7 p.m.

Sincerely,

Appeals Department
mbsharp

Cc: Dr. David Drake

Discrimination is Against the Law

WellCare of Kentucky complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WellCare of Kentucky does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WellCare of Kentucky provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

WellCare of Kentucky also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call us toll-free at **1-877-389-9457** (TTY: **711**). We're here for your Monday–Friday from 7 a.m. to 7 p.m.

If you believe that WellCare of Kentucky has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

EEO/Civil Rights Compliance Branch
Cabinet for Health and Family Services
Office of Human Resource Management
275 E. Main St, Mail Stop 5C-D
Frankfort, KY 40621
Telephone: **1-502-564-7770**
Fax: **1-502-564-3129**
Email/Web: **https://chfs.ky.gov/Pages/civil-rights.aspx**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the EEO/Civil Rights Compliance Branch is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F
HHH Building
Washington, D.C. 20201
Telephone: **1-800-368-1019**, **1-800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-389-9457** (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-389-9457** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-389-9457** (TTY: **711**)。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-389-9457** (TTY: **711**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-389-9457** (TTY: **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-389-9457** (TTY: **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-389-9457** (TTY: **711**).

주의: 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-389-9457** (TTY: **711**)번으로 전화해 주십시오 .

Opmierksamkeet: Wann du Deitsch (Pennsylvania German/ Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff **1-877-389-9457** (TTY: **711**).

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-877-389-9457** (TTY: **711**)।

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-877-389-9457** (TTY: **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-389-9457** (TTY: **711**).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-389-9457** (TTY: **711**).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona **1-877-389-9457** (TTY: **711**).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-877-389-9457** (TTY: **711**).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-389-9457** (TTY: **711**) まで、お電話にてご連絡ください。

Site I KyHealth Choices

Click Here To Open New Window

Next search by: Member ID | Case ID | SSN | EPSDT

Member Information

Member ID	(b)(6)	Name	(b)(6)	Active	(b)(6)
		Suffix		Linked ID	
HIC		Prev Name		Benefit Plan	
SSN		Home Street Address 1		Medicare Coverage	
Pseudo Number		Street Address 2		Managed Care	
Gender		Street Address 3		TPL	
Date of Birth		City		Suspension Code	
Date of Death		State		Level of Care	
Age		Zip Code		Patient Liability	
Race		Home County		Medicare Buy-in	
Multi-Race Code		County Office ID		Case/Last Updated	
Ethnicity		Twin		Application Date	
Citizen		Duplicate		Redetermination Date	
Language		DJJ		DJJ	
Phone		Foster Care Ind		Foster Care	
Phone Type		Guardianship Ind		Guardianship	
Add Phone		Pregnancy Ind		Expected Delivery Date	
Add Phone Type		Trust Type		Investigation Ind	
Latitude		Longitude		Header Inst Status	
		Above FPL		KI-HIPP	

Member Maintenance

Select area to add or modify below.

Member	Capitated Lock-in Assignment History	Encounter Threshold	M/W Assignment
Managed Care	MCO Case/Disease Management	MCO Lock-in	MCO Member Information
Medicare	MCO PCP panel	Member MC Special Conditions	PMP Assignment History
Previous Data	PMP Lockout		

Base Information

PMP Assignment History

Status: Active Only

(b)(6)

Type changes below.

MC Program	MANAGED CARE ORGANIZATION	Start Reason	44 - MCAPS AUTOMATIC ENROLLMENT
Effective Date	01/01/2021	Stop Reason	46 - MCAPS DISENROLLMENT
End Date	12/31/2299	Assignment Source	MCAPS ASSIGNMENT
Status	Active	Group Member ID	
PMP ID	7100164990 MCD	Group Member Source	
Provider Name	WELLCARE OF KENTUCKY, INC.		
Site Number	0000		
MC Region	MEDICAL REGION 07	Focus	1915(B) MCO
Added Date	12/19/2020	Copay Indicator	

M/W Assignment

Status: Active Only

(b)(6)

MCO Enrollment Type	M	Effective Date	
MCO Type		End Date	
Status	Active	Date Added	
Original Source		Last Updated Date	
Last Updated Source		User Id	

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
275 EAST MAIN STREET, 1E-B
FRANKFORT, KY 40621-0001

COMPLAINT TRACKING SYSTEM

Case Summary

Case Name: (b)(6)
Case Number: (b)(6)
Case County: *BOYD*
Contact Date: *6/7/2022*
Contact Agency: *QUALITY ADVANCEMENT*
Contact Staff: *Noble, Amy N*

Complainant Name	*Social Security*	*Phone Number*
(b)(6)		

MCO Name	*MCO Other Name*	*Phone Number*
Wellcare		

Topic #	*Program / Subject / Issue*	*Status*	*Status Date*	*Workers Complained About*
1	DMS / MCO / MANAGED CARE	HEARABLE	6/15/2022	

Narrative:

On 2/7/2022 CAS received an appeal request regarding transgender related care denial for member (b)(6)

On 6/7/2022 CAS sent the following email:

From: Noble, Amy N (CHFS)
Sent: Tuesday, June 7, 2022 9:39 AM
To: , .KY_DMS_INQUIRY <KY_DMS_INQUIRY@wellcare.com>; Tammy L. Sanders <Tammy.Sanders@wellcare.com>; LaTrice N. Majors <La'Trice.Majors@wellcare.com>
Subject: DMS SFH request - (b)(6)

Good morning,

Please see the attached hearing request. Forward all relevant documentation by 6/14/2022.

Thank you,

Amy Noble, RD, LD
Citizen Assistance Specialist

Conclusions:

On 6/14/2022 CAS received the following email:

From: LaTrice N. Majors <La'Trice.Majors@wellcare.com>
Sent: Tuesday, June 14, 2022 8:45 AM
To: Noble, Amy N (CHFS) <amy.noble@ky.gov>; , .KY_DMS_INQUIRY <KY_DMS_INQUIRY@wellcare.com>; Tammy L. Sanders <Tammy.Sanders@wellcare.com>
Cc: Tara L. Carnes <Tara.Carnes@wellcare.com>
Subject: ${SECURE}RE: DMS SFH request - (b)(6)

CAUTION PDF attachments may contain links to malicious sites. Please contact the COT Service Desk ServiceCorrespondence@ky.gov for any assistance.

Good Morning Amy

Please see the attached from WellCare. The initial denial and appeal denial.

Thank you in advance,

La'Trice Majors
Senior Compliance Analyst, G&A-Compliance
WellCare Health Plans, Inc.

The adverse benefit determination was dated 5/4/2022 regarding the denial of the request for female to male breast reduction surgery- a surgery to remove a breast.

The notice of appeal decision regarding the denial of reduction mammoplasty was dated 6/2/2022 and upheld the denial. There was also a provider denial dated 6/2/2022 regarding the denial of reduction mammoplasty.

The appeal request was received on 6/7/2022 via email and was timely.

This appeal request is hearable in keeping with 907 KAR 17:010. This request will be forwarded to the Hearings Branch. A letter explaining this will be mailed to (b)(6)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DIVISION OF ADMINISTRATIVE HEARINGS
HEALTH SERVICES ADMINISTRATIVE HEARINGS BRANCH
Administrative Case No. DMS 22-0323

IN RE: (b)(6)

Denial of Coverage for Reduction Mammoplasty

NOTICE OF HEARING
AND ORDER SETTING PREHEARING CONFERENCE

ALL PERSONS RECEIVING THIS SHALL TAKE NOTICE: (b)(6) a/k/a (b)(6) has requested a hearing to challenge a denial of coverage for reduction mammoplasty by the WellCare of Kentucky (WellCare), THEREFORE, IT IS ORDERED:

1. **THE PARTIES SHALL APPEAR FOR A PREHEARING CONFERENCE ON MONDAY, JULY 18, 2022 at 1:00 PM ET/12:00 PM CT.** Persons attending the conference shall call the Division of Administrative Hearing's conference line at (b)(6) and input participant code (b)(6) Callers will be placed on hold until the Hearing Officer starts the conference. The parties shall call the Division of Administrative Hearings at (b)(6) if there is a problem. KRS 13B.070.

2. **THE PURPOSE OF THE PREHEARING CONFERENCE SET ABOVE SHALL BE TO SCHEDULE A HEARING DATE AND TIME CONVENIENT TO ALL THE PARTIES, AS REQUIRED BY KRS 13B.050(1).** The Hearing Officer shall also consider alternative hearing sites (if allowed by law), motions, stipulations, evidence, witnesses, exhibits, settlement or mediation, and any other action that will promote a prompt and orderly hearing. KRS 13B.050(1), .080(1).

3. THE PARTIES SHALL FILE ANY WRITTEN RESPONSE TO A MOTION with the Division of Administrative Hearings, at the address below, AT LEAST FIVE (5) BUSINESS DAYS after the motion is stamped filed. THE PARTIES SHALL NOT FILE A REPLY unless specifically ordered by the Hearing Officer.

4. THE HEARING will be the opportunity for all parties to offer evidence for or against Anthem's determination. At the hearing, parties may present witnesses and exhibits, examine all documents and records presented, make argument without undue interference, question or contest evidence, and confront and cross-examine witnesses. KRS 13B.050(3).

5. THIS CASE HAS BEEN ASSIGNED to Hearing Officer Matthew Mooney for hearing. Hearing Officer Mooney's mailing address is:

DIVISION OF ADMINISTRATIVE HEARINGS
HEALTH SERVICES ADMINISTRATIVE HEARINGS BRANCH
105 SEA HERO ROAD, SUITE 2
FRANKFORT, KY 40601

KRS 13B.050(3)(b).

6. THE LAW PROHIBITS A HEARING OFFICER FROM TALKING TO ONE PARTY ALONE without all other parties being present. KRS 13B.100. THE PARTIES SHALL DIRECT all questions about this Notice and Order, this case, filings or motions filed, and requests to reschedule, to the DAH staff by fax at 502-573-1014, or by phone at 502-564-6621, or by email at CHFS.HSAHB@ky.gov.

7. THE CONTACT INFORMATION FOR THE APPELLANT is:

(b)(6)
(b)(6)
(b)(6)
Phone: (b)(6)
Email:
Appellant

8. THE CONTACT INFORMATION FOR THE APPELLEE'S COUNSEL is:

Joyce A. Merritt
Samantha T. Nance
Embry Merritt Shaffar Womack PLLC
201 East Main Street, Suite 1402
Lexington, KY 40507
Phone: (859) 543-0453
Fax: (800) 505-0113
Email: joyce.merritt@emwnlaw.com
Email: samantha.nance@emwnlaw.com

KRS 13B.050(3)(c).

9. THE FACTUAL GROUNDS for Appellant (b)(6) administrative claim is set forth in the request for hearing and attached documents. Copies of the request are attached to and made a part of this Notice by reference. KRS 13B.050(3)(d).

10. THE FOLLOWING STATE AND FEDERAL LAWS relating to this dispute govern this case: 907 KAR 1:835, 907 KAR 1:563, KRS Chapter 13B. Copies of these laws are available in local county and city law libraries and from the Legislative Research Commission in Frankfort, Kentucky and on the Internet at https://legislature.ky.gov/pages/index.aspx. KRS 13B.050(3)(e).

11. THE PARTIES HAVE THE RIGHT TO COUNSEL in this case, at their own expense. An individual person is not required to have legal counsel and may speak for himself. However, corporate entities are required to have an attorney appear in this matter. Kentucky Bar Ass'n v. Henry Vogt Machine Co., Inc., 416 S.W. 2d 727 (Ky. 1967). Information about free legal help may be available at local DCBS offices, the Kentucky Bar Association, and at local Legal Services offices. KRS 13B.050(3)(f).

12. THE PARTIES SHALL FILE ALL ORIGINAL EXHIBITS, MOTIONS AND OTHER DOCUMENTS by mailing them to DAH at the addresses and numbers given below. The filing party also shall send a copy of anything filed to every other party at the addresses and numbers listed in this Notice and Order. KRS 13B.080(2).

13. EACH PARTY SHALL FILE A LIST OF WITNESSES AND EXHIBITS AND A COPY OF EVERY EXHIBIT the party intends to use at the hearing AT LEAST FIVE (5) BUSINESS DAYS BEFORE THE HEARING. The parties also shall allow other parties to inspect any document or physical evidence they have relating to the issues in dispute, including any case files, forms, photographs, reports, or other documents used to support the disputed action or decision. In addition, Anthem shall allow the Appellant to look at any exculpatory information it possesses. Confidential information shall not be used or considered at the hearing, except as allowed by law. KRS 13B.050(3)(g), .090(3).

14. THE HEARING OFFICER MAY HOLD ANY PARTY IN DEFAULT THAT FAILS TO ATTEND OR PARTICIPATE IN PROCEEDINGS AS REQUIRED OR TO OBEY AN ORDER. On a default, the Hearing Officer may conduct proceedings without the defaulting

party and decide this case based solely on the opposing party's evidence or may issue a summary order resolving this matter. KRS 13B.050(3)(h).

SO NOTICED AND ORDERED this July 1, 2022.

MATTHEW L. MOONEY, HEARING OFFICER
DIVISION OF ADMINISTRATIVE HEARINGS
HEALTH SERVICES ADMIN HEARINGS BRANCH
105 SEA HERO ROAD, SUITE 2
FRANKFORT, KY 40601
Tel: 502-564-6621 / Fax: 502-573-1014
Email: CHFS.HSAHB@ky.gov

CERTIFICATE OF SERVICE

I certify this Notice and Order was filed with the Division of Administrative Hearings, and a copy served BY U.S. MAIL, CERTIFIED, RETURN RECEIPT REQUESTED, and by electronic mail with delivery and read receipt requested as indicated, on July 10th, 2022, on:

(b)(6)

Phone: (b)(6)
Email:
Appellant

Joyce A. Merritt
Samantha T. Nance
Embry Merritt Shaffar Womack PLLC
201 East Main Street, Suite 1402
Lexington, KY 40507
Email: joyce.merritt@emwnlaw.com
Email: samantha.nance@emwnlaw.com
Counsel for the Appellee

Division of Administrative Hearings

Noble, Amy N (CHFS)

From: (b)(6)
Sent: Tuesday, June 7, 2022 9:16 AM
To: Noble, Amy N (CHFS)
Subject: (b)(6)
Attachments: IMG_20220607_091420981.jpg; IMG_20220607_091432770.jpg; IMG_20220607_091442734.jpg

Hi! Here's my letter, please let me know if I need to change anything!

Hello, to whom it may concern, I am a transgender male who is in process of transitioning. I have my name in process of legally switching my name. I have a court order, I'm just switching other documents.

My name is (b)(6) on my insurance documents.
My name is (b)(6) on my state ID.
My name is (b)(6) on my court order.
My (b)(6)
My social security number is (b)(6)

I am writing to request a state fair hearing. I am requesting this on this grounds of Welleare's blanket exclusion on gender affirming surgeries, and the denial of my appeal for top surgery.

My plan's exclusion of coverage of transgender-related care should not govern this decision as such an exclusion is prohibited by the Affordable Care Act - instead, WellCare must evaluate this decision on the basis of medical necessity. Wellcare should approve my request for precertification of code (b)(6) on the basis of the medical necessity documented by my medical providers and duly provided in my initial request, and appeal.

I. My plan's current exclusion of coverage of transgender-related care, which dictated WellCares denial of my precertification request, and appeal request is prohibited by the Affordable Care Act.

WellCare based its denial of my request on a blanket exclusion in my health insurance plan. This exclusion violates section 1557 of the Affordable Care Act.

Section 1557 of the Affordable Care Act (42 U.S.C. 18116) sets forth the requirement for non-discrimination in health care coverage, requiring that:

> "[A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection."

Title IX of the Education Amendments of 1972 provides, in pertinent part:

> "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance [...]"

Further guidance on Section 1557 of the Affordable Care Act is provided in the rule on Nondiscrimination in Health Programs and Activities, which expands upon the definition of sex discrimination:

> *"On the basis of sex* includes, but is not limited to, on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or **gender identity**. [...]
>
> We noted that like other Federal agencies, HHS has previously interpreted sex discrimination to include discrimination on the basis of gender identity. We also noted that courts, including in the context of Section 1557, have recognized that sex discrimination includes discrimination based on gender identity. Thus, we proposed to adopt formally this well-accepted interpretation of discrimination "on the basis of sex.""

The rule goes on to explain:

> "OCR proposed to apply basic nondiscrimination principles in evaluating whether a covered entity's denial of a claim for coverage for transition-related care is the product of discrimination. We noted that based on these principles, **an explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to gender transition is unlawful** on its face under paragraph (b)(4); in singling out the entire category of gender transition services, **such an exclusion or limitation systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex.**
>
> Moreover, we proposed in § 92.207(b)(5) to bar a covered entity from denying or limiting coverage, or denying a claim for coverage, for specific health services related to gender transition where such a denial or limitation results in discrimination against a transgender individual. **In evaluating whether it is discriminatory to deny or limit a request for coverage for a particular service for an individual seeking the service as part of transition-related care, we provided that OCR will start by inquiring whether and to what extent coverage is available when the same service is not related to gender transition.** If, for example, an issuer or State Medicaid agency denies a claim for coverage for a hysterectomy that a patient's provider says is medically necessary to treat gender dysphoria, OCR will evaluate the extent of the covered entity's coverage policy for hysterectomies under other circumstances. We noted that OCR will also carefully scrutinize whether the covered entity's explanation for the

[illegible] [illegible] of coverage for transition-related care is legitimate and not a pretext for discrimination."

[illegible] routinely covers mastectomies and breast reconstructive surgeries deemed to be medically necessary, including areolar reconstruction, when not related to gender transition. To exclude identical [illegible] for transgender individuals based merely on their medical necessity being due to gender [illegible] opposed to other diagnoses "systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex" in violation of Section 1557.

II. Because WellCares blanket exclusion of transition-related healthcare is unlawful under the Affordable Care Act, WellCare must evaluate my request for precertification on the basis of medical necessity.

I meet criteria for medical necessity [illegible] and as [illegible] to gender reassignment surgery (GRS). I meet and exceed the criteria [illegible] by the World Professional Association for Transgender Health (WPATH), as well as for a diagnosis of Gender Dysphoria as set forth by the DSM-5. Further, it is the clinical opinion of [illegible], who [illegible] all of the characteristics of a Qualified Mental Health Professional defined by WPATH, that surgery is the appropriate treatment for my long-standing Gender Dysphoria and that my [illegible] health and overall well-being would greatly benefit from this procedure.

I would like for Wellcare to reevaluate their decision, and approve my request for "top surgery," as well as reevaluate their policy against GRS as it is discrimination against transgender individuals and is unlawful.

Sincerely,

(b)(6) [redacted]

(b)(6) [redacted]

Noble, Amy N (CHFS)

From: Dienst, Richard D (CHFS)
Sent: Monday, June 6, 2022 2:29 PM
To: CHFS OMB Constituent Services
Cc: Noble, Amy N (CHFS)
Subject: RE: Wellcare: Appeal

We can follow up and see if they want to submit a state fair hearing request...which is the next step after the denial of the internal MCO appeal.

Rick

From: CHFS OMB Constituent Services <ConstituentServices@ky.gov>
Sent: Monday, June 6, 2022 2:24 PM
To: Dienst, Richard D (CHFS) <Richard.Dienst@ky.gov>
Subject: Wellcare: Appeal

Hi Rick,
This constituent is saying she wants to appeal the decision on the CPT code for Wellcare. Is this something you can look into?
Thanks,

Emy Pastrano
Executive Advisor
Constituent Services
Office of the Ombudsman and Administrative Review
Cabinet for Health and Family Services
275 East Main St. 2E-O
Frankfort, KY 40621
Office: (502) 564-5497
Cell #: (b)(6)

From: Hockensmith Pane, Angela D (Gov Office) <Angela.HockensmithPane@ky.gov>
Sent: Monday, June 6, 2022 10:55 AM
To: CHFS OMB Constituent Services <ConstituentServices@ky.gov>
Subject: FW: Angela shared a message with you

Please send to appropriate staff to address. Thanks!

From: iConstituent notifications <governor@ky.gov>
Sent: Monday, June 6, 2022 9:02 AM
To: Hockensmith Pane, Angela D (Gov Office) <Angela.HockensmithPane@ky.gov>
Subject: Angela shared a message with you

iConstituent

Angela shared a message

Angela

AH

(b)(6) said:

Subject: Illegal Medicaid actions. Hi! In writing to inform you that Wellcare of Kentucky is not following federal regulations for protected class, which includes gender. I am a transgender male. I was denied coverage for my top surgery. My appeal letter was as follows.

05/06/2022

WellCare of Kentucky
2480 Fortune Dr Ste 200
Lexington, KY 40509

Member Name:
(b)(6)
Member Number ID:
(b)(6)
Provider Name:
David Drake MD
Payer:
WellCare of Ky

Plan name:
Medicaid

Contact Name:
(b)(6)
Contact Email:
(b)(6)
Contact Phone Number:
(b)(6)
Contact Address:

(b)(6)

Subject: Request for [LEVEL 2 Appeal]

To Whom It May Concern:

I am writing to request a LEVEL 2 appeal. I wish to appeal the decision relating to CPT code (b)(6) for Authorization (b)(6) CaseID# (b)(6)

My plan's exclusion of coverage of transgender-related care should not govern this decision as such an exclusion is prohibited by the Affordable Care Act - instead, WellCare must evaluate this decision on the basis of medical necessity. Wellcare should approve my request for precertification of code (b)(6) on the basis of the medical necessity documented by my medical providers and duly provided in my initial request.

My plan's current exclusion of coverage of transgender-related care, which dictated WellCares denial of my precertification request, is prohibited by the Affordable Care Act.

WellCare based its denial of my request on a blanket exclusion in my health insurance plan. This exclusion violates section 1557 of the Affordable Care Act.

Section 1557 of the Affordable Care Act (42 U.S.C. 18116) sets forth the requirement for non-discrimination in health care coverage, requiring that:

"[A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection."

Title IX of the Education Amendments of 1972 provides, in pertinent part:

"No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance [...]"

Further guidance on Section 1557 of the Affordable Care Act is provided in the rule on Nondiscrimination in Health Programs and Activities, which expands upon the definition of sex discrimination:

"On the basis of sex includes, but is not limited to, on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or gender identity. [...]

We noted that like other Federal agencies, HHS has previously interpreted sex discrimination to include discrimination on the basis of gender identity. We also noted that courts, including in the context of Section 1557, have recognized that sex
discrimination includes discrimination based on gender identity. Thus, we proposed

to adopt formally this well-accepted interpretation of discrimination "on the basis of sex.""

The rule goes on to explain:

"OCR proposed to apply basic nondiscrimination principles in evaluating whether a covered entity's denial of a claim for coverage for transition-related care is the product of discrimination. We noted that based on these principles, an explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to gender transition is unlawful on its face under paragraph (b)(4); in singling out the entire category of gender transition services, such an exclusion or limitation systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex.

Moreover, we proposed in § 92.207(b)(5) to bar a covered entity from denying or limiting coverage, or denying a claim for coverage, for specific health services related to gender transition where such a denial or limitation results in discrimination against a transgender individual. In evaluating whether it is discriminatory to deny or limit a request for coverage for a particular service for an individual seeking the service as part of transition-related care, we provided that OCR will start by inquiring whether and to what extent coverage is available when the same service is not related to gender transition. If, for example, an issuer or State Medicaid agency denies a claim for coverage for a hysterectomy that a patient's provider says is medically necessary to treat gender dysphoria, OCR will evaluate the extent of the covered entity's coverage policy for hysterectomies under other circumstances. We noted that OCR will also carefully scrutinize whether the covered entity's explanation for the denial or limitation of coverage for transition-related care is legitimate and not a pretext for discrimination."

WellCare routinely covers mastectomies and breast reconstructive surgeries deemed to be medically necessary, including areolar reconstruction, when not related to gender transition. To exclude identical procedures for transgender individuals based merely on their medical necessity being due to gender dysphoria as opposed to other diagnoses, "systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex" in violation of Section 1557.

Because WellCares blanket exclusion of transition-related healthcare is unlawful

under the Affordable Care Act, WellCare must evaluate my request for precertification on the basis of medical necessity.

I meet criteria for medical necessity both generally and as it pertains to gender reassignment surgery (GRS. I meet and exceed the criteria as set forth by the World Professional Association for Transgender Health (WPATH) as well as for a diagnosis of Gender Dysphoria as set forth by the DSM 5. Further, it is the clinical opinion of my therapist, a M.S., LPCC., who possesses all of the characteristics of a Qualified Mental Health Professional defined by WPATH, that surgery is the appropriate treatment for my long-standing Gender Dysphoria and that my mental health and overall well-being would greatly benefit from this procedure (see attached letter of referral from Sydney King).

I request that WellCare, in recognizing its blanket exclusion of transition related healthcare coverage as unlawful, approve my request for precertification for codes on the basis of medical necessity as described in WellCares Enrollee Handbook and specifically confirmed by my medical providers in accordance with the general requirements for medical necessity defined by WellCare.
WellCares Enrollee Handbook states, "We approve care that is medically needed or necessary. This means the care, services, or supplies give you the treatment you need. The care, services, or supplies must:
• Be right for your medical condition • Be care accepted by most doctors • Not be for convenience • Be in the right amount, at the right place, and at the right time • Be safe for you

Clinically Appropriate We approve care that is clinically right or appropriate. This just means the services or supplies you get are standard. Standards are set by national guidelines, such as InterQual®."

The requested procedure meets WellCares criteria for medically needed.

Sincerely,
(b)(6)

Wellcares member handbook states specifically that transgender surgeries are excluded, which goes against the protections afforded to me by the ACA.

I would like help with protecting my rights as a Kentucky citizen, and a transgender individual. I would like for Wellcare to be made to seriously look at, and correct how illegal their blanket exclusion of transgender healthcare is, and remedy it.

Thank you so much.

I prefer to be contacted VIA telephone. My phone number is (b)(6) Thank you again.

(b)(6)

(b)(6)

(b)(6)

View message

WellCare
Beyond Healthcare. A Better You.

PO Box 31370
Tampa, FL 33631-3370

KRISTEN MURPHY
432 16TH ST
ASHLAND, KY 41101

05/04/2022

Notice of Adverse Benefit Determination

Name: (b)(6)
Member ID: (b)(6)
Reference #: (b)(6)
DOB: (b)(6)
DOS:

Dear Provider:

We have taken the following action on your service request regarding the member noted above:

The request for female to male breast reduction surgery-a surgery to remove a breast is not approved. The service is not covered by your Plan. Please follow up with your doctor for a new referral for a covered service.
Criteria Referenced: Kentucky Enrollee Handbook, Section: Services Not Covered by WellCare of Kentucky

You may request a copy of the clinical criteria, benefit provision or other information used to make this decision by calling Provider Services at **1-877-389-9457 (TTY/TDD: 711)** Monday through Friday, 7 a.m. to 7 p.m. EST.

This does not mean that you cannot provide the service(s) you requested. It means you may not be reimbursed for the service(s).

YOU HAVE THE RIGHT TO ASK FOR AN APPEAL OF THIS DECISION.

If you do not agree with this decision, you may appeal. Your request must be submitted within sixty (60) calendar days of the date of this notice. We will issue an appeal decision in writing within thirty (30) calendar days of receiving the appeal request, unless we need a fourteen (14) calendar day extension. If we need an extension, we will request it from you.

WellCare
Beyond Healthcare. A Better You.
PO Box 31370
Tampa, FL 33631-3370

To appeal this decision, please fax or mail your request to:

WellCare of Kentucky Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253
Fax: 1-866-201-0657

For assistance in filing an appeal call Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7:00 a.m. to 7:00 p.m. EST.

Sincerely,

Utilization Management Department

Printout

Friday, May 27, 2022 2:40 PM

WellCare
Beyond Healthcare. A Better You.

PO Box 31370
Tampa, FL 33631-3370

LEXINGTON SURGERY CENTER LTD
2115 HARRODSBURG RD
LEXINGTON, KY 40504

05/04/2022

Notice of Adverse Benefit Determination

Name: (b)(6)
Member ID: (b)(6)
Reference #: (b)(6)
DOB: (b)(6)
DOS:

Dear Provider:

We have taken the following action on your service request regarding the member noted above:

The request for female to male breast reduction surgery-a surgery to remove a breast is not approved. The service is not covered by your Plan. Please follow up with your doctor for a new referral for a covered service.
Criteria Referenced: Kentucky Enrollee Handbook, Section: Services Not Covered by WellCare of Kentucky

You may request a copy of the clinical criteria, benefit provision or other information used to make this decision by calling Provider Services at **1-877-389-9457** (TTY/TDD: 711) Monday through Friday, 7 a.m. to 7 p.m. EST.

This does not mean that you cannot provide the service(s) you requested. It means you may not be reimbursed for the service(s).

YOU HAVE THE RIGHT TO ASK FOR AN APPEAL OF THIS DECISION.

If you do not agree with this decision, you may appeal. Your request must be submitted within sixty (60) calendar days of the date of this notice. We will issue an appeal decision in writing within thirty (30) calendar days of receiving the appeal request, unless we need a fourteen (14) calendar day extension. If we need an extension, we will request it from you.

WellCare
Beyond Healthcare. A Better You.
PO Box 31370
Tampa, FL 33631-3370

To appeal this decision, please fax or mail your request to:

WellCare of Kentucky Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253
Fax: 1-866-201-0657

For assistance in filing an appeal call Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7:00 a.m. to 7:00 p.m. EST.

Sincerely,

Utilization Management Department

Printout

Friday, May 27, 2022 2:41 PM

WellCare
Beyond Healthcare. A Better You.

PO Box 31370
Tampa, FL 33631-3370

DAVID DRAKE
2195 HARRODSBURG RD 2ND FLOOR
LEXINGTON, KY 40504

05/04/2022

Notice of Adverse Benefit Determination

Name: (b)(6)
Member ID: (b)(6)
Reference #: (b)(6)
DOB: (b)(6)
DOS:

Dear Provider:

We have taken the following action on your service request regarding the member noted above:

The request for female to male breast reduction surgery-a surgery to remove a breast is not approved. The service is not covered by your Plan. Please follow up with your doctor for a new referral for a covered service.
Criteria Referenced: Kentucky Enrollee Handbook, Section: Services Not Covered by WellCare of Kentucky

You may request a copy of the clinical criteria, benefit provision or other information used to make this decision by calling Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7 a.m. to 7 p.m. EST.

This does not mean that you cannot provide the service(s) you requested. It means you may not be reimbursed for the service(s).

YOU HAVE THE RIGHT TO ASK FOR AN APPEAL OF THIS DECISION.

If you do not agree with this decision, you may appeal. Your request must be submitted within sixty (60) calendar days of the date of this notice. We will issue an appeal decision in writing within thirty (30) calendar days of receiving the appeal request, unless we need a fourteen (14) calendar day extension. If we need an extension, we will request it from you.

WellCare
Beyond Healthcare. A Better You.
PO Box 31370
Tampa, FL 33631-3370

To appeal this decision, please fax or mail your request to:

WellCare of Kentucky Attn: Appeals Department
P.O. Box 436080
Louisville, KY 40253
Fax: 1-866-201-0657

For assistance in filing an appeal call Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7:00 a.m. to 7:00 p.m. EST.

Sincerely,

Utilization Management Department

WellCare
Beyond Healthcare. A Better You.
P.O. Box 436000
Louisville, KY 40253

Notice of Appeal Decision

(b)(6)

June 2, 2022

Re: (b)(6)
ID#: (b)(6)
File #: (b)(6)
Request: Reduction Mammoplasty CPT
(b)(6)

Dear (b)(6)

On May 4, 2022, we received your appeal. This appeal was about: Reduction Mammoplasty.

An Appeals Review Nurse looked at your request.

We reached this decision: The procedure to make your breasts smaller is not approved.

We made this decision because the notes say you want smaller breasts so you will look like a male. The health plan does not cover this kind of procedure. The reasons for the denial are based on a set of benefits/criteria, which include Kentucky Enrollee Handbook 2022 Section: Services Not Covered by WellCare of Kentucky

Kentucky law says we cover services that are "medically necessary." Per *907 KAR 17:020 and 907 KAR 3:130,* "medically necessary" means:

- Care or supplies required to meet an enrollee's medical needs
- The care or supplies must:

- Be right for the enrollee's medical condition;
- Be care accepted by most doctors;
- Not be for convenience;
- Be in the right amount, at the right place and at the right time; and
- Be safe for the enrollee.

This decision will not affect the services or supplies you may need in the future.

You, your doctor, or someone you choose can get a copy of any paperwork used to make this decision. You can get this at no charge. Call **1-877-389-9457** or write to:

WellCare of Kentucky
Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253

We also want to let you know that, per *907 KAR 17:035*, if your provider gets an adverse final decision of a denial, in whole or in part, of a health service or claim for reimbursement related to this service, he or she may ask for an external, independent third-party review. Your provider must first complete an internal appeal with WellCare of Kentucky. Provider requests for external review will only be considered for dates of service on or after December 1, 2016.

If an external, independent third-party review is held, your provider and WellCare of Kentucky may, depending on the outcome of this review, ask for an administrative hearing. This is per *907 KAR 17:040.*

You do not have to take action if your provider files for an external, independent third-party review or administrative hearing. This does not affect your appeal rights or right to ask for a State Fair Hearing.

You Have the Right to Ask for a State Fair Hearing

You have the right to ask for a State Fair Hearing if you do not agree with the decision. A hearing officer from the Kentucky Cabinet for Health and Family Services will review our decision. You, a friend, a relative, lawyer, or someone you choose may ask for a hearing for you. You must give this person permission in writing to act for you.

You must ask for a State Fair Hearing within **120** days from the date of this letter. See *907 KAR 17:010.*

If you ask for a hearing to appeal our decision, you may continue to receive these services. But you must ask for the hearing within 10 days of receiving this notice. You may have to pay for these services if the hearing officer agrees with WellCare that the services are not needed.

You may request a State Fair Hearing at this address:

Office of the Ombudsman
Office of the Ombudsman and Administrative Review
Attn: Medical Appeals and Reconsiderations
275 East Main Street, 2E-O
Frankfort, KY 40621
Phone: 502-564-5497 (TTY **711**)
Fax: 502-564-9523

Contact us or the Kentucky Department for Medicaid Services if:

- You want to know if you can ask for a State Fair Hearing on the denial.
- You want to know if you can still get the care you asked for.
- You want to learn more.

Other things to know:

- You do not have to pay for the State Fair Hearing.
- You have the right to name someone you trust to file a State Fair Hearing for you. You must give the person permission in writing to do so.

Questions? Just call Customer Service at **1-877-389-9457**. TTY users may call **711**. We are here to help you. You can call Monday–Friday, 7 a.m. to 7 p.m.

Sincerely,

Appeals Department
mbsharp

Cc: Dr. David Drake

Discrimination is Against the Law

WellCare of Kentucky complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WellCare of Kentucky does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WellCare of Kentucky provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

WellCare of Kentucky also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call us toll-free at **1-877-389-9457** (TTY: **711**). We're here for your Monday–Friday from 7 a.m. to 7 p.m.

If you believe that WellCare of Kentucky has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

EEO/Civil Rights Compliance Branch
Cabinet for Health and Family Services
Office of Human Resource Management
275 E. Main St, Mail Stop 5C-D
Frankfort, KY 40621
Telephone: **1-502-564-7770**
Fax: **1-502-564-3129**
Email/Web: **https://chfs.ky.gov/Pages/civil-rights.aspx**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the EEO/Civil Rights Compliance Branch is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F
HHH Building
Washington, D.C. 20201
Telephone: **1-800-368-1019**, **1-800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-389-9457** (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-389-9457** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-389-9457** (TTY: **711**)。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-389-9457** (TTY: **711**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-389-9457** (TTY: **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-389-9457** (TTY: **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-389-9457** (TTY: **711**).

주의: 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-389-9457** (TTY: **711**)번으로 전화해 주십시오 .

Opmierksamkeet: Wann du Deitsch (Pennsylvania German/ Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff **1-877-389-9457** (TTY: **711**).

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् **1-877-389-9457** (TTY: **711**)।

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-877-389-9457** (TTY: **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-389-9457** (TTY: **711**).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-389-9457** (TTY: **711**).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona **1-877-389-9457** (TTY: **711**).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-877-389-9457** (TTY: **711**).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-389-9457** (TTY: **711**) まで、お電話にてご連絡ください。

WellCare
Beyond Healthcare. A Better You.
P.O. Box 436000
Louisville, KY 40253

Notice of Appeal Decision

Dr. David Drake
2195 Harrodsburg Road, 2nd Floor
Lexington, KY 40504

June 2, 2022

Re: (b)(6)
ID#: (b)(6)
File #: (b)(6)
Request: Reduction Mammoplasty CPT
(b)(6)

Dear (b)(6)

On May 4, 2022, we received your appeal. This appeal was about: Reduction Mammoplasty.

An Appeals Review Nurse looked at your request.

We reached this decision: The procedure to make your breasts smaller is not approved.

We made this decision because the notes say you want smaller breasts so you will look like a male. The health plan does not cover this kind of procedure. The reasons for the denial are based on a set of benefits/criteria, which include Kentucky Enrollee Handbook 2022 Section: Services Not Covered by WellCare of Kentucky

Kentucky law says we cover services that are "medically necessary." Per *907 KAR 17:020 and 907 KAR 3;130,* "medically necessary" means:

- Care or supplies required to meet an enrollee's medical needs
- The care or supplies must:

- Be right for the enrollee's medical condition;
- Be care accepted by most doctors;
- Not be for convenience;
- Be in the right amount, at the right place and at the right time; and
- Be safe for the enrollee.

This decision will not affect the services or supplies you may need in the future.

You, your doctor, or someone you choose can get a copy of any paperwork used to make this decision. You can get this at no charge. Call **1-877-389-9457** or write to:

WellCare of Kentucky
Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253

We also want to let you know that, per *907 KAR 17:035*, if your provider gets an adverse final decision of a denial, in whole or in part, of a health service or claim for reimbursement related to this service, he or she may ask for an external, independent third-party review. Your provider must first complete an internal appeal with WellCare of Kentucky. Provider requests for external review will only be considered for dates of service on or after December 1, 2016.

If an external, independent third-party review is held, your provider and WellCare of Kentucky may, depending on the outcome of this review, ask for an administrative hearing. This is per *907 KAR 17:040*.

You do not have to take action if your provider files for an external, independent third-party review or administrative hearing. This does not affect your appeal rights or right to ask for a State Fair Hearing.

You Have the Right to Ask for a State Fair Hearing

You have the right to ask for a State Fair Hearing if you do not agree with the decision. A hearing officer from the Kentucky Cabinet for Health and Family Services will review our decision. You, a friend, a relative, lawyer, or someone you choose may ask for a hearing for you. You must give this person permission in writing to act for you.

You must ask for a State Fair Hearing within **120** days from the date of this letter. See *907 KAR 17:010*.

If you ask for a hearing to appeal our decision, you may continue to receive these services. But you must ask for the hearing within 10 days of receiving this notice. You may have to pay for these services if the hearing officer agrees with WellCare that the services are not needed.

You may request a State Fair Hearing at this address:

Office of the Ombudsman
Office of the Ombudsman and Administrative Review
Attn: Medical Appeals and Reconsiderations
275 East Main Street, 2E-O
Frankfort, KY 40621
Phone: 502-564-5497 (TTY 711)
Fax: 502-564-9523

Contact us or the Kentucky Department for Medicaid Services if:

- You want to know if you can ask for a State Fair Hearing on the denial.
- You want to know if you can still get the care you asked for.
- You want to learn more.

Other things to know:

- You do not have to pay for the State Fair Hearing.
- You have the right to name someone you trust to file a State Fair Hearing for you. You must give the person permission in writing to do so.

Questions? Just call Customer Service at **1-877-389-9457**. TTY users may call **711**. We are here to help you. You can call Monday–Friday, 7 a.m. to 7 p.m.

Sincerely,

Appeals Department
mbsharp

Cc: Dr. David Drake

Discrimination is Against the Law

WellCare of Kentucky complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WellCare of Kentucky does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WellCare of Kentucky provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

WellCare of Kentucky also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call us toll-free at **1-877-389-9457** (TTY: **711**). We're here for your Monday–Friday from 7 a.m. to 7 p.m.

If you believe that WellCare of Kentucky has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

EEO/Civil Rights Compliance Branch
Cabinet for Health and Family Services
Office of Human Resource Management
275 E. Main St, Mail Stop 5C-D
Frankfort, KY 40621
Telephone: **1-502-564-7770**
Fax: **1-502-564-3129**
Email/Web: **https://chfs.ky.gov/Pages/civil-rights.aspx**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the EEO/Civil Rights Compliance Branch is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F
HHH Building
Washington, D.C. 20201
Telephone: **1-800-368-1019**, **1-800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-389-9457** (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-389-9457** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-389-9457** (TTY: **711**)。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-389-9457** (TTY: **711**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-389-9457** (TTY: **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-389-9457** (TTY: **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-389-9457** (TTY: **711**).

주의: 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-389-9457** (TTY: **711**)번으로 전화해 주십시오 .

Opmierksamkeet: Wann du Deitsch (Pennsylvania German/ Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff **1-877-389-9457** (TTY: **711**).

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नम्िति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-877-389-9457** (TTY: **711**)।

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-877-389-9457** (TTY: **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-389-9457** (TTY: **711**).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-389-9457** (TTY: **711**).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona **1-877-389-9457** (TTY: **711**).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-877-389-9457** (TTY: **711**).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-389-9457** (TTY: **711**) まで、お電話にてご連絡ください。

Site I KyHealth Choices

Click Here To Open New Window

Next search by: Member ID | Case ID | SSN | GPSDT

Member Information

Member ID	(b)(6)	Name	(b)(6)	Active	(b)(6)
		Suffix		Linked ID	
HIC		Prev Name		Benefit Plan	
SSN		Street Address 1		Medicare Coverage	
Pseudo Number		Street Address 2		Managed Care	
Gender		Street Address 3		TPL	
Date of Birth		City		Suspension Code	
Date of Death		State		Level of Care	
Age		Zip Code		Patient Liability	
Race		Home County		Medicare Buy-in	
Multi-Race Code		County Office ID		Case/Last Updated	
Ethnicity		Twin		Application Date	
Citizen		Duplicate		Redetermination Date	
Language		DJJ		DJJ	
Phone		Foster Care Ind		Foster Care	
Phone Type		Guardianship Ind		Guardianship	
Add Phone		Pregnancy Ind		Expected Delivery Date	
Add Phone Type		Trust Type		Investigation Ind	
Latitude		Longitude		Header Inst Status	
		Above FPL		KI-HIPP	

Member Maintenance

Select area to add or modify below.

Member | Capitated Lock-in Assignment History | Encounter Threshold | M/W Assignment
Managed Care | MCO Case/Disease Management | MCO Lock-in | MCO Member Information
Medicare | MCO PCP panel | Member MC Special Conditions | PMP Assignment History
Previous Data | PMP Lockout

Base Information

PMP Assignment History

Status: Active Only

(b)(6)

Type changes below.

MC Program	MANAGED CARE ORGANIZATION	Start Reason	44 - MCAPS AUTOMATIC ENROLLMENT
Effective Date	01/01/2021	Stop Reason	46 - MCAPS DISENROLLMENT
End Date	12/31/2299	Assignment Source	MCAPS ASSIGNMENT
Status	Active	Group Member ID	
PMP ID	7100164990 MCD	Group Member Source	
Provider Name	WELLCARE OF KENTUCKY, INC.		
Site Number	0000		
MC Region	MEDICAL REGION 07	Focus	1915(B) MCO
Added Date	12/19/2020	Copay Indicator	

M/W Assignment

Status: Active Only

(b)(6)

Select row above to update -or- click Add button below.

MCO Enrollment Type	M	Effective Date	
MCO Type		End Date	
Status	Active	Date Added	
Original Source		Last Updated Date	
Last Updated Source		User Id	

7020 3160 0000 4185 1093

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at www.usps.com

(b)(6)

MLM

NOH

Certified Mail Fe

$

Extra Services &

- ☐ Return Receipt (hardcopy) $
- ☐ Return Receipt (electronic) $
- ☐ Certified Mail Restricted Delivery $
- ☐ Adult Signature Required $
- ☐ Ac

#DMS 22-0323

Postmark Here

Posta

$

Total

$

Sent

Stree

(b)(6)

City, State, ZIP+4®

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at *www.usps.com®*.

(b)(6)

Certified Mail Fee

$ Not

Extra Services & Fees (check box, add fee as appropriate)

- ☐ Return Receipt (hardcopy) $
- ☐ Return Receipt (electronic) $
- ☐ Certified Mail Restricted Delivery $
- ☐ Adult Signature Required $
- ☐ Adult Signature Restricted Delivery $

#DWS 22-0323

Postmark Here

Postage

$

Total Postage and Fees

$

Sent To

Joyce A. Merritt
Samantha T. Nance
Embry Merritt Shaffar Womack PLLC
201 East Main Street, Suite 1402
Lexington, KY 40507

Street and Apt. No., or PO Box No.

City, State, ZIP+4®

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7020 3160 0000 4185 1086

Sydney T. King, M.S., LPCC
The Self Collective, LLC
Sydney@TheSelfCollective.com
Ph: 614-427-0875; Fax: 614-421-7987

04/19/2022

To:
UK HealthCare
1000 S. Limestone
University of Kentucky
Lexington, KY 40536

Re:
(b)(6)

Reason for Referral:
(b)(6)

Dr. David Drake and Team:

This is a letter of support for (b)(6) to receive (b)(6)
(b)(6)

I am a licensed professional clinical counselor specializing in work with transgender and gender expansive individuals. My work is informed by the Standards of Care outlined by the World Professional Association for Transgender Health (WPATH). My practice has included psychotherapy and assessment of transgender and gender expansive individuals, both those who do and do not wish to make a physical transition via hormone therapy and/or surgery.

(b)(6)

(b)(6)

(b)(6)

Please feel free to contact me should you have any questions or need any further information. Thank you in advance for the care that you will provide to Hiara.

Sydney T. King, M.S., LPCC
Ohio #E.2001814

Sydney@TheSelfCollective.com
Ph: 614-427-0875

(b)(6)

APPELLANT

v.

Wellcare of Kentucky, INC

APPELLEE

RESPONSE TO MOTION FOR SUMMARY RECOMMENDED ORDER

As it currently stands, WellCare does not afford coverage for gender-conforming surgical care as treatment for gender dysphoria. Ultimately, the exclusion in the healthcare plan precludes coverage for these surgical treatments when a person is diagnosed with gender dysphoria. However, the same or similar surgical treatments are available to persons when the diagnosis requiring that treatment is not gender dysphoria determining whether or not such treatment is covered by WellCare hinges on a diagnosis—but when treatment is precluded for a diagnosis based on one's gender identity, such exclusion invidiously discriminates on the basis of sex and transgender status.

WellCare maintains a comprehensive state plan for medical assistance which is detailed in Member Handbook, The Policy Manual provides a blanket exclusion for "transsexual surgery," (Exhibit D provided by APPELLEE)

This blanket exclusion:

1. Denies Equal Protection under the Fourteenth Amendment
2. Violates the Affordable Care Act
3. Violates the Comparability Requirement of the Medicaid Act
4. Violates the Availability Requirement of the Medicaid Act

1. Equal Protection under the Fourteenth Amendment

The exclusion for the surgical treatment of gender dysphoria violates transgender individuals rights under the Equal Protection clause of the Fourteenth Amendment. The Equal Protection Clause provides that "[n]o State shall… deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1. This "keeps governmental decision makers from treating differently persons who are in all relevant respects alike." *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992). A claim for an equal protection violation requires a plaintiff/APPELLANT to show that they have "been treated differently from others with whom he is similarly situated and that the unequal treatment was the result of intentional or purposeful discrimination." *Morrison v. Garraghty*, 239 F.3d 648, 654 (4th Cir. 2001). Once this demonstration is made, next it must be determined whether the disparity in treatment can be justified under the requisite level of scrutiny." *Id.*; *City of Cleburne v. Cleburne Living Ctr., Inc.*, 43 U.S. 432, 440 (1985).

i. Policy exclusion and covered services

The exclusion at issue here is the exclusion for "transsexual surgery," stating that such a service is not covered..

Nonetheless, the policy does cover other treatments related to transgender healthcare. The policy covers psychiatric diagnosis evaluation, psychotherapy, psychological evaluation, counseling, office visits, hormones, and lab work when medically necessary even if the treatments are related to gender-confirming care. The APPELLANT has received those very services in the past. Transgender individuals are covered for the same care as cisgender individuals when such treatment is not surgical.

'Top surgery" or a 'bilateral mammoplasty' is defined as removal of excess breast tissue. Mammoplasty is commonly covered in the case of cisgender women who have health related issues due to the size of their breasts, the treatment being to reduce the size of their breasts to alleviate symptoms. The treatment for gender dyphoria in transgender men is the same; reduction of the chest to alleviate their gender dysphoria . The treatments are fundamentally the same. The same surgical treatments can be performed to address several different diagnoses. For example, a vaginoplasty can be performed for a transgender patient to treat gender dysphoria or for a non-transgender woman as a treatment for congenital absence of the vagina. When documenting and billing for these surgical treatments, health care providers utilize Current Procedural Terminology (CPT) codes developed and maintained by the American Medical Association. The same CPT codes are used to document and bill the same surgical treatment when performed for a transgender patient with gender dysphoria and for any patient for a different diagnosis.

"In determining what level of scrutiny applies to the APPELLANT's equal protection claim, look to the basis of the distinction between the classes of persons." *Grimm*, 972 F.3d at 607 (citing *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 n.4, (1938)). The classifications in most state policies are generally held to be valid when those classifications drawn are "rationally related to a legitimate state interest." *Cleburne*, 473 U.S. at 440. However, "[t]his general rule 'gives way'... when the policy discriminates based on membership in certain suspect classes." *Kadel v. Folwell*, 1:19-cv-272, 2022 WL 2106270, *18 (M.D.N.C. June 10, 2022) (citing *Cleburne*, 473 U.S. at 440).

We can look to the Fourth Circuit also as an example, it has determined that policies that discriminate on sex or transgender status are reviewed under a heightened scrutiny. *Grimm*, 972 F.3d at 608–10.[3,4] Policies that classify based on a quasi-suspect classification are found to be

unconstitutional unless they are "substantially related to a sufficiently important governmental interest." *Cleburne*, 473 U.S. at 441.

[3] When considering whether a certain group constitutes a quasi-suspect class, factors the 4th court considered are
- Whether the class historically has been subject to discrimination
- Whether the class has a defining characteristic that bears a relation to its ability to perform or contribute to society
- Whether the class may be defined as a discrete group by obvious, immutable, or distinguishing characteristics
- Whether the class lacks political power.

Grimm v. Gloucester Cty. School Bd., 972 F.3d 586, 607–08 (4th Cir. 2020) (internal citations omitted).[3] The *Grimm* court discussed the history of discrimination of transgender peoples in education, employment, housing, healthcare access, and military service, in addition to the history of violence and harassment of transgender peoples. The court then opined that one's transgender status "bears no… relation" to one's ability to "perform or contribute to society." *Id.* at 612 (internal quotation omitted). Moving on, the court discussed that a person's gender identity is "as natural and immutable as being cisgender," and that transgender people constitute a minority lacking political power, as only 0.6% of the United States population identify as transgender.

Many courts have held that discrimination against transgender persons is sex-based discrimination for Equal Protection purposes because such policies punish transgender persons for gender non-conformity, thus relying on sex stereotypes. *Id.* at 608. Thus, this Court follows *Grimm* and finds that the Plaintiffs in this case fall within a quasi suspect class, necessitating the application of heightened scrutiny.

[4] At the outset, the Court notes that Defendants have argued that *Grimm* should not apply to this analysis. Defendants argue that the matter before this Court is a case of first impression, entirely novel from the *Grimm* case, where the Fourth Circuit considered a challenge to a policy requiring students to use bathrooms based on their biological, or birth-assigned, sex. Here, in contrast, the Court is grappling with a Medicaid benefits case. But the context of the cases is immaterial to the application of the applicable level of scrutiny. Regardless of the specific set of facts under which each case arises, the Court must use the appropriate level of scrutiny to analyze each of the policies. The four-factor test enumerated in *Grimm* aids this Court's determination of whether a suspect class exists here.

The APPELLANT's equal protection act claim is that he is denied the medically necessary surgeries that participants receiving those same surgeries for non-gender dysphoria related treatments are allowed—thus, the classification is based on transgender status.

Inherent in a gender dysphoria diagnosis is a person's identity as transgender. In other words, a person cannot suffer from gender dysphoria without identifying as transgender. *See Kadel*, 2022 WL 2106270, at *20 Discrimination against individuals suffering from gender dysphoria is also discrimination based on sex and transgender status. As with the plan's exclusions, one cannot

explain

gender dysphoria 'without referencing sex' or a synonym." (quoting *Grimm*, 972 F.3d at 608)).

Transgender people have access to the same surgeries for other diagnosis—the exclusion is aimed specifically at a gender change procedure. Thus, the exclusion targets transgender people because they are transgender.

The exclusion at issue here denies coverage to transgender people with a gender dysphoria diagnosis seeking medically necessary surgeries.

The relevant comparison here is to persons who seek the same, medically necessary surgeries for non-gender dysphoria related treatments. The Kentucky Medicaid Program, and WellCare provide, for example, medically necessary mastectomies for non-gender dysphoria related diagnoses. The only difference between this scenario and the APPELLANT's circumstances is that the APPELANT seeks this surgery to treat gender dysphoria—thus, a distinction hinging on his transgender identity.

The surgeries for both gender-affirming and non-gender-affirming reasons utilize the same CPT codes in documenting and billing. The only difference, which results in the preclusion of coverage for APPELANT's, is that his diagnosis is for gender dysphoria, arising from his identity as transgender.

The exclusion denies coverage for "transsexual surgery." This language refers explicitly to sex—one seeking a "transsexual surgery" seeks to change from their sex assigned at birth to the

sex that more accurately reflects their gender identify. Only individuals who identify as transgender would seek "transsexual surgery," and as the Supreme Court reasoned in *Bostock v. Clayton County, Georgia*,

one cannot consider the term "transgender" without considering sex. *Bostock*, 140 S. Ct. at 1746 ("[T]ry writing out instructions for who should check the [transgender] box [on a job application] without using the words man, woman, or sex (or some synonym). It can't be done."). *See Kadel*, 2022 WL 2106270, at *19 (finding that the health plan's exclusions for sex changes or

modifications and related care facially discriminate); *see also Fletcher v. Alaska*, 443 F. Supp. 3d 1024, 1030 (D. Alaska 2020) ("In sum, defendant's policy of excluding coverage for medically necessary surgery such as vaginoplasty and mammoplasty for employees, such a[s] plaintiff, whose natal sex is male while providing coverage for such medically necessary surgery for employees whose natal sex is female is discriminatory on its face and is direct evidence of sex discrimination.").

2. Consistency with CMS policy

The APPALEE's claim that providing coverage consistent with what is required by the 'contract' with the Department of Kentucky Medicaid Services is an important purpose for the exclusion. Centers for Medicare & Medicaid Services (CMS) oversees all state Medicaid programs by maintaining the Medicaid regulations and approving state plans and state plan amendments. *See Sarah Young Dep.*, ECF No 252-1, at 42–43. The Medicaid Program bases "all of [its] policies and procedures within the confines of the federal regulation, the state code, state laws, and [it] ensure[s] that the covered services are available to members." *Id.* at 20. CMS communicates with the Medicaid Program to dictate changes to the program or clarify a policy. *Id.* at 21.

CMS neither mandates nor prohibits coverage for the surgical care of gender dysphoria—this decision is left up to the individual states. *See id.* at 42. The APPELLEE asserts that contained in the contract, is guidance from Kentucky Medicaid to determine required coverages. Since surgical treatment of gender dysphoria is not a mandated coverage dictated by Kentucky Medicaid. The APPELLEE asserts that excluding this coverage is simply following

contractual guidance. The APPELLANT asserts that since the contract between Wellcare, and Kentucky Medicaid, is ignoring federal laws, and regulations, namely the ACA, and the 14th amendment, among others mentioned in this document it cannot be upheld.

Importantly, the lack of reimbursement by Kentucky Medicaid does not permit the APPELLEE to ignore their obligations under the Constitution, and the Affordable Health Care act. CMS's lack of guidance on the matter does not give a green light for the states to enact discriminatory policies. Wellcare agreeing to follow a discriminatory policy is complicity to discrimination.

The Affordable Care Act (ACA) "aims to increase the number of Americans covered by health insurance" through the creation of "a comprehensive national plan to provide universal health insurance coverage." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538, 583 (2012). An important component of the ACA is the anti-discrimination mandate in section 1557. *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, 485 F. Sup. 3d 1, 11 (D.D.C. 2020). This section provides that "[e]xcept as otherwise provided… an individual shall not, on the ground prohibited under title VI of the Civil Rights Act…[and] title IX…be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance…". 42

U.S.C. § 18116. Because the ACA explicitly incorporates Title VI and Title IX, if Title VII is used to guide the evaluation of claims under Title IX, the test announced in *Bostock* is the appropriate test to determine whether a policy discriminates in violation of the ACA. *Kadel*, 2022 WL 2106270, at *29.

To prevail on a section 1557 claim, a plaintiff/APPELLANT must show that:

1. Defendant/Appellee is a health program or activity that receives federal funds, and

2. Plaintiff/APPALENT was subjected to discrimination in healthcare services on the basis of sex.

See id.

WellCare by definition is a "health program or activity" for purposes of Section 1557 analysis. WellCare is a MCO of Kentucky Medicaid. Kentucky Medicaid is jointly funded by the State of Kentucky and the federal government.

3. Violation of Medicaid

The APPELLANT asserts that the Exclusion violates the Availability and Comparability requirements of the Medicaid Act, because coverage for medically necessary treatments for gender dysphoria are excluded from coverage while the same treatments are covered for other medically necessary reasons.

The Medicaid Program is established in Title XIX of the Social Securities Act. 42 U.S.C. §§ 1396 *et seq*. The purpose of this act is to enable "each State, as far as practicable under the conditions in such state, to furnish... medical assistance [to individuals] whose income and resources are insufficient to meet the costs of necessary medical services." *Id.* § 1396-1. Participation in Medicaid is optional—however, once a state elects to participate in the Medicaid program, it is subject to federal laws and regulations. *See Antrican v. Odom*, 290 F.3d 178, 183

n.2 (4th Cir. 2002); *Flack v. Wisconsin Dep't of Health and Servs.*, 395 F. Supp. 3d 1001, 1015 (W.D. Wisc.

2019) (noting that a state Medicaid Program "must comply with all federal statutory and regulatory requirements").

A state Medicaid Program "must... provide... for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), (28), (29), and (30) of section 1905(a)." 42 U.S.C. § 1396a(a)(10)(A). A state must provide coverage for mandatory categories of treatment and must cover services when they (1) fall within a category of mandatory medical services or optional medical services that the state has elected to provide; and (2) are "medically necessary" for a particular participant. *See Beal v. Doe*, 432 U.S. 438 (1977). The state "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 C.F.R. § 440.230. "These limits must be 'reasonable' and 'consistent with the objectives of the [Medicaid] Act." *Flack*, 395 F. Supp. 3d at 1015 (quoting *Rush v. Parham*, 625 F.2d 1150, 1155 (5th Cir. 1980)).

The APPELLANT asserts that Kentucky Medicaid has either mandated or chosen to cover the same surgical procedures for non-gender-dysphoria related treatment and that the unrebutted evidence in the record demonstrates the medical necessity of surgical care. The surgical care precluded by the exclusion is made available and covered by Medicaid when the surgical care is to

treat diagnoses other than gender dysphoria. Indeed, the same CPT codes are used to document the surgeries, whether performed for gender dysphoria treatment or for treatment of another diagnosis. *See Alvarez v. Betlach*, 572 F. App'x 519, 521 (9th Cir. 2014) (discussing that states are prohibited "from denying coverage of 'medically necessary' services that fall under a category covered in their Medicaid plans." (quoting *Beal v. Doe*, 432 U.S. 438, 444 (1977)); *see Bontrager v. Ind. Fam. Soc. Servs. Admin.*, 697 F.3d 604, 608 (7th Cir. 2012) ("[T]he State is

required to provide Medicaid coverage for medically necessary in those service areas that the State opts to provide such

coverage."); *see Beal*, 432 U.S. at 444 ("[S]erious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage…").

b. Violation of Medicaid's comparability requirement

The State Medicaid Program provides coverage for both the "categorically needy" and "medically needy" participants. "Categorically needy" individuals receive some form of public assistance, *see* 42 U.S.C. § 1396a(a)(10)(A), while "medically needy" individuals are those "whose incomes are too large to qualify as categorically needy," yet "lack the funds to pay for medical

expenses." *Benjamin H. v. Ohl*, No. Civ. A. 3:99-0338, 1999 WL 34783552, *3 (S.D.W. Va. July 15, 1999) (citing *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981)).

The Medicaid statute provides that:

> The medical assistance made available to any individual described
>
> in subparagraph (A)—
> (i) Shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual and
> (ii) Shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

42 U.S.C. § 1396a(a)(10)(B). Further, the regulations promulgated pursuant to the Medicaid Act provide that:

> (a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in

amount, duration, and scope than those services available to a medically needy recipient; and

(b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:

a. The categorically needy

b. A covered medically needy group

42 C.F.R. § 440.240. The regulations also provide that "[t]he agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 U.S.C. § 440.230.

The APPELLANT asserts that WellCare violated the comparability requirement of the Medicaid Act as a Medicaid MCO by providing particular services to some participants but not others based

solely on diagnosis. Surgeries to treat gender dysphoria, such as mastectomies, which are covered to treat non-gender dysphoria diagnoses are materially the same as the surgeries provided to treat gender dysphoria. Thus, the difference in treatment clearly violates the comparability requirement, which requires that all persons within a specific category be treated equally. *See White v. Beal*, 555 F.2d 1146, 1151 (3d Cir. 1977) ("We find nothing in the federal statute that permits discrimination based upon etiology rather than need for the services.").

The exclusion essentially denies services to some categorically needy persons while the same services are provided for other persons with similar needs. *See Davis v. Shah*, 821 F.3d 231, 258 (2d Cir. 2016) (discussing that an analysis under the comparability requirement must "entail some

independent judicial assessment of whether a state has made its services available to all categorically needy individuals with equivalent medical needs").

The exclusion "fails to make covered treatments available in sufficient amount, duration and

scope" and discriminates on the basis of diagnosis. *Flack*, 395 F. Supp. 3d at 1019 (internal quotation omitted). Thus, it violates the comparability requirement of the Medicaid Act.

Looking at decisions made by other courts, we can see that the general consensus is that it is in fact a violation of transgender individuals rights.

Fain v. Crouch

Baker v. Aetna Life Ins

Being v. Crum

Whitman-Walker Clinic v. HHS

ARGUMENT

Wellcare's contract with Medicaid of Ky cannot be upheld. It is in violation of the Equal Protection clause under the Fourteenth Amendment, violates the Affordable Care Act, violates the Comparability Requirement of the Medicaid Act, and violates the Availability Requirement of the Medicaid Act. An illegal contact cannot be enforced by the law.

Bilateral Mammoplasty/ Bilateral Mastectomy is routinely covered by WellCare for cisgender individuals for which it is the appropriate treatment, but not for transgender individuals when its the appropriate treatment backed by WPATH. This demonstrates that the decision to not cover the treatment is based on discrimination of their diagnosis of Gender Dysphoria.

WellCare should approve my request for 'top surgery' based on the above facts, and arguments.

I certify that this document is sent via the methods listed below, on 8/12/2022

(b)(6)

JOYCE A. MERRITT

EMBRY MERRITT WOMACK NANCE, PLLC

201 E Main St, STE 1402

Lexington, KY 40507

via email::: joyce.merritt@emwnlaw.com

Hearing Officer Mooney

Cabinet for Health and Family Services

Health Services Administrative Branch

105 Sea Hero Dr. STE 2

Frankfort KY 40601

via email :::: chss.hsahb@ky.gov

05/06/2022

WellCare of Kentucky
2480 Fortune Dr Ste 200
Lexington, KY 40509

Member Name:
Member Number ID:
Provider Name:
Payer:

(b)(6)

Plan name: Medicaid

Contact Name:
Contact Email:
Contact Phone Number:
Contact Address:

(b)(6)

Subject: Request for [LEVEL 2 Appeal]

To Whom It May Concern:

I am writing to request a LEVEL 2 appeal. I wish to appeal the decision relating to CPT codes:19318.

My plan's exclusion of coverage of transgender-related care should not govern this decision as such an exclusion is prohibited by the Affordable Care Act - instead, WellCare must evaluate this decision on the basis of medical necessity. Wellcare should approve my request for precertification of codes 19318 on the basis of the medical necessity documented by my medical providers and duly provided in my initial request.

I. My plan's current exclusion of coverage of transgender-related care, which dictated WellCares denial of my precertification request, is prohibited by the Affordable Care Act.

WellCare based its denial of my request on a blanket exclusion in my health insurance plan.[1] This exclusion violates section 1557 of the Affordable Care Act.

Section 1557 of the Affordable Care Act (42 U.S.C. 18116) sets forth the requirement for non-discrimination in health care coverage, requiring that:

> "[A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20

[1] My plan, 'WellCare of Ky Medicaid' specifically excludes "Sex Reassignment Surgeries."

> U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection."

Title IX of the Education Amendments of 1972 provides, in pertinent part:

> "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance [...]"

Further guidance on Section 1557 of the Affordable Care Act is provided in the rule on Nondiscrimination in Health Programs and Activities, which expands upon the definition of sex discrimination:

> *"On the basis of sex* includes, but is not limited to, on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or **gender identity**. [...]
>
> We noted that like other Federal agencies, HHS has previously interpreted sex discrimination to include discrimination on the basis of gender identity.[2] We also noted that courts, including in the context of Section 1557, have recognized that sex discrimination includes discrimination based on gender identity. Thus, we proposed to adopt formally this well-accepted interpretation of discrimination "on the basis of sex.""

The rule goes on to explain:

> "OCR proposed to apply basic nondiscrimination principles in evaluating whether a covered entity's denial of a claim for coverage for transition-related care is the product of discrimination. We noted that based on these principles, **an explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to**

---

[2] Three years before the proposed rule on Nondiscrimination in Health Programs and Activities was introduced, HHS agreed that Section 1557's sex discrimination prohibition extends to claims of discrimination based on gender identity. See Letter from Leon Rodriguez, Director of Office for Civil Rights, Department of Health & Human Services to Maya Rupert, Federal Policy Director, National Center for Lesbian Rights (Jul. 12, 2012) (OCR Transaction No. 12-000800). Additional instances of this interpretation can be found in the full text of the proposed rule on Nondiscrimination in Health Programs and Activities (HHS-OCR-2015-0006) and the final rule, which can be found in the Federal Register, Vol. 81, No. 96, Part IV, published Wednesday, May 18, 2016 (45 CFR Part 92; RIN 0945–AA02).

gender transition is unlawful on its face under paragraph (b)(4); in singling out the entire category of gender transition services, **such an exclusion or limitation systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex.**

Moreover, we proposed in § 92.207(b)(5) to bar a covered entity from denying or limiting coverage, or denying a claim for coverage, for specific health services related to gender transition where such a denial or limitation results in discrimination against a transgender individual. **In evaluating whether it is discriminatory to deny or limit a request for coverage for a particnlar service for an individual seeking the service as part of transition-related care, we provided that OCR will start by inquiring whether and to what extent coverage is available when the same service is not related to gender transition.** If, for example, an issuer or State Medicaid agency denies a claim for coverage for a hysterectomy that a patient's provider says is medically necessary to treat gender dysphoria, OCR will evaluate the extent of the covered entity's coverage policy for hysterectomies under other circumstances. We noted that OCR will also carefully scrutinize whether the covered entity's explanation for the denial or limitation of coverage for transition-related care is legitimate and not a pretext for discrimination."

WellCare routinely covers mastectomies and breast reconstructive surgeries deemed to be medically necessary, including areolar reconstruction, when not related to gender transition.[3] To exclude identical procedures for transgender individuals based merely on their medical necessity being due to gender dysphoria as opposed to other diagnoses, "systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex" in violation of Section 1557.

II. Because WellCares blanket exclusion of transition-related healthcare is unlawful under the Affordable Care Act, WellCare must evaluate my request for precertification on the basis of medical necessity.

I meet criteria for medical necessity both generally and as it pertains to gender reassignment surgery (GRS. I meet and exceed the criteria as set forth by the World Professional Association for Transgender Health (WPATH) as well as for a diagnosis of Gender Dysphoria as set forth by the DSM 5. Further, it is the clinical opinion of my therapist, a M.S., LPCC., who possesses all of the characteristics of a Qualified Mental Health Professional defined by WPATH, that surgery is the appropriate treatment for my long-standing Gender Dysphoria and that my mental health and overall well-being would greatly benefit from this procedure (see attached letter of referral from Sydney King).

I request that WellCare, in recognizing its blanket exclusion of transition related healthcare coverage as unlawful, approve my request for precertification for codes on the basis of medical necessity as described in WellCares Enrollee Handbook and specifically confirmed by my medical providers in accordance with the general requirements for medical necessity defined by WellCare.

3

WellCares Enrollee Handbook states, "We approve care that is medically needed or necessary. This means the care, services, or supplies give you the treatment you need. The care, services, or supplies must:
• Be right for your medical condition • Be care accepted by most doctors • Not be for convenience • Be in the right amount, at the right place, and at the right time • Be safe for you

Clinically Appropriate We approve care that is clinically right or appropriate. This just means the services or supplies you get are standard. Standards are set by national guidelines, such as InterQual®."

The requested procedure meets WellCares criteria for medically needed.

Sincerely,

(b)(6)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
HEALTH SERVICES ADMINISTRATION HEARINGS BRANCH
ADMINISTRATIVE ACTION NO. HSAHB DMS 22-0323

(b)(6)

APPELLANT

v.

WELLCARE OF KENTUCKY, INC. **APPELLEE**

MOTION FOR SUMMARY RECOMMENDED ORDER

WellCare of Kentucky, Inc. ("WellCare"), for its Motion for Summary Recommended Order, states as follows:

BACKGROUND AND RELEVANT FACTS

WellCare is one of several MCOs under contract with the Commonwealth of Kentucky to provide its Medicaid product under a 1915(b) Waiver. The Commonwealth of Kentucky's Medicaid program changed from a fee-for-service provider to a managed care program for most of its Medicaid population in November 2011. The contract between the Commonwealth of Kentucky, Department for Medicaid Services and WellCare (hereinafter "Contract") outlines the obligations and agreement between WellCare and the Commonwealth of Kentucky.

In return for providing coverage to Medicaid enrollees, WellCare receives from the Commonwealth a per enrollee, per month capitation payment. That capitation rate is "established in accordance with," among other provisions, 42 C.F.R. Part 438. Under these provisions, the capitation rate must be "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO . . . for the time

period and the population covered under the terms of the contract," 42 C.F.R. § 438.4(a), and must be "adequate to allow the MCO . . . to efficiently deliver covered services to Medicaid-eligible individuals." *Id.* § 438.3(c). In setting capitation rates, the Commonwealth must take into account "utilization" of Medicaid services and "data that are developed from actual experience of the Medicaid population." *Id.* § 438.5(b). These requirements ensure that the Commonwealth's Medicaid program, and its administration by MCOs like WellCare, is "[a]ctuarially sound"—that is, that the Commonwealth's funding of the program is tethered to an MCO's actual losses and related costs. *Id.* § 438.4(a).

The Contract provides that WellCare may place limits on services in accordance with the requirements of the Contract. Appendix F to the Contract contains a listing of non-covered services. Appendix F, Section IV, A lists services not covered by Kentucky Medicaid and states "[T]he Contractor is not required to cover services that Kentucky Medicaid has elected not to cover for Members". The list of services not covered by the Kentucky Medicaid Program includes "cosmetic procedures or services performed solely to improve appearance" and "sex transformation services". Exhibit A (emphasis added).[1]

On May 2, 2022, WellCare received from UK Healthcare, a prior authorization request for "Top Surgery" with CPT code 19318 and diagnosis code F64.9 (gender identity). Exhibit B. The fax cover page stated the following:

> Please pay attention to the diagnosis. This is a NON COVERED service, and cannot be approved by WellCare Medicaid. I have attached WellCare guidelines

[1] The full contract may be found at the following link: https://chfs.ky.gov/agencies/dms/dpqo/Pages/mco-contracts.aspx

> noting this is non-covered. Please call me with questions 859-562-0276 or fax 859-218-7606.[2]

Exhibit B. Further, the prior authorization request form contained the following information under "Additional Information":

> Please pay attention to the diagnosis*** this is a NON COVERED benefit with KY Medicaid/WellCare. Surgery request is for Bilateral Top Surgery for Gender Identity. I have attached WellCare guidelines.

Exhibit B. Attached to the prior authorization request was a page from WellCare's Provider Manual, p. 62 which lists non-covered services including cosmetic services and gender reassignment services. Exhibit B.

On May 4, 2022, WellCare sent a letter to Appellant denying the request for female to male breast reduction surgery (bilateral mammaplasty) as the requested service was not a covered benefit. Exhibit C. The WellCare member handbook contains a list of non-covered services which include cosmetic procedures or services and sex change services. See excerpt at Exhibit D.

Thereafter, on or about May 9, 2022, Appellant appealed the denial. Therein, Appellant argued that Wellcare's exclusion of coverage for the requested service was prohibited by the Affordable Care Act, Section 1557, the 2016 Final Rule, and 45 CFR 92.207(b)(5).[3] Appellant further argued that WellCare routinely covers mastectomies and breast reconstructive surgeries and thus should cover a different service, that is, breast reduction surgery to transition from female to male.

---

[2] Per the contents of the prior authorization request, this is the phone and fax number for the requesting service provider, Dr. David Drake. Exhibit A.

[3] Appellant's citations to the 2016 Final Rule are outdated. The section Appellant cites to specifically relies upon 45 CFR 92.207(b)(5) in support of the commentary. 45 CFR 92.207 was repealed on August 18, 2020.

On June 2, 2022, WellCare sent the appeal denial letter to Appellant upholding the denial of the requested service as the service was not a covered benefit. Exhibit E.

On or about June 7, 2022, Appellant requested a hearing on the same grounds as those contained in the appeal letter.

ARGUMENT

WellCare is not responsible for the provision or cost of a service not covered by the Kentucky Medicaid Program. 907 KAR 17:020 § 1(3)(f). Further, pursuant to 907 KAR 17:010 § 14(1) all aspects of managed care shall be governed by the negotiated terms of the contract between the managed care organization and the department.

Pursuant to the terms of the Contract, WellCare is not required to cover "cosmetic procedures or services performed solely to improve appearance" or "sex transformation services.

In addition, 907 KAR 10:012 § 4(1)(i) states that the department shall not reimburse for cosmetic surgery, except as required for prompt repair of accidental injury or for the improvement of the functioning of a malformed or diseased body member. The prior authorization request was for CPT code 19318 for "Top Surgery" for gender dysphoria which is not for repair of accidental injury to the breasts or for the improvement of the functioning of malformed or diseased breasts.

Since the Kentucky Medicaid Program does not cover gender transition surgery or cosmetic procedures, WellCare is not required to cover such services pursuant to the Contract and 907 KAR 17:020. As such, WellCare is entitled to judgment as a matter of law as the service is not a covered benefit. WellCare respectfully requests this tribunal enter a summary Recommended Order in its favor.

Respectfully submitted,

BY: _____

JOYCE A. MERRITT, Ky Bar ID 85567
EMBRY MERRITT WOMACK NANCE, PLLC
201 E. Main St., STE 1402
Lexington Kentucky 40507
(859) 543-0453
(800) 505-0113 fax
Joyce.merritt@emwnlaw.com
Attorney for Appellee

CERTIFICATE OF SERVICE

The undersigned hereby certified that a copy of the foregoing was served via the methods indicated below on the following on this 3rd day of August 2022:

Hearing Officer Mooney
Cabinet for Health and Family Services
Health Services Administrative Hearings Branch
105 Sea Hero Dr., STE 2
Frankfort KY 40601
Via email only per temporary policy of AHB

(b)(6)

Via certified mail

_____
Joyce A. Merritt

then current Kentucky State Medicaid Plan, as designated by the department in administrative regulations adopted in accordance with KRS Chapter 13A and as required by federal and state regulations, guidelines, transmittals, and procedures.

This Appendix was developed to provide, for illustration purposes only, the Contractor with a summary of currently covered Kentucky Medicaid services and to communicate guidelines for the submission of specified Medicaid reports. The summary is not meant to act, nor serve as a substitute for the then current administrative regulations and the more detailed information relating to services which is contained in administrative regulations governing provision of Medicaid services (907 KAR Chapters 1, 3 4, 8, 9, 10, 11, 13, 15 and 17) and in individual Medicaid program services benefits summaries incorporated by reference in the administrative regulations. If the Contractor questions whether a service is a Covered Service or Non-Covered Service, the Department reserves the right to make the final determination, based on the then current administrative regulations in effect at the time of the contract.

Administrative regulations and incorporated by reference Medicaid program services benefits summaries may be accessed by contacting:

Kentucky Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Kentucky's Medicaid State Plan, administrative regulations, and incorporated by reference materials are also accessible via the Internet at http://www.chfs.ky.gov/dms/Regs.htm.

Kentucky Medicaid covers only Medically Necessary services. These services are considered by the Department to be those which are reasonable and necessary to establish a diagnosis and provide preventive, palliative, curative or restorative treatment for physical or mental conditions in accordance with the standards of health care generally accepted at the time services are provided, including but not limited to services for children in accordance with 42 USC 1396d(r). Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The amount, duration, or scope of coverage must not be arbitrarily denied or reduced solely because of the diagnosis, scope of illness, or condition.

The Contractor shall provide any Covered Services ordered to be provided to a Member by a Court, to the extent not in conflict with federal laws. The Department shall provide written notification to the Contractor of any court-ordered service. The Contractor shall additionally cover forensic pediatric and adult sexual abuse examinations performed by health care professional(s) credentialed to perform such examinations and any physical and sexual abuse examination(s) for any Member when the Department for Community Based Services is conducting an investigation and determines that the examination(s) is necessary.

III. EMERGENCY CARE SERVICES (42 CFR 431.52)

The Contractor must provide, or arrange for the provision of, all covered emergency care immediately using health care providers most suitable for the type of injury or illness in accordance with Medicaid policies and procedures, even when services are provided outside the Contractor's region or are not available using Contractor enrolled providers. Conditions related to provision of emergency care are shown in 42 CFR 438.144.

IV. MEDICAID SERVICES COVERED AND NOT COVERED BY THE CONTRACTOR

The Contractor must provide Covered Services under current administrative regulations. The scope of services may be expanded with approval of the Department and as necessary to comply with federal mandates and state laws. Certain Medicaid services are currently excluded from the Contractor benefits package, but continue to be covered through the traditional fee-for-service Medicaid Program. The Contractor will be expected to be familiar with these Contractor excluded services, designated Medicaid "wrap-around" services and to coordinate with the Department's providers in the delivery of these services to Members.

Information relating to these excluded services' programs may be accessed by the Contractor from the Department to aid in the coordination of the services.

A. Health Services Not Covered Under Kentucky Medicaid

Under federal law, Medicaid does not receive federal matching funds for certain services. Some of these excluded services are optional services that the Department may or may not elect to cover. The Contractor is not required to cover services that Kentucky Medicaid has elected not to cover for Members.

Following are services currently not covered by the Kentucky Medicaid Program:

- Any laboratory service performed by a provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual providers of any laboratory service;
- Cosmetic procedures or services performed solely to improve appearance;
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, invitro fertilization, etc.);
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions;
- Paternity testing;
- Personal service or comfort items;
- Post mortem services;
- Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental in nature;
- Sex transformation services;
- Sterilization of a mentally incompetent or institutionalized member;
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services;
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein; and
- Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.;

V. Health Services Limited by Prior Authorization

The following services are currently limited by Prior Authorization of the Department for Members. Other than the Prior Authorization of organ transplants, the Contractor may establish its own policies and procedures relating to Prior Authorization.

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Special Services

The Contractor is responsible for providing and coordinating Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), and EPSDT Special Services, through the primary care provider (PCP), for any Member under the age of twenty-one (21) years.

EPSDT Special Services must be covered by the Contractor and include any Medically

UK HealthCare®

Fax Cover Sheet

TO: Wellcare	FROM:
FAX: 877-431-0950	PAGES: 14
PHONE:	DATE: 5/2/2022 1:05:32 PM
RE:	CC:

Please pay attention to diagnosis. This is a non-covered service, and cannot be approved by Wellcare Medicaid.
I have attached Wellcare guidelines noting this is non covered. Please call me with questions 859-562-0276 or fax 859-218-7606

EXHIBIT B

MAP 9 –MCO 042018

Kentucky Medicaid MCO
Prior Authorization Request Form

Check the box of the MCO in which the member is enrolled		
☐ Anthem BCBS Medicaid	☐ Aetna Better Health	☐ Humana
☐ Passport Health Plan	☐ WellCare of Kentucky	

Not all plans require PAs for the same services. Check with the plan before submitting

Please complete all appropriate fields

Failure to provide sufficient information will result in a delay in your request

Date 05/02/22 Time Faxed/Emailed 4:00pm

Requesting Provider Dr. David Drake Telephone # 859-562-0276 Fax # 859-218-7606

NPI # 1902975527

Type of Request

☐ Urgent *Urgent is defined as 'significant impact to health of member'* ☐ Non-Urgent

☐ Pre-Service ☐ Post-Service ☐ Concurrent ☐ Emergent

Member Information

(b)(6)

Servicing Provider Information

Servicing Provider Dr. David Drake / Lexington Surgery Center NPI 1902975527 / 1750343383 Tax ID# 610945743 / 611028190

Address 2195 Harrodsburg Rd

City Lexington State KY ZIP 40504

Phone 859-562-0276 Fax# 859-218-7606

Are any supporting documents included? ■ Yes ☐ No Number of Documents

Type of Service

☐ Behavioral Health	☐ EPSDT	☐ Medical Care - Inpatient	☐ Radiology
☐ Behavioral Health - Inpatient	☐ Gastric By-pass	☐ Medical Care - Outpatient	☐ Substance Abuse
☐ Case Management	☐ Home Health	☐ Observation	☐ Surgical - Inpatient
☐ Dental Care	☐ Hospice	☐ OT/PT/ST	■ Surgical - Outpatient
☐ DME Purchase	☐ Inhalation Therapy	☐ Oral Surgery	☐ Transportation
☐ DME Rental	☐ Maternity	☐ Private Duty Nursing	☐ Vision/Optometry

☐ OTHER

Clinical Information: Request MUST include medical documentation to be reviewed for medical necessity

Primary ICD-10 Code F64.9 Description Gender identity disorder

Dates of Service		Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits
Start	Stop				
09/08/22	10/07/22	19318	F64.9	Top Surgery	2

Additional Information:

Please pay attention to diagnosis*** this is a NON COVERED benefit with KY Medicaid/Wellcare. Surgery request is for Bilateral Top Surgery for Gender Identity I have attached Wellcare guidelines

This form completed by Eileen H Fax 859-218-7605 Phone # 859-562-0276


2021
Kentucky Medicaid
Provider Manual
WellCare
Beyond Healthcare. A Better You.

care plan, a WellCare Review Nurse/Care Manager who is familiar with that Enrollee will provide a Transition of Care report to the receiving plan or appropriate contact person for the designated fee-for-service program.

If a Provider receives an adverse claim determination which he or she believes was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals Department with documentation of approval for reconsideration. For contact information, please refer to the *Quick Reference Guide* at www.wellcare.com/Kentucky/Providers/Medicaid.

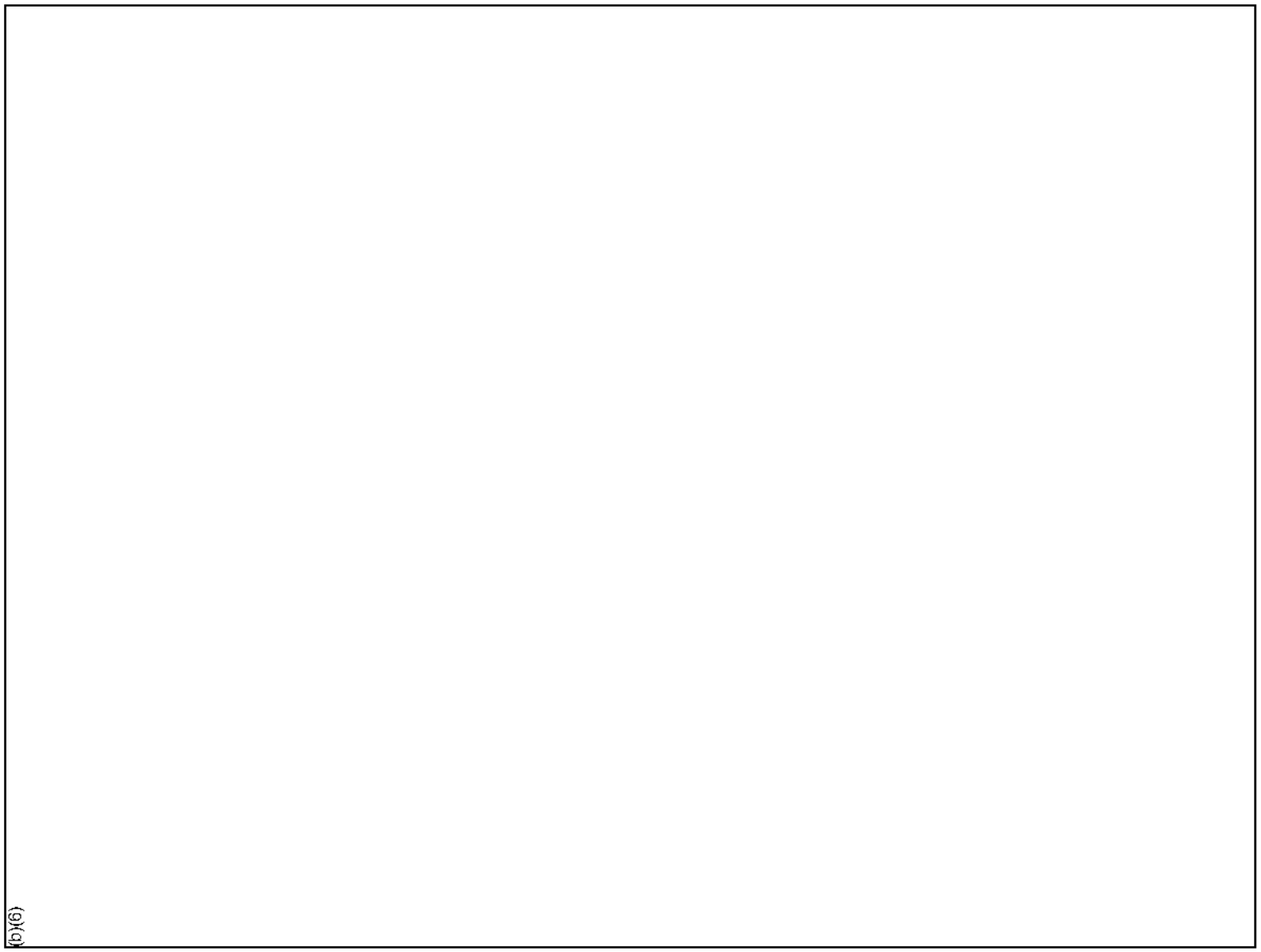
WellCare will participate in transition planning and continued Care Coordination for Enrollees with SMI who are transitioning from licensed Personal Care Homes, psychiatric hospitals, or other institutional settings to integrated, community based housing.

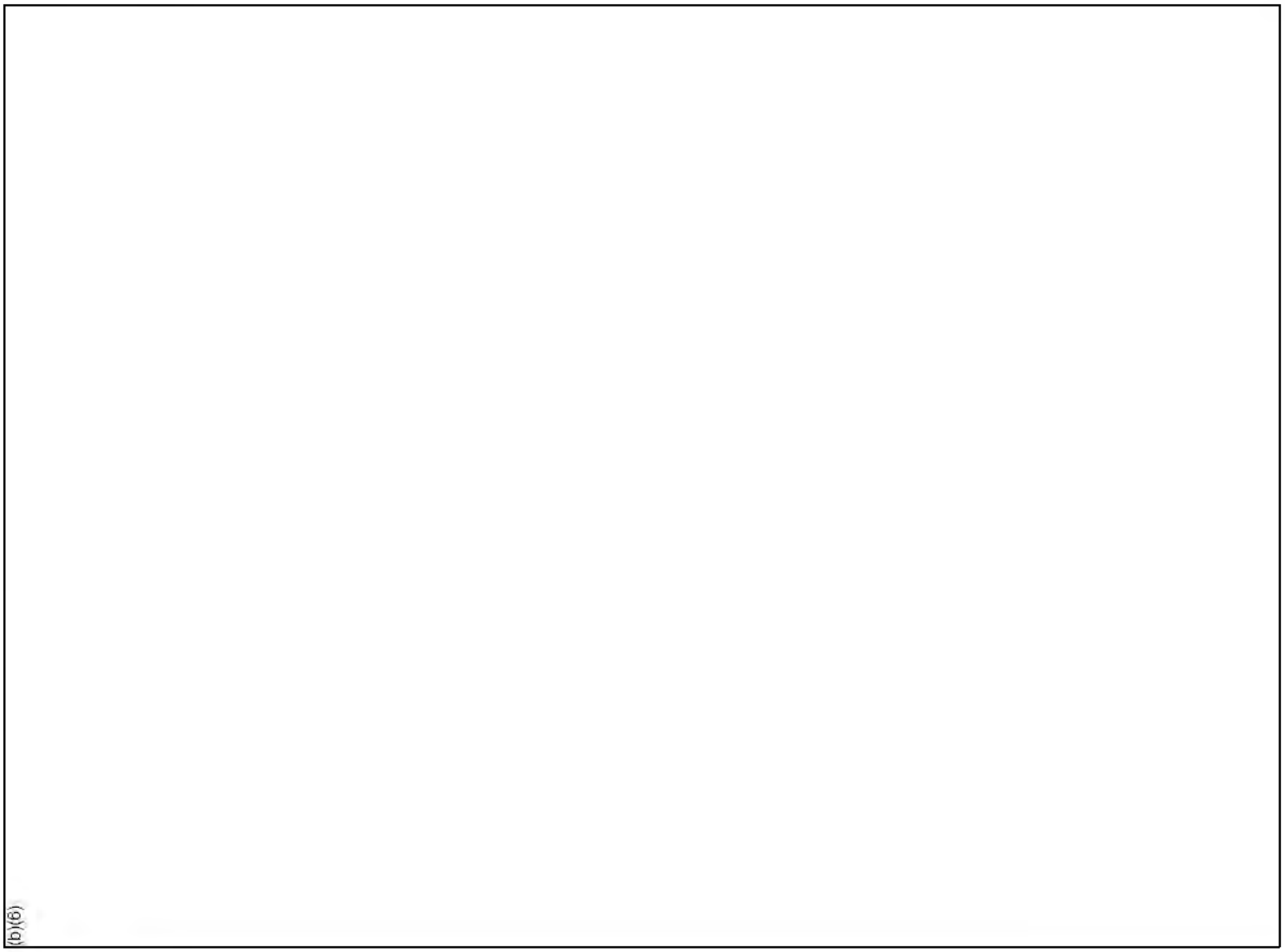
WellCare will perform a comprehensive physical and behavioral health assessment designed to support the successful transition to community based housing within 14 days of transition. To perform such assessment, WellCare will review the Enrollee's Person-Centered Recovery Plan and level of care determination developed by the provider agency in tandem with WellCare's routine UM procedures and will provide services that are recommended in the Person-Centered Recovery Plan and that meet Medical Necessity criteria.

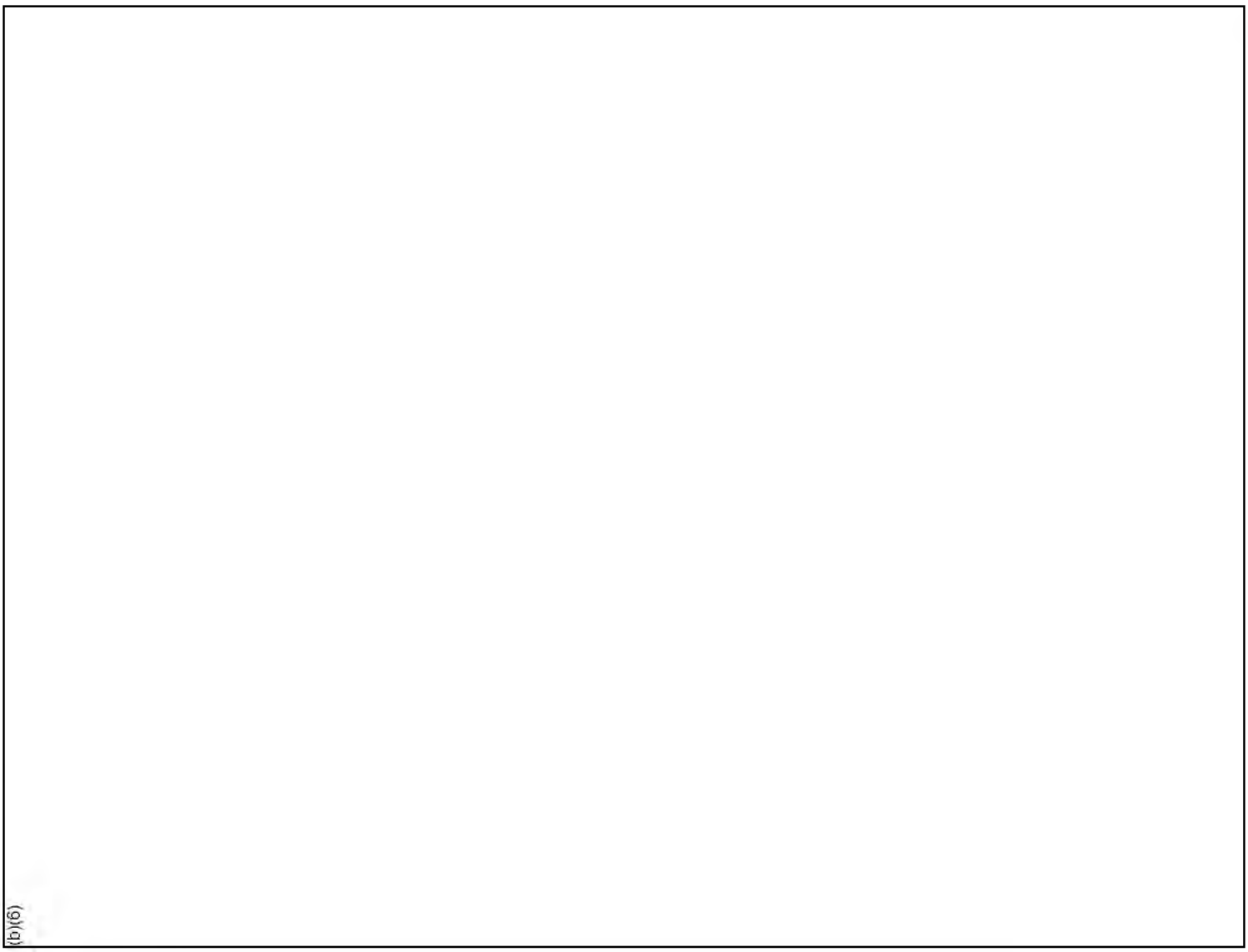
Non-Covered Services

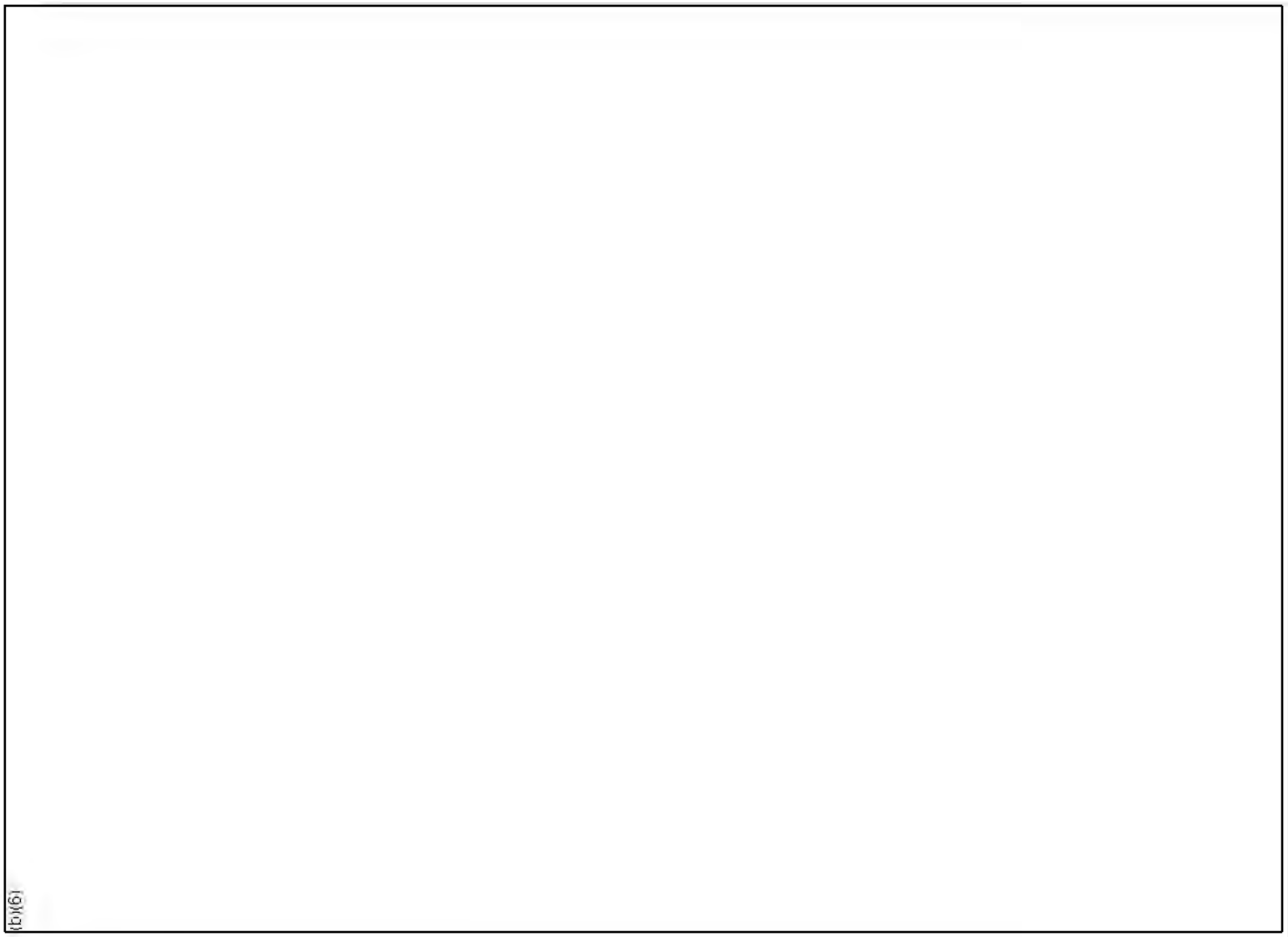
The following list is representative of non-covered services and procedures, and is not meant to be exhaustive:

- Any laboratory service performed by a Provider without current certification in accordance with the CLIA. This requirement applies to all facilities and individual Providers of any laboratory service;
- Cosmetic procedures or services performed solely to improve appearance;
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
- Medical or surgical treatment of infertility (for example, the reversal of sterilization, in vitro fertilization, etc.);
- Induced abortion and miscarriage performed out of compliance with federal and Kentucky laws and judicial opinions;
- Paternity testing;
- Personal service or comfort items;
- Postmortem services;
- Services that are investigational, mainly for research purposes, or experimental in nature. This includes, but is not limited to, drugs;
- Gender reassignment services;
- Sterilization of a mentally incompetent or institutionalized Enrollee;
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services;
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid Program regulations referenced herein; and
- Services for which the Enrollee has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.


(b)(6)


(b)(6)


(b)(6)


(b)(6)

FAX

MRN: 110480888 DOS: 3/11/2022
Kaukereit, Laura
Prefers: Hiara DOB: 6/7/1992
AC2001024627392

To:

Name: Dr David Drake

Company: UK HealthCare

Fax Number: 859-257-5901

From:

Name: Sydney King

Fax Number: 1-614-421-7987

Phone Number: 1-614-427-0875

Company Name: The Self Collective, LLC

Subject:

Letter for Gender-Affirming Medical Care

(b)(6)

MRN: 110480888 DOS: 3/11/2022
Kaukereit, Laura
Prefers: Hiara DOB: 6/7/1992
AC2001024627392

Sydney T. King, M.S., LPCC
The Self Collective, LLC
Sydney@TheSelfCollective.com
Ph. 614-427-0875; Fax: 614-421-7987

04/19/2022

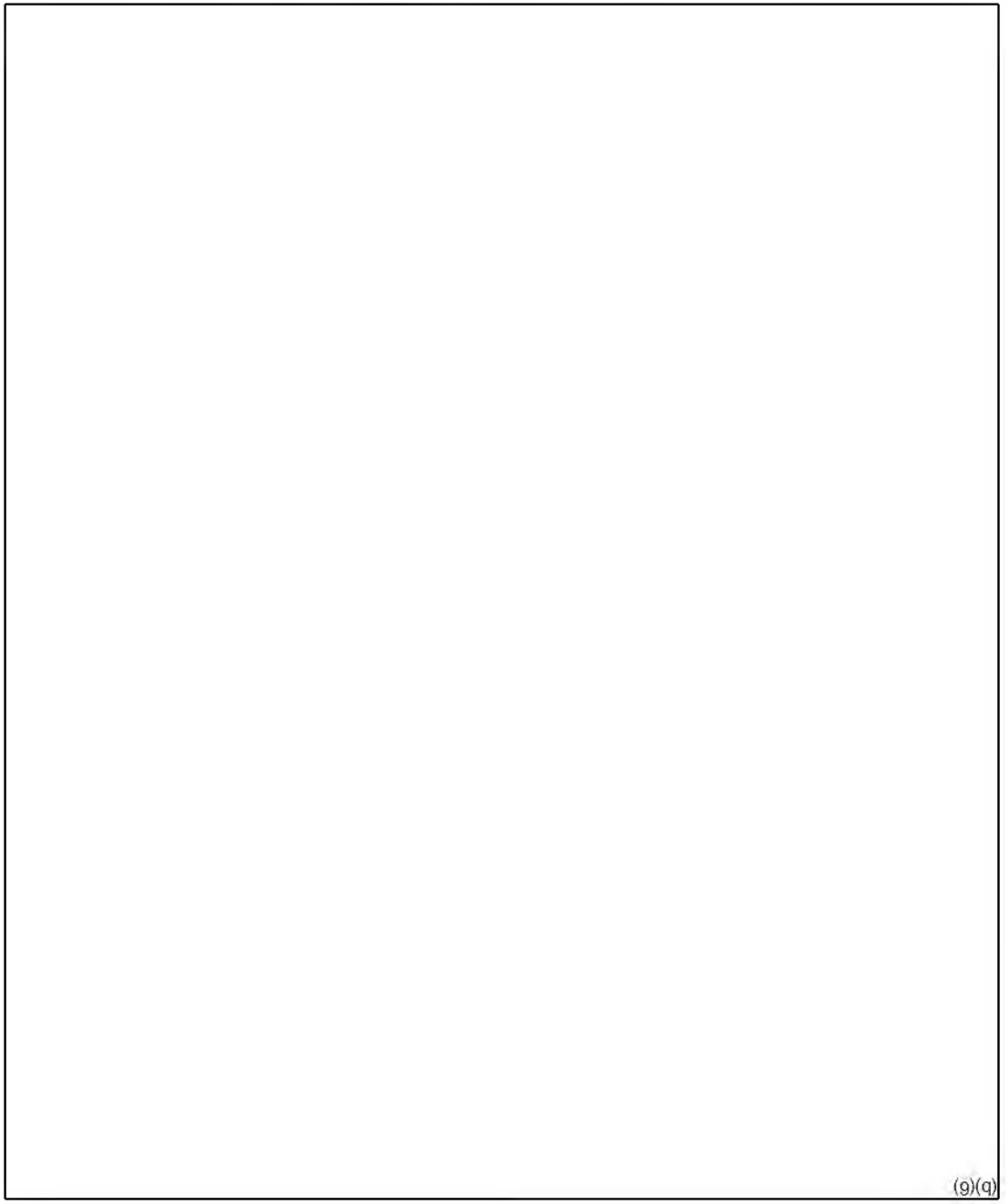
To:
UK HealthCare
1000 S. Limestone
University of Kentucky
Lexington, KY 40536

Re:
(b)(6)

Reason for Referral:
(b)(6)

Dr. David Drake and Team:

This is a letter of support for (b)(6)
(b)(6)



(g)(q)

(b)(6)

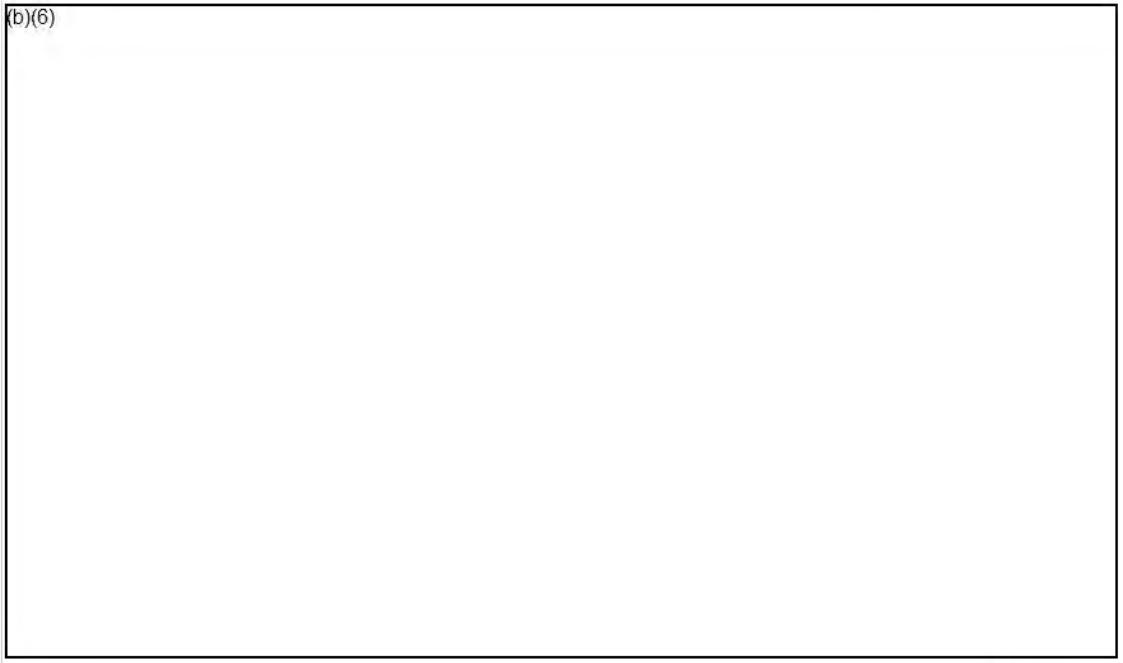
Please feel free to contact me should you have any questions or need any further information. Thank you in advance for the care that you will provide to Hiara.

Sydney T. King, M.S., LPCC
Ohio #E.2001814

Sydney@TheSelfCollective.com
Ph: 614-427-0875

(g)(q)

(b)(6)



WellCare
Beyond Healthcare. A Better You.

PO Box 31370
Tampa, FL 33631-3370

DAVID DRAKE
2195 HARRODSBURG RD 2ND FLOOR
LEXINGTON, KY 40504

05/04/2022

Notice of Adverse Benefit Determination

(b)(6)

Dear Provider:

We have taken the following action on your service request regarding the member noted above:

The request for female to male breast reduction surgery-a surgery to remove a breast is not approved. The service is not covered by your Plan. Please follow up with your doctor for a new referral for a covered service.
Criteria Referenced: Kentucky Enrollee Handbook, Section: Services Not Covered by WellCare of Kentucky

You may request a copy of the clinical criteria, benefit provision or other information used to make this decision by calling Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7 a.m. to 7 p.m. EST.

This does not mean that you cannot provide the service(s) you requested. It means you may not be reimbursed for the service(s).

YOU HAVE THE RIGHT TO ASK FOR AN APPEAL OF THIS DECISION.

If you do not agree with this decision, you may appeal. Your request must be submitted within sixty (60) calendar days of the date of this notice. We will issue an appeal decision in writing within thirty (30) calendar days of receiving the appeal request, unless we need a fourteen (14) calendar day extension. If we need an extension, we will request it from you.

EXHIBIT C

WellCare
Beyond Healthcare. A Better You.
PO Box 31370
Tampa, FL 33631-3370

To appeal this decision, please fax or mail your request to:

WellCare of Kentucky Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253
Fax: 1-866-201-0657

For assistance in filing an appeal call Provider Services at **1-877-389-9457** (TTY/TDD: **711**) Monday through Friday, 7:00 a.m. to 7:00 p.m. EST.

Sincerely,

Utilization Management Department

SERVICES NOT COVERED BY WELLCARE OF KENTUCKY

- Any lab service performed by a facility or individual provider without current certification from the Clinical Laboratory Improvement Amendment (CLIA)
- Cosmetic procedures or services performed only to improve appearance
- Hysterectomies performed only to prevent pregnancy
- Medical or surgical treatment of infertility (for example, the reversal of sterilization, in vitro fertilization, etc.)
- Induced abortion and miscarriage services that go against federal and Kentucky laws and judicial opinions
- Paternity test
- Personal service or comfort items
- Post-mortem services
- Services or drugs that are investigational or experimental
- Sex change services
- Sterilization of a mentally incompetent or institutionalized Enrollee
- Services provided outside of the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services
- Services or supplies greater than what's allowed by federal or state laws, judicial opinions and the Kentucky Medicaid program
- Services for which an Enrollee is not required to pay and for which no other person has a legal responsibility to pay

EXHIBIT D

WellCare
Beyond Healthcare. A Better You.
P.O. Box 436000
Louisville, KY 40253

Notice of Appeal Decision

(b)(6)

June 2, 2022

Re: (b)(6)
ID#: (b)(6)
File # (b)(6)
Request: Reduction Mammoplasty CPT 19318

Dear (b)(6)

On May 4, 2022, we received your appeal. This appeal was about: Reduction Mammoplasty.

An Appeals Review Nurse looked at your request.

We reached this decision: The procedure to make your breasts smaller is not approved.

We made this decision because the notes say you want smaller breasts so you will look like a male. The health plan does not cover this kind of procedure. The reasons for the denial are based on a set of benefits/criteria, which include Kentucky Enrollee Handbook 2022 Section: Services Not Covered by WellCare of Kentucky

Kentucky law says we cover services that are "medically necessary." Per *907 KAR 17:020 and 907 KAR 3:130,* "medically necessary" means:

- Care or supplies required to meet an enrollee's medical needs
- The care or supplies must:

EXHIBIT E

- Be right for the enrollee's medical condition;
- Be care accepted by most doctors;
- Not be for convenience;
- Be in the right amount, at the right place and at the right time; and
- Be safe for the enrollee.

This decision will not affect the services or supplies you may need in the future.

You, your doctor, or someone you choose can get a copy of any paperwork used to make this decision. You can get this at no charge. Call **1-877-389-9457** or write to:

WellCare of Kentucky
Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253

We also want to let you know that, per *907 KAR 17:035*, if your provider gets an adverse final decision of a denial, in whole or in part, of a health service or claim for reimbursement related to this service, he or she may ask for an external, independent third-party review. Your provider must first complete an internal appeal with WellCare of Kentucky. Provider requests for external review will only be considered for dates of service on or after December 1, 2016.

If an external, independent third-party review is held, your provider and WellCare of Kentucky may, depending on the outcome of this review, ask for an administrative hearing. This is per *907 KAR 17:040*.

You do not have to take action if your provider files for an external, independent third-party review or administrative hearing. This does not affect your appeal rights or right to ask for a State Fair Hearing.

You Have the Right to Ask for a State Fair Hearing

You have the right to ask for a State Fair Hearing if you do not agree with the decision. A hearing officer from the Kentucky Cabinet for Health and Family Services will review our decision. You, a friend, a relative, lawyer, or someone you choose may ask for a hearing for you. You must give this person permission in writing to act for you.

You must ask for a State Fair Hearing within **120** days from the date of this letter. See *907 KAR 17:010*.

If you ask for a hearing to appeal our decision, you may continue to receive these services. But you must ask for the hearing within 10 days of receiving this notice. You may have to pay for these services if the hearing officer agrees with WellCare that the services are not needed.

You may request a State Fair Hearing at this address:

Office of the Ombudsman
Office of the Ombudsman and Administrative Review
Attn: Medical Appeals and Reconsiderations
275 East Main Street, 2E-O
Frankfort, KY 40621
Phone: 502-564-5497 (TTY **711**)
Fax: 502-564-9523

Contact us or the Kentucky Department for Medicaid Services if:

- You want to know if you can ask for a State Fair Hearing on the denial.
- You want to know if you can still get the care you asked for.
- You want to learn more.

Other things to know:

- You do not have to pay for the State Fair Hearing.
- You have the right to name someone you trust to file a State Fair Hearing for you. You must give the person permission in writing to do so.

Questions? Just call Customer Service at **1-877-389-9457**. TTY users may call **711**. We are here to help you. You can call Monday–Friday, 7 a.m. to 7 p.m.

Sincerely,

Appeals Department
mbsharp

Cc: Dr. David Drake

Sydney T. King, M.S., LPCC
The Self Collective, LLC
Sydney@TheSelfCollective.com
Ph: 614-427-0875; Fax: 614-421-7987

04/19/2022

To:
UK HealthCare
1000 S. Limestone
University of Kentucky
Lexington, KY 40536

Re:
(b)(6)

Reason for Referral:
(b)(6)

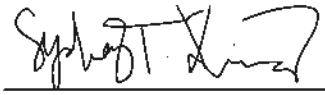
Dr. David Drake and Team:

This is a letter of support for (b)(6)
(b)(6)

(b)(6)

(b)(6)

Please feel free to contact me should you have any questions or need any further information. Thank you in advance for the care that you will provide to Hiara.



Sydney T. King, M.S., LPCC
Ohio #E.2001814

Sydney@TheSelfCollective.com
Ph: 614-427-0875

05/06/2022

WellCare of Kentucky
2480 Fortune Dr Ste 200
Lexington, KY 40509

Member Name: (b)(6)
Member Number ID:
Provider Name:
Payer:

Plan name: Medicaid

Contact Name: (b)(6)
Contact Email:
Contact Phone Number:
Contact Address:

Subject: Request for [LEVEL 2 Appeal]

To Whom It May Concern:

I am writing to request a LEVEL 2 appeal. I wish to appeal the decision relating to CPT codes:19318.

My plan's exclusion of coverage of transgender-related care should not govern this decision as such an exclusion is prohibited by the Affordable Care Act - instead, WellCare must evaluate this decision on the basis of medical necessity. Wellcare should approve my request for precertification of codes 19318 on the basis of the medical necessity documented by my medical providers and duly provided in my initial request.

I. My plan's current exclusion of coverage of transgender-related care, which dictated WellCares denial of my precertification request, is prohibited by the Affordable Care Act.

WellCare based its denial of my request on a blanket exclusion in my health insurance plan.[1] This exclusion violates section 1557 of the Affordable Care Act.

Section 1557 of the Affordable Care Act (42 U.S.C. 18116) sets forth the requirement for non-discrimination in health care coverage, requiring that:

> "[A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20

[1] My plan, 'WellCare of Ky Medicaid' specifically excludes "Sex Reassignment Surgeries."

> U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection."

Title IX of the Education Amendments of 1972 provides, in pertinent part:

> "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance [...]"

Further guidance on Section 1557 of the Affordable Care Act is provided in the rule on Nondiscrimination in Health Programs and Activities, which expands upon the definition of sex discrimination:

> *"On the basis of sex* includes, but is not limited to, on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or **gender identity**. [...]
>
> We noted that like other Federal agencies, HHS has previously interpreted sex discrimination to include discrimination on the basis of gender identity.[2] We also noted that courts, including in the context of Section 1557, have recognized that sex discrimination includes discrimination based on gender identity. Thus, we proposed to adopt formally this well-accepted interpretation of discrimination "on the basis of sex.""

The rule goes on to explain:

> "OCR proposed to apply basic nondiscrimination principles in evaluating whether a covered entity's denial of a claim for coverage for transition-related care is the product of discrimination. We noted that based on these principles, **an explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to**

---

[2] Three years before the proposed rule on Nondiscrimination in Health Programs and Activities was introduced, HHS agreed that Section 1557's sex discrimination prohibition extends to claims of discrimination based on gender identity. See Letter from Leon Rodriguez, Director of Office for Civil Rights, Department of Health & Human Services to Maya Rupert, Federal Policy Director, National Center for Lesbian Rights (Jul. 12, 2012) (OCR Transaction No. 12-000800). Additional instances of this interpretation can be found in the full text of the proposed rule on Nondiscrimination in Health Programs and Activities (HHS-OCR-2015-0006) and the final rule, which can be found in the Federal Register, Vol. 81, No. 96, Part IV, published Wednesday, May 18, 2016 (45 CFR Part 92; RIN 0945–AA02).

gender transition is unlawful on its face under paragraph (b)(4); in singling out the entire category of gender transition services, **such an exclusion or limitation systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex.**

Moreover, we proposed in § 92.207(b)(5) to bar a covered entity from denying or limiting coverage, or denying a claim for coverage, for specific health services related to gender transition where such a denial or limitation results in discrimination against a transgender individual. **In evaluating whether it is discriminatory to deny or limit a request for coverage for a particular service for an individual seeking the service as part of transition-related care, we provided that OCR will start by inquiring whether and to what extent coverage is available when the same service is not related to gender transition.** If, for example, an issuer or State Medicaid agency denies a claim for coverage for a hysterectomy that a patient's provider says is medically necessary to treat gender dysphoria, OCR will evaluate the extent of the covered entity's coverage policy for hysterectomies under other circumstances. We noted that OCR will also carefully scrutinize whether the covered entity's explanation for the denial or limitation of coverage for transition-related care is legitimate and not a pretext for discrimination."

WellCare routinely covers mastectomies and breast reconstructive surgeries deemed to be medically necessary, including areolar reconstruction, when not related to gender transition.[3] To exclude identical procedures for transgender individuals based merely on their medical necessity being due to gender dysphoria as opposed to other diagnoses, "systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex" in violation of Section 1557.

II. Because WellCares blanket exclusion of transition-related healthcare is unlawful under the Affordable Care Act, WellCare must evaluate my request for precertification on the basis of medical necessity.

(b)(6)

[redacted]

3

WellCares Enrollee Handbook states, "We approve care that is medically needed or necessary. This means the care, services, or supplies give you the treatment you need. The care, services, or supplies must:
• Be right for your medical condition • Be care accepted by most doctors • Not be for convenience • Be in the right amount, at the right place, and at the right time • Be safe for you

Clinically Appropriate We approve care that is clinically right or appropriate. This just means the services or supplies you get are standard. Standards are set by national guidelines, such as InterQual®."

The requested procedure meets WellCares criteria for medically needed.

Sincerely,

(b)(6)

United States Court of Appeals
For The Eighth Circuit
Thomas F. Eagleton U.S. Courthouse
111 South 10th Street, Room 24.329
St. Louis, Missouri 63102

Michael E. Gans
Clerk of Court

VOICE (314) 244-2400
FAX (314) 244-2780
www.ca8.uscourts.gov

August 25, 2022

Mr. Dylan L. Jacobs
ATTORNEY GENERAL'S OFFICE
200 Catlett-Prien Building
323 Center Street
Little Rock, AR 72201-0000

RE: 21-2875 Dylan Brandt, et al v. Leslie Rutledge, et al

Dear Counsel:

The court has issued an opinion in this case. Judgment has been entered in accordance with the opinion.

Please review Federal Rules of Appellate Procedure and the Eighth Circuit Rules on post-submission procedure to ensure that any contemplated filing is timely and in compliance with the rules. Note particularly that petitions for rehearing and petitions for rehearing en banc must be received in the clerk's office within 14 days of the date of the entry of judgment. Counsel-filed petitions must be filed electronically in CM/ECF. Paper copies are not required. No grace period for mailing is allowed, and the date of the postmark is irrelevant for pro-se-filed petitions. Any petition for rehearing or petition for rehearing en banc which is not received within the 14 day period for filing permitted by FRAP 40 may be denied as untimely.

Michael E. Gans
Clerk of Court

CRJ

Enclosure(s)

cc: Ms. Lauren R. Adams
Mr. Barrett James Anderson
Mr. Gabriel Arkles
Mr. Jess Askew III
Mr. Paul V. Avelar
Ms. Elizabeth Baia
Ms. Shireen A. Barday
Mr. Garrard R. Beeney
Mr. Boris Bershteyn
Ms. Carmine D Boccuzzi Jr.
Ms. Kathleen Boergers

Mr. Andrew Bonzani
Ms. Gretchen Borchelt
Mr. Alexander Barrett Bowdre
Mr. Nicholas J. Bronni
Ms. Vernadette R. Broyles
Mr. John J. Bursch
Mr. Michael A. Cantrell
Ms. Sunu Chandy
Ms. Jennifer C. Chavez
Mr. JD Colavecchio
Ms. Leslie Cooper
Mr. Ezra Cukor
Mr. Andrew Rhys Davies
Ms. Tammy H. Downs
Ms. Sharon Elizabeth Echols
Mr. James D. Esseks
Ms. Sarah C. Everett
Mr. Omar Gonzalez-Pagan
Mr. Nicholas Guillory
Ms. Lindsay Harris
Ms. Kathleen R. Hartnett
Mr. Alexander S. Holland
Mr. William Racilla Isasi
Ms. Katelyn Kang
Mr. Andrew King
Mr. Caleb B. King
Mr. Edmund G. LaCour Jr.
Mr. Cortlin Hall Lannin
Mr. Michael J. Lanosa
Ms. Karen Loewy
Mr. Jesse Ryan Loffler
Mr. Peter Drake Mann
Mr. Thomas A. Mars
Ms. Dorianne Mason
Ms. Mary Elizabeth McAlister
Mr. Gary McCaleb
Mr. Christopher Ernest Mills
Mr. William J. O'Brien
Mr. Justin L. Ormand
Ms. Laura Kabler Oswell
Ms. Elizabeth F. Reinhardt
Ms. Bonnie I. Robin-Vergeer
Ms. Mary C. Ross
Mr. Andrew J. Schrag
Ms. Barbara Schwabauer
Ms. J. G. Piper Sheren
Mr. Paul M. Sherman
Mr. Steven W. Shuldman
Mr. Chase B. Strangio
Mr. Gary L. Sullivan
Ms. Alison Ann Tanner
Mr. Joel H. Thornton

Mr. Ernest G. Trakas
Mr. Christopher L. Travis
Ms. Julie Veroff
Ms. D. Jean Veta
Ms. Breean Walas
Ms. Lily Grace Weaver
Ms. Stephanie Yu
Mr. Howard S. Zelbo

District Court/Agency Case Number(s): 4:21-cv-00450-JM

United States Court of Appeals
For The Eighth Circuit
Thomas F. Eagleton U.S. Courthouse
111 South 10th Street, Room 24.329
St. Louis, Missouri 63102

Michael E. Gans
Clerk of Court

VOICE (314) 244-2400
FAX (314) 244-2780
www.ca8.uscourts.gov

August 25, 2022

West Publishing
Opinions Clerk
610 Opperman Drive
Building D D4-40
Eagan, MN 55123-0000

RE: 21-2875 Dylan Brandt, et al v. Leslie Rutledge, et al

Dear Sir or Madam:

A published opinion was filed today in the above case.

Counsel who presented argument on behalf of the appellants was Dylan L. Jacobs, Assistant Solicitor General, of Little Rock, AR. The following attorney(s) appeared on the appellants' brief; Vincent M. Wagner, Deputy Solicitor General, of Little Rock, AR., Ka Tina R. Guest, AAG, of Little Rock, AR., Nicholas J. Bronni, Solicitor General, of Little Rock, AR., Michael A. Cantrell, Assistant Solicitor General, of Little Rock, AR.

Counsel who presented argument on behalf of the appellees and appeared on the appellees' brief, was Chase B. Strangio, of New York, NY. The following attorney(s) also appeared on the appellees' brief; Leslie Cooper, of New York, NY., James Esseks, of New York, NY., Breean Walas, of Bozeman, MT., Garrard R. Beeney, of New York, NY., Jonathan J. Ossip, of New York, NY., Brandyn J. Rodgerson, of New York, NY., Alexander S. Holland, of New York, NY., Beth Echols, of Little Rock, AR., Christopher Travis, of Little Rock, AR., Drake Mann, of Little Rock, AR., Gill Ragon Owen, of Little Rock, AR., Gary L. Sullivan, of Little Rock, AR., Sarah Everett, of Little Rock, AR., Laura Kabler Oswell, of Palo Alto, CA., Duncan C. Simpson LaGoy, of Palo Alto, CA.

Counsel who represented amicus group of the State of Alabama, State of Alaska, State of Arizona, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Kentucky, State of Louisiana, State of Mississippi, State of Missouri, State of Montana, State of Nebraska, State of South Carolina, State of South Dakota, State of Tennessee, State of Texas, State of Utah and State of West Virginia, was Edmund G. LaCour Jr., Solicitor General, of Montgomery, AL., Steve Marshall, Attorney General, of Montgomery, AL., A. Barrett Bowdre, Deputy Solicitor General, of Montgomery, AL., Treg R. Taylor, Attorney General of Alaska, Mark Brnovich, Attorney General of Arizona, Christopher M. Carr, Attorney General of Georgia, Lawrence G. Wasden, Attorney General of Idaho, Theodore E. Rokita, Attorney General of Indiana, Derek Schmidt, Attorney General of Kansas, Daniel Cameron, Attorney General of Kentucky, Jeff Landry, Attorney General of Louisiana, Lynn Fitch, Attorney General of Mississippi, Eric Schmitt, Attorney General of Missouri, Austin Knudsen, Attorney General of Montana, Doug

Peterson, Attorney General of Nebraska, Alan Wilson, Attorney General of South Carolina, Jason R. Ravnsborg, Attorney General of South Dakota, Herbert Slatery III, Attorney General of Tennesse, Ken Paxton, Attorney General of Texas, Sean D. Reyes, Attorney General of Utah, Patrick Morrisey, Attorney General of West Virginia.

Counsel who represented amicus group Family Research Council, was Christopher Mills, of Charleston, SC.

Counsel who represented amicus group Women's Liberation Front, was Jennifer C. Chavez, of Washington, DC., Lauren R. Adams, of Washington, DC.

Counsel who represented amicus group of Jeffrey E. Hansen, Ph. D., Michael K. Laidlaw, MD, Quentin L. Van Meter, MD and Andre Van Mol, MD, was Gary S. McCaleb, of Scottsdale, AZ., John J. Bursch, of Washington, DC.

Counsel who represented amicus group of Kellie C., Jeanne Crowley, Barbara F., Ted Hudacko, Bri Miller, Helen S., Martha S., Yaacov Sheinfeld, Kristine W. and Lauren W., was Mary E. McAlister, of Johns Creek, GA., Vernadette R. Broyles, of Johns Creek, GA., Joel H. Thornton, of Johns Creek, GA.

Counsel who represented amicus group of Laura Becker, Keira Bell, Kathy Grace Duncan, Carol Freitas, Laura Reynolds and Sinead Watson, was Ernest G. Trakas, of St. Louis, MO.

Counsel who represented amicus group of Equality South Dakota, Family Equality, Freedom for All Americans, GLBTQ Legal Advocates & Defenders, Gender Justice, Human Rights Campaign, Intransitive (Mabelvale, Arkansas), Lambda Legal Defense and Education Fund, Legal Voice, Lucie's Place (Little Rock, Arkansas), National Center for Lesbian Rights, National Center for Transgender Equality, National LGBTQ Task Force, National Women's Law Center, One Iowa, OutNebraska, PFLAG, SisterReach, South Dakota Transformation Project, Southwest Women's Law Center, Transformation Project Advocacy Network and Women's Law Project, was Gretchen Borchelt, of Washington, DC., Sunu Chandy, of Washington, DC., Dorianne Mason, of Washington, DC., Alison Tanner, of Washington, DC., Nicholas Guillory, of Dallas, TX., Omar Gonzalez-Pagan, of New York, NY., Karen Loewy, of Washington, DC.

Counsel who represented amicus group Biomedical Ethics and Public Health Scholars, was Katelyn Kang, of New York, NY., Elizabeth F. Reinhardt, of Boston, MA., Kathleen Hartnett, of San Francisco, CA., Julie Veroff, of San Francisco, CA., Barrett Anderson, of San Diego, CA.

Counsel who represented amicus group of Acoustic, L.P., Acxiom LLC, Arkansas State Chamber of Commerce, Asana, Inc., CYCLQ LLC, IPG, Kinesso, LLC, LiveRamp Holdings, Inc., Northwest Arkansas Council, The Walton Family Foundation, Inc., Winthrop Rockefeller Foundation and Xperi Holding Corp., was Boris Bershteyn, of New York, NY., William J. O'Brien, of New York, NY., Andrew J. Schrag, of New York, NY., J.G. Piper Sheren, of New York, NY., Mary C. Ross, of New York, NY., Caleb B. King, of New York, NY., Thomas A. Mars, of Rogers, AR., Andrew Bonzani, of New York, NY.

Counsel who represented amicus United States, was Kristen Clarke, AAG, Washington, DC., Bonnie I. Robin-Vergeer, USDOJ, of Washington, DC., Barbara Schwabauer, USDOJ, of Washington, DC.

Counsel who represented amicus group of Academic Pediatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Association of Physicians for Human Rights, Inc., ACOP, AMA, APS, American Psychiatric Association, ARAAP, ACCAP, Arkansas Medical Society, Arkansas Psychiatric Society, AMSPDC, Endocrine Society, NAPNAP, PES, SPU, Society for Adolescent Health and Medicine, SPR, SPN and World Professional Association for Transgender Health, was Jess Askew, III, of Little Rock, AR., Andrew King, of Little Rock, AR., D. Jean Veta, of Washington, DC., Cortlin Lannin, of Washington, DC., William Isasi, of Washington, DC., Michael Lanosa, of Washington, DC., Elizabeth Baia, of Washington, DC.

Counsel who represented amicus group Institute for Justice, was Paul Avelar, of Tempe, AZ., Paul M. Sherman, of Arlington, VA.

Counsel who represented amicus group of AusPATH, BVT*, FELGBTI+, Fundacion, LGBT+ Denmark, FRI, PATHA NZ, Stonewall UK and RFSL, was Andrew Rhys Davies, of New York, NY., Justin L. Ormand, of New York, NY., Steven W. Shuldman, of New York, NY.

Counsel who represented amicus group Families with Transgender Children, was Jesse Ryan Loffler, of Pittsburgh, PA.

Counsel who represented amicus group of District of Columbia, State of California, State of Colorado, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Maine, State of Maryland, State of Massachusetts, State of Michigan, State of Minnesota, State of Nevada, State of New Jersey, State of New Mexico, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont and State of Washington, was Rob Bonta, Attorney General of California., Kathleen Boergers, Supervising Deputy Attorney General of California., Stephanie T. Yu, Deputy AAG, of Sacramento, CA., Lily G. Weaver, Deputy AAG, of Sacramento, CA., Philip J. Weiser, Attorney General of Colorado, Kathleen Jennings, Attorney General of Delaware, Holly T. Shikada, Attorney General of Hawaii, Aaron M. Frey, Attorney General of Maine, William Tong, Attorney General of Connecticut, Karl A. Racine, Attorney General of District of Columbia, Kwame Raoul, Attorney General of Illinois, Brian E. Frosh, Attorney General of Maryland, Maura Healey, Attorney General of Massachusetts, Keith Ellison, Attorney General of Minnesota, Andrew J. Bruck, Acting Attorney General of New Jersey, Letitia James, Attorney General of New York, Ellen F Rosenblum, Attorney General of Oregon, Thomas J. Donovan, Jr., Attorney General of Vermont, Dana Nessel, Attorney General of Michigan, Aaorn D. Ford, Attorney General of Nevada, Hector Baldera, Attorney General of New Mexico, Joshua H. Stein, Attorney General of North Carolina, Peter F. Nerohna, Attorney General of Rhode Island, Robert W. Ferguson, Attorney General of Washington.

Counsel who represented amicus group Elliot Page and 57 Other Individuals, was Carmine D. Boccuzzi, Jr. of New York, NY., Howard S. Zelbo, of New York, NY., JD Colavecchio, of New York, NY., Lindsay Harris, of New York, NY., Gabriel Arkles, of New York, NY., Ezra Cukor, of New York, NY.

Counsel who represented amicus group The Trevor Project, Inc., was Shireen A. Barday, of New York, NY.

The judge who heard the case in the district court was Honorable James M. Moody, Jr.. The judgment of the district court was entered on July 21, 2021.

If you have any questions concerning this case, please call this office.

Michael E. Gans
Clerk of Court

CRJ

Enclosure(s)

cc: MO Lawyers Weekly

District Court/Agency Case Number(s): 4:21-cv-00450-JM

United States Court of Appeals

For the Eighth Circuit

No. 21-2875

Dylan Brandt, by and through his mother Joanna Brandt; Joanna Brandt; Sabrina Jennen, by and through her parents Lacey and Aaron Jennen; Lacey Jennen; Aaron Jennen; Brooke Dennis, by and through her parents Amanda and Shayne Dennis; Amanda Dennis; Shayne Dennis; Parker Saxton, by and through his father Donnie Saxton; Donnie Saxton; Michele Hutchison, on behalf of herself and parents; Kathryn Stambough, on behalf of herself and her parents

Plaintiffs - Appellees

v.

Leslie Rutledge, in her official capacity as the Arkansas Attorney General; Amy E. Embry, in her official capacity as the Executive Director of the Arkansas State Medical Board; Sylvia D. Simon, in official capacity as member of the Arkansas State Medical Board; Robert Breving, Jr., in official capacity as member of the Arkansas State Medical Board; John H. Scribner, in official capacity as member of the Arkansas State Medical Board; Elizabeth Anderson, in official capacity as member of the Arkansas State Medical Board; Rhys L. Branman, in official capacity as member of the Arkansas State Medical Board; Edward Gardner, "Ward"; in official capacity as member of the Arkansas State Medical Board; Rodney Griffin, in official capacity as member of the Arkansas State Medical Board; Betty Guhman, in official capacity as member of the Arkansas State Medical Board; Brian T. Hyatt, in official capacity as member of the Arkansas State Medical Board; Timothy C. Paden, in official capacity as member of the Arkansas State Medical Board; Don R. Philips, in official capacity as member of the Arkansas State Medical Board; William L. Rutledge, in official capacity as member of the Arkansas State Medical Board; David L. Staggs, in official capacity as member of the Arkansas State Medical Board; Veryl D. Hodges, in official capacity as member of the Arkansas State Medical Board

Defendants - Appellants

Keira Bell; Laura Becker; Sinead Watson; Kathy Grace Duncan; Laura Reynolds; Carol Freitas; Yaacov Sheinfeld; Jeanne Crowley; Ted Hudacko; Lauren W.; Martha S.; Kellie C.; Kristine W.; Bri Miller; Helen S.; Barbara F.; State of Alabama; State of Alaska; State of Arizona; State of Georgia; State of Idaho; State of Indiana; State of Kansas; State of Kentucky; State of Louisiana; State of Mississippi; State of Missouri; State of Montana; State of Nebraska; State of South Carolina; State of South Dakota; State of Tennessee; State of Texas; State of Utah; State of West Virginia; Family Research Council; Women's Liberation Front; Quentin L. Van Meter, MD; Michael K. Laidlaw, MD; Andre Van Mol, MD; Jeffrey E. Hansen, Ph. D.

Amici on Behalf of Appellant(s)

Lambda Legal Defense and Education Fund; National Women's Law Center; Equality South Dakota; Family Equality; Freedom for All Americans; Gender Justice; GLBTQ Legal Advocates & Defenders; Human Rights Campaign; Intransitive (Mabelvale, Arkansas); Legal Voice; Lucie's Place (Little Rock, Arkansas); National Center for Lesbian Rights; National Center for Transgender Equality; National LGBTQ Task Force; One Iowa; OutNebraska; PFLAG; SisterReach; South Dakota Transformation Project; Southwest Women's Law Center; Transformation Project Advocacy Network; Women's Law Project; American Academy of Pediatrics; Academic Pediatric Association; American Academy of Child and Adolescent Psychiatry; American Association of Physicians for Human Rights, Inc.; American College of Osteopathic Pediatricians; American Medical Association; American Pediatric Society; American Psychiatric Association; Arkansas Chapter of the American Academy of Pediatrics; Arkansas Council on Child and Adolescent Psychiatry; Arkansas Medical Society; Arkansas Psychiatric Society; Association of Medical School Pediatric Department Chairs; Endocrine Society; National Association of Pediatric Nurse Practitioners; Pediatric Endocrine Society; Society for Adolescent Health and Medicine; Society for Pediatric Research; Society of Pediatric Nurses; Societies for Pediatric Urology; World Professional Association for Transgender Health; Biomedical Ethics and Public Health Scholars; United States; LiveRamp Holdings, Inc.; Acxiom LLC; Kinesso, LLC; The Walton Family Foundation, Inc.; Arkansas State Chamber of Commerce; Northwest Arkansas Council; Asana, Inc.; Xperi Holding Corp.; Interpublic Group of Companies, Inc.; Winthrop Rockefeller Foundation; Acoustic, L.P.; CYCLQ LLC, doing business as Blue Star Business Services; Institute for Justice; State of California; State of Colorado; State of Connecticut;

State of Delaware; State of Hawaii; State of Illinois; State of Maine; State of Maryland; State of Massachusetts; State of Michigan; State of Minnesota; State of Nevada; State of New Jersey; State of New Mexico; State of New York; State of North Carolina; State of Oregon; State of Rhode Island; State of Vermont; State of Washington; District of Columbia; Stonewall UK; Swedish Federation for Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Rights; Australian Professional Association for Trans Health; Professional Association for Transgender Health Aotearoa New Zealand; LGBT+ Denmark; Bundesverband Trans e.V.; Federacion Estatal de Lesbianas, Gais, Trans, Bisexuales, Intersexuales y mas; Fundacion Colectivo Hombres XX, AC; Norwegian Organization for Sexual and Gender Diversity; The Trevor Project, Inc.; Elliot Page and 57 Other Individuals; Families with Transgender Children

Amici on Behalf of Appellee(s)

Appeal from United States District Court
for the Eastern District of Arkansas - Central

Submitted: June 15, 2022
Filed: August 25, 2022

Before LOKEN and KELLY, Circuit Judges, and MENENDEZ, District Judge.[1]

KELLY, Circuit Judge.

Arkansas state officials (collectively, Arkansas or the State) appeal the order of the district court[2] preliminarily enjoining Act 626 of the 93rd General Assembly

---

[1]The Honorable Katherine M. Menendez, United States District Judge for the District of Minnesota, sitting by designation.

[2]The Honorable James M. Moody, Jr., United States District Judge for the Eastern District of Arkansas.

of Arkansas. This court has jurisdiction under 28 U.S.C. § 1292(a)(1) to review an interlocutory order granting a preliminary injunction, and we affirm.

I. Background

On April 6, 2021, the Arkansas state legislature overrode the governor's veto and enacted Act 626. The Act prohibits a healthcare professional from "provid[ing] gender transition procedures to any individual under eighteen (18) years of age" or "refer[ring] any individual under eighteen (18) years of age to any healthcare professional for gender transition procedures." Ark. Code Ann. § 20-9-1502(a), (b). "Gender transition procedures" is defined to include "any medical or surgical service, including without limitation physician's services, inpatient and outpatient hospital services, or prescribed drugs" that are intended to "[a]lter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex" or "[i]nstill or create physiological or anatomical characteristics that resemble a sex different from the individual's biological sex." Id. § 20-9-1501(6)(A). Specifically identified services include "puberty-blocking drugs, cross-sex hormones, or other mechanisms to promote the development of feminizing or masculinizing features in the opposite biological sex, or genital or nongenital gender reassignment surgery performed for the purpose of assisting an individual with a gender transition." Id. "Gender transition procedures" specifically does not include "[s]ervices to persons born with a medically verifiable disorder of sex development." Id. § 20-9-1501(6)(B).

Act 626 was set to take effect on July 28, 2021. In May, Plaintiffs in this matter—transgender youth (Minor Plaintiffs), their parents (Parent Plaintiffs), and two healthcare professionals (Physician Plaintiffs)—filed a complaint seeking declaratory and injunctive relief. Plaintiffs allege that Act 626 violates the Equal Protection Clause of the Fourteenth Amendment because it discriminates against Minor Plaintiffs and Physician Plaintiffs' minor patients on the basis of sex and transgender status. Parent Plaintiffs further allege the Act violates the Due Process Clause of the Fourteenth Amendment by limiting their fundamental right to seek and

follow medical advice for their children. Finally, Plaintiffs allege that, by banning referrals, Act 626 violates their First Amendment rights by limiting what Physician Plaintiffs can say and what Minor and Parent Plaintiffs can hear.

In June, Plaintiffs moved for a preliminary injunction to stop Act 626 from going into effect. Arkansas moved to dismiss the complaint pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). After a hearing on the motions, the district court denied the motion to dismiss and granted the motion for preliminary injunction, concluding that Plaintiffs had standing and showed a likelihood of success on the merits of each of their claims and a likelihood of irreparable harm. Arkansas appeals.

II. Standing

As an initial matter, the State challenges Plaintiffs' standing to seek an injunction of specific aspects of the Act. Constitutional standing requires that at least one plaintiff demonstrate they have suffered a concrete and particularized injury that is fairly traceable to the challenged action and is likely to be redressed by a court ruling in the plaintiff's favor. See Lujan v. Defenders of Wildlife, 504 U.S. 555, 560–61 (1992). Arkansas argues that because no Minor Plaintiff has declared an intent to undergo gender-reassignment surgery as a minor, no Plaintiff has established standing to challenge the ban as to that type of gender transition procedure. The State also argues that Plaintiffs lack standing to challenge the section of the statute that provides for private enforcement because no defendant is involved in enforcement of the Act by private right of action. But Arkansas does not contest that Plaintiffs have met their burden under Lujan to challenge other parts of the Act, and this court declines the State's invitation to modify well-established constitutional standing principles to require that a plaintiff demonstrate an injury

traceable to every possible application of the challenged statute in order to satisfy the constitutional standing requirement.[3]

III. Preliminary Injunction

A. Legal Standard

"In reviewing the issuance of a preliminary injunction, we consider the threat of irreparable harm to the movant, the likelihood that the movant will succeed on the merits, the balance between the harm to the movant and injury that an injunction would inflict on other parties, and the public interest." Brakebill v. Jaeger, 932 F.3d 671, 676 (8th Cir. 2019) (citing Dataphase Sys., Inc. v. C L Sys., Inc., 640 F.2d 109, 113 (8th Cir. 1981) (en banc)). A party challenging a state statute must show that she is likely to prevail on the merits. See Planned Parenthood Minn., N.D., S.D. v. Rounds, 530 F.3d 724, 730 (8th Cir. 2008). "The plaintiff[s] need only establish a likelihood of succeeding on the merits of any one of [their] claims." Richland/Wilkin Joint Powers Auth. v. U.S. Army Corps of Eng'rs, 826 F.3d 1030, 1040 (8th Cir. 2016) (quotation omitted).

We review the decision to grant a preliminary injunction for abuse of discretion. See Rodgers v. Bryant, 942 F.3d 451, 456 (8th Cir. 2019). "An abuse of discretion occurs where the district court rests its conclusion on clearly erroneous factual findings or erroneous legal conclusions." Rounds, 530 F.3d at 733 (quotation omitted). "If a factual finding is supported by substantial evidence on the record, it is not clearly erroneous." Dixon v. Crete Med. Clinic, P.C., 498 F.3d 837, 847 (8th Cir. 2007). "Clear error exists when despite evidence supporting the finding, the evidence as a whole leaves us with a definite and firm conviction that the finding is a mistake." Richland/Wilkin, 826 F.3d at 1036 (quotation omitted).

---

[3]The State also argues that Physician Plaintiffs lack third-party standing to sue on behalf of their minor patients. But since there is at least one plaintiff with standing to bring each of Plaintiffs' claims, we need not address this argument at this juncture.

B. Likelihood of Success on the Merits

To evaluate Plaintiffs' likelihood of success on the merits of their equal protection claim, we must first determine the appropriate level of scrutiny. Cf. Libertarian Party of Ark. v. Thurston, 962 F.3d 390, 399 (8th Cir. 2020) (determining as a threshold matter what level of scrutiny applied to the challenged statute governing ballot access). Act 626 prohibits "gender transition procedures," which are defined as procedures or medications that are intended to change "the individual's biological sex." Ark. Code Ann. § 20-9-1501(6)(A). The statute defines "biological sex" as the person's sex "at birth, without regard to an individual's psychological, chosen, or subjective experience of gender." Id. § 20-9-1501(1). Thus, under the Act, medical procedures that are permitted for a minor of one sex are prohibited for a minor of another sex. A minor born as a male may be prescribed testosterone or have breast tissue surgically removed, for example, but a minor born as a female is not permitted to seek the same medical treatment. Because the minor's sex at birth determines whether or not the minor can receive certain types of medical care under the law, Act 626 discriminates on the basis of sex.

Arkansas's characterization of the Act as creating a distinction on the basis of medical procedure rather than sex is unpersuasive. Arkansas argues that administering testosterone to a male should be considered a different procedure than administering it to a female because the "procedure allows a boy to develop normally" whereas for a girl it has the effect of "disrupting normal development." But this conflates the classifications drawn by the law with the state's justification for it. The biological sex of the minor patient is the basis on which the law distinguishes between those who may receive certain types of medical care and those who may not. The Act is therefore subject to heightened scrutiny. See Heckler v. Mathews, 465 U.S. 728, 744 (1984). Cf. Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ., 858 F.3d 1034, 1051 (7th Cir. 2017) (holding that where "the School District's policy cannot be stated without referencing sex, as the School District decides which bathroom a student may use based upon the sex listed on the student's birth certificate," the policy "is inherently based upon a sex-

classification and heightened review applies") (abrogation on other grounds recognized by Ill. Republican Party v. Pritzker, 973 F.3d 760 (7th Cir. 2020)).[4]

Statutes that discriminate based on sex must be supported by an "exceedingly persuasive justification." United States v. Virginia, 518 U.S. 515, 531 (1996). The government meets this burden if it can show that the statute is substantially related to a sufficiently important government interest. Id. at 533. Arkansas relies on its interest in protecting children from experimental medical treatment and regulating ethics in the medical profession to justify Act 626.

The district court found that the Act prohibits medical treatment that conforms with "the recognized standard of care for adolescent gender dysphoria," that such treatment "is supported by medical evidence that has been subject to rigorous study," and that the purpose of the Act is "not to ban a treatment [but] to ban an outcome that the State deems undesirable." The record at this stage provides substantial evidence to support these factual findings.

Arkansas complains the district court failed to consider the medical evidence it submitted. Both parties provided scientific literature and declarations from medical experts and discussed the expert opinions in their briefs and at the motion hearing. The district court acknowledged at the hearing that "experts [on both] sides of this case don't agree, and I get that. That's part of the deal." We find no clear error in the district court's weighing of the competing evidence. See Med. Shoppe Int'l, Inc. v. S.B.S. Pill Dr., Inc., 336 F.3d 801, 803 (8th Cir. 2003) ("Our deferential review [of preliminary injunctions] arises from the district court's institutional advantages in evaluating witness credibility and weighing evidence.").

---

[4]The district court also concluded that heightened scrutiny was appropriate because the Act facially discriminates against transgender people, who constitute a quasi-suspect class. We discern no clear error in the district court's factual findings underlying this legal conclusion, but we need not rely on it to apply heightened scrutiny because the Act also discriminates on the basis of sex.

Furthermore, substantial evidence in the record supports the district court's factual findings, despite the contrary assertions of the State's experts. For example, while Arkansas's experts criticize the structure and scale of research on hormone therapies for adolescents with gender dysphoria, study design is only one factor among many that medical professionals properly consider when they review research and determine what course of action to recommend to a patient. And there is evidence in the record that these hormone treatments have been evaluated in the same manner as many other medical innovations. According to surveys of the research on hormone treatment for adolescents done by the British National Institute for Health & Care Excellence, several studies have shown statistically significant positive effects of hormone treatment on the mental health, suicidality, and quality of life of adolescents with gender dysphoria. None has shown negative effects.

Additionally, there is substantial evidence to support the district court's conclusion that the Act prohibits medical treatment that conforms with the recognized standard of care. Even international bodies that consider hormone treatment for adolescents to be "experimental" have not banned the care covered by Act 626. For example, Arkansas submitted to the district court a report from the Council for Choices in Health Care in Finland in which the council concluded that "[i]n light of available evidence, gender reassignment of minors is an experimental practice," but the report still recommends that gender-affirming care be available to minors under appropriate circumstances. In fact, the Finnish council's recommendations for treatment closely mirror the standards of care laid out by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society, two organizations the State repeatedly criticizes. Like WPATH, the Finnish council concluded that puberty-suppressing hormones might be appropriate for adolescents at the onset of puberty who have exhibited persistent gender nonconformity and who are already addressing any coexisting psychological issues. Similarly, the WPATH Standards of Care and the Finnish council both recommend that cross-sex hormones be considered only where the adolescent is

experiencing persistent gender dysphoria, other mental health conditions are well-managed, and the minor is able to meet the standards to consent to the treatment.[5]

In sum, having reviewed the evidence as a whole, we are not left with the "definite and firm conviction" that the district court's factual findings are clearly erroneous. Rather, substantial evidence in the record supports its factual findings. In light of those findings, the district court did not err in concluding Act 626 is not substantially related to Arkansas's interests in protecting children from experimental medical treatment and regulating medical ethics, and Plaintiffs have demonstrated a likelihood of success on the merits of their equal protection claim.

C. Balance of the Equities

In considering the risk of irreparable harm to the Plaintiffs, the district court found that if Act 626 went into effect, Minor Plaintiffs would be denied access to hormone treatment (including needing to stop treatment already underway), undergo endogenous puberty—a process that cannot be reversed—and suffer heightened gender dysphoria. These factual findings are supported by Minor Plaintiffs' affidavits and are not clearly erroneous. The findings support the conclusion that Plaintiffs will suffer irreparable harm absent a preliminary injunction.

Additionally, it is "always in the public interest to prevent the violation of a party's constitutional rights." Bao Xiong ex rel. D.M. v. Minn. State High Sch. League, 917 F.3d 994, 1004 (8th Cir. 2019) (quoting Awad v. Ziriax, 670 F.3d 1111,

[5]The State also emphasized the judicial decision in Bell v. Tavistock & Portman NHS Foundation Trust, 2020 EWHC (Admin) 3274, in the United Kingdom, in which the court decided that minors under 16 years old could not consent to receive hormone therapies and required court approval because it is "a very unusual treatment" with "limited evidence as to its efficacy." Id. at ¶ 134. That judgment has since been reversed, however, with the court of appeals concluding that "[n]othing about the nature or implications of the treatment with puberty blockers allows for a real distinction to be made" from other medical treatment an adolescent might seek. 2021 EWCA (Civ) 1363, at ¶ 76.

1132 (10th Cir. 2012)). These interests, weighed against the potential harm to Arkansas of not enforcing Act 626 between now and a final ruling on the merits of the litigation, convince us that the district court did not abuse its discretion in granting Plaintiffs' motion for preliminary injunction.

D. Scope of the Injunction

Arkansas's final argument is that the district court abused its discretion by granting a facial injunction. It is true, as the State points out, that some minors experiencing gender dysphoria may choose not to pursue the gender transition procedures covered by the Act and therefore would not be harmed by its enforcement. A party bringing a facial challenge must "establish that no set of circumstances exists under which the Act would be valid," United States v. Salerno, 481 U.S. 739, 745 (1987), but the State describes minors for whom the Act simply would have no application, see City of Los Angeles v. Patel, 576 U.S. 409, 418–19 (2015) ("The proper focus of the [facial] constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." (quotation omitted)). Moreover, Arkansas has failed to offer a more narrowly tailored injunction that would remedy Plaintiffs' injuries. The district court did not abuse its discretion by granting a facial injunction.

IV. Conclusion

Because we conclude the district court did not abuse its discretion in granting a preliminary injunction based on Plaintiffs' equal protection claim, we need not address the State's challenges to Plaintiffs' other claims. The decision of the district court is affirmed.

From: (b)(6) (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=E90EF156ED05483F959D8C4039D9B906-LORDEN, SUS <(b)(6)>

To: Mitchell, Steven M (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=userf53b56e8 <Steven.Mitchell@HHS.GOV>; Garcia, Art (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=3f3e15a704cd4274bb9916d41a1923a9-Garcia, Art <Art.Garcia@HHS.GOV>

CC: (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-Dekervor, D (b)(6)

Subject: MW Region - GAC complaints

Date: 2022/11/08 10:30:50

Priority: Normal

Type: Note

Good morning,

Thanks for sending over new GAC complaints. (b)(5)

(b)(5)

I'm not sure if you want others to join the call, but it looks like the following times are available next week. Do any of these work? Thanks, (b)(6)

Wed. 11/16: 10-10:30am ET/9-9:30am CT
Fri. 11/18: 10-10:30am ET/9-9:30am CT; 11-11:30 ET/10-10:30 CT; 12-12:30pm ET/11-11:30am CT

(b)(5)

(b)(5)

From: Garcia, Art (HHS/OCR) <Art.Garcia@HHS.GOV>

Sent: Friday, November 4, 2022 9:37 AM
To: (b)(6) (HHS/OCR) <(b)(6)>; (b)(6) (HHS/OCR)
(b)(6)
Cc: Mitchell, Steven M (HHS/OCR) <Steven.Mitchell@HHS.GOV>; Garcia, Art (HHS/OCR) <Art.Garcia@HHS.GOV>
Subject: 05-23-503663

(b)(5)

Sender: (b)(6) (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=E90EF156ED05483F959D8C4039D9B906-LORDEN, SUS (b)(6)

Recipient: Mitchell, Steven M (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=userf53b56e8 <Steven.Mitchell@HHS.GOV>; Garcia, Art (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=3f3e15a704cd4274bb9916d41a1923a9-Garcia, Art <Art.Garcia@HHS.GOV>; (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-Dekervor, D (b)(6)

Sent Date: 2022/11/08 10:30:49

Delivered Date: 2022/11/08 10:30:50

Message Flags: Unread

DEFENDANT'S EXHIBIT 2

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER, *et al.*,	)	
Plaintiffs,	)	
v.	)	No. 2:22-cv-00184-LCB-SRW
KAY IVEY, in her official capacity as Governor of the State of Alabama, *et al.*,	)	
Defendants.	)	

DECLARATION OF DR. JAMES CANTOR

My name is James Michael Cantor. I am over the age of 19, I am qualified to give this declaration, and, I have personal knowledge of the matters set forth herein.

My CV is attached to this declaration. Recent publications are listed on my CV.

In the past four years, I have provided expert testimony in the following cases:

2022	Hersom & Doe v WVa Health & Human Services	Southern Dist, West Virginia (b)(5)
2022	BPJ v WVa Board of Education	Southern Dist, West Virginia (b)(5)
2021	Cross et al. v Loudoun School Board	Loudoun, Virginia (b)(5)
2021	Allan M. Josephson v Neeli Bendapudi	Western District of Kentucky
2021	Re Commitment of Michael Hughes (Frye Hearing)	Cook County, Illinois
2019	US vs Peter Bright	Southern Dist, NY, NY
2019	Probate and Family Court (Custody Hearing)	Boston, Massachusetts
2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, Illinois
2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, New York
2018	Re Commitment of Fernando Little (Frye Hearing)	Utica, New York
2018	Canada vs John Fitzpatrick (Sentencing Hearing)	Toronto, Ontario, Canada

I am compensated a the rate of $400 per hour for my work on this matter. My compensation is not dependent upon the substance of my opinions or the outcome of the case.

TABLE OF CONTENTS

I. Introduction

A. Background & Credentials

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

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

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

of human sexuality, the classification of sexual interest patterns, the assessment and treatment of atypical sexualities, and the application of statistics and research methodology in sex research. I am the author of over 50 peer-reviewed articles in my field, spanning the (b)(5) I am the author of the past three editions of the (b)(5) chapter of the *Oxford Textbook of Psychopathology*. These works are now routinely cited in the field and are included in numerous other textbooks of sex research.

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

5. I have served as an expert witness in 11 cases in the past five years. These are listed on my *curriculum vitae*, attached here as Appendix 1.

6. A substantial proportion of the existing research on gender dysphoria comes from two clinics, one in Canada and one in the Netherlands. The CAMH gender clinic (previously, Clarke Institute of Psychiatry) was in operation for several decades, and its research was directed by Dr. Kenneth Zucker. I was employed by CAMH between 1998 and 2018. I (b)(5)

7. For my work in this case, I am being compensated at the hourly rate of $400

per hour. My compensation does not change based on the conclusions and opinions that I provide here or later in this case or on the outcome of this lawsuit.

B. Overview

8. The principal opinions that I offer and explain in detail in this report include that:

a. A(b)(5)n medical transition services for youth under age 18 is consistent with international standards; (b)(5)

b. The large majority of gender dysphoric, pre-pubescent youth cease to feel gender dysphoric by puberty;

c. Among youth under age 18, follow-up studies show positive results in association with psychotherapy, not medically aided transition; and

d. Follow-up studies of medical transition have shown positive results only in samples of adults ages 18 and older.(b)(5)

9. To prepare the present report, I reviewed the following resources related to this litigation:

a. Text of Alabama Bill SB-184;

b. Memorandum in support of plaintiffs' motion for temporary restraining order & preliminary injunction;

c. Declaration of Linda A. Hawkins, Ph.D., LPC in support of plaintiffs' motion for temporary restraining order & preliminary injunction;

d. Declaration of Morissa J. Ladinsky, MD, FAAP, in support of plaintiffs' motion for temporary restraining order & preliminary injunction;

e. Declaration of Stephen Rosenthal, MD, in support of plaintiffs' motion for temporary restraining order & preliminary injunction.

II. Fact-Check of Assertions of Plaintiffs' Experts' Reports

10. I have reviewed the memorandum supporting the plaintiffs' motion, including its declarations by Drs. Hawkins, Ladinsky, and Rosenthal, and compared

its claims with the published, peer-reviewed scientific literature of gender dysphoria, its treatment and outcomes. The motion and all three experts asserted very many very bold claims, but vanishingly little citation of any objective science at all. Of the many (b)(5) n this topic, Dr. Hawkins cited three, Dr. Ladinsky cited none at all, and Dr. Rosenthal cited eight, four of which were from the same research team, also cited by Dr. Hawkins. As demonstrated in the following, that small set of articles represents a highly cherry-picked misrepresentation of the relevant body of science, failing to reflect the consensus of the research literature. Their declarations not only fail to reflect the consensus of the science, but also repeatedly assert claims in direct opposition to that science. A comprehensive summary of the research literature on gender dysphoria is provided herein.

(b)(5)

A. Professional and International Standards of Care

11. The claims expressed in the plaintiffs' documents largely rely on their claims of professional standards, citing the American Association of Pediatrics (AAP), the World Professional Association for Transgender Health (WPATH), and the Endocrine Society. In so doing, the plaintiffs provided only misleading half-truths, yielding only an incomplete and inaccurate portrayal of the field. Missing from the plaintiffs documentation were that these that these standards have repeatedly been found to be wanting, that their application has failed to produce improvement among patients, and that it is these U.S.-based associations that are out of line with the international consensus of health care experts.

12. First, the plaintiffs' documentation misrepresents the contents of the associations' policies themselves. With the broad exception of the AAP, their statements repeatedly noted instead that:

- Desistance of gender dysphoria occurs in the majority of prepubescent children.

- Mental health issues need to be assessed as potentially contributing factors and need to be addressed before transition.
- (b)(5)
- Social transition is not generally recommended until after puberty.

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

13. Second, the WPATH and the Endocrine Society guidelines have both been subjected to standardized evaluation, the Appraisal of Guidelines for Research and Evaluation ("AGREE II") method, as part of an appraisal of all published CPGs regarding sex and gender minority healthcare.[1] Utilizing community stakeholders to set domain priorities for the evaluation, the assessment concluded that the guidelines regarding HIV and its prevention were of high quality, but that "[t]ransition-related CPGs tended to lack methodological rigour and rely on patchier, lower-quality primary research."[2] Neither the Endocrine Society's or WPATH's guidelines were recommended for use. Indeed, the WPATH guidelines received unanimous ratings of "Do not recommend."[3] Thus, despite the exuberant adjectives offered in the plaintiffs' experts' reports, objective analysis yields the opposite conclusion.

(b)(5)

(b)(5)

14. The AAP differed from the other (U.S.-based) associations in outlining far less conservative clinical decision-making, but only in contradiction with the published research. Immediately following the publication of the AAP policy, I conducted a point-by-point fact-check of the claims it asserted and the references it cited in support. I submitted that to the *Journal of Sex & Marital Therapy*, a well-known research journal of my field, where it underwent blind peer review and was published. I append that article as part of this report. *See* Appendix 1. A great deal of published attention ensued; however, the AAP has yet to respond to the errors I

[1] Dahlen, *et al.*, 2021.
[2] Dahlen, *et al.*, 2021, at 6.
[3] Dahlen, *et al.*, 2021, at 7.

(b)(5)

demonstrated its policy contained. Writing for *The Economist* about the use of puberty blockers, Helen Joyce asked AAP directly, "Has the AAP responded to Dr Cantor? If not, have you any response now?" The AAP Media Relations Manager, Lisa Black, responded: "We do not have anyone available for comment."

15. Finally, the opinions of these U.S.-based associations are in stark opposition to international standards: Public healthcare systems throughout the world have instead been withdrawing their earlier support for childhood transition, responding to the increasingly recognized risks associated with hormonal interventions and the now clear lack of evidence that medical transition was benefitting most children, as opposed to the mental health counseling accompanying transition. These have included the United Kingdom[4], Finland,[5] Sweden[6], and France[7].

B. Claims attributed to Olson and Durwood, *et al.*

16. The Hawkins and Rosenthal reports both cited Olson, *et al.* (2016), claiming it to demonstrate that transition reduce risk of mental illness. That claim entirely misrepresents, indeed reverses, the state of the scientific literature. Although Olson, *et al.* (2016) did indeed report that gender dysphoric children showed no mental health differences from the non-transgender control groups, that report turned out to be incorrect: Not pointed out by Drs Hawkins or Rosenthal is that the Olson data were subsequently subjected to a re-analysis and that, after correcting for statistical errors in the original analysis, the data instead showed that the gender dysphoric children under Olson's care *did*, in fact, exhibit significantly lower mental health[8].

17. I conducted an electronic search of the research literature to identify any

---

4 U.K. National Institute for Health and Care Excellence, 2020.
5 Council for Choices in Health Care in Finland, 2020.
6 Swedish National Board of Health and Welfare, 2022.
7 Académie Nationale de Médecine, 2022, Feb. 25.
8 Schumm & Crawford, 2020; Schumm, *et al.*, 2019.

responses from the Olson team regarding the Schumm and Crawford re-analysis of the Olson data and was not able to locate any. I contacted Professor Schumm by email on August 22, 2021 to verify that conclusion, to which he wrote there has been: "No response [from Olson]"[9].

18. Rosenthal also cited a retrospective study from the Olson team, published as Durwood et al., 2017. That study surveyed children in the TransYouth Project—people who have socially transitioned, their families, and any contacts they had, by word of mouth. This method is referred to as "convenience sampling," and differs from genuinely representative samples in applying to means of ensuring study participants accurately represent the population being studied. There were three groups of children for comparison: (i) children who had already socially transitioned, (ii) their siblings, and (iii) children in a university database of families interested in participating in child development research. As noted by the study authors, "For the first time, this article reports on socially transitioned gender children's mental health as reported by the children."[10] Reports from parents were also recorded.[11] In contrast, no reports or ratings were provided by any mental health care professional or researcher at all. That is, although adding self-assessments to the professional assessments might indeed provide novel insights, this project did not add self-assessment to professional assessment. Rather, it replaced professional assessment with self-assessment. Moreover, as already noted, Olson's data did not show what the Olson team claimed.[12] The dataset was subsequently re-analyzed, and "[T]o the contrary, the transgender children, even when supported by their parents, had significantly lower average scores on anxiety and self-worth."[13]

(b)(5)

19. It is well established in the field of psychology that participant self-

9 Schumm, email communication, Aug. 22, 2021 (on file with author).
10 Durwood, *et al.*, 2017, at 121 (italics added).
11 *See* Olson, *et al.*, 2016.
12 Schumm, *et al.*, 2019.
13 Schumm & Crawford, 2020, p. 9

assessment can be severely unreliable for multiple reasons. For example, one well-known phenomenon in psychological research is known as "socially desirable responding"—the tendency of subjects to give answers that they believe will make themselves look good, rather than accurate answers. Specifically, subjects' reports that they are enjoying good mental health and functioning well could reflect the subjects' desire to be *perceived* as healthy and as having made good choices, rather than reflecting their actual mental health. (b)(5)

20. In their analyses, the study reported finding no significant differences between the transgender children, their non-transgender siblings, or the community controls. As the authors noted, "[t]hese findings are in striking contrast to previous work with gender-nonconforming children who had not socially transitioned, which found very high rates of depression and anxiety."[14] The authors are correct to note that their result contrasts with the previous research, but they do not discuss that this could reflect a problem with the novel research design they used: The subjective self-reports of the children and their parents' reports may not be reflecting reality objectively, as careful professional researchers would. Because the study did not employ any method to detect and control for participants indulging in "socially desirable responding" or acting under other biasing motivations, this possibility cannot be assessed or ruled out.

21. Because this was a single-time study relying on self-reporting, rather than a (b)(5) it is not possible to know if the children reported as well-functioning are in fact well-functioning, nor if so whether they are well-functioning because they were permitted to transition, or whether instead the fact is that they were already well-functioning and therefore permitted to transition. Finally, because the TransYouth project lacks a prospective design, it cannot be known how many cases attempted transition, (b)(5)

[14] Durwood, *et al.*, 2017, at 116.

reacted poorly, and then detransitioned, thus never having entered into the study in the first place.

C. Claims attributed to de Vries, et al.

22. Drs. Hawkins and Rosenthal both cited de Vries, *et al.* (2014) to support their assertion that medical transition of minors improved their mental health. It is not possible for one to come to that conclusion from that study, however. The clinic treating these children (the originators of "The Dutch Protocol"[15]) provides psychotherapy together with medical services. In research science, this situation is called a "confound." It is not possible to distinguish whether any changes were due to the medical services, the psychotherapy, or an interaction between them. Nonetheless, another study, left uncited by the plaintiff's experts, demonstrated that improvements in mental health are associated with receiving psychotherapy rather than medical services. As detailed later in this report, Costa, *et al.*, (2015) conducted a follow-up study of youth in the U.K., one group receiving only psychotherapy, and one group first receiving only psychotherapy and then receiving both psychotherapy and medical services. (b)(5)

(b)(5)

D. Claims attributed to Spack.

23. Dr. Rosenthal also misrepresented the views of Dr. Norman Spack. The article Rosenthal cited—Spack, 2012—repeatedly emphasized that children with gender dysphoria exhibit very many symptoms of mental illnesses. Spack asserted unambiguously that "Gender dysphoric children who do not receive *counseling* have a high risk of behavioural and emotional problems and psychiatric diagnoses"[16]. Dr. Rosenthal's context misrepresents Spack so as to suggest Spack was advocating for

[15] de Vries, *et al.*, 2011.
[16] Spack, *et al.*, 2012, at 422, italics added.

medical transition to treat the gender dysphoria rather than counseling to treat suicidality and any other mental health issues. Moreover still, missing from the Rosenthal report was Spack's conclusion that "[m]ental health intervention should persist for the long term, even after surgery, *as patients continue to be at mental health risk, including for suicide.* While the causes of suicide are multifactorial, the possibility cannot be ruled out that some patients unrealistically believe that surgery(ies) solves their psychological distress."[17] Whereas Rosenthal (selectively) cited Spack to support the insinuation that medical transition relieves distress, Spack instead explicitly warned against drawing exactly that conclusion.

(b)(5)

E. Other claims

24. Rosenthal cited Green, *et al.,* (2021) and Turban, *et al.* (2021) to assert that "hormone therapy usage is significantly related to lower rates of depression and suicidality" [Rosenthal, paragraph 45]. In coming to that conclusion, Dr. Rosenthal violates a well-known principal of science: Correlation does not imply causation. That is, this very pattern is what one would predict from clinical gate-keeping: Mental health constitute exclusion criteria by clinical guidelines. Thus, samples of those receiving hormone therapy would necessarily have passed that criterion, whereas the non-medical group would contain those with already identifiable mental health concerns.

25. The plaintiff's experts indicated medical services to alleviate mental health distress; however, people with gender dysphoria continue to experience those mental health symptoms even transition, including a 19 times greater risk of death from suicide.[18] It is this consistent finding in the research literature conclusion that yielded clinical guidelines repeatedly to indicate that mental health issues should be resolved *before* any transition.

(b)(5)

[17] Spack, 2013, at 484, italics added
[18] Dhejne, *et al.*, 2011.

III. Science of Gender Dysphoria and Transsexualism

26. One of the most widespread public misunderstandings about transsexualism and people with gender dysphoria is that all cases of gender dysphoria represent the same phenomenon; however, the clinical science has long and consistently demonstrated that gender dysphoric children (cases of *early-onset* gender dysphoria) do not represent the same phenomenon as adult gender dysphoria (cases of *late-onset* gender dysphoria),[19] merely attending clinics at younger ages. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in every known regard, from sexual interest patterns, to responses to treatments. A third presentation has recently become increasingly observed among people presenting to gender clinics: These cases appear to have an onset in adolescence in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or "rapid-onset" gender dysphoria (ROGD).

(b)(5)

27. In the context of the present proceedings, the adult-onset phenomenon would not seem relevant; however, very many public misunderstandings and expert misstatements come from misattributing evidence or personal experience from one of these types to the other. For example, there exist only very few cases of transition regret among *adult* transitioners, whereas the research has unanimously shown that the majority of children with gender dysphoria desist—that is, they cease to experience such dysphoria by or during puberty. A brief summary of the adult-onset phenomenon is therefore included here to facilitate distinguishing features which are unique to each type of gender dysphoria.

A. Adult-Onset Gender Dysphoria

28. People with adult-onset gender dysphoria typically attend clinics requesting transition services in mid-adulthood, usually in their 30s or 40s. Such individuals are nearly exclusively male.[20] They typically report being sexually

(b)(5)

[19] Blanchard, 1985.
[20] Blanchard, 1990, 1991.

attracted to women and sometimes to both men and women. Some cases profess asexuality, but very few indicate any sexual interest in or behavior involving men.[21] Cases of adult-onset gender dysphoria are typically associated with a sexual interest pattern (medically, a *paraphilia*) involving themselves in female form.[22]

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

29. Clinical research facilities studying gender dysphoria have repeatedly reported low rates of regret (less than 3%) among adult-onset patients who underwent complete transition (*i.e.*, social, plus hormonal, plus surgical transition). This has been widely reported by clinics in Canada,[23] Sweden,[24] and the Netherlands.[25]

30. Importantly, each of the Canadian, Swedish, and Dutch clinics for adults with gender dysphoria all performed "gate-keeping" procedures, disqualifying from medical services people with mental health or other contraindications. One would not expect the same results to emerge in the absence of such gate-keeping or when gate-keepers apply only minimal standards or cursory assessment.

2. Mental Health Issues in Adult-Onset Gender Dysphoria

31. The research evidence on mental health issues in gender dysphoria indicates it to be different between adult-onset versus adolescent-onset versus prepubescent-onset types. The co-occurrence of mental illness with gender dysphoria in adults is widely recognized and widely documented.[26] A research team in 2016 published a comprehensive and systematic review of all studies examining rates of mental health issues in transgender adults.[27] There were 38 studies in total. The review indicated that many studies were methodologically weak, but nonetheless

---

21 Blanchard, 1988.
22 Blanchard 1989a, 1989b, 1991.
23 Blanchard, *et al.*, 1989.
24 Dhejneberg, *et al.*, 2014.
25 Wiepjes, *et al.*, 2018.
26 *See, e.g.*, Hepp, *et al.*, 2005.
27 Dhejne, *et al.*, 2016.

demonstrated (1) that rates of mental health issues among people are highly elevated both before and after transition, (2) but that rates were less elevated among those who completed transition. Analyses were not conducted in a way so as to compare the elevation in mental health issues observed among people newly attending clinics to improvement after transition. Also, several studies showed more than 40% of patients becoming "lost to follow-up." With attrition rates that high, it is unclear to what extent the information from the available participants genuinely reflects the whole sample. The very high rate of "lost to follow-up" leaves open the possibility of considerably more negative results overall.

32. An important caution applies to interpreting these results: These very high proportions of mental health issues come from people who are attending a clinic for the first time and are undergoing assessment. Clinics serving a "gate-keeper" role divert candidates with mental health issues away from medical intervention. The side-effect of removing these people from the samples of transitioners is that if a researcher compared the average mental health of individuals coming into the clinic with the average mental health of individuals going through medical transition, then the post-transition group would appear to show a substantial improvement, even though transition had *no effect at all*: The removal of people with poorer mental health created the statistical illusion of improvement among the remaining people.

33. The long-standing and consistent finding that gender dysphoric adults have high rates of mental health issues both before and after transition and the finding that those mental health issues cause the gender dysphoria (the epiphenomenon) rather than the other way around indicate a critical point: (b)(5)

(b)(5)

(b)(5)

B. Childhood Onset (Pre-Puberty) Gender Dysphoria

1. Prospective Studies of Childhood-Onset Gender Dysphoria Show that Most Children Desist in the "Natural Course" by Puberty

34. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 2–6 biological male children to each female.[28]

35. Prepubescent children (and their parents) have been approaching mental health professionals for help with their unhappiness with their sex and belief they would be happier living as the other for many decades. Projects following-up and reporting on such cases began being published in the 1970s, with subsequent generations of research employing increasingly sophisticated methods studying the outcomes of increasingly large samples. In total, there have now been 11 such outcomes studies, listed as Appendix 2.

36. In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, all spanning four decades, every study without exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies. Such cases are often referred to as "desisters," whereas children who continue to feel gender dysphoria are often called "persisters."

37. Notably, in most cases, these children were receiving professional psychosocial support across the study period aimed not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, the inclusion of therapy in the study protocol represents a complication for the interpretation of the results: That is, it is not possible to know to what extent the observed outcomes (predominant desistance, with a small but consistent occurrence of persistence) were

[28] Cohen-Kettenis, *et al.*, 2003; Steensma, *et al.*, 2018; Wood, *et al.*, 2013.

influenced by the psychosocial support, or would have emerged regardless. It can be concluded only that prepubescent children who suffer gender dysphoria and receive psychosocial support focused on issues other than "affirmation" of cross-gender identification do in fact desist in suffering from gender dysphoria, at high rates, over the course of puberty.

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

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

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

41. It is also important to note that research has not yet identified any reliable procedure for discerning which children who present with gender dysphoria will persist, as against the majority who will desist, absent transition and "affirmation." Such a method would be valuable, as the more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can

be weighted. Such "risk prediction" and behavioral "test construction" are standard components of applied statistics in the behavioral sciences. Multiple research teams have reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to usefully predict the course of a particular child.[29]

42. In contrast, a single research team (the aforementioned Olson group) claimed the opposite, asserting that they developed a method of distinguishing persisters from desisters, using a single composite score representing a combination of children's "peer preference, toy preference, clothing preference, gender similarity, and gender identity."[30] The reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they indicated, "Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability."[31] Although the Olson team declared that "social transitions may be predictable from gender identification and preferences,"[32] their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.[33] Both of those are lower than the value of .75, so both of those would be more likely than not to desist, rather than to proceed to transition. That is, Olson's model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

43. Although it remains possible for some future finding to yield a method to

---

29 Singh, *et al.* (2021); Steensma *et al.*, 2013.
30 Rae, *et al.*, 2019, at 671.
31 Rae, *et al.*, 2019, at 673.
32 Rae, *et al.*, 2019, at 669.
33 Rae, *et al.*, 2019, Supplemental Material at 6, Table S1, bottom line.

identify with sufficient accuracy which gender dysphoric children will persist, there does not exist such a method at the present time. Moreover, in the absence of long-term follow-up, it cannot be known what proportions come to regret having transitioned and then *de*transition. Because only a minority of gender dysphoric children persist in feeling gender dysphoric in the first place, "transition-on-demand" increases the probably of unnecessary transition and unnecessary medical risks.

2. "Watchful Waiting" and "The Dutch Approach"

44. It was this state of the science—that the majority of prepubescent children will desist in their feelings of gender dysphoria and that we lack an accurate method of identifying which children will persist—that led to the development of a clinical approach, often called "The Dutch Approach" (referring to The Netherlands clinic where it was developed) including "Watchful Waiting" periods. Internationally, the Dutch Approach is currently the most widely respected and utilized method for treatment of children who present with gender dysphoria.

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

46. The Dutch Approach (also called the "Dutch Protocol") was developed over many years by the Netherlands' child gender identity clinic, incorporating the accumulating findings from their own research as well as those reported by other clinics working with gender dysphoric children. They summarized and explicated the approach in their peer-reviewed report, *Clinical management of gender dysphoria in children and adolescents: The Dutch Approach* (de Vries & Cohen-Kettenis, 2012). The components of the Dutch Approach are:

- no social transition at all considered before age 12 (watchful waiting

period),

- no puberty blockers considered before age 12,
- cross-sex hormones considered only after age 16, and
- resolution of mental health issues before any transition.

47. For youth under age 12, "the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty."[34]

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

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

50. Within the Dutch approach, there is no social transition before age twelve. That is, social affirmation of the new gender may not begin until age 12—as desistance is less likely to occur past that age. "Watchful Waiting" refers to a child's developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Such children and families typically present with substantial distress involving both gender and non-gender issues. It is during the watchful waiting period that a child (and other family members as appropriate) would undergo therapy, resolving other issues which may be exacerbating psychological stress or dysphoria. As noted by the Dutch clinic, "[T]he adolescents in this study received extensive family or other social support . . . [and they] were all regularly seen by one of the clinic's psychologists or psychiatrists."[35] One is actively treating

[34] de Vries & Cohen-Kettenis, 2012, at 301.
[35] de Vries, *et al.*, 2011, at 2280-81.

the person, while carefully "watching" the dysphoria.

51. The inclusion of psychotherapy and support during the watchful waiting period is, clinically, a great benefit to the gender dysphoric children and their parents. The inclusion of psychotherapy and support poses a scientific complication, however: It becomes difficult to know to what extent the outcomes of these cases might be related to receiving psychotherapy received versus being "spontaneous" desistance, which would have occurred on its own anyway. This situation is referred to in science as a "confound."

3. Studies of Transition Outcomes: Overview

52. Very many strong claims have appeared in the media and on social media asserting that transition results in improved mental health or, contradictorily, in decreased mental health. In the highly politicized context of gender and transgender research, many authors have cited only the findings which appear to support one side, cherry-picking from the complete set of research reports. Seemingly contradictory findings are common in science with on-going research projects. When considered together, however, the full set of relevant reports show that a coherent pattern and conclusion has emerged over time, as detailed in the following sections. Initial optimism was suggested by reports of improvements in mental health.[36] Upon continued analysis, these seeming successes turned out to be illusory, however: The Bränström and Pachankis (2019) finding has been retracted.[37] The greater mental health among transitioners reported by Costa, *et al.* (2015) was noted to be because the control group consisted of cases excluded from hormone eligibility exactly because they showed poor mental health to begin with.[38] The improvements reported by the de Vries studies from the Dutch Clinic themselves appear genuine; however, because that clinic also provides psychotherapy to all cases receiving puberty-blockers, it

[36] Bränström & Pachankis 2019; Costa, *et al.*, 2015; de Vries, *et al.*, 2011; de Vries, *et al.*, 2014.
[37] Kalin, 2020.
[38] Biggs, 2019.

remains entirely plausible that the psychotherapy and not the puberty blockers caused the improvements.[39] New studies continue to appear an accelerating rate, repeatedly reporting deteriorations or lacks of improvement in mental health[40] or lack of improvement beyond psychotherapy alone,[41] and other studies continue to report on only the combined effect of both psychotherapy and hormone treatment together.[42]

a. Outcomes of The Dutch Approach (studies from before 2017): Mix of positive, negative, and neutral outcomes

53. The research confirms that some, but not all, adolescents improve on some, but not all, indicators of mental health and that those indicators are inconsistent across studies. Thus, the balance of potential benefits to potential risks differs across cases, and thus suggests different courses of treatment across cases.

54. The Dutch clinical research team followed up 70 youth undergoing puberty suppression at their clinic.[43] The youth improved on several variables upon follow-up as compared to pre-suppression measurement, including depressive symptoms and general functioning. No changes were detected in feelings of anxiety or anger or in gender dysphoria as a result of puberty suppression; however, natal females using puberty suppression suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics.[44]

55. As the report authors noted, while it is possible that the improvement on some variables was due to the puberty-blockers, it is also possible that the improvement was due to the mental health support, and it is possible that the improvement occurred only on its own with natural maturation. So any conclusion that puberty blockers improved the mental health of the treated children is not

---

39 Biggs, 2020.
40 Carmichael, *et al.*, 2021; Hisle-Gorman, *et al.*, 2021; Kaltiala, *et al.*, 2020.
41 Achille, *et al.*, 2020.
42 Kuper, *et al.*, 2020; van der Miesen, *et al.*, 2020, at 703.
43 de Vries, *et al.* 2011.
44 Biggs, 2020.

justified by the data. Because this study did not include a control group (another group of adolescents matching the first group, but *not* receiving medical or social support), these possibilities cannot be distinguished from each other, representing a confound. The authors of the study were explicit in noting this themselves: "All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents."[45]

56. The authors were careful not to overstate the implications of their results, "We *cautiously* conclude that puberty suppression *may be* a valuable *element* in clinical management of adolescent gender dysphoria."[46]

57. Costa, *et al.* (2015) reported on preliminary outcomes from the Tavistock and Portman NHS Foundation Trust clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication. Both groups improved in psychological functioning over the course of the study, but no statistically significant differences between the groups was detected at any point.[47] As those authors concluded, "Psychological support and puberty suppression were both associated with an improved global psychosocial functioning in GD adolescence. Both these interventions may be considered effective in the clinical management of psychosocial functioning difficulties in GD adolescence."[48] Because psychological support does not pose the physical health risks that hormonal interventions or surgery does (such as loss of reproductive function), one cannot justify taking on the greater risks of social transition, puberty blockers or surgery without evidence of such treatment producing superior results. Such evidence does not exist.

b. Clinicians and advocates have invoked the Dutch Approach

[45] de Vries, *et al.* 2011, at 2281.
[46] de Vries, *et al.* 2011, at 2282, italics added.
[47] Costa, *et al.*, at 2212 Table 2.
[48] Costa, *et al.*, at 2206.

while departing from its protocols in important ways.

58. The reports of partial success contained in de Vries, *et al.* 2011 called for additional research, both to confirm those results and to search for ways to maximize beneficial results and minimize negative outcomes. Instead, many other clinics and clinicians proceeded on the basis of the positives only, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, one and a half *years*[49]) became approvals after one or two assessment sessions. Validated, objective measures of youths' psychological functioning were replaced with clinicians' subjective (and first) opinions, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

59. Notably, Dr. Thomas Steensma, central researcher of the Dutch clinic, has decried other clinics for "blindly adopting our research" despite the indications that those results may not actually apply: "We don't know whether studies we have done in the past are still applicable to today. Many more children are registering, and also a different type."[50] Steensma opined that "every doctor or psychologist who is involved in transgender care should feel the obligation to do a good pre- and post-test." But few if any are doing so.

c. Studies by other clinicians in other countries have failed to reliably replicate the positive components of the results reported by the Dutch clinicians in de Vries et al. 2011.

60. The indications of potential benefit from puberty suppression in at least

[49] de Vries, *et al.*, 2011.
[50] Tetelepta, 2021.

some cases has led some clinicians to attempt to replicate the positive aspects of those findings. These efforts have not succeeded.

61. The Tavistock and Portman clinic in the U.K. recently released its findings, attempting to replicate the outcomes reported by the Dutch clinic.[51] Study participants were ages 12–15 (Tanner stages 3 for natal males, Tanner 2 for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious mental illnesses (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients' or their parents' perspective.

62. A multidisciplinary team from Dallas published a prospective follow-up study which included 25 youths as they began puberty suppression.[52] (The other 123 study participants were undergoing cross-sex hormone treatment.) Interventions were administered according to "Endocrine Society Clinical Practice Guidelines."[53] Their analyses found *no statistically significant changes* in the group undergoing puberty suppression on any of the nine measures of wellbeing measured, spanning tests of body satisfaction, depressive symptoms, or anxiety symptoms.[54] (Although the authors reported detecting some improvements, these were only found when the large group undergoing cross-sex hormone treatment were added in.) Although the Dutch Approach includes age 12 as a minimum for puberty suppression treatment, this team provided such treatment beginning at age 9.8 years (full range: 9.8–14.9 years).[55]

63. Achille, *et al.* (2020) at Stony Brook Children's Hospital in New York treated a sample of 95 youth with gender dysphoria, providing follow-up data on 50

---

51 Carmichael, *et al.*, 2021.
52 Kuper, *et al.*, 2020, at 5.
53 Kuper, *et al.*, 2020, at 3, referring to Hembree, *et al.*, 2017.
54 Kuper, *et al.*, 2020, at Table 2.
55 Kuper, *et al.*, 2020, at 4.

of them. (The report did not indicate how these 50 were selected from the 95.) As well as receiving puberty blocking medications, "Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional."[56] The puberty blockers themselves "were introduced in accordance with the Endocrine Society and the WPATH guidelines."[57] Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, "*most predictors did not reach statistical significance.*"[58] That is, puberty blockers did not improve mental health any more than did mental health care on its own.

64. In a recent update, the Dutch clinic reported continuing to find improvement in transgender adolescents' psychological functioning, reaching age-typical levels, "after the start of specialized transgender care involving puberty suppression."[59] Unfortunately, because the transgender care method of that clinic involves both psychosocial support and puberty suppression, it cannot be known which of those (or their combination) is driving the improvement. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. As the study authors themselves noted, "The present study can, therefore, not provide evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes."[60]

65. It has not yet been determined why the successful outcomes reported by the Dutch child gender clinic a decade ago failed to emerge when applied by others more recently. It is possible that:

(1) The Dutch Approach itself does *not* work and that their originally successful results were a fluke;

---

56 Achille, *et al.*, 2020, at 2.
57 Achille, *et al.*, 2020, at 2.
58 Achille, *et al.*, 2020, at 3 (italics added).
59 van der Miesen, *et al.*, 2020, at 699.
60 van der Miesen, *et al.*, 2020, at 703.

(2) The Dutch Approach *does* work, but only in the Netherlands, with local cultural, genetic, or other unrecognized factors that do not generalize to other countries;

(3) The Dutch Approach itself *does* work, but other clinics and individual clinicians are removing safeguards and adding short-cuts to the approach, and those changes are hampering success.

(4) The Dutch Approach *does* work, but the cause of the improvement is the psychosocial support, rather than any medical intervention, which other clinics are *not* providing.

66. The failure of other clinics to repeat the already very qualified success of the Dutch clinic demonstrates the need for still greater caution before endorsing transition and the greater need to resolve potential mental health obstacles before doing so.

4. Mental Health Issues in Childhood-Onset Gender Dysphoria

67. As shown by the outcomes studies, there is no statistically significant evidence that transition reduces the presence of mental illness among transitioners. As shown repeatedly by clinical guidelines from multiple professional associations, mental health issues are expected or required to be resolved *before* undergoing transition. The reasoning behind these conclusions is that children may be expressing gender dysphoria, not because they are experiencing what gender dysphoric adults report, but because they mistake what their experiences indicate or to what they might lead. For example, a child experiencing depression from social isolation might develop hope—and the unrealistic expectation—that transition will help them fit in, this time as and with the other sex.

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

69. Elevated rates of multiple mental health issues among gender dysphoric

children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed 52% fulfilled criteria for a DSM axis-I disorder.[61] A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, but a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment instruments (Child Behavior Check List, or CBCL) demonstrated that the average score was in the clinical rather than healthy range, among children in both clinics.[62] When expressed as percentages, among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample were in the clinical range.

70. A systematic, comprehensive review of all studies of Autism Spectrum Disorders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children diagnosed with gender dysphoria was recently conducted. It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD I youth with gender dysphoria. Studies reviewing medical records of children and adolescents referred to gender clinics showed 5–26% to have been diagnosed with ASD.[63] Moreover, those authors gave specific caution on the "considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results."[64] When two or more issues are present at the same time (in this case, gender dysphoria present at the same time as ADHD or ASD), researchers cannot distinguish when a result is associated with or caused by the issue of interest (gender dysphoria itself) or one of the side issues, called *confounds* (ADHD or ASD,

---

61 Wallien, *et al.*, 2007.
62 Cohen-Kettenis, *et al.*, 2003, at 46.
63 Thrower, *et al.*, 2020.
64 Thrower, *et al.*, 2020, at 703.

in the present case).[65] The rate of ADHD among children with GD was 8.3–11%. Conversely, in data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported "gender variance."[66]

C. Adolescent-Onset Gender Dysphoria

1. Features of Adolescent-Onset Gender Dysphoria

71. In the social media age, a third profile has recently begun to present to clinicians or socially, characteristically distinct from the previously identified ones.[67] Unlike adult-onset gender dysphoria and unlike childhood-onset, this group is predominately biologically female. This group first presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is this feature which led to the term Rapid Onset Gender Dysphoria (ROGD).[68] The majority of cases appear to occur within clusters of peers and in association with increased social media use[69] and especially among people with autism or other neurodevelopmental or mental health issues.[70]

72. It cannot be easily determined whether the self-reported gender dysphoria is a result of other underlying issues or if those mental health issues are the result of the stresses of being a sexual minority, as some writers are quick to assume.[71] (The science of the *Minority Stress Hypothesis* appears in its own section.) Importantly, and unlike other presentations of gender dysphoria, people with rapid-onset gender dysphoria often (47.2%) experienced *declines* rather than improvements in mental health when they publicly acknowledged their gender status.[72] Although long-term outcomes have not yet been reported, these distinctions demonstrate that one cannot

---

65 Cohen-Kettenis *et al.*, 2003, at 51; Skelly *et al.*, 2012.
66 Janssen, *et al.*, 2016.
67 Kaltiala-Heino, *et al.*, 2015; Littman, 2018.
68 Littman, 2018.
69 Littman, 2018.
70 Kaltiala-Heino, *et al.*, 2015; Littman, 2018; Warrier, *et al.*, 2020.
71 Boivin, *et al.*, 2020.
72 Biggs, 2020; Littman, 2018.

apply findings from the other types of gender dysphoria to this type. That is, in the absence of evidence, researchers cannot assume that the pattern found in childhood-onset or adult-onset gender dysphoria also applies to rapid-onset (aka adolescent-onset) gender dysphoria. The group differences already observed argue against the conclusion that any given feature would be present, in general, throughout all types of gender dysphoria.

2. Prospective Studies of Social Transition and Puberty Blockers in Adolescence

73. There do not yet exist prospective outcomes studies either for social transition or for medical interventions for people whose gender dysphoria began in adolescence. That is, instead of taking a sample of individuals and following them forward over time (thus permitting researchers to account for people dropping out of the study, people misremembering the order of events, etc.), all studies have thus far been *retrospective*. It is not possible for such studies to identify what factors caused what outcomes. No study has yet been organized in such a way as to allow for an analysis of the adolescent-onset group, as distinct from childhood-onset or adult-onset cases. Many of the newer clinics (not the original clinics which systematically tracked and reported on their cases' results) fail to distinguish between people who had childhood-onset gender dysphoria and have aged into adolescence and people whose onset was not until adolescence. Similarly, there are clinics failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria. Studies selecting groups according to their current age instead of their ages of onset can produce only confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

3. Mental Illness in Adolescent-Onset Gender Dysphoria

74. In 2019, a Special Section of the *Archives of Sexual Behavior* was published:

"Clinical Approaches to Adolescents with Gender Dysphoria." It included this brief yet thorough summary of rates of mental health issues among adolescents expressing gender dysphoria by Dr. Aron Janssen of the Department of Child and Adolescent Psychiatry of New York University:[73] The literature varies in the range of percentages of adolescents with co-occurring disorders. The range for depressive symptoms ranges was 6–42%,[74] with suicide attempts ranging 10 to 45%.[75] Self-injurious thoughts and behaviors range 14–39%.[76] Anxiety disorders and disruptive behavior difficulties including Attention Deficit/Hyperactivity Disorder are also prevalent.[77] Gender dysphoria also overlaps with Autism Spectrum Disorder.[78]

75. Of particular concern in the context of adolescent onset gender dysphoria is *Borderline Personality Disorder* (BPD). The DSM-5-TR criteria for BPD are[79]:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
> 2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.
> 3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
> 4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
> 5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
> 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

---

[73] Janssen, *et al.*, 2019.
[74] Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013; Wallien, *et al.*, 2007.
[75] Reisner, *et al.*, 2015.
[76] Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013.
[77] de Vries, *et al.*, 2011; Mustanski, *et al.*, 2010; Wallien, *et al.*, 2007.
[78] de Vries, *et al.*, 2010; Jacobs, *et al.*, 2014; Janssen, *et al.*, 2016; May, *et al.*, 2016; Strang, *et al.*, 2014, 2016.
[79] American Psychiatric Association, 2022, pp. 752–753, italics added.

7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Italics added.)

76. It is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria are actually cases of BPD.[80] That is, some people may be misinterpreting their experiences to represent a gender identity issue, when it instead represents the "identity disturbance" noted in symptom Criterion 3. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence, is substantially more common among biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people (*i.e.*, 0.02%). Thus, if even only a portion of people with BPD had 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.

77. A primary cause for concern is symptom Criterion 5: recurrent suicidality. Regarding the provision of mental health care, this is a crucial distinction: A person with BPD going undiagnosed will not receive the appropriate treatments (the currently most effective of which is Dialectical Behavior Therapy). A person with a cross-gender identity would be expected to feel relief from medical transition, but someone with BPD would not: The problem was not about *gender* identity, but about having an *unstable* identity. Moreover, after a failure of medical transition to provide relief, one would predict for these people increased levels of hopelessness and increased risk of suicidality. One would predict also that misdiagnoses would occur more often if one reflexively dismissed or discounted symptoms of BPD as responses to "minority stress." The Minority Stress Hypothesis is discussed in its own section

[80] *E.g.*, Anzani, *et al.*, 2020; Zucker, 2019.

herein.

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

IV. Other Scientific Claims Assessed

A. Conversion Therapy

79. Activists and social media increasingly, but erroneously, apply the term "conversion therapy" moving farther and farther from what the research has reported. "Conversion therapy" (or "reparative therapy" and other names) was the attempt to change a person's sexual orientation; however, with the public more frequently accustomed to "LGB" being expanded to "LGBTQ+", the claims relevant only to sexual orientation are being misapplied to gender identity. The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, this is only very rarely are mistaken. That is entirely unlike gender identity, wherein the great majority of children who declare cross-gender identity cease to do so by puberty, as shown unanimously by every follow-up study ever published. As the field grows increasingly polarized, any therapy failing to provide affirmation-on-demand is mislabeled "conversion therapy."[81] Indeed, even actions of non-therapists, unrelated to any therapy have been labelled conversion therapy, including the prohibition of biological males competing on female teams.[82]

B. Assessing Claims of Suicidality

80. In the absence of scientific evidence associating improvement with

---

[81] D'Angelo, *et al.*, 2021.
[82] Turban, 2021, March 16.

transition among youth, demands for transition are increasingly accompanied by hyperbolic warnings of suicide should there be delay or obstacle to affirmation-on-demand. Social media circulate claims of extreme suicidality accompanied by declarations that "I'd rather have a trans daughter than a dead son." Such claims convey only grossly misleading misrepresentations of the research literature, however.

81. Despite that the media treat them as near synonyms, suicide and suicidality are distinct phenomena. They represent different behaviors with different motivations, with different mental health issues, and with differing clinical needs. *Suicide* refers to completed suicides and the sincere intent to die. It is substantially associated with impulsivity, using more lethal means, and being a biological male.[83] *Suicidality* refers to parasuicidal behaviors, including suicidal ideation, threats, and gestures. These typically represent cries for help rather than an intent to die and are more common among biological females. Suicidal threats can indicate any of many problems or represent emotional blackmail, as typified in "If you leave me, I will kill myself." Professing suicidality is also used for attention- seeking or for the support or sympathy it evokes from others, indicating distress much more frequently than an intent to die.

82. The scientific study of suicide is inextricably linked to that of mental illness. For example, as noted in the preceding, suicidality is a well-documented symptom of Borderline Personality Disorder (as are chronic identity issues), and personality disorders are highly elevated among transgender populations, especially adolescent-onset. Thus, the elevations of suicidality among gender dysphoric adolescents may not be a result of anything related to transition (or lack of transition), but to the overlap with mental illness of which suicidality is a substantial part. Conversely,

---

[83] Freeman, *et al.*, 2017.

improvements in suicidality reported in some studies may not be the result of anything related to transition, but rather to the concurrent general mental health support which is reported by the clinical reported prospective outcomes. Studies that include more than one factor at the same time without accounting for each other represent a "confound," and it cannot be known which factor (or both) is the one causing the effects observed. That is, when a study provides both mental health services and medical transition services at the same time, it cannot be known which (or both) is what caused any changes.

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

84. Despite that mental health issues, including suicidality, are repeatedly required by clinical standards of care to be resolved before transition, threats of suicide are instead oftentimes used as the very justification for labelling transition a 'medical necessity'. However plausible it might seem that failing to affirm transition causes suicidality, the epidemiological evidence indicates that hypothesis to be incorrect: Suicide rates remains elevated even after complete transition, as shown by a comprehensive review of 17 studies of suicidality in gender dysphoria.[84]

85. Of particular relevance in the present context is suicidality as a well-documented symptom of Borderline Personality Disorder (BPD) and that very many cases appearing to be adolescent-onset gender dysphoria actually represent cases of BPD. [See full DSM-5-TR criteria already listed herein.] That is, some people may be

[84] McNeil, *et al.*, 2017.

misinterpreting their experiencing of the broader "identity disturbance" of symptom Criterion 3 to represent a gender identity issue specifically. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence and occurs in 2–3% of the population, rather than 1-in-5,000 people. (Thus, if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.)

86. Rates of completed suicide are elevated among post-transition transsexuals, but are nonetheless rare,[85] and BPD is repeatedly documented to be greatly elevated among sexual minorities[86]. Overall, rates of suicidal ideation and suicidal attempts appear to be related—not to transition status—but to the social support received: The research evidence shows that support decreases suicidality, but that transition itself does not. Indeed, in some situations, social support was associated with increased suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support.[87]

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

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

---

[85] Wiepjes, *et al.*, 2020.
[86] Reuter, *et al.*, 2016; Rodriguez-Seiljas, *et al.*, 2021; Zanarni, *et al.*, 2021.
[87] Bauer, *et al.*, 2015; Canetto, et al., 2021.

the other parent.

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

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

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

91. Many outcomes studies have been published examining the results of gate-keeper models, but no such studies have been published regarding affirmation-on-demand with children. Although there have been claims that affirmation-on-demand causes mental health or other improvement, these have been the result only of

"retrospective" rather than "prospective" studies. That is, such studies did not take a sample of children and follow them up over time, to see how many dropped out altogether, how many transitioned successfully, and how many transitioned and regretted it or detransitioned. Rather, such studies took a sample of successfully transitioned adults and asked them retrospective questions about their past. In such studies, it is not possible to know how many other people dropped out or regretted transition, and it is not possible to infer causality from any of the correlations detected, despite authors implying and inferring causality.

D. Assessing the "Minority Stress Hypothesis"

92. The elevated levels of mental health problems among lesbian, gay, and bisexual populations is a well-documented phenomenon, and the idea that it is caused by living within a socially hostile environment is called the *Minority Stress Hypothesis*.[88] The association is not entirely straight-forward, however. For example, although lesbian, gay, and bisexual populations are more vulnerable to suicide ideation overall, the evidence specifically on adult lesbian and bisexual women is unclear. Meyer did not include transgender populations in originating the hypothesis, and it remains a legitimate question to what extent and in what ways it might apply to gender identity.

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

[88] Meyer, 2003.

only for the first time.

94. Also suggesting minority stress cannot be the full story is that the mental health symptoms associated with minority stress do not entirely correspond with those associated with gender dysphoria. The primary symptoms associated with minority stress are depressive symptoms, substance use, and suicidal ideation.[89] The symptoms associated with gender dysphoria indeed include depressive symptoms and suicidal ideation, but also include anxiety symptoms, Autism Spectrum Disorders, and personality disorders.

V. Assessing Statements from Professional Associations

A. Understanding the Value of Statements from Professional Associations

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

[89] Meyer, 2003.

feel strongly about political implications of an issue, instead of scientists engaged in the objective study of the topic.

96. Thus, documents from professional associations may represent required standards, the violation of which may merit sanctions, or may represent only recommendations or guidelines. A document may represent the views of an association's full membership or only of the committee's members (or majorities thereof). Documents may be based on systematic, comprehensive reviews of the available research or selected portions of the research. In sum, the weight best placed on any association's statement is the amount by which that association employed evidence versus other considerations in its process.

B. Misrepresentations of statements of professional associations.

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

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

1. World Professional Association for Transgender Health (WPATH)

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

> [I]n follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).[90]

100. That is, "In most children, gender dysphoria will disappear before, or early in, puberty."[91]

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

> Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre, van de Waal & Cohen-Kettenis, 2006; Zucker et al., [2012]).[92]

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

> Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.[93]

103. It does caution, however, "Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria."[94]

2. Endocrine Society (ES)

---

90 Coleman, *et al.*, 2012, at 172.
91 Coleman, *et al.*, 2012, at 173.
92 Coleman, *et al.*, 2012, at 173.
93 Coleman, *et al.*, 2012, at 176.
94 Coleman, *et al.*, 2012, at 176 (quoting Drummond, *et al.*, 2008; Wallien & Cohen-Kettenis, 2008).

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

105. The document acknowledged the frequency of desistance among gender dysphoric children:

> Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence. . . . In adolescence, a significant number of these desisters identify as homosexual or bisexual.[95]

106. The statement similarly acknowledges inability to predict desistance or persistence, "With current knowledge, we cannot predict the psychosexual outcome for any specific child."[96]

107. Although outside their area of professional expertise, mental health issues were also addressed by the Endocrine Society, repeating the need to handle such issues before engaging in transition, "In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues."[97] This ordering—to address mental health issues before embarking on transition—avoids relying on the unproven belief that transition will solve such issues.

---

[95] Hembree, *et al.*, 2017, at 3876.
[96] Hembree, *et al.*, 2017, at 3876.
[97] Hembree, *et al.*, 2017, at 3877.

108. The Endocrine Society did not endorse any affirmation-only approach. The guidelines were neutral with regard to social transitions before puberty, instead advising that such decisions be made only under clinical supervision: "We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional."[98]

109. The Endocrine Society guidelines make explicit that, after gathering information from adolescent clients seeking medical interventions and their parents, the clinician "provides correct information to prevent unrealistically high expectations [and] assesses whether medical interventions may result in unfavorable psychological and social outcomes."[99]

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

110. In 2020, the 1500-member Pediatric Endocrine Society partnered with the Endocrine Society to create and endorse a brief, two-page position statement.[100] Although strongly worded, the document provided no specific guidelines, instead deferring to the Endocrine Society guidelines.[101]

111. It is not clear to what extent this endorsement is meaningful, however. According to the PES, the Endocrine Society "recommendations include evidence that treatment of gender dysphoria/gender incongruence is medically necessary and should be covered by insurance."[102] However, the Endocrine Society makes neither statement. Although the two-page PES document mentioned insurance coverage four times, the only mention of health insurance by the Endocrine Society was: "If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an

98 Hembree, *et al.*, 2017, at 3872.
99 Hembree, *et al.*, 2017, at 3877.
100 PES, online; Pediatric Endocrine Society & Endocrine Society, Dec. 2020.
101 Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1; Hembree, *et al.*, 2017.
102 Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1.

antiandrogen that directly suppresses androgen synthesis or action."[103] Despite the PES asserting it as "medically necessary," the Endocrine Society stopped short of that. Its only use of that phrase was instead limiting: "We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being."[104]

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

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

> Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects. . . . In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent.[105]

113. The AACAP's language repeats the description of the use of puberty blockers only as an exception: "For situations in which deferral of sex reassignment decisions until adulthood is *not clinically feasible*, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues."[106]

114. The AACAP statement acknowledges the long-term outcomes literature for gender dysphoric children: "In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood,"[107] adding that "[c]linicians should be aware of current evidence on the natural course of gender

---

[103] Hembree, *et al.* 2017, at 3883.
[104] Hembree, *et al.*, 2017 at 3872, 3894.
[105] Adelson & AACAP, 2012, at 969.
[106] Adelson & AACAP, 2012, at 969 (italics added).
[107] Adelson & AACAP, 2012, at 963.

discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality."[108]

115. The policy similarly includes a provision for resolving mental health issues: "Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and *treatment of associated mental health problems*."[109] The document also includes minority stress issues and the need to deal with mental health aspects of minority status (*e.g.*, bullying).[110]

116. Rather than endorse social transition for prepubertal children, the AACAP indicates: "There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so."[111]

5. American College of Obstetricians & Gynecologists (ACOG)

117. The American College of Obstetricians & Gynecologists (ACOG) published a "Committee Opinion" expressing recommendations in 2017. The statement indicates it was developed by the ACOG's Committee on Adolescent Health Care, but does not indicate participation based on professional expertise or a systematic method of objectively assessing the existing research. It includes the disclaimer: "This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed."[112]

118. Prepubertal children do not typically have clinical contact with gynecologists, and the ACOG recommendations include that the client additionally

[108] Adelson & AACAP, 2012, at 968.
[109] Adelson & AACAP, 2012, at 970 (italics added).
[110] Adelson & AACAP, 2012, at 969.
[111] Adelson & AACAP, 2012, at 969.
[112] ACOG, 2017, at 1.

have a primary health care provider.[113]

119. The ACOG statement cites the statements made by other medical associations—European Society for Pediatric Endocrinology (ESPE),, PES, and the Endocrine Society—and by WPATH.[114] It does not cite any professional association of *mental* health care providers, however. The ACOG recommendations repeat the previously mentioned eligibility/readiness criteria of having no mental illness that would hamper diagnosis and no medical contraindications to treatment. It notes: "*Before* any treatment is undertaken, the patient must display eligibility and readiness (Table 1), meaning that the adolescent has been evaluated by a mental health professional, has no contraindications to therapy, and displays an understanding of the risks involved."[115]

120. The "Eligibility and Readiness Criteria" also include, "Diagnosis established for gender dysphoria, transgender, transsexualism."[116] This standard, requiring a formal diagnosis, forestalls affirmation-on-demand because self-declared self-identification is not sufficient for DSM diagnosis.

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

6. American College of Physicians (ACP)

122. The American College of Physicians published a position paper broadly expressing support for the treatment of LGBT patients and their families, including nondiscrimination, antiharassment, and defining "family" by emotional rather than biological or legal relationships in visitation policies, and the inclusion of transgender

---

[113] ACOG, 2017, at 1.
[114] ACOG, 2017, at 1, 3.
[115] ACOG, 2017, at 1, 3 (citing the Endocrine Society guidelines) (italics added).
[116] ACOG, 2017, at 3 Table 1.

health care services in public and private health benefit plans.[117]

123. ACP did not provide guidelines or standards for child or adult gender transitions. The policy paper opposed attempting "reparative therapy;" however, the paper confabulated sexual orientation with gender identity in doing so. That is, on the one hand, ACP explicitly recognized that "[s]exual orientation and gender identity are inherently different."[118] It based this statement on the fact that "the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change *sexual orientation*."[119] The APA's document, entitled "Report of the American Psychological Task Force on appropriate therapeutic responses to *sexual orientation*" does not include or reference research on gender identity.[120] Despite citing no research about transgenderism, the ACP nonetheless included in its statement: "Available research does not support the use of reparative therapy as an effective method in the treatment of LGB*T* persons."[121] That is, the inclusion of "T" with "LGB" is based on something other than the existing evidence.

124. There is another statement,[122] which was funded by ACP and published in the Annals of Internal Medicine under its "*In the Clinic*" feature, noting that "'In the Clinic' does not necessarily represent official ACP clinical policy."[123] The document discusses medical transition procedures for adults rather than for children, except to note that "[n]o medical intervention is indicated for prepubescent youth,"[124] that a "mental health provider can assist the child and family with identifying an appropriate time for a social transition,"[125] and that the "child should be assessed and managed for coexisting mood disorders during this period because risk for suicide is

---

117 Daniel & Butkus, 2015a, 2015b.
118 Daniel & Butkus, 2015b, at 2.
119 Daniel & Butkus, 2015b, at 8 (italics added).
120 APA, 2009 (italics added).
121 Daniel & Butkus, 2015b, at 8 (italics added).
122 Safer & Tangpricha, 2019.
123 Safer & Tangpricha, 2019, at ITC1.
124 Safer & Tangpricha, 2019, at ITC9.
125 Safer & Tangpricha, 2019, at ITC9.

higher than in their cisgender peers."[126]

7. American Academy of Pediatrics (AAP)

125. The policy of the American Academy of Pediatrics (AAP) is unique among the major medical associations in being the only one to endorse an affirmation-on-demand policy, including social transition before puberty without any watchful waiting period. Although changes in recommendations can obviously be appropriate in response to new research evidence, the AAP provided none. Rather, the research studies AAP cited in support of its policy simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting.[127] Moreover, of all the outcomes research published, the AAP policy cited *one*, and that without mentioning the outcome data it contained.[128].

8. The ESPE-LWPES GnRH Analogs Consensus Conference Group

126. Included in the interest of completeness, there was also a collaborative report in 2009, between the European Society for Pediatric Endocrinology (ESPE) and the Lawson Wilkins Pediatric Endocrine Society (LWPES).[129] Thirty experts were convened, evenly divided between North American and European labs and evenly divided male/female, who comprehensively rated the research literature on gonadotropin-release hormone analogs in children.

127. The effort concluded that "[u]se of gonadotropin-releasing hormone analogs for conditions other than central precocious puberty requires additional investigation and cannot be suggested routinely."[130] However, gender dysphoria was not explicitly mentioned as one of those other conditions.

---

[126] Safer & Tangpricha, 2019, at ITC9.
[127] Cantor, 2020.
[128] Cantor, 2020, at 1.
[129] Carel et al., 2009.
[130] Carel et al. 2009, at 752.

C. International Health Care Consensus

1. United Kingdom

128. The National Health Service (NHS) of the United Kingdom centralizes gender counselling and transitioning services in a single clinic, the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust. Between 2008 and 2018, the number of referrals to the clinic had increased by a factor of 40, leading to a government inquiry into the causes[131]. The GIDS was repeatedly accused of over-diagnosing and permitting transition in cases despite indicators against patient transition, including by 35 members of the GIDS staff, who resigned by 2019[132].

129. The NHS appointed Dr. Hilary Cass, former President of the Royal College of Paediatrics and Child Health, to conduct an independent review[133]. That review included a systematic consolidation of all the research evidence, following established procedures for preventing the "cherry-picking" or selective citation favouring or down-playing any one conclusion[134]. The review's results were unambiguous: "The critical outcomes for decision making are the impact on gender dysphoria, mental health and quality of life. The quality of evidence for these outcomes was assessed as very low"[135], again using established procedures for assessing clinical research evidence (called GRADE). The review also assessed as "very low" the quality of evidence regarding "body image, psychosocial impact, engagement with health care services, impact on extent of an satisfaction with surgery and stopping treatment"[136]. The report concluded that of the existing research, "The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding....They suggest little change with GnRH analogues [puberty

131 Marsh, 2020; Rayner, 2018.
132 BBC, 2021; Donnelly, 2019.
133 National Health Service, 2020, Sept. 22.
134 National Institute for Health and Care Excellence, 2020.
135 National Institute for Health and Care Excellence, 2020, p. 4.
136 National Institute for Health and Care Excellence, 2020, p. 5.

blockers] from baseline to follow-up"[137].

2. Finland

130. In Finland, the assessments of mental health and preparedness of minors for transition services are centralized by law into two research clinics, Helsinki University Central Hospital and Tampere University Hospital. The eligibility of minors began in 2011. In 2019, Finnish researchers published an analysis of the outcomes of adolescents diagnosed with transsexualism and receiving cross-sex hormone treatment[138]. That study showed that despite the purpose of medical transition to improve mental health: "Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development"[139]. The patients who were functioning well after transition were those who were already functioning well before transition, and those who were functioning poorly, continued to function poorly after transition.

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

[137] National Institute for Health and Care Excellence, 2020, p. 13.
[138] Kaltiala et al., 2020.
[139] Kaltiala et al., 2020, p. 213.

ceased and adolescent development is progressing normally"[140]. The council was explicit in noting the lack of research needed for decision-making, "There is also a need for more information on the *disadvantages* of procedures and on people who regret them"[141].

3. Sweden

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

133. Sweden has long been very accepting with regard to sexual and gender diversity. In 2018, a law was proposed to lower the age of eligibility for ?surgical care from age 18 to 15, remove the requirement for parental consent, and lower legal change of gender to age 12. A series of cases of regret and suicide were reported in the Swedish media, leading to questions of mental health professionals failing to consider. In 2019, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) therefore conducted its own comprehensive review of the research[142]. Like the UK, the Swedish investigation employed methods to ensure the encapsulation of the all the relevant evidence[143].

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

[140] Council for Choices in Health Care in Finland, 2020; italics added.
[141] Council for Choices in Health Care in Finland, 2020; italics added.
[142] Orange, 2020, Feb 22.
[143] Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019.

"recommends restraint when it comes to hormone treatment...Based on the results that have emerged, the National Board of Health and Welfare's overall conclusion is that the risks of anti-puberty and sex-confirming hormone treatment for those under 18 currently outweigh the possible benefits for the group as a whole"[144]. Neither puberty blockers nor cross-sex hormones would be provided under age 16, and patients ages 16–18 would receive such treatments only within research settings (clinical trials monitored by the appropriate Swedish research ethics board).

4. France

135. In 2022, the Académie Nationale de Médecine of France issued a strongly worded statement, citing the Swedish ban on hormone treatments. "[A] great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause...such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause"[145]. For hormones, the Académie concluded "the greatest reserve is required in their use," and for surgical treatments, "[T]heir irreversible nature must be emphasized." The Académie did not outright ban medical interventions, but warned "the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to "detransition". Rather than medical interventions, it advised health care providers "to extend as much as possible the psychological support phase." The Académie reviewed and emphasized the evidence indicating the very large and very sudden increase in youth requesting medical transition. It attributed the change, not to society now being more accepting of sexual diversity, but to social media, "underlining the addictive character of excessive consultation of social networks which is both

[144] Swedish National Board of Health and Welfare, 2022.
[145] Académie Nationale de Médecine, 2022, Feb. 25.

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

References

Académie Nationale de Médecine. (2022, Feb. 25). Medicine and gender transidentity in children and adolescents. Retrieved from https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en

Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results. *International Journal of Pediatric Endocrinology*. doi: 10.1186/s13633-020-00078-2

Adelson, S. L., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues. (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*, 957–974.

American College of Obstetricians and Gynecologists. (2017). Care for transgender Adolescents. Committee Opinion No. 685. Retrieved from www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/01/care-for-transgender-adolescents

American Psychiatric Association. (2022). Diagnostic and statistical manual for mental disorders, fifth edition, text revision (DSM-5-TR). Washington, DC: Author.

American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Retrieved from http://www. apa.org/pi/lgbc/publications/therapeutic-resp.html

Anzani, A., De Panfilis, C., Scandurra, C., & Prunas, A. (2020). Personality disorders and personality profiles in a sample of transgender individuals requesting gender-affirming treatments. *International Journal of Environmental Research and Public Health, 17,* 1521. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7084367/

Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: A respondent driven sampling study in Ontario, Canada. *BMC Public Health*, 15, 525.

BBC News. (2021, Sept. 5). NHS child gender identity clinic whistleblower wins tribunal. *British Broadcasting Company*. Retrieved from https://www.bbc.com/news/uk-58453250

Biggs, M. (2019). A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine, 16,* 2043.

Biggs, M. (2020). Gender dysphoria and psychological functioning in adolescents

treated with GnRHa: Comparing Dutch and English prospective studies. *Archives of Sexual Behavior*, 49, 2231–2236.

Blanchard, R. (1985). Typology of male-to-female transsexualism. *Archives of Sexual Behavior*, 14, 247–261.

Blanchard, R. (1988). Nonhomosexual gender dysphoria. *The Journal of Sex Research*, 24, 188–193.

Blanchard, R. (1989a). The classification and labeling of nonhomosexual gender dysphorias. *Archives of Sexual Behavior*, 18, 315–334.

Blanchard, R. (1989b). The concept of autogynephilia and the typology of male gender dysphoria. *Journal of Nervous and Mental Disease*, 177, 616–623.

Blanchard, R. (1990). Gender identity disorders in adult women. In R. Blanchard & B. W. Steiner (Eds.), *Clinical management of gender identity disorders in children and adults* (pp. 77–91). Washington, DC: American Psychiatric Press.

Blanchard, R. (1991). Clinical observations and systematic studies of autogynephilia. *Journal of Sex and Marital Therapy*, 17, 235–251.

Blanchard, R., Steiner, B. W., Clemmensen, L. H., & Dickey, R. (1989). Prediction of regrets in postoperative transsexuals. *Canadian Journal of Psychiatry*, 34, 43–45.

Boivin, L., Notredame, C.-E., Jardri, R., & Medjkane, F. (2020). Supporting parents of transgender adolescents: Yes, but how? *Archives of Sexual Behavior*, 49, 81–83.

Bränström, R., & Pachankis, J. E. (2019). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: A total population study. *American Journal of Psychiatry, 177,* 727–734.

Canetto, S. S., Antonelli, P., Ciccotti, A., Dettore, D., & Lamis, D. A. (2021). Suicidal as normal: A lesbian, gay, and bisexual youth script? *Crisis, 42,* 292–300.

Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy*, 46, 307–313.

Carel, J. C., Eugster, E. A., Rogol, A., Ghizzoni, L., Palmert, M. R.; ESPE-LWPES GnRH Analogs Consensus Conference Group, Antoniazzi, F., Berenbaum, S., Bourguignon, J. P., Chrousos, G. P., Coste, J., Deal, S., de Vries, L., Foster, C., Heger, S., Holland, J., Jahnukainen, K., Juul, A., Kaplowitz, P., Lahlou, N., Lee, M. M., Lee, P., Merke, D. P., Neely, E. K., Oostdijk, W., Phillip, M., Rosenfield, R. L., Shulman, D., Styne, D., Tauber, M., Wit, J. M. (2009). Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*, 123(4), e752–e762.

Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., Viner, R. M. (2021). 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. *PLosONE*, 16(2): e0243894.

Cohen-Kettenis, P. T. (2001). Gender identity disorder in DSM? *Journal of the American Academy of Child & Adolescent Psychiatry*, 40, 391–391.

Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology*, 31, 41–53.

Cohen, J., Cohen, P., West, S. G. Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences (3rd ed.)*. Mahwah, NJ: Lawrence Erlbaum Associates.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., Lev, A. I., Mayer, G., Meyer-Bahlburg, H., Hall, B. P., Pfaefflin, F., Rachlin, K., Robinson, B., Schechter, L. S., Tangpricha, V., van Trotsenburg, M., Vitale, A., Winter, S., Whittle, S., Wylie, K. R., & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, 13, 165–232.

Costa, R., Dunsford, M., Skagerberg, E., Holt V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 12, 2206–2214.

Council for Choices in Health Care in Finland (COHERE). (2020, June 16). Medical treatment methods for dysphoria associated with variations in gender identity in minors—Recommendation. [Translated] Retrieved from https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474

Dahlen, S., Connolly, D., Arif, I., Hyder Junejo, M., Bewley, S., & Meads, C. (2021). *International clinical practice guidelines for gender minority/trans people: Systematic review and quality assessment. BMJ Open, 11,* e048943.

D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior, 50,* 7–16.

Daniel, H., & Butkus, R. (2015a). Lesbian, gay, bisexual, and transgender health disparities: Executive summary of a policy position paper from the American College of Physicians. *Annals of Internal Medicine*, 163, 135–137.

Daniel, H., & Butkus, R. (2015b). Appendix: Lesbian, gay, bisexual, and transgender health disparities: A policy position paper from the American College of Physicians. *Annals of Internal Medicine*, 163(2), [unpaginated].

de Vries, A. L. C. & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch Approach. *Journal of Homosexuality*, 59, 301–320.

de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134, 1–9.

de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine*, 8, 2276–2283.

de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry*, 52, 1195–1202.

de Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer- Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, 40, 930–936.

Delemarre-van de Waal, H. A., & Cohen- Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155 (suppl 1), S131–S137.

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Langström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE 6*(2), e16885.

Dhejne, C., Van Vlerken, R., Geylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry*, 28, 44–57.

Dhejneberg, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: Prevalence, incidence, and regrets. *Archives of Sexual Behavior*, 43, 1535–1545.

Donnelly, L. (2019, Dec. 12). Children's transgender clinic hit by 35 resignations in three years as psychologists warn of gender dysphoria 'over-diagnoses'. *The Telegraph*. Retrieved from https://www.telegraph.co.uk/news/2019/12/12/childrens-transgender-clinic-hit-35-resignations-three-years/?WT.mc_id=tmg_share_em

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow up study of girls with gender identity disorder. *Developmental Psychology*, 44, 34–45.

Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56, 116–123.

Finland Ministry of Social Affairs and Health, Council for Choices in Health Care. (2020, June 11). *Medical treatment methods for dysphoria associated with variations in gender identity in minors—Recommendation.* Retrieved from https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474

Finland Ministry of Social Affairs and Health, Council for Choices in Health Care. (2020, June 16). *Medical treatments for gender dysphoria that reduces functional capacity in transgender people—Recommendation.* Retrieved from https://palveluvalikoima.fi/documents/1237350/22895838/Summary+transgender.pdf/2cc3f053-2e34-39ce-4e21-becd685b3044/Summary+transgender.pdf?t=1592318543000

Freeman, A., Mergl, R., Kohls, E., Székely, A., Gusmao, R., Arensman, E., Koburger, N., Hegerl, U., & Rummel-Kluge, C. (2017). A cross-national study on gender differences in suicide intent. *BMC Psychiatry, 17,* 234.

Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality.* New Haven, CT: Yale University Press.

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, T. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/ gender-incongruent persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism*, 102, 3869–3903.

Hepp, U., Kraemer, B., Schnyder, U., Miller, N., & Delsignore, A. (2005). Psychiatric comorbidity in gender identity disorder. *Journal of Psychosomatic Research, 58*, 259–261.

Hisle-Gorman, E., Schvey, N. A., Adirim, T. A., Rayne, A. K., Susi, A., Roberts, T. A., & Klein, D. A. (2021). Mental healthcare utilization of transgender youth before and after affirming treatment. *The Journal of Sexual Medicine, 18,* 1444–1454.

Holt, V., Skagerberg, E., & Dunsford, M. (2016). Young people with features of gender dysphoria: Demographics and associated difficulties. *Clinical Child Psychology and Psychiatry, 21*, 108–118.

Jacobs, L. A., Rachlin, K., Erickson-Schroth, L., & Janssen, A. (2014). Gender dysphoria and co-occurring autism spectrum disorders: Review, case examples, and treatment considerations. *LGBT Health, 1*, 277–282.

Janssen, A., Busa, S., Wernick, J. (2019). The complexities of treatment planning for transgender youth with co-occurring severe mental illness: A literature review and case study. *Archives of Sexual Behavior, 48*, 2003–2009.

Janssen, A., Huang, H., & Duncan, C. (2016). Gender variance among youth with autism spectrum disorders: A retrospective chart review. *Transgender Health, 1*, 63–68.

Kalin, N. H. (2020). Reassessing mental health treatment utilization reduction in transgender individuals after gender-affirming surgeries: A comment by the Editor on the process. *American Journal of Psychiatry, 177,* 765.

Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., & Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health, 9*, 9.

Kaltiala, R, Heino, E., Työläjärvi, & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry, 74,* 213–219.

Kaltiala, R., Heino, E., Työläjärvi, & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry, 74,* 213–219.

Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender- affirming hormone therapy. *Pediatrics, 145*, e20193006.

Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a raid onset of gender dysphoria. *PLoS ONE, 13*(8), e0202330.

Marsh, S. (2020, Sept. 20). NHS to hold review into gender identity services for children and young people. *The Guardian.* Retrieved from https://www.theguardian.com/society/2020/sep/22/nhs-to-hold-review-into-gender-identity-services-for-children-and-young-people

May, T., Pang, K., & Williams, K. J. (2016). Gender variance in children and adolescents with autism spectrum disorder from the National Database for Autism Research. *International Journal of Transgenderism, 18*, 7–15.

McCall, B. (2021, October 7). Psychiatrists shift stance on gender dysphoria, recommend therapy. *Medscape Psychiatry.* Retrieved from www.medscape.com/viewarticle/960390?src=soc_tw_share

McNeil, J., Ellis, S. J., & Eccles, F. J. R. (2017). Suicide in trans populations: A systematic review of prevalence and correlates. *Psychology of Sexual Orientation and Gender Diversity, 4,* 341–353.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*, 674–697.

Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/ role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology, 4*, 29–41.

Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health, 100*, 2426–2432.

Nainggolan, L. (2021, May 12). Hormonal Tx of youth with gender dysphoria stops in Sweden. Medscape Psychiatry. Retrieved from www.medscape.com/viewarticle/950964?src=soc_tw_share

National Health Service (NHS). (2020, Sept. 22). NHS announces independent review into gender identity services for children and young people. United Kingdom. Retrieved from https://www.england.nhs.uk/2020/09/nhs-announces-independent-review-into-gender-identity-services-for-children-and-young-people/

National Institute for Health and Care Excellence (NICE). (2020, Oct. 14). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. Retrieved from https://arms.nice.org.uk/resources/hub/1070905/attachment

Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics, 137*, e20153223.

Orange, R. (2020, Feb 22). Teenage transgender row splits Sweden as dysphoria diagnoses soar by 1,500%: New health report and TV debates highlight backlash against gender reassignment. *The Guardian*. Retrieved from https://www.theguardian.com/society/2020/feb/22/ssweden-teenage-transgender-row-dysphoria-diagnoses-soar

Pediatric Endocrine Society & Endocrine Society. (2020, December 15). *Transgender health*. Retrieved from www.endocrine.org/advocacy/position-statements/transgender-health.

Pediatric Endocrine Society. (Online). About PES. Retrieved from https://pedsendo.org/about-pes/

Rae, J. R., Gülgoz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science, 30*, 669–681.

Rafferty, J., AAP Committee on psychosocial aspects of child and family health, AAP Committee on adolescence, AAP Section on lesbian, gay, bisexual, and transgender health and wellness. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics, 142*(4), e20182162

Rayner, G. (2018, Sept. 16). Minister orders inquiry into 4000 percent rise in children wanting to change sex. *The Telegraph*. Retrieved from https://www.telegraph.co.uk/politics/2018/09/16/minister-orders-inquiry-4000-per-cent-rise-children-wanting/

Reisner, S. L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *Journal of Adolescent Health, 56(3)*, 274–279.

Reuter, T. R., Sharp, C., Kalpakci, A. H., Choi, H. J., & Temple, J. R. (2016). Sexual orientation and Borderline Personality Disorder features in a community sample of adolescents. *Journal of Personality Disorders, 30,* 694–707.

Rodriguez-Seiljas, C., Morgan, T. A., & Zimmerman, M. (2021). A population-based examination of criterion-level disparities in the diagnosis of Borderline Personality Disorder among sexual minority adults. *Assessment, 28,* 1097–1109.

Safer, J. D., Tangpricha, V. (2019). In the clinic: Care of the transgender patient. *Annals of Internal Medicine, 171*(1), ITC1–ITC6.

Schumm, W. R., & Crawford, D. W. (2020). Is research on transgender children

what it seems? Comments on recent research on transgender children with high levels of parental support. *The Linacre Quarterly, 87,* 9–24.

Schumm, W. R., Crawford, D. W., Fawver, M. M., Gray, N. K., Niess, Z. M., & Wagner, A. D. (2019). Statistical errors in major journals: Two case studies used in a basic statistics class to assess understanding of applied statistics. *Psychology and Education—An Interdisciplinary Journal, 56,* 35–42.

Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. *Frontiers in Psychiatry*, 12, 632784.

Skagerberg, E., Parkinson, R., & Carmichael, P. (2013). Self-harming thoughts and behaviors in a group of children and adolescents with gender dysphoria. *International Journal of Transgenderism, 14*, 86–92.

Skelly, A. C., Dettori, J. R., & Brodt, E. D. (2012). Assessing bias: The importance of considering confounding. *Evidence-based Spine-Care Journal, 3,* 9–12.

Spack, N. P. (2013). Management of transgenderism. *Journal of the American Medical Association, 309,* 478–484.

Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics, 129,* 418–425.

Steensma, T. D., Cohen-Kettenis, P. T., & Zucker, K. J. (2018). Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988–2016). *Journal of Sex & Marital Therapy, 44,* 713–715.

Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*, 582–590.

Strang, J. F., Kenworthy, L., Dominska, A., Sokoloff, J., Kenealy, L. E., Berl, M., ... Wallace, G. L. (2014). Increased gender variance in autism spectrum disorders and attention deficit hyperactivity disorder. *Archives of Sexual Behavior, 43*, 1525–1533.

Strang, J. F., Meagher, H., Kenworthy, L., de Vries, A. L., Menvielle, E., Leibowitz, S., ... Anthony, L. G. (2016). Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *Journal of Clinical Child and Adolescent Psychology, 47*, 105–115.

Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU). (2019, Sept. 6). Gender dysphoria in children and adolescents: An inventory of the literature. A systematic scoping review. Retrieved from https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/

Swedish Agency of Health Technology Assessment and Assessment of Social Services. (2019). *Gender dysphoria in children and adolescents: An inventory of the literature.* Retrieved from: www.sbu.se/en/publications/sbu-bereder/gender-

dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/

Swedish National Board of Health and Welfare (NBHW). (2020, Feb. 22). Uppdaterade rekommendationer för hormonbehandling vid könsdysfori hos unga. [*Updated recommendations for hormone therapy for gender dysphoria in young people.*] Author: Socialstyrelsen. Retrieved from https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdaterade-rekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/

Tetelepta, B. (2021, Feb 27). More research is urgently needed into transgender care for young people: 'Where does the large flow of children come from?' [translated]. Algemeen Dagblad. Retrieved from www.ad.nl/nijmegen/dringend-meer-onderzoek-nodig-naar-transgenderzorg-aan-jongeren-waar-komt-de-grote-stroom-kinderen-vandaan~aec79d00/?referrer=https%3A%2F%2Ft.co%2F.

Thrower, E., Bretherton, I., Pang, K. C., Zajac, J. D., & Cheung, A. S. (2020). Prevalence of Autism Spectrum Disorder and Attention-Deficit Hyperactivity Disorder amongst individuals with Gender Dysphoria: A systematic review. *Journal of Autism and Developmental Disorders*, 50, 695–706.

Turban, J. (2021, March 16). Trans girls belong on girls' sports teams. *Scientific American*. www.scientificamerican.com/article/trans-girls-belong-on-girls-sports-teams/

United Kingdom National Health Service (NHS), National Institute for Health and Care Excellence, (2021, March 11). *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria.* Retrieved from www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3ffrom%3d2020-01-01%26q%3dgender%2bdysphoria%26sp%3don%26to%3d2021-03-31

van der Miesen, A. I. R., Steensma, T. D., de Vries, A. L. C., Bos, H., Popma, A. (2020). Psychological functioning in transgender adolescence before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health, 66*, 699–704.

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*, 1413–1423.

Wallien, M. S., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*, 1307–1314.

Warrier, V., Greenberg, D. M., Weir, E., Buckingham, C., Smith, P., Lai, M.-C., Allison, C., & Baron-Cohen, S. (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature Communications, 11,* 3959.

Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Block, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). *Acta Psychiatrica Scandinavica, 141,* 486–491.

Wiepjes, C. M., Nota, N. M., de Bok, C. J. M., Klaver, M., de Vries, A. L. C., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M-B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels B. P. C., & den Heijer, M. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine, 15*, 582–590.

Wood, H., Sasaki, S., Bradley, S. J., Singh, D., Fantus, S., Own-Anderson, A., Di Giacomo, A., Bain, J., & Zucker, K. J. (2013). Patterns of referral to a gender identity service for children and adolescents (1976–2011): Age, sex ratio, and sexual orientation. *Journal of Sex & Marital Therapy, 39,* 1–6.

Zanarini, M. C., Magni, L. R., Temes, C. M., Hein, K. E., Aguirre, B. A., & Goodman, M. (2021). Sexual orientation and gender of intimate relationship partners among adolescents with BPD and psychiatrically healthy adolescents. *Journal of Personality Disorders, 35 (Suppl. B),* 1–7.

Zucker, K. J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior, 48,* 1983–1992.

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (2012). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy, 38,* 151–189.

Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*, 90–97.

APPENDICES

Appendix 1

Curriculum Vita

Appendix 2

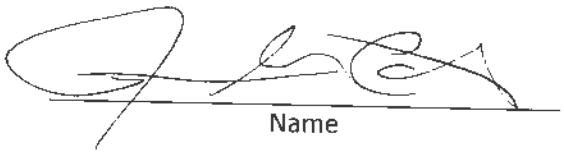
Peer-reviewed article:

Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy, 46,* 307–313. doi: 10.1080/0092623X.2019.1698481

Appendix 3

The Outcomes Studies of Childhood-Onset Gender Dysphoria

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed on 30 April, 2022.



Name

James M. Cantor, PhD

Toronto Sexuality Centre
2 Carlton Ave., suite 1820
Toronto, Ontario, Canada M5B 1J3

[redacted]

EDUCATION

Postdoctoral Fellowship Jan., 2000–May, 2004
Centre for Addiction and Mental Health • Toronto, Canada

Doctor of Philosophy Sep., 1993–Jun., 2000
Psychology • McGill University • Montréal, Canada

Master of Arts Sep., 1990–Jan., 1992
Psychology • Boston University • Boston, MA

Bachelor of Science Sep. 1984–Aug., 1988
Interdisciplinary Science • Rensselaer Polytechnic Institute • Troy, NY
Concentrations: Computer science, mathematics, physics

EMPLOYMENT HISTORY

Director Feb., 2017–Present
Toronto Sexuality Centre • Toronto, Canada

Senior Scientist (Inaugural Member) Aug., 2012–May, 2018
Campbell Family Mental Health Research Institute
Centre for Addiction and Mental Health • Toronto, Canada

Senior Scientist Jan., 2012–May, 2018
Complex Mental Illness Program
Centre for Addiction and Mental Health • Toronto, Canada

Head of Research Nov., 2010–Apr. 2014
Sexual Behaviours Clinic
Centre for Addiction and Mental Health • Toronto, Canada

Research Section Head Dec., 2009–Sep. 2012
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Psychologist May, 2004–Dec., 2011
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

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

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

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

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

ACADEMIC APPOINTMENTS

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

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

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

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

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

PUBLICATIONS

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

10.1177/1079063215612444

15. Stephens, S., Cantor, J. M., Goodwill, A. M., & Seto, M. C. (2017). Multiple indicators of sexual interest in prepubescent or pubescent children as predictors of sexual recidivism. *Journal of Consulting and Clinical Psychology, 85,* 585–595. doi: 10.1037/ccp0000194
16. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2017). Evidence of construct validity in the assessment of hebephilia. *Archives of Sexual Behavior, 46,* 301–309. doi: 10.1007/s10508-016-0907-z
17. Walton, M. T., Cantor, J. M., & Lykins, A. D. (2017). An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior. *Archives of Sexual Behavior, 46,* 721–733. doi: 10.1007/s10508-015-0606-1
18. Cantor, J. M., Lafaille, S. J., Hannah, J., Kucyi, A., Soh, D. W., Girard, T. A., & Mikulis, D. J. (2016). Independent component analysis of resting-state functional magnetic resonance imaging in pedophiles. *Journal of Sexual Medicine, 13,* 1546–1554. doi: 10.1016/j.jsxm.2016.08.004
19. Cantor, J. M., & McPhail, I. V. (2016). Non-offending pedophiles. *Current Sexual Health Reports, 8,* 121–128. doi: 10.1007/s11930-016-0076-z
20. Cantor, J. M. (2015). Milestones in sex research: What causes pedophilia? In J. S. Hyde, J. D. DeLamater, & E. S. Byers (Eds.), *Understanding human sexuality* (6th Canadian ed.) (pp. 452–453). Toronto: McGraw-Hill Ryerson.
21. Cantor, J. M. (2015). Pedophilia. In R. Cautin & S. Lilienfeld (Eds.), *Encyclopedia of clinical psychology.* Malden, MA: Wiley-Blackwell. doi: 10.1002/9781118625392.wbecp184
22. Nunes, K. L., & Cantor, J. M. (2015). Sex offenders. In P. Whelehan & A. Bolin (Eds.), *International encyclopedia of human sexuality.* Malden, MA: Wiley-Blackwell.
23. Cantor, J. M., Lafaille, S., Soh, D. W., Moayedi, M., Mikulis, D. J., & Girard, T. A. (2015). Diffusion Tensor Imaging of pedophilia. *Archives of Sexual Behavior, 44,* 2161–2172. doi: 10.1007/s10508-015-0599-9
24. Cantor, J. M., & McPhail, I. V. (2015). Sensitivity and specificity for the phallometric test of hebephilia. *Journal of Sexual Medicine, 12,* 1940–1950. doi: 10.1111/jsm12970
25. Dyshniku, F., Murray, M. E., Fazio, R. L., Lykins, A. D., & Cantor, J. M. (2015). Minor physical anomalies as a window into the prenatal origins of pedophilia. *Archives of Sexual Behavior, 44,* 2151–2159. doi: 10.1007/s10508-015-0564-7
26. Fazio, R. L., & Cantor, J. M. (2015). Factor structure of the Edinburgh Handedness Inventory versus the Fazio Laterality Inventory in a population with established atypical handedness. *Applied Neuropsychology, 22,* 156–160. doi: 10.1080/23279095.2014.940043
27. Lykins, A. D., Robinson, J. J., LeBlanc, S., & Cantor, J. M. (2015). The effects of common medications on volumetric phallometry. *Journal of Sexual Aggression, 21,* 385–393. doi: 10.1080/13552600.2014.900121
28. Sutton, K. S., Stratton, N., Pytyck, J., Kolla, N. J., & Cantor, J. M. (2015). Patient characteristics by type of hypersexuality referral: A quantitative chart review of 115 consecutive male cases. *Journal of Sex and Marital Therapy, 41,* 563−580. doi: 10.1080/0092623X.2014.935539
29. Cantor, J. M. (2014). Gold star pedophiles in general sex therapy practice. In Y. M. Binik and K. Hall (Eds.), *Principles and practice of sex therapy* (5th ed.) (pp. 219–234). New York: Guilford.

30. Cantor, J. M., & Sutton, K. S. (2014). Paraphilia, gender dysphoria, and hypersexuality. In P. H. Blaney & T. Millon (Eds.), *Oxford textbook of psychopathology* (3rd ed.) (pp. 589–614). New York: Oxford University Press.
31. Chivers, M. L., Roy, C., Grimbos, T., Cantor, J. M., & Seto, M. C. (2014). Specificity of sexual arousal for sexual activities in men and women with conventional and masochistic sexual interests. *Archives of Sexual Behavior, 43,* 931−940. doi: 10.1007/s10508-013-0174-1
32. Fazio, R. L., Lykins, A. D., & Cantor, J. M. (2014). Elevated rates of atypical-handedness in paedophilia: Theory and implications. *Laterality, 19,* 690−704. doi: 10.1080/1357650X.2014.898648
33. Lykins, A. D., & Cantor, J. M. (2014). Vorarephilia: A case study in masochism and erotic consumption. *Archives of Sexual Behavior, 43,* 181–186. doi: 10.1007/s10508-013-0185-y
34. Cantor, J. M., Klein, C., Lykins, A., Rullo, J. E., Thaler, L., & Walling, B. R. (2013). A treatment-oriented typology of self-identified hypersexuality referrals. *Archives of Sexual Behavior, 42,* 883–893. doi: 10.1007/s10508-013-0085-1
35. Blanchard, R., Kuban, M. E., Blak, T., Klassen, P. E., Dickey, R., & Cantor, J. M. (2012). Sexual attraction to others: A comparison of two models of alloerotic responding in men. *Archives of Sexual Behavior, 41,* 13–29. doi: 10.1007/s10508-010-9675-3
36. Cantor, J. M. (2012). Brain research and pedophilia: What it says and what it means [Invited article]. *Sex Offender Law Report, 13,* 81–85.
37. Cantor, J. M. (2012). Is homosexuality a paraphilia? The evidence for and against. *Archives of Sexual Behavior, 41,* 237–247. doi: 10.1007/s10508-012-9900-3
38. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010). Sexual arousal to female children in gynephilic men. *Sexual Abuse: A Journal of Research and Treatment, 22,* 279–289. doi: 10.1177/1079063210372141
39. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010). The relation between peak response magnitudes and agreement in diagnoses obtained from two different phallometric tests for pedophilia. *Sexual Abuse: A Journal of Research and Treatment, 22,* 42–57. doi: 10.1177/1079063209352094
40. Cantor, J. M., Blanchard, R., & Barbaree, H. E. (2009). Sexual disorders. In P. H. Blaney & T. Millon (Eds.), *Oxford textbook of psychopathology* (2nd ed.) (pp. 527–548). New York: Oxford University Press.
41. Barbaree, H. E., Langton, C. M., Blanchard, R., & Cantor, J. M. (2009). Aging versus stable enduring traits as explanatory constructs in sex offender recidivism: Partitioning actuarial prediction into conceptually meaningful components. *Criminal Justice and Behavior: An International Journal, 36,* 443–465. doi: 10.1177/0093854809332283
42. Blanchard, R., Kuban, M. E., Blak, T., Cantor, J. M., Klassen, P. E., & Dickey, R. (2009). Absolute versus relative ascertainment of pedophilia in men. *Sexual Abuse: A Journal of Research and Treatment, 21,* 431–441. doi: 10.1177/1079063209347906
43. Blanchard, R., Lykins, A. D., Wherrett, D., Kuban, M. E., Cantor, J. M., Blak, T., Dickey, R., & Klassen, P. E. (2009). Pedophilia, hebephilia, and the DSM–V. *Archives of Sexual Behavior, 38,* 335–350. doi: 10.1007/s10508-008-9399-9.
44. Cantor, J. M. (2008). MRI research on pedophilia: What ATSA members should know

[Invited article]. *ATSA Forum, 20*(4), 6–10.

45. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2008). Cerebral white matter deficiencies in pedophilic men. *Journal of Psychiatric Research, 42,* 167–183. doi: 10.1016/j.jpsychires.2007.10.013
46. Blanchard, R., Kolla, N. J., Cantor, J. M., Klassen, P. E., Dickey, R., Kuban, M. E., & Blak, T. (2007). IQ, handedness, and pedophilia in adult male patients stratified by referral source. *Sexual Abuse: A Journal of Research and Treatment, 19,* 285–309. doi: 10.1007/s11194-007-9049-0
47. Cantor, J. M., Kuban, M. E., Blak, T., Klassen, P. E., Dickey, R., & Blanchard, R. (2007). Physical height in pedophilia and hebephilia. *Sexual Abuse: A Journal of Research and Treatment, 19,* 395–407. doi: 10.1007/s11194-007-9060-5
48. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2006). Interaction of fraternal birth order and handedness in the development of male homosexuality. *Hormones and Behavior, 49,* 405–414. doi: 10.1016/j.yhbeh.2005.09.002
49. Blanchard, R., Kuban, M. E., Blak, T., Cantor, J. M., Klassen, P., & Dickey, R. (2006). Phallometric comparison of pedophilic interest in nonadmitting sexual offenders against stepdaughters, biological daughters, other biologically related girls, and unrelated girls. *Sexual Abuse: A Journal of Research and Treatment, 18,* 1–14. doi: 10.1007/s11194-006-9000-9
50. Blanchard, R., Cantor, J. M., & Robichaud, L. K. (2006). Biological factors in the development of sexual deviance and aggression in males. In H. E. Barbaree & W. L. Marshall (Eds.), *The juvenile sex offender* (2nd ed., pp. 77–104). New York: Guilford.
51. Cantor, J. M., Kuban, M. E., Blak, T., Klassen, P. E., Dickey, R., & Blanchard, R. (2006). Grade failure and special education placement in sexual offenders' educational histories. *Archives of Sexual Behavior, 35,* 743–751. doi: 10.1007/s10508-006-9018-6
52. Seto, M. C., Cantor, J. M., & Blanchard, R. (2006). Child pornography offenses are a valid diagnostic indicator of pedophilia. *Journal of Abnormal Psychology, 115,* 610–615. doi: 10.1037/0021-843X.115.3.610
53. Zucker, K. J., Mitchell, J. N., Bradley, S. J., Tkachuk, J., Cantor, J. M., & Allin, S. M. (2006). The Recalled Childhood Gender Identity/Gender Role Questionnaire: Psychometric properties. *Sex Roles, 54,* 469–483. doi 10.1007/s11199-006-9019-x
54. Cantor, J. M., Blanchard, R., Robichaud, L. K., & Christensen, B. K. (2005). Quantitative reanalysis of aggregate data on IQ in sexual offenders. *Psychological Bulletin, 131,* 555–568. doi: 10.1037/0033-2909.131.4.555
55. Cantor, J. M., Klassen, P. E., Dickey, R., Christensen, B. K., Kuban, M. E., Blak, T., Williams, N. S., & Blanchard, R. (2005). Handedness in pedophilia and hebephilia. *Archives of Sexual Behavior, 34,* 447–459. doi: 10.1007/s10508-005-4344-7
56. Cantor, J. M., Blanchard, R., Christensen, B. K., Dickey, R., Klassen, P. E., Beckstead, A. L., Blak, T., & Kuban, M. E. (2004). Intelligence, memory, and handedness in pedophilia. *Neuropsychology, 18,* 3–14. doi: 10.1037/0894-4105.18.1.3
57. Blanchard, R., Kuban, M. E., Klassen, P., Dickey, R., Christensen, B. K., Cantor, J. M., & Blak, T. (2003). Self-reported injuries before and after age 13 in pedophilic and non-pedophilic men referred for clinical assessment. *Archives of Sexual Behavior, 32,* 573–581.

58. Blanchard, R., Christensen, B. K., Strong, S. M., Cantor, J. M., Kuban, M. E., Klassen, P., Dickey, R., & Blak, T. (2002). Retrospective self-reports of childhood accidents causing unconsciousness in phallometrically diagnosed pedophiles. *Archives of Sexual Behavior, 31,* 511–526.

59. Cantor, J. M., Blanchard, R., Paterson, A. D., Bogaert, A. F. (2002). How many gay men owe their sexual orientation to fraternal birth order? *Archives of Sexual Behavior, 31,* 63–71.

60. Cantor, J. M., Binik, Y. M., & Pfaus, J. G. (1999). Chronic fluoxetine inhibits sexual behavior in the male rat: Reversal with oxytocin. *Psychopharmacology, 144,* 355–362.

61. Binik, Y. M., Cantor, J., Ochs, E., & Meana, M. (1997). From the couch to the keyboard: Psychotherapy in cyberspace. In S. Kiesler (Ed.), *Culture of the internet* (pp. 71–100). Mahwah, NJ: Lawrence Erlbaum.

62. Johnson, M. K., O'Connor, M., & Cantor, J. (1997). Confabulation, memory deficits, and frontal dysfunction. *Brain and Cognition, 34,* 189–206.

63. Keane, M. M., Gabrieli, J. D. E., Monti, L. A., Fleischman, D. A., Cantor, J. M., & Nolan, J. S. (1997). Intact and impaired conceptual memory processes in amnesia. *Neuropsychology, 11,* 59–69.

64. Pilkington, N. W., & Cantor, J. M. (1996). Perceptions of heterosexual bias in professional psychology programs: A survey of graduate students. *Professional Psychology: Research and Practice, 27,* 604–612.

PUBLICATIONS

LETTERS AND COMMENTARIES

1. Cantor, J. M. (2015). Research methods, statistical analysis, and the phallometric test for hebephilia: Response to Fedoroff [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2499–2500. doi: 10.1111/jsm.13040
2. Cantor, J. M. (2015). In his own words: Response to Moser [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2502–2503. doi: 10.1111/jsm.13075
3. Cantor, J. M. (2015). Purported changes in pedophilia as statistical artefacts: Comment on Müller et al. (2014). *Archives of Sexual Behavior, 44,* 253–254. doi: 10.1007/s10508-014-0343-x
4. McPhail, I. V., & Cantor, J. M. (2015). Pedophilia, height, and the magnitude of the association: A research note. *Deviant Behavior, 36,* 288–292. doi: 10.1080/01639625.2014.935644
5. Soh, D. W., & Cantor, J. M. (2015). A peek inside a furry convention [Letter to the Editor]. *Archives of Sexual Behavior, 44,* 1–2. doi: 10.1007/s10508-014-0423-y
6. Cantor, J. M. (2012). Reply to Italiano's (2012) comment on Cantor (2011) [Letter to the Editor]. *Archives of Sexual Behavior, 41,* 1081–1082. doi: 10.1007/s10508-012-0011-y
7. Cantor, J. M. (2012). The errors of Karen Franklin's *Pretextuality* [Commentary]. *International Journal of Forensic Mental Health, 11,* 59–62. doi: 10.1080/14999013.2012.672945
8. Cantor, J. M., & Blanchard, R. (2012). White matter volumes in pedophiles, hebephiles, and teleiophiles [Letter to the Editor]. *Archives of Sexual Behavior, 41, 749–752.* doi: 10.1007/s10508-012-9954-2
9. Cantor, J. M. (2011). New MRI studies support the Blanchard typology of male-to-female transsexualism [Letter to the Editor]. *Archives of Sexual Behavior, 40,* 863–864. doi: 10.1007/s10508-011-9805-6
10. Zucker, K. J., Bradley, S. J., Own-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex and Marital Therapy, 34,* 287–290.
11. Cantor, J. M. (2003, Summer). Review of the book *The Man Who Would Be Queen* by J. Michael Bailey. *Newsletter of Division 44 of the American Psychological Association, 19*(2), 6.
12. Cantor, J. M. (2003, Spring). What are the hot topics in LGBT research in psychology? *Newsletter of Division 44 of the American Psychological Association, 19*(1), 21–24.
13. Cantor, J. M. (2002, Fall). Male homosexuality, science, and pedophilia. *Newsletter of Division 44 of the American Psychological Association, 18*(3), 5–8.
14. Cantor, J. M. (2000). Review of the book *Sexual Addiction: An Integrated Approach. Journal of Sex and Marital Therapy, 26,* 107–109.

EDITORIALS

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

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

FUNDING HISTORY

Principal Investigators:	Doug VanderLaan, Meng-Chuan Lai
Co-Investigators:	James M. Cantor, Megha Mallar Chakravarty, Nancy Lobaugh, M. Palmert, M. Skorska
Title:	*Brain function and connectomics following sex hormone treatment in adolescents experience gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Behavioural Sciences-B-2
Funds:	$650,250 / 5 years (July, 2018)
Principal Investigator:	Michael C. Seto
Co-Investigators:	Martin Lalumière , James M. Cantor
Title:	*Are connectivity differences unique to pedophilia?*
Agency:	University Medical Research Fund, Royal Ottawa Hospital
Funds:	$50,000 / 1 year (January, 2018)
Principal Investigator:	Lori Brotto
Co-Investigators:	Anthony Bogaert, James M. Cantor, Gerulf Rieger
Title:	*Investigations into the neural underpinnings and biological correlates of asexuality*
Agency:	Natural Sciences and Engineering Research Council (NSERC), Discovery Grants Program
Funds:	$195,000 / 5 years (April, 2017)
Principal Investigator:	Doug VanderLaan
Co-Investigators:	Jerald Bain, James M. Cantor, Megha Mallar Chakravarty, Sofia Chavez, Nancy Lobaugh, and Kenneth J. Zucker
Title:	*Effects of sex hormone treatment on brain development: A magnetic resonance imaging study of adolescents with gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Transitional Open Grant Program
Funds:	$952,955 / 5 years (September, 2015)
Principal Investigator:	James M. Cantor
Co-Investigators:	Howard E. Barbaree, Ray Blanchard, Robert Dickey, Todd A. Girard, Phillip E. Klassen, and David J. Mikulis
Title:	*Neuroanatomic features specific to pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$1,071,920 / 5 years (October, 2008)
Principal Investigator:	James M. Cantor
Title:	*A preliminary study of fMRI as a diagnostic test of pedophilia*
Agency:	Dean of Medicine New Faculty Grant Competition, Univ. of Toronto
Funds:	$10,000 (July, 2008)

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

KEYNOTE AND INVITED ADDRESSES

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

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

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

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

PAPER PRESENTATIONS AND SYMPOSIA

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

preferences. Symposium presented at the 37th annual meeting of the International Academy of Sex Research, Los Angeles, USA.

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

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

POSTER PRESENTATIONS

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

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

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

EDITORIAL AND PEER-REVIEWING ACTIVITIES

Editor-in-Chief

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

Editorial Board Memberships

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

Ad hoc Journal Reviewer Activity

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

GRANT REVIEW PANELS

2017–2021 Member, College of Reviewers, *Canadian Institutes of Health Research,* Canada.

2017 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2017 Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2016 Reviewer. National Science Center [*Narodowe Centrum Nauki*], Poland.

2016 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2015 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2015 Reviewer. *Czech Science Foundation,* Czech Republic.

2015 Reviewer, "Off the beaten track" grant scheme. *Volkswagen Foundation,* Germany.

2015 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada

2015 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2014 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2014 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada.

2014 Panel Member, Dean's Fund—Clinical Science Panel. *University of Toronto Faculty of Medicine*, Canada.

2014 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2013 Panel Member, Grant Miller Cancer Research Grant Panel. *University of Toronto Faculty of Medicine*, Canada.

2013 Panel Member, Dean of Medicine Fund New Faculty Grant Clinical Science Panel. *University of Toronto Faculty of Medicine,* Canada.

2012 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence (2nd round). *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2012 External Reviewer, University of Ottawa Medical Research Fund. *University of Ottawa Department of Psychiatry*, Canada.

2012 External Reviewer, Behavioural Sciences—B. *Canadian Institutes of Health Research*, Canada.

2011 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

TEACHING AND TRAINING

PostDoctoral Research Supervision
Law & Mental Health Program, Centre for Addiction and Mental Health, Toronto, Canada

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

Doctoral Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

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

Masters Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

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

Undergraduate Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

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

Clinical Supervision (Doctoral Internship)
Clinical Internship Program, Centre for Addiction and Mental Health, Toronto, Canada

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

TEACHING AND TRAINING

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

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

PROFESSIONAL SOCIETY ACTIVITIES

OFFICES HELD

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

PROFESSIONAL SOCIETY ACTIVITIES

MEMBERSHIPS

2017–2021 Member • *Canadian Sex Research Forum*

2009–Present Member • *Society for Sex Therapy and Research*

2006–Present Member (elected) • *International Academy of Sex Research*

2006–Present Research and Clinical Member • *Association for the Treatment of Sex Abusers*

2003–2006 Associate Member (elected) • *International Academy of Sex Research*

2002 Founding Member • CPA Section on Sexual Orientation and Gender Identity

2001–2013 Member • *Canadian Psychological Association* (CPA)

2000–2015 Member • *American Association for the Advancement of Science*

2000–2015 Member • *American Psychological Association* (APA)

APA Division 12 (Clinical Psychology)

APA Division 44 (Society for the Psychological Study of LGB Issues)

2000–2020 Member • *Society for the Scientific Study of Sexuality*

1995–2000 Student Member • *Society for the Scientific Study of Sexuality*

1993–2000 Student Affiliate • *American Psychological Association*

1990–1999 Member, American Psychological Association of Graduate Students (APAGS)

CLINICAL LICENSURE/REGISTRATION

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

AWARDS AND HONORS

2017 Elected Fellow, Association for the Treatment of Sexual Abusers

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

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

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

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

1995 Dissertation Research Grant
Society for the Scientific Study of Sexuality

1994–1996 McGill University Doctoral Scholarship

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

MAJOR MEDIA

(Complete list available upon request.)

Feature-length Documentaries

Vice Canada Reports. *Age of Consent.* 14 Jan 2017.
Canadian Broadcasting Company. *I, Pedophile.* Firsthand documentaries. 10 Mar 2016.

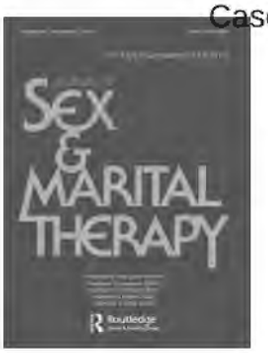
Appearances and Interviews

11 Mar 2020. Ibbitson, John. It is crucial that Parliament gets the conversion-therapy ban right. *The Globe & Mail.*
25 Jan 2020. Ook de hulpvaardige buurman kan verzamelaar van kinderporno zin. *De Morgen.*
3 Nov 2019. Village of the damned. *60 Minutes Australia.*
1 Nov 2019. HÅKON F. HØYDAL. Norsk nettovergriper: – Jeg hater meg selv: Nordmannen laster ned overgrepsmateriale fra nettet – og oppfordrer politiet til å gi amnesti for slike som ham.
10 Oct 2019. Smith, T. Growing efforts are looking at how—or if—#MeToo offenders can be reformed. *National Public Radio.*
29 Sep 2019. Carey, B. Preying on Children: The Emerging Psychology of Pedophiles. *New York Times.*
29 Apr 2019. Mathieu, Isabelle. La poupée qui a troublé les Terre-Neuviens. *La Tribune.*
21 Mar 2019. Pope Francis wants psychological testing to prevent problem priests. But can it really do that? *The Washington Post.*
12 Dec 2018. Child sex dolls: Illegal in Canada, and dozens seized at the border. Ontario Today with Rita Celli. *CBC.*
12 Dec 2018. Celli, R. & Harris, K. Dozens of child sex dolls seized by Canadian border agents. *CBC News.*
27 Apr 2018. Rogers, Brook A. The online 'incel' culture is real–and dangerous. *New York Post.*
25 Apr 2018. Yang, J. Number cited in cryptic Facebook post matches Alek Minassian's military ID: Source. *Toronto Star.*
24 Ap 2018 Understanding 'incel'. *CTV News.*
27 Nov 2017. Carey, B. Therapy for Sexual Misconduct? It's Mostly Unproven. *New York Times.*
14 Nov 2017. Tremonti, A. M. The Current. *CBC.*
9 Nov2017. Christensen, J. Why men use masturbation to harass women. *CNN.* http://www.cnn.com/2017/11/09/health/masturbation-sexual-harassment/index.html
7 Nov 2017. Nazaryan, A. Why is the alt-right obsessed with pedophilia? *Newsweek.*
15 Oct 2017. Ouatik, B. Déscouvre. Pédophilie et science. *CBC Radio Canada.*
12 Oct 2017. Ouatik, B. Peut-on guérir la pédophilie? *CBC Radio Canada.*
11 Sep 2017. Burns, C. The young paedophiles who say they don't abuse children. *BBC News.*
18 Aug 2017. Interview. *National Post Radio.* Sirius XM Canada.
16 Aug 2017. Blackwell, Tom. Man says he was cured of pedophilia at Ottawa clinic: 'It's like a weight that's been lifted': But skeptics worry about the impact of sending pedophiles into the world convinced their curse has been vanquished. *National Post.*
26 Apr 2017. Zalkind, S. Prep schools hid sex abuse just like the catholic church. *VICE.*
24 Apr 2017. Sastre, P. Pédophilie: une panique morale jamais n'abolira un crime. *Slate France.*
12 Feb 2017. Payette, G. Child sex doll trial opens Pandora's box of questions. *CBC News.*
26 Nov 2016. Det morke uvettet ["The unknown darkness]". *Fedrelandsvennen.*
13 July 2016. Paedophilia: Shedding light on the dark field. *The Economist.*

1 Jul 2016. Debusschere, B. Niet iedereen die kinderporno kijkt, is een pedofiel: De mythes rond pedofilie ontkracht. *De Morgen.*
12 Apr 2016. O'Connor, R. Terence Martin: The Tasmanian MP whose medication 'turned him into a paedophile'. *The Independent.*
8 Mar 2016. Bielski, Z. 'The most viscerally hated group on earth': Documentary explores how intervention can stop pedophiles. *The Globe and Mail.*
1 Mar 2016. Elmhirst, S. What should we do about paedophiles? *The Guardian.*
24 Feb 2016. The man whose brain tumour 'turned him into a paedophile'. *The Independent.*
24 Nov 2015. Byron, T. The truth about child sex abuse. *BBC Two.*
20 Aug 2015. The Jared Fogle case: Why we understand so little about abuse. *Washington Post.*
19 Aug 2015. Blackwell, T. Treat sex offenders for impotence to keep them out of trouble, Canadian psychiatrist says. *National Post.*
2 Aug 2015. Menendez, J. BBC News Hour. *BBC World Service.*
13 Jul 2015. The nature of pedophilia. *BBC Radio 4.*
9 Jul 2015. The sex-offender test: How a computerized assessment can help determine the fate of men who've been accused of sexually abusing children. *The Atlantic.*
10 Apr 2015. NWT failed to prevent sex offender from abusing stepdaughter again. *CBC News.*
10 Feb 2015. Savage, D. "The ethical sadist." In Savage Love. *The Stranger.*
31 Jan 2015. Begrip voor/van pedofilie [Understanding pedophilia]. *de Volkskrant.*
9 Dec 2014. Carey, B. When a rapist's weapon is a pill. *New York Times.*
1 Dec 2014. Singal, J. Can virtual reality help pedophiles? *New York Magazine.*
17 Nov2014. Say pedófile, busco aydua. *El Pais.*
4 Sep 2014. Born that way? *Ideas, with Paul Kennedy.* CBC Radio One.
27 Aug 2014. Interrogating the statistics for the prevalence of paedophilia. BBC.
25 Jul 2014. Stephenson, W. The prevalence of paedophilia. *BBC World Service.*
21 Jul 2014. Hildebrandt, A. Virtuous Pedophiles group gives support therapy cannot. *CBC.*
26 Jan 2014. Paedophilia a result of faulty wiring, scientists suggest. *Daily Mail.*
22 Dec 2013. Kane, L. Is pedophilia a sexual orientation? *Toronto Star.*
21 Jul 2013. Miller, L. The turn-on switch: Fetish theory, post-Freud. *New York Magazine.*
1 Jul 2013. Morin, H. Pédophilie: la difficile quête d'une origine biologique. *Le Monde.*
2 Jun 2013. Malcolm, L. The psychology of paedophilia. *Australian National Radio.*
1 Mar 2013. Kay, J. The mobbing of Tom Flanagan is unwarranted and cruel. *National Post.*
6 Feb 2013. Boy Scouts board delays vote on lifting ban on gays. *L.A. Times.*
31 Aug 2012. CNN Newsroom interview with Ashleigh Banfield. *CNN.*
24 Jun 2012. CNN Newsroom interview with Don Lemon. *CNN.*

LEGAL TESTIMONY, PAST 5 YEARS

2022	Hersom & Doe v WVa Health & Human Services	Southern District, West Virginia
2022	BPJ v WVa Board of Education	Southern District, West Virginia
2021	Cross et al. v Loudoun School Board	Loudoun, Virginia
2021	Allan M. Josephson v Neeli Bendapudi	Western District of Kentucky
2021	Re Commitment of Michael Hughes (Frye Hearing)	Cook County, Illinois
2019	US vs Peter Bright	Southern Dist. of New York, NY
2019	Probate and Family Court (Custody Hearing)	Boston, Massachusetts
2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, Illinois
2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, New York
2018	Re Commitment of Fernando Little (Frye Hearing)	Utica, New York
2018	Canada vs John Fitzpatrick (Sentencing Hearing)	Toronto, Ontario, Canada



Routledge
Taylor & Francis Group

Journal of Sex & Marital Therapy

ISSN: 0092-623X (Print) 1521-0715 (Online) Journal homepage: https://www.tandfonline.com/loi/usmt20

Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

James M. Cantor

To cite this article: James M. Cantor (2020) Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy, Journal of Sex & Marital Therapy, 46:4, 307-313, DOI: 10.1080/0092623X.2019.1698481

To link to this article: https://doi.org/10.1080/0092623X.2019.1698481

JOURNAL OF SEX & MARITAL THERAPY
2020, VOL. 46, NO. 4, 307–313
https://doi.org/10.1080/0092623X.2019.1698481

Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

James M. Cantor

Toronto Sexuality Centre, Toronto, Canada

ABSTRACT

The American Academy of Pediatrics (AAP) recently published a policy statement: *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping gender diverse (GD) children, the AAP statement instead rejected that consensus, endorsing *gender affirmation* as the only acceptable approach. Remarkably, not only did the AAP statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its citations, which repeatedly said the very opposite of what AAP attributed to them.

The American Academy of Pediatrics (AAP) recently published a policy statement entitled, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, 2018). These are children who manifest discontent with the sex they were born as and desire to live as the other sex (or as some alternative gender role). The policy was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping transgender and gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only *gender affirmation*. That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition. With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy, however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.

The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in the aggregate—It was merely disappeared. (The list of all existing studies appears in the appendix.) As they make clear, *every* follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition. AAP is, of course, free to establish whatever policy it likes on

CONTACT James Cantor jamescantorphd@gmail.com Toronto Sexuality Centre, 2 Carlton Street, suite 1820, Toronto, Ontario M5B 1J3, Canada.

whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.

AAP divided clinical approaches into three types—conversion therapy, watchful waiting, and gender affirmation. It rejected the first two and endorsed *gender affirmation* as the only acceptable alternative. Most readers will likely be familiar already with attempts to use conversion therapy to change sexual orientation. With regard to gender identity, AAP wrote:

> "[C]onversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. ... Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42]

The citations were:

38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol.* 1994;62(2):221–227.

29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 2012;51(9):957–974.

39. Byne W. Regulations restrict practice of conversion therapy. *LGBT Health.* 2016;3(2):97–99.

40. Cohen-Kettenis PT, Delemarrevan de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med.* 2008;5(8):1892–1897.

41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Soc Policy.* 2006;3(3):23–39.

42. World Professional Association for Transgender Health. *WPATH De-Psychopathologisation Statement.* Minneapolis, MN: World Professional Association for Transgender Health; 2010.

AAP's claims struck me as odd because *there are no studies of conversion therapy for gender identity.* Studies of conversion therapy have been limited to *sexual orientation,* and, moreover, to the sexual orientation *of adults,* not to gender identity and not of children in any case. The article AAP cited to support their claim (reference number 38) is indeed a classic and well-known review, but it is a review of sexual orientation research *only.* Neither gender identity, nor even children, received a single mention in it. Indeed, the narrower scope of that article should be clear to anyone reading even just its title: "The practice and ethics of *sexual orientation* conversion therapy" [italics added].

AAP continued, saying that conversion approaches for GD children have already been rejected by medical consensus, citing five sources. This claim struck me as just as odd, however—I recalled associations banning conversion therapy for sexual orientation, but not for gender identity, exactly because there is no evidence for generalizing from adult sexual orientation to childhood gender identity. So, I started checking AAP's citations for that, and these sources too pertained only to sexual orientation, not gender identity (specifics below). What AAP's sources *did* repeatedly emphasize was that:

A. Sexual orientation of adults is unaffected by conversion therapy and any other [known] intervention;
B. Gender dysphoria in childhood before puberty desists in the majority of cases, becoming (cis-gendered) homosexuality in adulthood, again regardless of any [known] intervention; and
C. Gender dysphoria in childhood persisting after puberty tends to persist entirely.

That is, in the context of GD children, it simply makes no sense to refer to externally induced "conversion": The majority of children "convert" to cisgender or "desist" from transgender

regardless of any attempt to change them. "Conversion" only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that "gender identity is not synonymous with 'sexual orientation'" (Rafferty et al., 2018, p. 3), they went ahead to treat them as such nonetheless.

To return to checking AAP's fidelity to its sources: Reference 29 was a practice guideline from the Committee on Quality Issues of the American Academy of Child and Adolescent Psychiatry (AACAP). Despite AAP applying this source to *gender identity*, AACAP was quite unambiguous regarding their intent to speak to sexual orientation and *only* to sexual orientation: "Principle 6. Clinicians should be aware that there is no evidence that *sexual orientation* can be altered through therapy, and that attempts to do so may be harmful. There is no established evidence that change in a predominant, enduring *homosexual* pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter *homosexuality*. Psychiatric efforts to alter *sexual orientation* through 'reparative therapy' *in adults* have found little or no change in *sexual orientation*, while causing significant risk of harm to self-esteem" (AACAP, 2012, p. 967, italics added).

Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP's actual view was decidedly neutral, noting the lack of evidence: "Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed" (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: "In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood" (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP's actual view.

Next, in reference 39, Byne (2016) also addressed only sexual orientation, doing so very clearly: "Reparative therapy is a subset of conversion therapies based on the premise that *same-sex attraction* are reparations for childhood trauma. Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing *same-sex attractions*" (Byne, 2016, p. 97). Byne does not say this of gender identity, as the AAP statement misrepresents.

In AAP reference 40, Cohen-Kettenis et al. (2008) did finally pertain to gender identity; however, this article never mentions conversion therapy. (!) Rather, in this study, the authors presented that clinic's lowering of their minimum age for cross-sex hormone treatment from age 18 to 16, which they did on the basis of a series of studies showing the high rates of success with this age group. Although it did strike me as odd that AAP picked as support against conversion therapy an article that did not mention conversion therapy, I could imagine AAP cited the article as an example of what the "mainstream of traditional medical practice" consists of (the logic being that conversion therapy falls outside what an 'ideal' clinic like this one provides). However, what this clinic provides is the very *watchful waiting* approach that AAP rejected. The approach

espoused by Cohen-Kettenis (and the other clinics mentioned in the source—Gent, Boston, Oslo, and now formerly, Toronto) is to make puberty-halting interventions available at age 12 because: "[P]ubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved" (Cohen-Kettenis et al., 2008, p. 1894).

Reference 41 presented a very interesting history spanning the 1960s–1990s about how feminine boys and tomboyish girls came to be recognized as mostly pre-homosexual, and how that status came to be entered into the DSM at the same time as homosexuality was being *removed* from the DSM. Conversion therapy is never mentioned. Indeed, to the extent that Bryant mentions treatment at all, it is to say that treatment is entirely irrelevant to his analysis: "An important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the DSM and not unique to GIDC)" (Bryant, 2006, p. 35). How this article supports AAP's claim is a mystery. Moreover, how AAP could cite a 2006 history discnssing events of the 1990s and earlier to support a claim about the *current* consensus in this quickly evolving discussion remains all the more unfathomable.

Cited last in this section was a one-paragraph press release from the World Professional Association for Transgender Health. Written during the early stages of the American Psychiatric Association's (APA's) update of the DSM, the statement asserted simply that "The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide." Very reasonable debate can (and should) be had regarding whether gender dysphoria should be removed from the DSM as homosexuality was, and WPATH was well within its purview to assert that it should. Now that the DSM revision process is years completed however, history has seen that APA ultimately retained the diagnostic categories, rejecting WPATH's urging. This makes AAP's logic entirely backwards: That WPATH's request to depathologize gender dysphoria was *rejected* suggests that it is *WPATH's* view—and therefore the AAP policy—which fall "outside the mainstream of traditional medical practice." (!)

AAP based this entire line of reasoning on their belief that conversion therapy is being used "to prevent children and adolescents from identifying as transgender" (Rafferty et al., 2018, p. 4). That claim is left without citation or support. In contrast, what is said by AAP's sonrces is "delaying affirmation should *not* be construed as conversion therapy or an attempt to change gender identity" in the first place (Byne, 2016, p. 2). Nonetheless, AAP seems to be doing exactly that: simply relabeling any alternative approach as equivalent to conversion therapy.

Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP's stated claim about the existing science on gender identity at all, never mind gender identity of children.

AAP also dismissed the watchful waiting approach out of hand, not citing any evidence, but repeatedly calling it "outdated." The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling watchful waiting the current standard. According to AAP:

> [G]ender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47]

The citations from AAP's reference list are:

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. *Int J Transgend.* 2018;19(2):251–268

47. Olson KR. Prepubescent transgender children: what we do and do not know. *J Am Acad Child Adolesc Psychiatry.* 2016;55(3):155–156.e3

I was surprised first by the AAP's claim that watchful waiting's delay to puberty was somehow "arbitrary." The literature, including AAP's sources, repeatedly indicated the pivotal importance of puberty, noting that outcomes strongly diverge at that point. According to AAP reference 29, in "*prepubertal* boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance" (Adelson & AACAP, 2012, p. 963, italics added), whereas "when gender variance with the desire to be the other sex is present *in adolescence*, this desire usually does persist through adulthood" (Adelson & AACAP, 2012, p. 964, italics added). Similarly, according to AAP reference 40, "Symptoms of GID *at prepubertal ages* decrease or even disappear in a considerable percentage of children (estimates range from 80–95%). Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting *into early puberty* appears to be highly persistent" (Cohen-Kettenis et al., 2008, p. 1895, italics added). That follow-up studies of prepubertal transition differ from postpubertal transition is the very meaning of non-arbitrary. AAP gave readers exactly the reverse of what was contained in its own sources. If AAP were correct in saying that puberty is an arbitrarily selected age, then AAP will be able to offer another point to wait for with as much empirical backing as puberty has.

Next, it was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim. The people in such programs often receive substantial support during this period. Also unclear is on what basis AAP could already know exactly which treatments are "critical" and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: It is only if one were already pre-convinced that gender affirmation is the only acceptable alternative that would make watchful waiting seem to withhold critical support—What it delays is gender affirmation, the method one has already decided to be critical.

Although AAP's next claim did not have a citation appearing at the end of its sentence, binary notions of gender were mentioned both in references 45 and 47. Specifically, both pointed out that existing outcome studies have been about people transitioning from one sex to the other, rather than from one sex to an in-between status or a combination of masculine/feminine features. Neither reference presented this as a reason to reject the results from the existing studies of complete transition however (which is how AAP cast it). Although it is indeed true that the outcome data have been about complete transition, some future study showing that partial transition shows a different outcome would not invalidate what is known about complete transition. Indeed, data showing that partial transition gives better outcomes than complete transition would, once again, support the watchful waiting approach which AAP rejected.

Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot.

Reference 47 was a one-and-a-half page commentary in which the author off-handedly mentions criticisms previously made of three of the eleven outcome studies of GD children, but does not provide any analysis or discussion. The only specific claim was that studies (whether early or late) had limited follow-up periods—the logic being that had outcome researchers lengthened the follow-up period, then people who seemed to have desisted might have returned to the clinic as

cases of "persistence-after-interruption." Although one could debate the merits of that prediction, AAP instead simply withheld from the reader the result from the original researchers having tested that very prediction directly: Steensma and Cohen-Kettenis (2015) conducted another analysis of their cohort, by then ages 19–28 (mean age 25.9 years), and found that 3.3% (5 people of the sample of 150) later returned. That is, in long-term follow-up, the childhood sample showed 66.7% desistence instead of 70.0% desistance.

Reference 45 did not support the claim that watchful-waiting is "outdated" either. Indeed, that source said the very opposite, explicitly referring to watchful waiting as the *current* approach: "Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model *favored by the standards,* we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5" (Ehrensaft et al., 2018, p. 255). Moreover, Ehrensaft et al. said there are cases in which they too would still use watchful waiting: "When a child's gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child" (p. 259). Ehrensaft et al. are indeed critical of the watchful waiting model (which they feel is applied too conservatively), but they do not come close to the position the AAP policy espouses. Where Ehrensaft summaries the potential benefits and potential risks both to transitioning and not transitioning, the AAP presents an ironically binary narrative.

In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all. AAP claimed, "This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population"; however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, "Current available research and expert opinion from clinical and research leaders ... will serve as the basis for recommendations" (pp. 1–2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion.

AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with Rafferty, however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence.

Disclosure statement

No potential conflict of interest was reported by the author.

References

Rafferty, J., AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics, 142*(4), e20182162 doi:10.1542/peds.2018-2162

Steensma, T. D., & Cohen-Kettenis, P. T. (2015). More than two developmental pathways in children with gender dysphoria? *Journal of the American Academy of Child and Adolescent Psychiatry, 52*, 147–148. doi:10.1016/j.jaac.2014.10.016

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 1413–1423. doi:10.1097/CHI.0b013e31818956b9

Appendix

Count	Group	Study
2/16 4/16 10/16	gay* trans-/crossdress straight*/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
2/16 2/16 12/16	trans- uncertain gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19,* 363–369.
0/9 9/9	trans- gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
2/45 10/45 33/45	trans-/crossdress uncertain gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
1/10 2/10 3/10 4/10	trans- gay uncertain straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,* 511–517.
1/44 43/44	trans- cis-	Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality.* New Haven, CT: Yale University Press.
0/8 8/8	trans- cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
21/54 33/54	trans- cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
3/25 6/25 16/25	trans- lesbian/bi- straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44,* 34–45.
17/139 122/139	trans- cis-	Singh, D. (2012). *A follow-up study of boys with gender identity disorder.* Unpublished doctoral dissertation, University of Toronto.
47/127 80/127	trans- cis-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.

*For brevity, the list uses "gay" for "gay and cis-", "straight" for "straight and cis-", etc.

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOHN DOE, by his guardian and next friend, Susan Doe, on behalf of themselves and all others similarly situated,

Plaintiff-Appellant,

v.

JAMI SNYDER, Director of the Arizona Health Care Cost Containment System, in her official capacity,

Defendant-Appellee.

No. 21-15668

D.C. No. 4:20-cv-00335-SHR

OPINION

Appeal from the United States District Court
for the District of Arizona
Scott H. Rash, District Judge, Presiding

Argued and Submitted November 19, 2021
Phoenix, Arizona

Filed March 10, 2022

Before: Richard R. Clifton, Consuelo M. Callahan, and Daniel A. Bress, Circuit Judges.

Opinion by Judge Callahan

SUMMARY*

Civil Rights

The panel affirmed the district court's order denying plaintiffs' motion for preliminary injunctive relief in a putative class action brought by two teenage transgender individuals alleging that a provision of Arizona law that precludes coverage for gender reassignment surgeries violates federal law and is unconstitutional.

Plaintiffs John Doe and D.H. sought a preliminary injunction compelling the Arizona Health Care Cost Containment System, Arizona's Medicaid program, to pay for their immediate male chest reconstruction surgeries and asserted that the exclusion of gender reassignment surgeries in Arizona Administrative Code R9-22-205(B)(4) constitutes sex discrimination. The district court determined that plaintiffs' request was for a mandatory injunction and denied the request based on a finding that plaintiffs had not shown that male chest reconstruction surgeries were medically necessary for them or safe and effective for correcting or ameliorating their gender dysphoria. Following the filing of the appeal, plaintiffs withdrew their motion for class certification and voluntarily dismissed plaintiff D.H. from the case and appeal.

The panel agreed with the district court that plaintiffs sought a mandatory injunction and noted that the standard for issuing a mandatory injunction is high. On this

* This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

preliminary record, given facts specific to remaining plaintiff Doe and the irreversible nature of the surgery, Doe had not shown that the district court's findings were illogical, implausible, or without support in inferences that could be drawn from the facts in the record. The panel noted that (1) defendants had proffered competing expert testimony challenging plaintiffs' assertion that top surgery was for them medically necessary, safe and effective; (2) Doe sought preliminary injunctive relief when he was a minor, which raised concerns as to whether he sufficiently appreciated the consequences of irreversible surgery; and (3) Doe had serious psychiatric issues distinct from, or related to, his gender dysphoria and his expert psychiatrist had not opined as to whether Doe himself was a suitable candidate for surgery and had not met or examined Doe.

Although the panel did not reach the merits of Doe's constitutional and statutory challenges, because there was ongoing litigation in the district court on Doe's claims and to ensure appropriate proceedings below, the panel noted two additional points. First, for Doe's claim under the Constitution's Equal Protection Clause, the panel noted that this court had already held in *Karnoski v. Trump*, 926 F.3d 1180 (9th Cir. 2019), that the level of scrutiny applicable to discrimination based on transgender status was "more than rational basis but less than strict scrutiny." Second, the district court's conclusion that the exclusion was not discriminatory as a threshold matter was based on an erroneous reading that *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020), was limited to Title VII discrimination claims involving employment. The panel noted that Section 1557 of the Affordable Care Act provides that "an individual shall not, on the ground prohibited under . . . title IX of the Education Amendments of 1972 . . . be excluded from participation in, be denied the benefits of, or be subjected to

discrimination under, any health program of activity, any part of which is receiving Federal financial assistance." 42 U.S.C. § 18116(a). Given the similarity in language prohibiting sex discrimination in Titles VII and IX of the Education Amendment of 1972, the panel did not think *Bostock* could be limited in the manner the district court suggested.

COUNSEL

Asaf Orr (argued), Shannon Minter, and Christopher Stoll, National Center for Lesbian Rights, San Francisco, California; Brent P. Ray, King & Spalding LLP, Chicago, Illinois; Daniel C. Barr, Perkins Coie LLP, Phoenix, Arizona; Abigail K. Coursolle, National Health Law Program, Los Angeles, California; for Plaintiff-Appellant.

David T. Barton (argued) and Kathryn Hackett King, BurnsBarton PLC, Phoenix, Arizona; Logan T. Johnston, Johnston Law Offices, P.L.C., Phoenix, Arizona; for Defendant-Appellee.

Boyd Johnson, Jeannette Boot, Claire M. Guehenno, Cindy Pan and Wilmer Cutler Pickering, Hale and Dorr LLP, New York, New York, for Amici Curiae Pediatric Endocrine Society, World Professional Association for Transgender Health, and United States Professional Association for Transgender Health.

John C. Dwyer, Maureen P. Alger, Alexander J. Kasner, and Joshua S. Walden, Cooley LLP, Palo Alto, California; Peter C. Renn and Nora Huppert, Los Angeles, California; for Amici Curiae Transgender Youth Support Organizations.

Mary E. McAlister, Vernadette R. Broyles, and Joel H. Thornton, Child & Parental Rights Campaign, Inc., Johns Creek, Georgia, for Amici Curiae Keira Bell, Laura Becker, Sinead Watson, Kathy Grace Duncan, Laura Reynolds, Carol Freitas, and Detransvoices.org.

Cindy C. Albracht-Crogan, Cohen Dowd Quigley P.C., Phoenix, Arizona, for Amicus Curiae Society for Evidence Based Medicine.

Michael G. Moore, Esq., Law Office of Michael Garth Moore, Tucson, Arizona, for Amici Curiae Psychotherapeutic Experts in the Field of Treatment of Trans-Identified Children.

OPINION

CALLAHAN, Circuit Judge:

Plaintiffs John Doe and D.H, two teenage transgender individuals who were born female, filed this putative class action on behalf of themselves and others similarly situated, alleging that a provision of Arizona law that precludes coverage for gender reassignment surgeries violates federal law and is unconstitutional. They sought a preliminary injunction compelling the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program, to pay for their immediate male chest reconstruction surgeries. The district court denied their request for a mandatory preliminary injunction and Plaintiffs appealed.

Doe, the remaining Plaintiff,[1] asserts that the exclusion of gender reassignment surgeries in Arizona Administrative Code R9-22-205(B)(4) constitutes sex discrimination. In addition, Doe seeks a mandatory preliminary injunction, which may not be "granted unless extreme or very serious damage will result." *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir. 2009) (quoting *Anderson v. United States*, 612 F.2d 1112, 1114 (9th Cir. 1980)) (cleaned up). We review the denial of a preliminary injunction for abuse of discretion and the district court's factual findings for clear error. *See Puente Arizona v. Arpaio*, 821 F.3d 1098, 1103 (9th Cir. 2016). "Clear error exists if the finding is 'illogical, implausible, or without support in inferences that may be drawn from the facts in the record.'" *Edmo v. Corizon, Inc.*, 935 F.3d 757, 784-85 (9th Cir. 2019) (quoting *La Quinta Worldwide LLC v. Q.R.T.M., S.A. de C.V.*, 762 F.3d 867, 879 (9th Cir. 2014)).

The district court denied the request for a mandatory preliminary injunction based on a finding that Plaintiffs had not shown that male chest reconstruction surgeries were medically necessary for them or safe and effective for correcting or ameliorating their gender dysphoria. On this preliminary record, given facts specific to Doe and the irreversible nature of the surgery, Doe has not shown that the district court's findings are "illogical, implausible, or without support in inferences that may be drawn from the facts in the record." Accordingly, we affirm the district court's denial of his request for a mandatory preliminary injunction.

[1] Following the filing of the appeal, Plaintiffs withdrew their motion for class certification and voluntarily dismissed D.H. from the case and appeal. Doe is now proceeding individually.

I

In August 2020, D.H., a seventeen-year-old transgender individual, and John Doe, a fifteen-year-old transgender individual, filed their complaint for declaratory and injunctive relief in the United States District Court for the District of Arizona. Plaintiffs were considered female at birth and have been undergoing medical treatment for gender dysphoria, including counseling and hormone therapy. They receive health coverage through the AHCCCS which covers their counseling and hormone therapy. Their health care providers recommend male chest reconstruction surgery to further alleviate their gender dysphoria. Their complaint alleged that a provision of Arizona law prohibits Medicaid coverage for "gender reassignment surgeries" (the "Challenged Exclusion"). Specifically, Arizona Administrative Code R9-22-205(B)(4) excludes the following from coverage:

> a. Infertility services, reversal of surgically induced infertility (sterilization), and *gender reassignment surgeries*;
>
> b. Pregnancy termination counseling services;
>
> c. Pregnancy terminations, unless required by state or federal law;
>
> d. Services or items furnished solely for cosmetic purposes; and
>
> e. Hysterectomies unless determined medically necessary.

(Emphasis added). Plaintiffs asserted that the Challenged Exclusion violates their civil rights under Section 1557 of the Patient Protection and Affordable Care Act (ACA), 42 U.S.C. § 18116; the Early and Periodic Screening, Diagnostic and Treatment requirements of the federal Medicaid Act, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); the comparability requirement of the Medicaid Act, 42 U.S.C. § 1396a(a)(10)(B); and the Equal Protection Clause of the Fourteenth Amendment to the Constitution.

Plaintiffs sought to represent a class of transgender individuals under the age of 21 who seek male chest reconstruction surgery (sometimes referred to as "top surgery"). [2] Along with their complaint, Plaintiffs filed a motion for preliminary injunction asserting that both Plaintiffs "urgently need male chest reconstruction surgery to alleviate their gender dysphoria" and that there is "broad consensus within the medical community that the surgery is a safe, effective, and medically necessary treatment for many

[2] The complaint sought the certification of the class, the appointment of Plaintiffs as representatives of the class, and the appointment of counsel for the class. It also sought preliminary and permanent injunctions on behalf of Plaintiffs, and all similarly situated individuals, and declaratory judgment that the denial of coverage for male chest reconstruction surgery violated the Medicaid Act, the ACA, and the Equal Protection Clause of the Fourteenth Amendment.

Plaintiffs defined the proposed class as "[a]ll transgender individuals under age 21 who are or will be enrolled in AHCCCS, have or will have a diagnosis of gender dysphoria, and are seeking or will seek coverage for male chest reconstruction surgery following a determination by their respective health care providers that the procedure is necessary to treat their gender dysphoria."

individuals with gender dysphoria, including adolescents."[3] The motion stated that the surgery is not cosmetic, but functional. It explained that "[a]s a result of the surgery, a transgender male's body matches the person's internal identity, thereby providing enormous psychological relief, and enables them to interact with others and to function in a male identity much more effectively and confidently." The motion further asserted that the surgery would eliminate the need for a chest binder, the extended use of which can cause difficulty breathing, exacerbate preexisting pulmonary conditions like asthma, and cause serious skin conditions.

The motion recited Plaintiffs' histories of gender dysphoria and their continued experiences of significant emotional distress and significant physical discomfort and pain. Both Plaintiffs had been taking testosterone for more than a year and had regularly worn their binders for far longer than the maximum daily time recommended by their health care providers. Both Plaintiffs also had various psychiatric issues. Doe had a referral letter for surgery from his mental health provider but was unable to schedule a surgical consult because he cannot afford the surgery and the AHCCCS will not cover it.

[3] Plaintiffs asserted that the "process of undergoing these treatments is called 'gender transition' and is guided by well-established, internationally recognized standards of care developed by the World Professional Association for Transgender Health (WPATH)." They further stated that the WPATH standards have been adopted by major professional associations of healthcare providers including the American Medical Association, American Psychological Association, the American Academy of Pediatrics, and the Endocrine Society.

II

The district court denied Plaintiffs' motion for a preliminary injunction. It noted the Ninth Circuit in *Monarch Content Management LLC v. Arizona Department of Gaming*, 971 F.3d 1021, 1027 (9th Cir. 2019), had quoted the Supreme Court's holding in *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 20 (2008), which stated that: "[a] plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." The district court determined that Plaintiffs' request was for a mandatory injunction because they sought "an injunction that not only enjoins Defendant from enforcing the law, but orders Defendant to take an affirmative action by providing coverage for a medical procedure that would be otherwise excluded, thus going well beyond the status quo." The court held that a request for a mandatory injunction was subject to heightened scrutiny and would be granted only when extreme or very serious damage would result that was not compensable in damages, and the merits of the case were not doubtful. *See Hernandez v. Sessions*, 872 F.3d 976, 999 (9th Cir. 2017); *Dahl v. HEM Pharms. Corp.*, 7 F.3d 1399, 1403 (9th Cir. 1993).

The district court first considered whether Plaintiffs had shown that top surgery was for them medically necessary, safe, and effective. Plaintiffs had submitted a number of declarations, including one from a psychiatrist who specializes in treating children and adolescents with gender dysphoria, and another from a plastic surgeon who specializes in gender reassignment surgery and would perform the surgeries for Plaintiffs. Both are members of

WPATH. According to the district court, the purpose of WPATH's "Standards of Care . . . is to assist health providers in delivering medical care to transgender people to provide them with safe and effective treatment for gender dysphoria, in order to maximize their overall health, psychological well-being and self-fulfillment." The district court noted that the psychiatrist had treated over 300 children and adolescents with gender dysphoria and considers male chest reconstruction surgery safe and effective for adolescents. The court observed that the psychiatrist opined that surgical treatment is necessary for some transgender youth, but that he had not met, examined, or consulted with Doe to determine whether surgery is medically necessary for him. The plastic surgeon had conducted virtual consultations with Plaintiffs and opined that they appear to be good candidates for male chest reconstruction surgery, that he is confident they are fully aware of the risks and benefits of the procedure, and that the surgery "is a safe, effective, and medically necessary treatment for each of them, assuming the absence of any pathology."

Defendant responded with declarations from two experts, an endocrinologist and a psychiatrist specializing in sexuality. The endocrinologist asserted that the purported "professional consensus" embodied in the WPATH's Standard of Care exists only within its confines and that there is no high-quality study showing male chest reconstruction surgery is safe, effective, or optimal for treating minors with gender dysphoria. He pointed to a 2016 decision by the Centers for Medicare & Medicaid Services that declined to issue a national coverage determination on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence was inconclusive for the Medicare population. The

endocrinologist opined that irreversible top surgery should not be performed on Plaintiffs because there is no way to predict whether they will outgrow their gender dysphoria and minors are "still undergoing brain development and as such they are immature with respect to intellect, emotion, judgment, and self-control."

Defendant's second expert had been an early member of WPATH but now alleged that "WPATH represents a self-selected subset of the mental health professions . . . [and] does not capture the clinical experiences of others." The psychiatrist asserted that WPATH "does not welcome skepticism, and therefore, deviates from the philosophical core of medical science." He opined that there is no reliable scientific data to support surgical intervention in adolescents with gender dysphoria, that the surgery will not eliminate the incongruence of female genitalia, and there is no reliable way to predict which patients' gender dysphoria will continue into adulthood.

Defendant also submitted a recent opinion from the United Kingdom's High Court of Justice, which reviewed a National Health Service clinic's practice of prescribing puberty-suppressing medication to individuals under age 18 with gender dysphoria. Although it heard evidence that such treatment was "required in accordance with the international frameworks of WPATH and the Endocrine Society," the United Kingdom court nonetheless concluded that treatment was "experimental or innovative in the sense that there are currently limited studies/evidence of the efficacy or long-term effects of the treatment." The district court noted that although the case did not involve surgery and was not controlling authority, it suggested that the "irreversible surgery Plaintiffs seek here is also experimental and perhaps risky." The district court determined that "Plaintiffs have

not clearly shown the surgery is medically necessary for them or that it is safe and effective for correcting or ameliorating their gender dysphoria."

The district court then turned to the controlling law. It noted that to prevail on their discrimination claim under the Equal Protection Clause and Section 1557 of the ACA, Plaintiffs had to show that (1) the AHCCCS is federally funded, (2) they were denied benefits on the basis of membership in a protected class (sex), and (3) the denial of benefits is a but-for cause of their injuries. The parties did not dispute that the AHCCCS received federal funds, but sharply disputed the other two elements.

Plaintiffs asserted that they were denied benefits and discriminated against by the AHCCCS, because they are transgender, citing *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020), and several cases from district courts in other states.

The district court did not find Plaintiffs' arguments compelling. First, it found their reliance on *Bostock* "unpersuasive" because the Supreme Court expressly limited its holding to Title VII claims involving employment and the case did not involve "a state Medicaid plan exclusion for surgical treatment for gender dysphoria in minors." The district court distinguished the cases from other district courts cited by Plaintiffs, noting that in those cases some coverages did not involve Medicaid, the plaintiffs were not minors, and the exclusions challenged were significantly different. The district court noted that in *Flack v. Wisconsin Department of Health Services*, 328 F. Supp. 3d 931 (W.D. Wis. 2018), the exclusion from Medicaid coverage included drugs and hormone therapy, whereas the Challenged Exclusion excluded only gender reassignment surgery, and did not exclude coverage for other treatments of gender

dysphoria such as hormone therapy. The district court agreed with Defendant that because the AHCCCS covers hormone treatment and mental health counseling for the treatment of gender dysphoria, Plaintiffs had failed to meet their high burden, especially because they "have not clearly shown the surgery they seek is safe and effective for treating gender dysphoria in adolescents." The district court further stated that because the AHCCCS covers certain treatments for gender dysphoria, Plaintiffs had not shown that the denial of coverage was based on sex rather than some other permissible rationale.

Finally, the district court addressed the balance of harm. Plaintiffs asserted that they would be irreparably harmed in the absence of an injunction both because such harm is presumed for violations of constitutional rights and because denying them surgery would cause them irreparable physical and emotional harm. The court noted that Defendant countered that Plaintiffs had not made the requisite showing of irreparable harm because: (1) "according to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition ('DSM-5'), gender dysphoria does not persist into adulthood for most children and, specifically, '[i]n natal females persistence has ranged from 12% to 50%'"; (2) Plaintiffs had not demonstrated that they are capable of providing informed consent, given their significant psychological disorders that pre-date their gender dysphoria; (3) one of the Plaintiffs had "worn a binder for five years without developing any skin conditions or exacerbating his asthma, so irreparable harm is unlikely"; and (4) Doe's "long-standing and pre-existing 'chronic post-traumatic stress disorder from early life attachment trauma' . . . should be addressed before irreversible surgical procedures are employed." The district court further noted that Plaintiffs

had not provided a declaration from any medical doctor who is treating Doe.

The court found that Plaintiffs had not met their heightened burden, noting it is not clear that the injury was not capable of compensation as Plaintiffs could pay for the surgeries out-of-pocket and seek reimbursement; and that the preliminary injunctive relief sought was identical to the ultimate relief sought. The district court noted that "the relief sought would completely change, rather than preserve, the status quo." The court concluded that it would be "premature to grant such relief prior to discovery and summary judgment briefing."

In sum, the district court denied the request for a preliminary injunction finding that Plaintiffs had "not clearly shown that the surgery they seek is medically necessary for them, that it is a safe and effective treatment for gender dysphoria in adolescents, or that the Challenged Exclusion violates the Medicaid Act, Section 1557, or the Equal Protection Clause." Plaintiffs filed a timely notice of appeal. On appeal, they limit their challenge to Section 1557 and the Equal Protection Clause, and do not challenge the district court's ruling under the Medicaid Act.

III

We have jurisdiction under 28 U.S.C. § 1292(a)(1) to review the denial of a preliminary injunction, and we review such a denial for abuse of discretion. *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011). As noted, for a preliminary injunction to issue, a plaintiff must establish a likelihood of success on the merits, irreparable harm in the absence of preliminary relief, a balance of equities in the movant's favor, and that the injunction is in the public interest. *Cal. Trucking Ass'n v. Bonta*, 996 F.3d

644, 652 (9th Cir. 2021) (citing *Winter*, 555 U.S. at 20). In addition, we have applied a "sliding scale" to this standard, allowing a stronger showing of one element to offset a weaker showing of another. *Alliance for the Wild Rockies*, 632 F.3d at 1131.

Although the district court held that Plaintiffs sought a mandatory preliminary injunction, their briefs argue that they seek "a quintessential prohibitory injunction" because they "seek to enjoin enforcement of the exclusion against them as individuals so that their coverage may be evaluated in the same way as any other request for coverage, without application of the exclusion." Doe argues that he has shown that he has been denied his right to equal protection under the law because his request has been denied solely based on the Challenged Exclusion and not on any individualized assessment.

In *Marlyn Nutraceuticals*, 571 F.3d at 879, we defined a mandatory injunction as one that goes beyond simply maintaining the status quo and orders the responsible party to take action pending the determination of the case on its merits. Here, rather than maintain the status quo pendente lite, Plaintiffs sought to compel Defendant to act prior to the entry of a final judgment. Thus, we agree with the district court that Plaintiffs sought a mandatory injunction.

The standard for issuing a mandatory preliminary injunction is high. "In general, mandatory injunctions 'are not granted unless extreme or very serious damage will result and are not issued in doubtful cases or where the injury complained of is capable of compensation in damages.'" *Id.*

(quoting *Anderson*, 612 F.2d at 1115).[4] Moreover, as the district court's evaluation of Plaintiffs' alleged harm is a factual determination, we review it for clear error, which exists "if the finding is 'illogical implausible, or without support in inferences that may be drawn from the facts in the record.'" *Edmo*, 935 F.3d at 784–85 (quoting *La Quinta Worldwide*, 762 F.3d at 879).

Here, Doe has not made a compelling showing of irreparable harm. Although his underlying claims alleged discrimination based on sex, the proffered reason for seeking preliminary injunctive relief was the alleged irreparable harm to him if his surgery was delayed. But to compel the issuance of a mandatory preliminary injunction, even where there has been a showing of likelihood of success on the underlying claim, a plaintiff need still show a likelihood of irreparable harm. *Marlyn Nutraceuticals*, 571 F.3d at 877. On appeal from the district court's finding of insufficient harm, Doe has the burden of showing that the district court's finding that there is not a likelihood of irreparable harm is illogical, implausible, or unsupported by the record. *Edmo*, 935 F.3d at 784–85.

Doe has not met his burden. First, although two experts testified that top surgery is safe and effective, even for adolescents, and has been approved by WPATH and most medical professional organizations, Defendant proffered competing expert testimony that WPATH's Standards of Care are not universally endorsed and questioning whether

[4] Based on this standard, we do not think that our "sliding scale" standard applies to this appeal. We read *Marlyn Nutraceuticals*, 571 F.3d at 879, as directing that on review of the denial of a mandatory preliminary injunction based on a factual evaluation of harm, weakness in a plaintiff's showing of harm cannot be offset by a stronger showing on the merits of the underlying legal claim.

there have been any high-quality studies showing that male chest reconstruction surgery is safe, effective, or optimal for treating gender dysphoria. For example, Defendant's expert noted that, as of 2016, the Centers for Medicare & Medicaid Services declined to issue a National Coverage Determination for gender reassignment surgery for Medicare patients with gender dysphoria "because the clinical evidence is inconclusive for the Medicare population." In its order, the district court explicitly noted that testimony in describing the evidence from Defendant's expert.

Second, when Doe sought preliminary injunctive relief, he was a minor. This gave rise to twin concerns: was his gender dysphoria permanent, and did he sufficiently appreciate the consequences of irreversible surgery? There are indications in the record and in the amici briefs filed in this appeal that some individuals who present as transgender during adolescence revert to their natal gender later on, regardless of whether they have had top surgery. Defendant argued, for instance, that gender dysphoria often resolves itself by adulthood and, specifically citing the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, that "[i]n natal females, persistence has ranged from 12% to 50%." The district court explicitly noted that testimony as well in describing the evidence from Defendant's expert. Also, given the evidence presented that the human brain continues to mature well into a person's twenties, it was reasonable for a district court to question whether Doe appreciated the impact of irreversible surgery and to require further counseling before "authorizing" surgery.

Third, these concerns are reinforced by the apparent fact that Doe had serious psychiatric issues distinct from, or related to, his gender dysphoria. There were representations

before the district court that gender dysphoria might mask other psychiatric issues and that top surgery might not address those other issues. Relatedly, and significantly, Doe failed to provide a declaration from any psychiatrist or medical doctor who is treating him that attested to the necessity and suitability of the surgery in his particular case. And as the district court noted, Doe's expert psychiatrist had not opined as to whether Doe himself is a suitable candidate for surgery and had not met or examined Doe.

Our analysis highlights how *Edmo* is factually and procedurally distinguishable. There, the district court in a "carefully considered, 45-page opinion," supported by "detailed factual findings [that] were amply supported by its careful review of extensive evidence and testimony," determined that gender confirmation surgery was "medically necessary to treat Edmo's gender dysphoria." *Id.* at 780. Here, by contrast, the district court's 20-page order denying the motion for a preliminary injunction finds, based on a preliminary record, that "Plaintiffs have not clearly shown the surgery is medically necessary for them or that it is safe and effective for correcting or ameliorating their gender dysphoria."[5] This determination is not illogical,

[5] The cases cited by Plaintiffs from district courts in other states are similarly factually distinct. In *Flack*, both of the plaintiffs who sought injunctive relief were adults who had received treatment for gender dysphoria for a number of years. Indeed, one had already "had his uterus, fallopian tubes, ovaries and cervix removed through a hysterectomy with bilateral salpingo-oophorectomy." *Flack*, 328 F. Supp. 3d at 938; *See also Flack v. Wis. Dep't of Health Serv.*, 395 F. Supp. 3d 1001 (W.D. Wis. 2019) (granting summary judgment and enjoining the provision of Wisconsin law prescribing gender-conforming surgery and hormone therapy, but as to adults only). In *Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wis. 2018), the plaintiffs were adults and the court ruled on cross motions for summary judgment, not on a request for preliminary injunction. In *Kadel v. Folwell*, 446 F. Supp. 3d 1 (M.D.N.C. 2020), the

implausible, or unsupported by the record that was before the court at that time.

We hold only that even accepting the merits of Doe's underlying claim of discrimination, he has not shown that the district court's denial of a mandatory preliminary injunction was unreasonable or unsupported by the record.[6] Although we do not reach the merits of Doe's constitutional and statutory challenges, because there is ongoing litigation in the district court on Doe's claims and to ensure appropriate proceedings below, we note two additional points.

First, for Doe's claim under the Constitution's Equal Protection Clause, we have already held in *Karnoski v. Trump*, 926 F.3d 1180 (9th Cir. 2019), that the level of scrutiny applicable to discrimination based on transgender status is "more than rational basis but less than strict scrutiny." *Id.* at 1201. *Karnoski* considered a policy that "discriminate[d] on the basis of transgender status on its face." 926 F.3d at 1201 n.18. The district court here did not address *Karnoski* in its order denying Plaintiffs' motion for a preliminary injunction because it concluded that the exclusion was not discriminatory as a threshold matter.

Second, this conclusion was based on an erroneous reading of *Bostock*. In considering whether the Supreme

---

court denied the defendants' motion to dismiss and did not consider injunctive relief. In *Fletcher v. Alaska*, 443 F. Supp. 3d 1024 (D. Alaska 2020), the plaintiff was a transgender adult and the court granted summary judgment.

[6] The other criteria for injunctive relief, the balance of hardships and public interest, do not weigh strongly in favor of either party and do not raise concerns that are not addressed in our discussion above.

Court's decision in *Bostock* applied to Plaintiffs' claim under Section 1557 of the ACA, the district court found Plaintiffs' reliance on *Bostock* "unpersuasive" because, it reasoned, "[t]he Supreme Court expressly limited its holding to Title VII claims involving employers who discriminated against employees because of their gay or transgender status." A faithful application of *Bostock* causes us to conclude that the district court's understanding of *Bostock* was too narrow.

Interpreting language in Title VII that made it unlawful for an employer to take an adverse employment action or otherwise to discriminate "because of . . . sex," *Bostock* held that "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex." *Bostock*, 140 S. Ct. at 1741. Thus, firing a person based on his sexual orientation or transgender status is discrimination "because of sex."

Section 1557 of the ACA provides that "an individual shall not, on the ground prohibited under . . . title IX of the Education Amendments of 1972 . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program of activity, any part of which is receiving Federal financial assistance." 42 U.S.C. § 18116(a). Under Title IX, "[n]o person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance." 20 U.S.C. § 1681. We construe Title IX's protections consistently with those of Title VII. *See, e.g.*, *Emeldi v. Univ. of Or.*, 673 F.3d 1218, 1224 (9th Cir. 2012), *as amended*, 698 F.3d 715 (9th Cir. 2012) ("[T]he Supreme Court has often looked to its Title VII interpretations of discrimination in illuminating Title IX.'" (quotations omitted); *see also Franklin v.Gwinnett*

Cty. Pub. Schs., 503 U.S. 60, 75 (1992). Given the similarity in language prohibiting sex discrimination in Titles VII and IX, we do not think *Bostock* can be limited in the manner the district court suggested. *See also Bostock*, 140 S. Ct. at 1778–82 (Alito, J., dissenting) (anticipating that *Bostock* "is virtually certain to have far-reaching consequences" because "[o]ver 100 federal statutes prohibit discrimination because of sex," and listing in particular Title IX and the ACA). While the language in Title VII is "because of sex" and the language in Title IX is "on the basis of sex," *Bostock* used those phrases interchangeably throughout the decision. *See, e.g.*, *Bostock*, 140 S. Ct. at 1737–38, 1743–45, 1753.

To be sure, Defendant argues that the Challenge Exclusion does not discriminate based on sex because, in its view, Arizona only prohibits a medical procedure while allowing transgendered persons to receive other types of treatment. Doe responds that disallowing gender reassignment surgery should be treated as discriminating against transgender persons because they are the only ones seeking this surgery. The district court did not address this issue because it narrowly read *Bostock*. The district court may have opportunity to address this issue as the case proceeds.

IV

We review only the district court's denial of Doe's request for a mandatory preliminary injunction. A mandatory preliminary injunction will not issue unless extreme or very serious damage will otherwise result. *Marlyn Nutraceuticals*, 571 F.3d at 879. Here, the district court determined, based on the evidence before it, that Doe had not shown that the surgery was medically necessary and safe and effective for correcting or ameliorating his gender dysphoria. This factual determination is reviewed for clear

error, which exists "if the finding is 'illogical, implausible, or without support in inferences that may be drawn from the facts in the record.'" *Edmo*, 935 F.3d at 784–85 (quoting *La Quinta Worldwide*, 762 F.3d at 879). Because Doe has not met his burden of showing that the district court's denial of a mandatory preliminary injunction was clear error, the district court's order is **AFFIRMED**.

Each side shall bear its own costs.

United States Court of Appeals for the Ninth Circuit

Office of the Clerk
95 Seventh Street
San Francisco, CA 94103

Information Regarding Judgment and Post-Judgment Proceedings

Judgment

- This Court has filed and entered the attached judgment in your case. Fed. R. App. P. 36. Please note the filed date on the attached decision because all of the dates described below run from that date, not from the date you receive this notice.

Mandate (Fed. R. App. P. 41; 9th Cir. R. 41-1 & -2)

- The mandate will issue 7 days after the expiration of the time for filing a petition for rehearing or 7 days from the denial of a petition for rehearing, unless the Court directs otherwise. To file a motion to stay the mandate, file it electronically via the appellate ECF system or, if you are a pro se litigant or an attorney with an exemption from using appellate ECF, file one original motion on paper.

Petition for Panel Rehearing (Fed. R. App. P. 40; 9th Cir. R. 40-1)
Petition for Rehearing En Banc (Fed. R. App. P. 35; 9th Cir. R. 35-1 to -3)

(1) A. Purpose (Panel Rehearing):

- A party should seek panel rehearing only if one or more of the following grounds exist:
  - A material point of fact or law was overlooked in the decision;
  - A change in the law occurred after the case was submitted which appears to have been overlooked by the panel; or
  - An apparent conflict with another decision of the Court was not addressed in the opinion.
- Do not file a petition for panel rehearing merely to reargue the case.

B. Purpose (Rehearing En Banc)

- A party should seek en banc rehearing only if one or more of the following grounds exist:

- ► Consideration by the full Court is necessary to secure or maintain uniformity of the Court's decisions; or
- ► The proceeding involves a question of exceptional importance; or
- ► The opinion directly conflicts with an existing opinion by another court of appeals or the Supreme Court and substantially affects a rule of national application in which there is an overriding need for national uniformity.

(2) Deadlines for Filing:

- A petition for rehearing may be filed within 14 days after entry of judgment. Fed. R. App. P. 40(a)(1).
- If the United States or an agency or officer thereof is a party in a civil case, the time for filing a petition for rehearing is 45 days after entry of judgment. Fed. R. App. P. 40(a)(1).
- If the mandate has issued, the petition for rehearing should be accompanied by a motion to recall the mandate.
- *See* Advisory Note to 9th Cir. R. 40-1 (petitions must be received on the due date).
- An order to publish a previously unpublished memorandum disposition extends the time to file a petition for rehearing to 14 days after the date of the order of publication or, in all civil cases in which the United States or an agency or officer thereof is a party, 45 days after the date of the order of publication. 9th Cir. R. 40-2.

(3) Statement of Counsel

- A petition should contain an introduction stating that, in counsel's judgment, one or more of the situations described in the "purpose" section above exist. The points to be raised must be stated clearly.

(4) Form & Number of Copies (9th Cir. R. 40-1; Fed. R. App. P. 32(c)(2))

- The petition shall not exceed 15 pages unless it complies with the alternative length limitations of 4,200 words or 390 lines of text.
- The petition must be accompanied by a copy of the panel's decision being challenged.
- A response, when ordered by the Court, shall comply with the same length limitations as the petition.
- If a pro se litigant elects to file a form brief pursuant to Circuit Rule 28-1, a petition for panel rehearing or for rehearing en banc need not comply with Fed. R. App. P. 32.

- The petition or response must be accompanied by a Certificate of Compliance found at Form 11, available on our website at www.ca9.uscourts.gov under *Forms*.
- You may file a petition electronically via the appellate ECF system. No paper copies are required unless the Court orders otherwise. If you are a pro se litigant or an attorney exempted from using the appellate ECF system, file one original petition on paper. No additional paper copies are required unless the Court orders otherwise.

Bill of Costs (Fed. R. App. P. 39, 9th Cir. R. 39-1)

- The Bill of Costs must be filed within 14 days after entry of judgment.
- See Form 10 for additional information, available on our website at www.ca9.uscourts.gov under *Forms*.

Attorneys Fees

- Ninth Circuit Rule 39-1 describes the content and due dates for attorneys fees applications.
- All relevant forms are available on our website at www.ca9.uscourts.gov under *Forms* or by telephoning (415) 355-7806.

Petition for a Writ of Certiorari

- Please refer to the Rules of the United States Supreme Court at www.supremecourt.gov

Counsel Listing in Published Opinions

- Please check counsel listing on the attached decision.
- If there are any errors in a published opinion, please send an email or letter **in writing within 10 days** to:
  - Thomson Reuters; 610 Opperman Drive; PO Box 64526; Eagan, MN 55123 (Attn: Maria Evangelista (maria.b.evangelista@tr.com));
  - and electronically file a copy of the letter via the appellate ECF system by using "File Correspondence to Court," or if you are an attorney exempted from using the appellate ECF system, mail the Court one copy of the letter.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 10. Bill of Costs

Instructions for this form: http://www.ca9.uscourts.gov/forms/form10instructions.pdf

9th Cir. Case Number(s)

Case Name

The Clerk is requested to award costs to *(party name(s))*:

I swear under penalty of perjury that the copies for which costs are requested were actually and necessarily produced, and that the requested costs were actually expended.

Signature **Date**

*(use "*s/[typed name]*" to sign electronically-filed documents)*

COST TAXABLE	**REQUESTED** *(each column must be completed)*			
DOCUMENTS / FEE PAID	No. of Copies	Pages per Copy	Cost per Page	TOTAL COST
Excerpts of Record*			$	$
Principal Brief(s) *(Opening Brief; Answering Brief; 1st, 2nd , and/or 3rd Brief on Cross-Appeal; Intervenor Brief)*			$	$
Reply Brief / Cross-Appeal Reply Brief			$	$
Supplemental Brief(s)			$	$
Petition for Review Docket Fee / Petition for Writ of Mandamus Docket Fee / Appeal from Bankruptcy Appellate Panel Docket Fee				$
			TOTAL:	$

***Example:** Calculate 4 copies of 3 volumes of excerpts of record that total 500 pages [Vol. 1 (10 pgs.) + Vol. 2 (250 pgs.) + Vol. 3 (240 pgs.)] as:*
No. of Copies: 4; Pages per Copy: 500; Cost per Page: $.10 (or actual cost IF less than $.10);
TOTAL: 4 x 500 x $.10 = $200.

Feedback or questions about this form? Email us at forms@ca9.uscourts.gov

DEFENDANT'S EXHIBIT 2

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER, *et al.*,	)	
Plaintiffs,	)	
v.	)	No. 2:22-cv-00184-LCB-SRW
KAY IVEY, in her official capacity as Governor of the State of Alabama, *et al.*,	)	
Defendants.	)	

DECLARATION OF DR. JAMES CANTOR

My name is James Michael Cantor. I am over the age of 19, I am qualified to give this declaration, and, I have personal knowledge of the matters set forth herein.

My CV is attached to this declaration. Recent publications are listed on my CV.

In the past four years, I have provided expert testimony in the following cases:

2022	Hersom & Doe v WVa Health & Human Services	Southern Dist, West Virginia
2022	BPJ v WVa Board of Education	Southern Dist, West Virginia
2021	Cross et al. v Loudoun School Board	Loudoun, Virginia
2021	Allan M. Josephson v Neeli Bendapudi	Western District of Kentucky
2021	Re Commitment of Michael Hughes (Frye Hearing)	Cook County, Illinois
2019	US vs Peter Bright	Southern Dist, NY, NY
2019	Probate and Family Court (Custody Hearing)	Boston, Massachusetts
2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, Illinois
2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, New York
2018	Re Commitment of Fernando Little (Frye Hearing)	Utica, New York
2018	Canada vs John Fitzpatrick (Sentencing Hearing)	Toronto, Ontario, Canada

I am compensated a the rate of $400 per hour for my work on this matter. My compensation is not dependent upon the substance of my opinions or the outcome of the case.

TABLE OF CONTENTS

I. Introduction

A. Background & Credentials

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

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

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

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

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

5. I have served as an expert witness in 11 cases in the past five years. These are listed on my *curriculum vitae*, attached here as Appendix 1.

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

7. For my work in this case, I am being compensated at the hourly rate of $400

per hour. My compensation does not change based on the conclusions and opinions that I provide here or later in this case or on the outcome of this lawsuit.

B. Overview

8. The principal opinions that I offer and explain in detail in this report include that:

a. A ban on medical transition services for youth under age 18 is consistent with international standards;

b. The large majority of gender dysphoric, pre-pubescent youth cease to feel gender dysphoric by puberty;

c. Among youth under age 18, follow-up studies show positive results in association with psychotherapy, not medically aided transition; and

d. Follow-up studies of medical transition have shown positive results only in samples of adults ages 18 and older.

9. To prepare the present report, I reviewed the following resources related to this litigation:

a. Text of Alabama Bill SB-184;

b. Memorandum in support of plaintiffs' motion for temporary restraining order & preliminary injunction;

c. Declaration of Linda A. Hawkins, Ph.D., LPC in support of plaintiffs' motion for temporary restraining order & preliminary injunction;

d. Declaration of Morissa J. Ladinsky, MD, FAAP, in support of plaintiffs' motion for temporary restraining order & preliminary injunction;

e. Declaration of Stephen Rosenthal, MD, in support of plaintiffs' motion for temporary restraining order & preliminary injunction.

II. Fact-Check of Assertions of Plaintiffs' Experts' Reports

10. I have reviewed the memorandum supporting the plaintiffs' motion, including its declarations by Drs. Hawkins, Ladinsky, and Rosenthal, and compared

its claims with the published, peer-reviewed scientific literature of gender dysphoria, its treatment and outcomes. The motion and all three experts asserted very many very bold claims, but vanishingly little citation of any objective science at all. Of the many hundred relevant, peer-reviewed research articles on this topic, Dr. Hawkins cited three, Dr. Ladinsky cited none at all, and Dr. Rosenthal cited eight, four of which were from the same research team, also cited by Dr. Hawkins. As demonstrated in the following, that small set of articles represents a highly cherry-picked misrepresentation of the relevant body of science, failing to reflect the consensus of the research literature. Their declarations not only fail to reflect the consensus of the science, but also repeatedly assert claims in direct opposition to that science. A comprehensive summary of the research literature on gender dysphoria is provided herein.

A. Professional and International Standards of Care

11. The claims expressed in the plaintiffs' documents largely rely on their claims of professional standards, citing the American Association of Pediatrics (AAP), the World Professional Association for Transgender Health (WPATH), and the Endocrine Society. In so doing, the plaintiffs provided only misleading half-truths, yielding only an incomplete and inaccurate portrayal of the field. Missing from the plaintiffs documentation were that these that these standards have repeatedly been found to be wanting, that their application has failed to produce improvement among patients, and that it is these U.S.-based associations that are out of line with the international consensus of health care experts.

12. First, the plaintiffs' documentation misrepresents the contents of the associations' policies themselves. With the broad exception of the AAP, their statements repeatedly noted instead that:

- Desistance of gender dysphoria occurs in the majority of prepubescent children.

- Mental health issues need to be assessed as potentially contributing factors and need to be addressed before transition.
- Puberty-blocking medication is an experimental, not a routine, treatment.
- Social transition is not generally recommended until after puberty.

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

13. Second, the WPATH and the Endocrine Society guidelines have both been subjected to standardized evaluation, the Appraisal of Guidelines for Research and Evaluation ("AGREE II") method, as part of an appraisal of all published CPGs regarding sex and gender minority healthcare.[1] Utilizing community stakeholders to set domain priorities for the evaluation, the assessment concluded that the guidelines regarding HIV and its prevention were of high quality, but that "[t]ransition-related CPGs tended to lack methodological rigour and rely on patchier, lower-quality primary research."[2] Neither the Endocrine Society's or WPATH's guidelines were recommended for use. Indeed, the WPATH guidelines received unanimous ratings of "Do not recommend."[3] Thus, despite the exuberant adjectives offered in the plaintiffs' experts' reports, objective analysis yields the opposite conclusion.

14. The AAP differed from the other (U.S.-based) associations in outlining far less conservative clinical decision-making, but only in contradiction with the published research. Immediately following the publication of the AAP policy, I conducted a point-by-point fact-check of the claims it asserted and the references it cited in support. I submitted that to the *Journal of Sex & Marital Therapy*, a well-known research journal of my field, where it underwent blind peer review and was published. I append that article as part of this report. *See* Appendix 1. A great deal of published attention ensued; however, the AAP has yet to respond to the errors I

[1] Dahlen, *et al.*, 2021.
[2] Dahlen, *et al.*, 2021, at 6.
[3] Dahlen, *et al.*, 2021, at 7.

demonstrated its policy contained. Writing for *The Economist* about the use of puberty blockers, Helen Joyce asked AAP directly, "Has the AAP responded to Dr Cantor? If not, have you any response now?" The AAP Media Relations Manager, Lisa Black, responded: "We do not have anyone available for comment."

15. Finally, the opinions of these U.S.-based associations are in stark opposition to international standards: Public healthcare systems throughout the world have instead been withdrawing their earlier support for childhood transition, responding to the increasingly recognized risks associated with hormonal interventions and the now clear lack of evidence that medical transition was benefitting most children, as opposed to the mental health counseling accompanying transition. These have included the United Kingdom[4], Finland,[5] Sweden[6], and France[7].

B. Claims attributed to Olson and Durwood, *et al.*

16. The Hawkins and Rosenthal reports both cited Olson, *et al.* (2016), claiming it to demonstrate that transition reduce risk of mental illness. That claim entirely misrepresents, indeed reverses, the state of the scientific literature. Although Olson, *et al.* (2016) did indeed report that gender dysphoric children showed no mental health differences from the non-transgender control groups, that report turned out to be incorrect: Not pointed out by Drs Hawkins or Rosenthal is that the Olson data were subsequently subjected to a re-analysis and that, after correcting for statistical errors in the original analysis, the data instead showed that the gender dysphoric children under Olson's care *did,* in fact, exhibit significantly lower mental health[8].

17. I conducted an electronic search of the research literature to identify any

---

4 U.K. National Institute for Health and Care Excellence, 2020.
5 Council for Choices in Health Care in Finland, 2020.
6 Swedish National Board of Health and Welfare, 2022.
7 Académie Nationale de Médecine, 2022, Feb. 25.
8 Schumm & Crawford, 2020; Schumm, *et al.*, 2019.

responses from the Olson team regarding the Schumm and Crawford re-analysis of the Olson data and was not able to locate any. I contacted Professor Schumm by email on August 22, 2021 to verify that conclusion, to which he wrote there has been: "No response [from Olson]"[9].

18. Rosenthal also cited a retrospective study from the Olson team, published as Durwood et al., 2017. That study surveyed children in the TransYouth Project—people who have socially transitioned, their families, and any contacts they had, by word of mouth. This method is referred to as "convenience sampling," and differs from genuinely representative samples in applying to means of ensuring study participants accurately represent the population being studied. There were three groups of children for comparison: (i) children who had already socially transitioned, (ii) their siblings, and (iii) children in a university database of families interested in participating in child development research. As noted by the study authors, "For the first time, this article reports on socially transitioned gender children's mental health as reported by the children."[10] Reports from parents were also recorded.[11] In contrast, no reports or ratings were provided by any mental health care professional or researcher at all. That is, although adding self-assessments to the professional assessments might indeed provide novel insights, this project did not add self-assessment to professional assessment. Rather, it replaced professional assessment with self-assessment. Moreover, as already noted, Olson's data did not show what the Olson team claimed.[12] The dataset was subsequently re-analyzed, and "[T]o the contrary, the transgender children, even when supported by their parents, had significantly lower average scores on anxiety and self-worth."[13]

19. It is well established in the field of psychology that participant self-

---

9 Schumm, email communication, Aug. 22, 2021 (on file with author).
10 Durwood, *et al.*, 2017, at 121 (italics added).
11 *See* Olson, *et al.*, 2016.
12 Schumm, *et al.*, 2019.
13 Schumm & Crawford, 2020, p. 9

assessment can be severely unreliable for multiple reasons. For example, one well-known phenomenon in psychological research is known as "socially desirable responding"—the tendency of subjects to give answers that they believe will make themselves look good, rather than accurate answers. Specifically, subjects' reports that they are enjoying good mental health and functioning well could reflect the subjects' desire to be *perceived* as healthy and as having made good choices, rather than reflecting their actual mental health.

20. In their analyses, the study reported finding no significant differences between the transgender children, their non-transgender siblings, or the community controls. As the authors noted, "[t]hese findings are in striking contrast to previous work with gender-nonconforming children who had not socially transitioned, which found very high rates of depression and anxiety."[14] The authors are correct to note that their result contrasts with the previous research, but they do not discuss that this could reflect a problem with the novel research design they used: The subjective self-reports of the children and their parents' reports may not be reflecting reality objectively, as careful professional researchers would. Because the study did not employ any method to detect and control for participants indulging in "socially desirable responding" or acting under other biasing motivations, this possibility cannot be assessed or ruled out.

21. Because this was a single-time study relying on self-reporting, rather than a before-and-after transition study relying on professional evaluation, it is not possible to know if the children reported as well-functioning are in fact well-functioning, nor if so whether they are well-functioning because they were permitted to transition, or whether instead the fact is that they were already well-functioning and therefore permitted to transition. Finally, because the TransYouth project lacks a prospective design, it cannot be known how many cases attempted transition,

[14] Durwood, *et al.*, 2017, at 116.

reacted poorly, and then detransitioned, thus never having entered into the study in the first place.

C. Claims attributed to de Vries, et al.

22. Drs. Hawkins and Rosenthal both cited de Vries, *et al.* (2014) to support their assertion that medical transition of minors improved their mental health. It is not possible for one to come to that conclusion from that study, however. The clinic treating these children (the originators of "The Dutch Protocol"[15]) provides psychotherapy together with medical services. In research science, this situation is called a "confound." It is not possible to distinguish whether any changes were due to the medical services, the psychotherapy, or an interaction between them. Nonetheless, another study, left uncited by the plaintiff's experts, demonstrated that improvements in mental health are associated with receiving psychotherapy rather than medical services. As detailed later in this report, Costa, *et al.*, (2015) conducted a follow-up study of youth in the U.K., one group receiving only psychotherapy, and one group first receiving only psychotherapy and then receiving both psychotherapy and medical services. Both groups improved, and the group receiving medical services failed to show significant differences from the group who received only psychotherapy throughout.

D. Claims attributed to Spack.

23. Dr. Rosenthal also misrepresented the views of Dr. Norman Spack. The article Rosenthal cited—Spack, 2012—repeatedly emphasized that children with gender dysphoria exhibit very many symptoms of mental illnesses. Spack asserted unambiguously that "Gender dysphoric children who do not receive *counseling* have a high risk of behavioural and emotional problems and psychiatric diagnoses"[16]. Dr. Rosenthal's context misrepresents Spack so as to suggest Spack was advocating for

[15] de Vries, *et al.*, 2011.
[16] Spack, *et al.*, 2012, at 422, italics added.

medical transition to treat the gender dysphoria rather than counseling to treat suicidality and any other mental health issues. Moreover still, missing from the Rosenthal report was Spack's conclusion that "[m]ental health intervention should persist for the long term, even after surgery, *as patients continue to be at mental health risk, including for suicide.* While the causes of suicide are multifactorial, the possibility cannot be ruled out that some patients unrealistically believe that surgery(ies) solves their psychological distress."[17] Whereas Rosenthal (selectively) cited Spack to support the insinuation that medical transition relieves distress, Spack instead explicitly warned against drawing exactly that conclusion.

E. Other claims

24. Rosenthal cited Green, *et al.,* (2021) and Turban, *et al.* (2021) to assert that "hormone therapy usage is significantly related to lower rates of depression and suicidality" [Rosenthal, paragraph 45]. In coming to that conclusion, Dr. Rosenthal violates a well-known principal of science: Correlation does not imply causation. That is, this very pattern is what one would predict from clinical gate-keeping: Mental health constitute exclusion criteria by clinical guidelines. Thus, samples of those receiving hormone therapy would necessarily have passed that criterion, whereas the non-medical group would contain those with already identifiable mental health concerns.

25. The plaintiff's experts indicated medical services to alleviate mental health distress; however, people with gender dysphoria continue to experience those mental health symptoms even transition, including a 19 times greater risk of death from suicide.[18] It is this consistent finding in the research literature conclusion that yielded clinical guidelines repeatedly to indicate that mental health issues should be resolved *before* any transition.

---

[17] Spack, 2013, at 484, italics added
[18] Dhejne, *et al.*, 2011.

III. Science of Gender Dysphoria and Transsexualism

26. One of the most widespread public misunderstandings about transsexualism and people with gender dysphoria is that all cases of gender dysphoria represent the same phenomenon; however, the clinical science has long and consistently demonstrated that gender dysphoric children (cases of *early-onset* gender dysphoria) do not represent the same phenomenon as adult gender dysphoria (cases of *late-onset* gender dysphoria),[19] merely attending clinics at younger ages. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in every known regard, from sexual interest patterns, to responses to treatments. A third presentation has recently become increasingly observed among people presenting to gender clinics: These cases appear to have an onset in adolescence in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or "rapid-onset" gender dysphoria (ROGD).

27. In the context of the present proceedings, the adult-onset phenomenon would not seem relevant; however, very many public misunderstandings and expert misstatements come from misattributing evidence or personal experience from one of these types to the other. For example, there exist only very few cases of transition regret among *adult* transitioners, whereas the research has unanimously shown that the majority of children with gender dysphoria desist—that is, they cease to experience such dysphoria by or during puberty. A brief summary of the adult-onset phenomenon is therefore included here to facilitate distinguishing features which are unique to each type of gender dysphoria.

A. Adult-Onset Gender Dysphoria

28. People with adult-onset gender dysphoria typically attend clinics requesting transition services in mid-adulthood, usually in their 30s or 40s. Such individuals are nearly exclusively male.[20] They typically report being sexually

[19] Blanchard, 1985.
[20] Blanchard, 1990, 1991.

attracted to women and sometimes to both men and women. Some cases profess asexuality, but very few indicate any sexual interest in or behavior involving men.[21] Cases of adult-onset gender dysphoria are typically associated with a sexual interest pattern (medically, a *paraphilia*) involving themselves in female form.[22]

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

29. Clinical research facilities studying gender dysphoria have repeatedly reported low rates of regret (less than 3%) among adult-onset patients who underwent complete transition (*i.e.*, social, plus hormonal, plus surgical transition). This has been widely reported by clinics in Canada,[23] Sweden,[24] and the Netherlands.[25]

30. Importantly, each of the Canadian, Swedish, and Dutch clinics for adults with gender dysphoria all performed "gate-keeping" procedures, disqualifying from medical services people with mental health or other contraindications. One would not expect the same results to emerge in the absence of such gate-keeping or when gate-keepers apply only minimal standards or cursory assessment.

2. Mental Health Issues in Adult-Onset Gender Dysphoria

31. The research evidence on mental health issues in gender dysphoria indicates it to be different between adult-onset versus adolescent-onset versus prepubescent-onset types. The co-occurrence of mental illness with gender dysphoria in adults is widely recognized and widely documented.[26] A research team in 2016 published a comprehensive and systematic review of all studies examining rates of mental health issues in transgender adults.[27] There were 38 studies in total. The review indicated that many studies were methodologically weak, but nonetheless

---

21 Blanchard, 1988.
22 Blanchard 1989a, 1989b, 1991.
23 Blanchard, *et al.*, 1989.
24 Dhejneberg, *et al.*, 2014.
25 Wiepjes, *et al.*, 2018.
26 *See, e.g.*, Hepp, *et al.*, 2005.
27 Dhejne, *et al.*, 2016.

demonstrated (1) that rates of mental health issues among people are highly elevated both before and after transition, (2) but that rates were less elevated among those who completed transition. Analyses were not conducted in a way so as to compare the elevation in mental health issues observed among people newly attending clinics to improvement after transition. Also, several studies showed more than 40% of patients becoming "lost to follow-up." With attrition rates that high, it is unclear to what extent the information from the available participants genuinely reflects the whole sample. The very high rate of "lost to follow-up" leaves open the possibility of considerably more negative results overall.

32. An important caution applies to interpreting these results: These very high proportions of mental health issues come from people who are attending a clinic for the first time and are undergoing assessment. Clinics serving a "gate-keeper" role divert candidates with mental health issues away from medical intervention. The side-effect of removing these people from the samples of transitioners is that if a researcher compared the average mental health of individuals coming into the clinic with the average mental health of individuals going through medical transition, then the post-transition group would appear to show a substantial improvement, even though transition had *no effect at all*: The removal of people with poorer mental health created the statistical illusion of improvement among the remaining people.

33. The long-standing and consistent finding that gender dysphoric adults have high rates of mental health issues both before and after transition and the finding that those mental health issues cause the gender dysphoria (the epiphenomenon) rather than the other way around indicate a critical point: To the extent that gender dysphoric children resemble adults, we should not expect mental health to improve as a result of transition. Mental health issues should be resolved before any transition.

B. Childhood Onset (Pre-Puberty) Gender Dysphoria

1. Prospective Studies of Childhood-Onset Gender Dysphoria Show that Most Children Desist in the "Natural Course" by Puberty

34. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 2–6 biological male children to each female.[28]

35. Prepubescent children (and their parents) have been approaching mental health professionals for help with their unhappiness with their sex and belief they would be happier living as the other for many decades. Projects following-up and reporting on such cases began being published in the 1970s, with subsequent generations of research employing increasingly sophisticated methods studying the outcomes of increasingly large samples. In total, there have now been 11 such outcomes studies, listed as Appendix 2.

36. In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, all spanning four decades, every study without exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies. Such cases are often referred to as "desisters," whereas children who continue to feel gender dysphoria are often called "persisters."

37. Notably, in most cases, these children were receiving professional psychosocial support across the study period aimed not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, the inclusion of therapy in the study protocol represents a complication for the interpretation of the results: That is, it is not possible to know to what extent the observed outcomes (predominant desistance, with a small but consistent occurrence of persistence) were

[28] Cohen-Kettenis, *et al.*, 2003; Steensma, *et al.*, 2018; Wood, *et al.*, 2013.

influenced by the psychosocial support, or would have emerged regardless. It can be concluded only that prepubescent children who suffer gender dysphoria and receive psychosocial support focused on issues other than "affirmation" of cross-gender identification do in fact desist in suffering from gender dysphoria, at high rates, over the course of puberty.

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

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

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

41. It is also important to note that research has not yet identified any reliable procedure for discerning which children who present with gender dysphoria will persist, as against the majority who will desist, absent transition and "affirmation." Such a method would be valuable, as the more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can

be weighted. Such "risk prediction" and behavioral "test construction" are standard components of applied statistics in the behavioral sciences. Multiple research teams have reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to usefully predict the course of a particular child.[29]

42. In contrast, a single research team (the aforementioned Olson group) claimed the opposite, asserting that they developed a method of distinguishing persisters from desisters, using a single composite score representing a combination of children's "peer preference, toy preference, clothing preference, gender similarity, and gender identity."[30] The reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they indicated, "Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability."[31] Although the Olson team declared that "social transitions may be predictable from gender identification and preferences,"[32] their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.[33] Both of those are lower than the value of .75, so both of those would be more likely than not to desist, rather than to proceed to transition. That is, Olson's model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

43. Although it remains possible for some future finding to yield a method to

---

29 Singh, *et al.* (2021); Steensma *et al.*, 2013.
30 Rae, *et al.*, 2019, at 671.
31 Rae, *et al.*, 2019, at 673.
32 Rae, *et al.*, 2019, at 669.
33 Rae, *et al.*, 2019, Supplemental Material at 6, Table S1, bottom line.

identify with sufficient accuracy which gender dysphoric children will persist, there does not exist such a method at the present time. Moreover, in the absence of long-term follow-up, it cannot be known what proportions come to regret having transitioned and then *de*transition. Because only a minority of gender dysphoric children persist in feeling gender dysphoric in the first place, "transition-on-demand" increases the probably of unnecessary transition and unnecessary medical risks.

2. "Watchful Waiting" and "The Dutch Approach"

44. It was this state of the science—that the majority of prepubescent children will desist in their feelings of gender dysphoria and that we lack an accurate method of identifying which children will persist—that led to the development of a clinical approach, often called "The Dutch Approach" (referring to The Netherlands clinic where it was developed) including "Watchful Waiting" periods. Internationally, the Dutch Approach is currently the most widely respected and utilized method for treatment of children who present with gender dysphoria.

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

46. The Dutch Approach (also called the "Dutch Protocol") was developed over many years by the Netherlands' child gender identity clinic, incorporating the accumulating findings from their own research as well as those reported by other clinics working with gender dysphoric children. They summarized and explicated the approach in their peer-reviewed report, *Clinical management of gender dysphoria in children and adolescents: The Dutch Approach* (de Vries & Cohen-Kettenis, 2012). The components of the Dutch Approach are:

- no social transition at all considered before age 12 (watchful waiting

period),

- no puberty blockers considered before age 12,
- cross-sex hormones considered only after age 16, and
- resolution of mental health issues before any transition.

47. For youth under age 12, "the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty."[34]

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

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

50. Within the Dutch approach, there is no social transition before age twelve. That is, social affirmation of the new gender may not begin until age 12—as desistance is less likely to occur past that age. "Watchful Waiting" refers to a child's developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Such children and families typically present with substantial distress involving both gender and non-gender issues. It is during the watchful waiting period that a child (and other family members as appropriate) would undergo therapy, resolving other issues which may be exacerbating psychological stress or dysphoria. As noted by the Dutch clinic, "[T]he adolescents in this study received extensive family or other social support . . . [and they] were all regularly seen by one of the clinic's psychologists or psychiatrists."[35] One is actively treating

[34] de Vries & Cohen-Kettenis, 2012, at 301.
[35] de Vries, *et al.*, 2011, at 2280-81.

the person, while carefully "watching" the dysphoria.

51. The inclusion of psychotherapy and support during the watchful waiting period is, clinically, a great benefit to the gender dysphoric children and their parents. The inclusion of psychotherapy and support poses a scientific complication, however: It becomes difficult to know to what extent the outcomes of these cases might be related to receiving psychotherapy received versus being "spontaneous" desistance, which would have occurred on its own anyway. This situation is referred to in science as a "confound."

3. Studies of Transition Outcomes: Overview

52. Very many strong claims have appeared in the media and on social media asserting that transition results in improved mental health or, contradictorily, in decreased mental health. In the highly politicized context of gender and transgender research, many authors have cited only the findings which appear to support one side, cherry-picking from the complete set of research reports. Seemingly contradictory findings are common in science with on-going research projects. When considered together, however, the full set of relevant reports show that a coherent pattern and conclusion has emerged over time, as detailed in the following sections. Initial optimism was suggested by reports of improvements in mental health.[36] Upon continued analysis, these seeming successes turned out to be illusory, however: The Bränström and Pachankis (2019) finding has been retracted.[37] The greater mental health among transitioners reported by Costa, *et al.* (2015) was noted to be because the control group consisted of cases excluded from hormone eligibility exactly because they showed poor mental health to begin with.[38] The improvements reported by the de Vries studies from the Dutch Clinic themselves appear genuine; however, because that clinic also provides psychotherapy to all cases receiving puberty-blockers, it

[36] Bränström & Pachankis 2019; Costa, *et al.*, 2015; de Vries, *et al.*, 2011; de Vries, *et al.*, 2014.
[37] Kalin, 2020.
[38] Biggs, 2019.

remains entirely plausible that the psychotherapy and not the puberty blockers caused the improvements.[39] New studies continue to appear an accelerating rate, repeatedly reporting deteriorations or lacks of improvement in mental health[40] or lack of improvement beyond psychotherapy alone,[41] and other studies continue to report on only the combined effect of both psychotherapy and hormone treatment together.[42]

a. Outcomes of The Dutch Approach (studies from before 2017): Mix of positive, negative, and neutral outcomes

53. The research confirms that some, but not all, adolescents improve on some, but not all, indicators of mental health and that those indicators are inconsistent across studies. Thus, the balance of potential benefits to potential risks differs across cases, and thus suggests different courses of treatment across cases.

54. The Dutch clinical research team followed up 70 youth undergoing puberty suppression at their clinic.[43] The youth improved on several variables upon follow-up as compared to pre-suppression measurement, including depressive symptoms and general functioning. No changes were detected in feelings of anxiety or anger or in gender dysphoria as a result of puberty suppression; however, natal females using puberty suppression suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics.[44]

55. As the report authors noted, while it is possible that the improvement on some variables was due to the puberty-blockers, it is also possible that the improvement was due to the mental health support, and it is possible that the improvement occurred only on its own with natural maturation. So any conclusion that puberty blockers improved the mental health of the treated children is not

---

39 Biggs, 2020.
40 Carmichael, *et al.*, 2021; Hisle-Gorman, *et al.*, 2021; Kaltiala, *et al.*, 2020.
41 Achille, *et al.*, 2020.
42 Kuper, *et al.*, 2020; van der Miesen, *et al.*, 2020, at 703.
43 de Vries, *et al.* 2011.
44 Biggs, 2020.

justified by the data. Because this study did not include a control group (another group of adolescents matching the first group, but *not* receiving medical or social support), these possibilities cannot be distinguished from each other, representing a confound. The authors of the study were explicit in noting this themselves: "All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents."[45]

56. The authors were careful not to overstate the implications of their results, "We *cautiously* conclude that puberty suppression *may be* a valuable *element* in clinical management of adolescent gender dysphoria."[46]

57. Costa, *et al.* (2015) reported on preliminary outcomes from the Tavistock and Portman NHS Foundation Trust clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication. Both groups improved in psychological functioning over the course of the study, but no statistically significant differences between the groups was detected at any point.[47] As those authors concluded, "Psychological support and puberty suppression were both associated with an improved global psychosocial functioning in GD adolescence. Both these interventions may be considered effective in the clinical management of psychosocial functioning difficulties in GD adolescence."[48] Because psychological support does not pose the physical health risks that hormonal interventions or surgery does (such as loss of reproductive function), one cannot justify taking on the greater risks of social transition, puberty blockers or surgery without evidence of such treatment producing superior results. Such evidence does not exist.

b. Clinicians and advocates have invoked the Dutch Approach

[45] de Vries, *et al.* 2011, at 2281.
[46] de Vries, *et al.* 2011, at 2282, italics added.
[47] Costa, *et al.*, at 2212 Table 2.
[48] Costa, *et al.*, at 2206.

while departing from its protocols in important ways.

58. The reports of partial success contained in de Vries, *et al.* 2011 called for additional research, both to confirm those results and to search for ways to maximize beneficial results and minimize negative outcomes. Instead, many other clinics and clinicians proceeded on the basis of the positives only, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, one and a half *years*[49]) became approvals after one or two assessment sessions. Validated, objective measures of youths' psychological functioning were replaced with clinicians' subjective (and first) opinions, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

59. Notably, Dr. Thomas Steensma, central researcher of the Dutch clinic, has decried other clinics for "blindly adopting our research" despite the indications that those results may not actually apply: "We don't know whether studies we have done in the past are still applicable to today. Many more children are registering, and also a different type."[50] Steensma opined that "every doctor or psychologist who is involved in transgender care should feel the obligation to do a good pre- and post-test." But few if any are doing so.

c. Studies by other clinicians in other countries have failed to reliably replicate the positive components of the results reported by the Dutch clinicians in de Vries et al. 2011.

60. The indications of potential benefit from puberty suppression in at least

[49] de Vries, *et al.*, 2011.
[50] Tetelepta, 2021.

some cases has led some clinicians to attempt to replicate the positive aspects of those findings. These efforts have not succeeded.

61. The Tavistock and Portman clinic in the U.K. recently released its findings, attempting to replicate the outcomes reported by the Dutch clinic.[51] Study participants were ages 12–15 (Tanner stages 3 for natal males, Tanner 2 for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious mental illnesses (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients' or their parents' perspective.

62. A multidisciplinary team from Dallas published a prospective follow-up study which included 25 youths as they began puberty suppression.[52] (The other 123 study participants were undergoing cross-sex hormone treatment.) Interventions were administered according to "Endocrine Society Clinical Practice Guidelines."[53] Their analyses found *no statistically significant changes* in the group undergoing puberty suppression on any of the nine measures of wellbeing measured, spanning tests of body satisfaction, depressive symptoms, or anxiety symptoms.[54] (Although the authors reported detecting some improvements, these were only found when the large group undergoing cross-sex hormone treatment were added in.) Although the Dutch Approach includes age 12 as a minimum for puberty suppression treatment, this team provided such treatment beginning at age 9.8 years (full range: 9.8–14.9 years).[55]

63. Achille, *et al.* (2020) at Stony Brook Children's Hospital in New York treated a sample of 95 youth with gender dysphoria, providing follow-up data on 50

---

51 Carmichael, *et al.*, 2021.
52 Kuper, *et al.*, 2020, at 5.
53 Kuper, *et al.*, 2020, at 3, referring to Hembree, *et al.*, 2017.
54 Kuper, *et al.*, 2020, at Table 2.
55 Kuper, *et al.*, 2020, at 4.

of them. (The report did not indicate how these 50 were selected from the 95.) As well as receiving puberty blocking medications, "Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional."[56] The puberty blockers themselves "were introduced in accordance with the Endocrine Society and the WPATH guidelines."[57] Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, "*most predictors did not reach statistical significance.*"[58] That is, puberty blockers did not improve mental health any more than did mental health care on its own.

64. In a recent update, the Dutch clinic reported continuing to find improvement in transgender adolescents' psychological functioning, reaching age-typical levels, "after the start of specialized transgender care involving puberty suppression."[59] Unfortunately, because the transgender care method of that clinic involves both psychosocial support and puberty suppression, it cannot be known which of those (or their combination) is driving the improvement. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. As the study authors themselves noted, "The present study can, therefore, not provide evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes."[60]

65. It has not yet been determined why the successful outcomes reported by the Dutch child gender clinic a decade ago failed to emerge when applied by others more recently. It is possible that:

(1) The Dutch Approach itself does *not* work and that their originally successful results were a fluke;

---

56 Achille, *et al.*, 2020, at 2.
57 Achille, *et al.*, 2020, at 2.
58 Achille, *et al.*, 2020, at 3 (italics added).
59 van der Miesen, *et al.*, 2020, at 699.
60 van der Miesen, *et al.*, 2020, at 703.

(2) The Dutch Approach *does* work, but only in the Netherlands, with local cultural, genetic, or other unrecognized factors that do not generalize to other countries;

(3) The Dutch Approach itself *does* work, but other clinics and individual clinicians are removing safeguards and adding short-cuts to the approach, and those changes are hampering success.

(4) The Dutch Approach *does* work, but the cause of the improvement is the psychosocial support, rather than any medical intervention, which other clinics are *not* providing.

66. The failure of other clinics to repeat the already very qualified success of the Dutch clinic demonstrates the need for still greater caution before endorsing transition and the greater need to resolve potential mental health obstacles before doing so.

4. Mental Health Issues in Childhood-Onset Gender Dysphoria

67. As shown by the outcomes studies, there is no statistically significant evidence that transition reduces the presence of mental illness among transitioners. As shown repeatedly by clinical guidelines from multiple professional associations, mental health issues are expected or required to be resolved *before* undergoing transition. The reasoning behind these conclusions is that children may be expressing gender dysphoria, not because they are experiencing what gender dysphoric adults report, but because they mistake what their experiences indicate or to what they might lead. For example, a child experiencing depression from social isolation might develop hope—and the unrealistic expectation—that transition will help them fit in, this time as and with the other sex.

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

69. Elevated rates of multiple mental health issues among gender dysphoric

children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed 52% fulfilled criteria for a DSM axis-I disorder.[61] A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, but a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment instruments (Child Behavior Check List, or CBCL) demonstrated that the average score was in the clinical rather than healthy range, among children in both clinics.[62] When expressed as percentages, among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample were in the clinical range.

70. A systematic, comprehensive review of all studies of Autism Spectrum Disorders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children diagnosed with gender dysphoria was recently conducted. It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD I youth with gender dysphoria. Studies reviewing medical records of children and adolescents referred to gender clinics showed 5–26% to have been diagnosed with ASD.[63] Moreover, those authors gave specific caution on the "considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results."[64] When two or more issues are present at the same time (in this case, gender dysphoria present at the same time as ADHD or ASD), researchers cannot distinguish when a result is associated with or caused by the issue of interest (gender dysphoria itself) or one of the side issues, called *confounds* (ADHD or ASD,

---

61 Wallien, *et al.*, 2007.
62 Cohen-Kettenis, *et al.*, 2003, at 46.
63 Thrower, *et al.*, 2020.
64 Thrower, *et al.*, 2020, at 703.

in the present case).[65] The rate of ADHD among children with GD was 8.3–11%. Conversely, in data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported "gender variance."[66]

C. Adolescent-Onset Gender Dysphoria

1. Features of Adolescent-Onset Gender Dysphoria

71. In the social media age, a third profile has recently begun to present to clinicians or socially, characteristically distinct from the previously identified ones.[67] Unlike adult-onset gender dysphoria and unlike childhood-onset, this group is predominately biologically female. This group first presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is this feature which led to the term Rapid Onset Gender Dysphoria (ROGD).[68] The majority of cases appear to occur within clusters of peers and in association with increased social media use[69] and especially among people with autism or other neurodevelopmental or mental health issues.[70]

72. It cannot be easily determined whether the self-reported gender dysphoria is a result of other underlying issues or if those mental health issues are the result of the stresses of being a sexual minority, as some writers are quick to assume.[71] (The science of the *Minority Stress Hypothesis* appears in its own section.) Importantly, and unlike other presentations of gender dysphoria, people with rapid-onset gender dysphoria often (47.2%) experienced *declines* rather than improvements in mental health when they publicly acknowledged their gender status.[72] Although long-term outcomes have not yet been reported, these distinctions demonstrate that one cannot

---

65 Cohen-Kettenis *et al.*, 2003, at 51; Skelly *et al.*, 2012.
66 Janssen, *et al.*, 2016.
67 Kaltiala-Heino, *et al.*, 2015; Littman, 2018.
68 Littman, 2018.
69 Littman, 2018.
70 Kaltiala-Heino, *et al.*, 2015; Littman, 2018; Warrier, *et al.*, 2020.
71 Boivin, *et al.*, 2020.
72 Biggs, 2020; Littman, 2018.

apply findings from the other types of gender dysphoria to this type. That is, in the absence of evidence, researchers cannot assume that the pattern found in childhood-onset or adult-onset gender dysphoria also applies to rapid-onset (aka adolescent-onset) gender dysphoria. The group differences already observed argue against the conclusion that any given feature would be present, in general, throughout all types of gender dysphoria.

2. Prospective Studies of Social Transition and Puberty Blockers in Adolescence

73. There do not yet exist prospective outcomes studies either for social transition or for medical interventions for people whose gender dysphoria began in adolescence. That is, instead of taking a sample of individuals and following them forward over time (thus permitting researchers to account for people dropping out of the study, people misremembering the order of events, etc.), all studies have thus far been *retrospective*. It is not possible for such studies to identify what factors caused what outcomes. No study has yet been organized in such a way as to allow for an analysis of the adolescent-onset group, as distinct from childhood-onset or adult-onset cases. Many of the newer clinics (not the original clinics which systematically tracked and reported on their cases' results) fail to distinguish between people who had childhood-onset gender dysphoria and have aged into adolescence and people whose onset was not until adolescence. Similarly, there are clinics failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria. Studies selecting groups according to their current age instead of their ages of onset can produce only confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

3. Mental Illness in Adolescent-Onset Gender Dysphoria

74. In 2019, a Special Section of the *Archives of Sexual Behavior* was published:

"Clinical Approaches to Adolescents with Gender Dysphoria." It included this brief yet thorough summary of rates of mental health issues among adolescents expressing gender dysphoria by Dr. Aron Janssen of the Department of Child and Adolescent Psychiatry of New York University:[73] The literature varies in the range of percentages of adolescents with co-occurring disorders. The range for depressive symptoms ranges was 6–42%,[74] with suicide attempts ranging 10 to 45%.[75] Self-injurious thoughts and behaviors range 14–39%.[76] Anxiety disorders and disruptive behavior difficulties including Attention Deficit/Hyperactivity Disorder are also prevalent.[77] Gender dysphoria also overlaps with Autism Spectrum Disorder.[78]

75. Of particular concern in the context of adolescent onset gender dysphoria is *Borderline Personality Disorder* (BPD). The DSM-5-TR criteria for BPD are[79]:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
> 2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.
> 3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
> 4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
> 5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
> 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

---

[73] Janssen, *et al.*, 2019.
[74] Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013; Wallien, *et al.*, 2007.
[75] Reisner, *et al.*, 2015.
[76] Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013.
[77] de Vries, *et al.*, 2011; Mustanski, *et al.*, 2010; Wallien, *et al.*, 2007.
[78] de Vries, *et al.*, 2010; Jacobs, *et al.*, 2014; Janssen, *et al.*, 2016; May, *et al.*, 2016; Strang, *et al.*, 2014, 2016.
[79] American Psychiatric Association, 2022, pp. 752–753, italics added.

7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Italics added.)

76. It is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria are actually cases of BPD.[80] That is, some people may be misinterpreting their experiences to represent a gender identity issue, when it instead represents the "identity disturbance" noted in symptom Criterion 3. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence, is substantially more common among biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people (*i.e.*, 0.02%). Thus, if even only a portion of people with BPD had 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.

77. A primary cause for concern is symptom Criterion 5: recurrent suicidality. Regarding the provision of mental health care, this is a crucial distinction: A person with BPD going undiagnosed will not receive the appropriate treatments (the currently most effective of which is Dialectical Behavior Therapy). A person with a cross-gender identity would be expected to feel relief from medical transition, but someone with BPD would not: The problem was not about *gender* identity, but about having an *unstable* identity. Moreover, after a failure of medical transition to provide relief, one would predict for these people increased levels of hopelessness and increased risk of suicidality. One would predict also that misdiagnoses would occur more often if one reflexively dismissed or discounted symptoms of BPD as responses to "minority stress." The Minority Stress Hypothesis is discussed in its own section

[80] *E.g.*, Anzani, *et al.*, 2020; Zucker, 2019.

herein.

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

IV. Other Scientific Claims Assessed

A. Conversion Therapy

79. Activists and social media increasingly, but erroneously, apply the term "conversion therapy" moving farther and farther from what the research has reported. "Conversion therapy" (or "reparative therapy" and other names) was the attempt to change a person's sexual orientation; however, with the public more frequently accustomed to "LGB" being expanded to "LGBTQ+", the claims relevant only to sexual orientation are being misapplied to gender identity. The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, this is only very rarely are mistaken. That is entirely unlike gender identity, wherein the great majority of children who declare cross-gender identity cease to do so by puberty, as shown unanimously by every follow-up study ever published. As the field grows increasingly polarized, any therapy failing to provide affirmation-on-demand is mislabeled "conversion therapy."[81] Indeed, even actions of non-therapists, unrelated to any therapy have been labelled conversion therapy, including the prohibition of biological males competing on female teams.[82]

B. Assessing Claims of Suicidality

80. In the absence of scientific evidence associating improvement with

---

[81] D'Angelo, *et al.*, 2021.
[82] Turban, 2021, March 16.

transition among youth, demands for transition are increasingly accompanied by hyperbolic warnings of suicide should there be delay or obstacle to affirmation-on-demand. Social media circulate claims of extreme suicidality accompanied by declarations that "I'd rather have a trans daughter than a dead son." Such claims convey only grossly misleading misrepresentations of the research literature, however.

81. Despite that the media treat them as near synonyms, suicide and suicidality are distinct phenomena. They represent different behaviors with different motivations, with different mental health issues, and with differing clinical needs. *Suicide* refers to completed suicides and the sincere intent to die. It is substantially associated with impulsivity, using more lethal means, and being a biological male.[83] *Suicidality* refers to parasuicidal behaviors, including suicidal ideation, threats, and gestures. These typically represent cries for help rather than an intent to die and are more common among biological females. Suicidal threats can indicate any of many problems or represent emotional blackmail, as typified in "If you leave me, I will kill myself." Professing suicidality is also used for attention- seeking or for the support or sympathy it evokes from others, indicating distress much more frequently than an intent to die.

82. The scientific study of suicide is inextricably linked to that of mental illness. For example, as noted in the preceding, suicidality is a well-documented symptom of Borderline Personality Disorder (as are chronic identity issues), and personality disorders are highly elevated among transgender populations, especially adolescent-onset. Thus, the elevations of suicidality among gender dysphoric adolescents may not be a result of anything related to transition (or lack of transition), but to the overlap with mental illness of which suicidality is a substantial part. Conversely,

---

[83] Freeman, *et al.*, 2017.

improvements in suicidality reported in some studies may not be the result of anything related to transition, but rather to the concurrent general mental health support which is reported by the clinical reported prospective outcomes. Studies that include more than one factor at the same time without accounting for each other represent a "confound," and it cannot be known which factor (or both) is the one causing the effects observed. That is, when a study provides both mental health services and medical transition services at the same time, it cannot be known which (or both) is what caused any changes.

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

84. Despite that mental health issues, including suicidality, are repeatedly required by clinical standards of care to be resolved before transition, threats of suicide are instead oftentimes used as the very justification for labelling transition a 'medical necessity'. However plausible it might seem that failing to affirm transition causes suicidality, the epidemiological evidence indicates that hypothesis to be incorrect: Suicide rates remains elevated even after complete transition, as shown by a comprehensive review of 17 studies of suicidality in gender dysphoria.[84]

85. Of particular relevance in the present context is suicidality as a well-documented symptom of Borderline Personality Disorder (BPD) and that very many cases appearing to be adolescent-onset gender dysphoria actually represent cases of BPD. [See full DSM-5-TR criteria already listed herein.] That is, some people may be

[84] McNeil, *et al.*, 2017.

misinterpreting their experiencing of the broader "identity disturbance" of symptom Criterion 3 to represent a gender identity issue specifically. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence and occurs in 2–3% of the population, rather than 1-in-5,000 people. (Thus, if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.)

86. Rates of completed suicide are elevated among post-transition transsexuals, but are nonetheless rare,[85] and BPD is repeatedly documented to be greatly elevated among sexual minorities[86]. Overall, rates of suicidal ideation and suicidal attempts appear to be related—not to transition status—but to the social support received: The research evidence shows that support decreases suicidality, but that transition itself does not. Indeed, in some situations, social support was associated with increased suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support.[87]

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

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

---

[85] Wiepjes, *et al.*, 2020.
[86] Reuter, *et al.*, 2016; Rodriguez-Seiljas, *et al.*, 2021; Zanarni, *et al.*, 2021.
[87] Bauer, *et al.*, 2015; Canetto, et al., 2021.

the other parent.

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

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

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

91. Many outcomes studies have been published examining the results of gate-keeper models, but no such studies have been published regarding affirmation-on-demand with children. Although there have been claims that affirmation-on-demand causes mental health or other improvement, these have been the result only of

"retrospective" rather than "prospective" studies. That is, such studies did not take a sample of children and follow them up over time, to see how many dropped out altogether, how many transitioned successfully, and how many transitioned and regretted it or detransitioned. Rather, such studies took a sample of successfully transitioned adults and asked them retrospective questions about their past. In such studies, it is not possible to know how many other people dropped out or regretted transition, and it is not possible to infer causality from any of the correlations detected, despite authors implying and inferring causality.

D. Assessing the "Minority Stress Hypothesis"

92. The elevated levels of mental health problems among lesbian, gay, and bisexual populations is a well-documented phenomenon, and the idea that it is caused by living within a socially hostile environment is called the *Minority Stress Hypothesis*.[88] The association is not entirely straight-forward, however. For example, although lesbian, gay, and bisexual populations are more vulnerable to suicide ideation overall, the evidence specifically on adult lesbian and bisexual women is unclear. Meyer did not include transgender populations in originating the hypothesis, and it remains a legitimate question to what extent and in what ways it might apply to gender identity.

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

[88] Meyer, 2003.

only for the first time.

94. Also suggesting minority stress cannot be the full story is that the mental health symptoms associated with minority stress do not entirely correspond with those associated with gender dysphoria. The primary symptoms associated with minority stress are depressive symptoms, substance use, and suicidal ideation.[89] The symptoms associated with gender dysphoria indeed include depressive symptoms and suicidal ideation, but also include anxiety symptoms, Autism Spectrum Disorders, and personality disorders.

V. Assessing Statements from Professional Associations

A. Understanding the Value of Statements from Professional Associations

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

[89] Meyer, 2003.

feel strongly about political implications of an issue, instead of scientists engaged in the objective study of the topic.

96. Thus, documents from professional associations may represent required standards, the violation of which may merit sanctions, or may represent only recommendations or guidelines. A document may represent the views of an association's full membership or only of the committee's members (or majorities thereof). Documents may be based on systematic, comprehensive reviews of the available research or selected portions of the research. In sum, the weight best placed on any association's statement is the amount by which that association employed evidence versus other considerations in its process.

B. Misrepresentations of statements of professional associations.

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

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

1. World Professional Association for Transgender Health (WPATH)

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

> [I]n follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).[90]

100. That is, "In most children, gender dysphoria will disappear before, or early in, puberty."[91]

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

> Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre, van de Waal & Cohen-Kettenis, 2006; Zucker et al., [2012]).[92]

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

> Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.[93]

103. It does caution, however, "Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria."[94]

2. Endocrine Society (ES)

---

90 Coleman, *et al.*, 2012, at 172.
91 Coleman, *et al.*, 2012, at 173.
92 Coleman, *et al.*, 2012, at 173.
93 Coleman, *et al.*, 2012, at 176.
94 Coleman, *et al.*, 2012, at 176 (quoting Drummond, *et al.*, 2008; Wallien & Cohen-Kettenis, 2008).

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

105. The document acknowledged the frequency of desistance among gender dysphoric children:

> Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence. . . . In adolescence, a significant number of these desisters identify as homosexual or bisexual.[95]

106. The statement similarly acknowledges inability to predict desistance or persistence, "With current knowledge, we cannot predict the psychosexual outcome for any specific child."[96]

107. Although outside their area of professional expertise, mental health issues were also addressed by the Endocrine Society, repeating the need to handle such issues before engaging in transition, "In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues."[97] This ordering—to address mental health issues before embarking on transition—avoids relying on the unproven belief that transition will solve such issues.

---

[95] Hembree, *et al.*, 2017, at 3876.
[96] Hembree, *et al.*, 2017, at 3876.
[97] Hembree, *et al.*, 2017, at 3877.

108. The Endocrine Society did not endorse any affirmation-only approach. The guidelines were neutral with regard to social transitions before puberty, instead advising that such decisions be made only under clinical supervision: "We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional."[98]

109. The Endocrine Society guidelines make explicit that, after gathering information from adolescent clients seeking medical interventions and their parents, the clinician "provides correct information to prevent unrealistically high expectations [and] assesses whether medical interventions may result in unfavorable psychological and social outcomes."[99]

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

110. In 2020, the 1500-member Pediatric Endocrine Society partnered with the Endocrine Society to create and endorse a brief, two-page position statement.[100] Although strongly worded, the document provided no specific guidelines, instead deferring to the Endocrine Society guidelines.[101]

111. It is not clear to what extent this endorsement is meaningful, however. According to the PES, the Endocrine Society "recommendations include evidence that treatment of gender dysphoria/gender incongruence is medically necessary and should be covered by insurance."[102] However, the Endocrine Society makes neither statement. Although the two-page PES document mentioned insurance coverage four times, the only mention of health insurance by the Endocrine Society was: "If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an

98 Hembree, *et al.*, 2017, at 3872.
99 Hembree, *et al.*, 2017, at 3877.
100 PES, online; Pediatric Endocrine Society & Endocrine Society, Dec. 2020.
101 Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1; Hembree, *et al.*, 2017.
102 Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1.

antiandrogen that directly suppresses androgen synthesis or action."[103] Despite the PES asserting it as "medically necessary," the Endocrine Society stopped short of that. Its only use of that phrase was instead limiting: "We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being."[104]

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

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

> Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects. . . . In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent.[105]

113. The AACAP's language repeats the description of the use of puberty blockers only as an exception: "For situations in which deferral of sex reassignment decisions until adulthood is *not clinically feasible*, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues."[106]

114. The AACAP statement acknowledges the long-term outcomes literature for gender dysphoric children: "In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood,"[107] adding that "[c]linicians should be aware of current evidence on the natural course of gender

---

[103] Hembree, *et al.* 2017, at 3883.
[104] Hembree, *et al.*, 2017 at 3872, 3894.
[105] Adelson & AACAP, 2012, at 969.
[106] Adelson & AACAP, 2012, at 969 (italics added).
[107] Adelson & AACAP, 2012, at 963.

discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality."[108]

115. The policy similarly includes a provision for resolving mental health issues: "Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and *treatment of associated mental health problems*."[109] The document also includes minority stress issues and the need to deal with mental health aspects of minority status (*e.g.*, bullying).[110]

116. Rather than endorse social transition for prepubertal children, the AACAP indicates: "There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so."[111]

5. American College of Obstetricians & Gynecologists (ACOG)

117. The American College of Obstetricians & Gynecologists (ACOG) published a "Committee Opinion" expressing recommendations in 2017. The statement indicates it was developed by the ACOG's Committee on Adolescent Health Care, but does not indicate participation based on professional expertise or a systematic method of objectively assessing the existing research. It includes the disclaimer: "This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed."[112]

118. Prepubertal children do not typically have clinical contact with gynecologists, and the ACOG recommendations include that the client additionally

[108] Adelson & AACAP, 2012, at 968.
[109] Adelson & AACAP, 2012, at 970 (italics added).
[110] Adelson & AACAP, 2012, at 969.
[111] Adelson & AACAP, 2012, at 969.
[112] ACOG, 2017, at 1.

have a primary health care provider.[113]

119. The ACOG statement cites the statements made by other medical associations—European Society for Pediatric Endocrinology (ESPE),, PES, and the Endocrine Society—and by WPATH.[114] It does not cite any professional association of *mental* health care providers, however. The ACOG recommendations repeat the previously mentioned eligibility/readiness criteria of having no mental illness that would hamper diagnosis and no medical contraindications to treatment. It notes: "*Before* any treatment is undertaken, the patient must display eligibility and readiness (Table 1), meaning that the adolescent has been evaluated by a mental health professional, has no contraindications to therapy, and displays an understanding of the risks involved."[115]

120. The "Eligibility and Readiness Criteria" also include, "Diagnosis established for gender dysphoria, transgender, transsexualism."[116] This standard, requiring a formal diagnosis, forestalls affirmation-on-demand because self-declared self-identification is not sufficient for DSM diagnosis.

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

6. American College of Physicians (ACP)

122. The American College of Physicians published a position paper broadly expressing support for the treatment of LGBT patients and their families, including nondiscrimination, antiharassment, and defining "family" by emotional rather than biological or legal relationships in visitation policies, and the inclusion of transgender

---

[113] ACOG, 2017, at 1.
[114] ACOG, 2017, at 1, 3.
[115] ACOG, 2017, at 1, 3 (citing the Endocrine Society guidelines) (italics added).
[116] ACOG, 2017, at 3 Table 1.

health care services in public and private health benefit plans.[117]

123. ACP did not provide guidelines or standards for child or adult gender transitions. The policy paper opposed attempting "reparative therapy;" however, the paper confabulated sexual orientation with gender identity in doing so. That is, on the one hand, ACP explicitly recognized that "[s]exual orientation and gender identity are inherently different."[118] It based this statement on the fact that "the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change *sexual orientation*."[119] The APA's document, entitled "Report of the American Psychological Task Force on appropriate therapeutic responses to *sexual orientation*" does not include or reference research on gender identity.[120] Despite citing no research about transgenderism, the ACP nonetheless included in its statement: "Available research does not support the use of reparative therapy as an effective method in the treatment of LGB*T* persons."[121] That is, the inclusion of "T" with "LGB" is based on something other than the existing evidence.

124. There is another statement,[122] which was funded by ACP and published in the Annals of Internal Medicine under its "*In the Clinic*" feature, noting that "'In the Clinic' does not necessarily represent official ACP clinical policy."[123] The document discusses medical transition procedures for adults rather than for children, except to note that "[n]o medical intervention is indicated for prepubescent youth,"[124] that a "mental health provider can assist the child and family with identifying an appropriate time for a social transition,"[125] and that the "child should be assessed and managed for coexisting mood disorders during this period because risk for suicide is

---

117 Daniel & Butkus, 2015a, 2015b.
118 Daniel & Butkus, 2015b, at 2.
119 Daniel & Butkus, 2015b, at 8 (italics added).
120 APA, 2009 (italics added).
121 Daniel & Butkus, 2015b, at 8 (italics added).
122 Safer & Tangpricha, 2019.
123 Safer & Tangpricha, 2019, at ITC1.
124 Safer & Tangpricha, 2019, at ITC9.
125 Safer & Tangpricha, 2019, at ITC9.

higher than in their cisgender peers."[126]

7. American Academy of Pediatrics (AAP)

125. The policy of the American Academy of Pediatrics (AAP) is unique among the major medical associations in being the only one to endorse an affirmation-on-demand policy, including social transition before puberty without any watchful waiting period. Although changes in recommendations can obviously be appropriate in response to new research evidence, the AAP provided none. Rather, the research studies AAP cited in support of its policy simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting.[127] Moreover, of all the outcomes research published, the AAP policy cited *one*, and that without mentioning the outcome data it contained.[128].

8. The ESPE-LWPES GnRH Analogs Consensus Conference Group

126. Included in the interest of completeness, there was also a collaborative report in 2009, between the European Society for Pediatric Endocrinology (ESPE) and the Lawson Wilkins Pediatric Endocrine Society (LWPES).[129] Thirty experts were convened, evenly divided between North American and European labs and evenly divided male/female, who comprehensively rated the research literature on gonadotropin-release hormone analogs in children.

127. The effort concluded that "[u]se of gonadotropin-releasing hormone analogs for conditions other than central precocious puberty requires additional investigation and cannot be suggested routinely."[130] However, gender dysphoria was not explicitly mentioned as one of those other conditions.

---

[126] Safer & Tangpricha, 2019, at ITC9.
[127] Cantor, 2020.
[128] Cantor, 2020, at 1.
[129] Carel et al., 2009.
[130] Carel et al. 2009, at 752.

C. International Health Care Consensus

1. United Kingdom

128. The National Health Service (NHS) of the United Kingdom centralizes gender counselling and transitioning services in a single clinic, the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust. Between 2008 and 2018, the number of referrals to the clinic had increased by a factor of 40, leading to a government inquiry into the causes[131]. The GIDS was repeatedly accused of over-diagnosing and permitting transition in cases despite indicators against patient transition, including by 35 members of the GIDS staff, who resigned by 2019[132].

129. The NHS appointed Dr. Hilary Cass, former President of the Royal College of Paediatrics and Child Health, to conduct an independent review[133]. That review included a systematic consolidation of all the research evidence, following established procedures for preventing the "cherry-picking" or selective citation favouring or down-playing any one conclusion[134]. The review's results were unambiguous: "The critical outcomes for decision making are the impact on gender dysphoria, mental health and quality of life. The quality of evidence for these outcomes was assessed as very low"[135], again using established procedures for assessing clinical research evidence (called GRADE). The review also assessed as "very low" the quality of evidence regarding "body image, psychosocial impact, engagement with health care services, impact on extent of an satisfaction with surgery and stopping treatment"[136]. The report concluded that of the existing research, "The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding....They suggest little change with GnRH analogues [puberty

131 Marsh, 2020; Rayner, 2018.
132 BBC, 2021; Donnelly, 2019.
133 National Health Service, 2020, Sept. 22.
134 National Institute for Health and Care Excellence, 2020.
135 National Institute for Health and Care Excellence, 2020, p. 4.
136 National Institute for Health and Care Excellence, 2020, p. 5.

blockers] from baseline to follow-up"[137].

2. Finland

130. In Finland, the assessments of mental health and preparedness of minors for transition services are centralized by law into two research clinics, Helsinki University Central Hospital and Tampere University Hospital. The eligibility of minors began in 2011. In 2019, Finnish researchers published an analysis of the outcomes of adolescents diagnosed with transsexualism and receiving cross-sex hormone treatment[138]. That study showed that despite the purpose of medical transition to improve mental health: "Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development"[139]. The patients who were functioning well after transition were those who were already functioning well before transition, and those who were functioning poorly, continued to function poorly after transition.

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

[137] National Institute for Health and Care Excellence, 2020, p. 13.
[138] Kaltiala et al., 2020.
[139] Kaltiala et al., 2020, p. 213.

ceased and adolescent development is progressing normally"[140]. The council was explicit in noting the lack of research needed for decision-making, "There is also a need for more information on the *disadvantages* of procedures and on people who regret them"[141].

3. Sweden

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

133. Sweden has long been very accepting with regard to sexual and gender diversity. In 2018, a law was proposed to lower the age of eligibility for ?surgical care from age 18 to 15, remove the requirement for parental consent, and lower legal change of gender to age 12. A series of cases of regret and suicide were reported in the Swedish media, leading to questions of mental health professionals failing to consider. In 2019, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) therefore conducted its own comprehensive review of the research[142]. Like the UK, the Swedish investigation employed methods to ensure the encapsulation of the all the relevant evidence[143].

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

[140] Council for Choices in Health Care in Finland, 2020; italics added.
[141] Council for Choices in Health Care in Finland, 2020; italics added.
[142] Orange, 2020, Feb 22.
[143] Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019.

"recommends restraint when it comes to hormone treatment...Based on the results that have emerged, the National Board of Health and Welfare's overall conclusion is that the risks of anti-puberty and sex-confirming hormone treatment for those under 18 currently outweigh the possible benefits for the group as a whole"[144]. Neither puberty blockers nor cross-sex hormones would be provided under age 16, and patients ages 16–18 would receive such treatments only within research settings (clinical trials monitored by the appropriate Swedish research ethics board).

4. France

135. In 2022, the Académie Nationale de Médecine of France issued a strongly worded statement, citing the Swedish ban on hormone treatments. "[A] great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause...such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause"[145]. For hormones, the Académie concluded "the greatest reserve is required in their use," and for surgical treatments, "[T]heir irreversible nature must be emphasized." The Académie did not outright ban medical interventions, but warned "the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to "detransition". Rather than medical interventions, it advised health care providers "to extend as much as possible the psychological support phase." The Académie reviewed and emphasized the evidence indicating the very large and very sudden increase in youth requesting medical transition. It attributed the change, not to society now being more accepting of sexual diversity, but to social media, "underlining the addictive character of excessive consultation of social networks which is both

[144] Swedish National Board of Health and Welfare, 2022.
[145] Académie Nationale de Médecine, 2022, Feb. 25.

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

References

Académie Nationale de Médecine. (2022, Feb. 25). Medicine and gender transidentity in children and adolescents. Retrieved from https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en

Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results. *International Journal of Pediatric Endocrinology*. doi: 10.1186/s13633-020-00078-2

Adelson, S. L., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues. (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*, 957–974.

American College of Obstetricians and Gynecologists. (2017). Care for transgender Adolescents. Committee Opinion No. 685. Retrieved from www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/01/care-for-transgender-adolescents

American Psychiatric Association. (2022). Diagnostic and statistical manual for mental disorders, fifth edition, text revision (DSM-5-TR). Washington, DC: Author.

American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Retrieved from http://www. apa.org/pi/lgbc/publications/therapeutic-resp.html

Anzani, A., De Panfilis, C., Scandurra, C., & Prunas, A. (2020). Personality disorders and personality profiles in a sample of transgender individuals requesting gender-affirming treatments. *International Journal of Environmental Research and Public Health, 17,* 1521. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7084367/

Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: A respondent driven sampling study in Ontario, Canada. *BMC Public Health*, 15, 525.

BBC News. (2021, Sept. 5). NHS child gender identity clinic whistleblower wins tribunal. *British Broadcasting Company*. Retrieved from https://www.bbc.com/news/uk-58453250

Biggs, M. (2019). A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine, 16,* 2043.

Biggs, M. (2020). Gender dysphoria and psychological functioning in adolescents

treated with GnRHa: Comparing Dutch and English prospective studies. *Archives of Sexual Behavior*, 49, 2231–2236.

Blanchard, R. (1985). Typology of male-to-female transsexualism. *Archives of Sexual Behavior*, 14, 247–261.

Blanchard, R. (1988). Nonhomosexual gender dysphoria. *The Journal of Sex Research*, 24, 188–193.

Blanchard, R. (1989a). The classification and labeling of nonhomosexual gender dysphorias. *Archives of Sexual Behavior*, 18, 315–334.

Blanchard, R. (1989b). The concept of autogynephilia and the typology of male gender dysphoria. *Journal of Nervous and Mental Disease*, 177, 616–623.

Blanchard, R. (1990). Gender identity disorders in adult women. In R. Blanchard & B. W. Steiner (Eds.), *Clinical management of gender identity disorders in children and adults* (pp. 77–91). Washington, DC: American Psychiatric Press.

Blanchard, R. (1991). Clinical observations and systematic studies of autogynephilia. *Journal of Sex and Marital Therapy*, 17, 235–251.

Blanchard, R., Steiner, B. W., Clemmensen, L. H., & Dickey, R. (1989). Prediction of regrets in postoperative transsexuals. *Canadian Journal of Psychiatry*, 34, 43–45.

Boivin, L., Notredame, C.-E., Jardri, R., & Medjkane, F. (2020). Supporting parents of transgender adolescents: Yes, but how? *Archives of Sexual Behavior*, 49, 81–83.

Bränström, R., & Pachankis, J. E. (2019). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: A total population study. *American Journal of Psychiatry, 177,* 727–734.

Canetto, S. S., Antonelli, P., Ciccotti, A., Dettore, D., & Lamis, D. A. (2021). Suicidal as normal: A lesbian, gay, and bisexual youth script? *Crisis, 42,* 292–300.

Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy*, 46, 307–313.

Carel, J. C., Eugster, E. A., Rogol, A., Ghizzoni, L., Palmert, M. R.; ESPE-LWPES GnRH Analogs Consensus Conference Group, Antoniazzi, F., Berenbaum, S., Bourguignon, J. P., Chrousos, G. P., Coste, J., Deal, S., de Vries, L., Foster, C., Heger, S., Holland, J., Jahnukainen, K., Juul, A., Kaplowitz, P., Lahlou, N., Lee, M. M., Lee, P., Merke, D. P., Neely, E. K., Oostdijk, W., Phillip, M., Rosenfield, R. L., Shulman, D., Styne, D., Tauber, M., Wit, J. M. (2009). Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*, 123(4), e752–e762.

Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., Viner, R. M. (2021). 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. *PLosONE*, 16(2): e0243894.

Cohen-Kettenis, P. T. (2001). Gender identity disorder in DSM? *Journal of the American Academy of Child & Adolescent Psychiatry*, 40, 391–391.

Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology*, 31, 41–53.

Cohen, J., Cohen, P., West, S. G. Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences (3rd ed.)*. Mahwah, NJ: Lawrence Erlbaum Associates.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., Lev, A. I., Mayer, G., Meyer-Bahlburg, H., Hall, B. P., Pfaefflin, F., Rachlin, K., Robinson, B., Schechter, L. S., Tangpricha, V., van Trotsenburg, M., Vitale, A., Winter, S., Whittle, S., Wylie, K. R., & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, 13, 165–232.

Costa, R., Dunsford, M., Skagerberg, E., Holt V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 12, 2206–2214.

Council for Choices in Health Care in Finland (COHERE). (2020, June 16). Medical treatment methods for dysphoria associated with variations in gender identity in minors—Recommendation. [Translated] Retrieved from https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474

Dahlen, S., Connolly, D., Arif, I., Hyder Junejo, M., Bewley, S., & Meads, C. (2021). *International clinical practice guidelines for gender minority/trans people: Systematic review and quality assessment. BMJ Open, 11,* e048943.

D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior, 50,* 7–16.

Daniel, H., & Butkus, R. (2015a). Lesbian, gay, bisexual, and transgender health disparities: Executive summary of a policy position paper from the American College of Physicians. *Annals of Internal Medicine*, 163, 135–137.

Daniel, H., & Butkus, R. (2015b). Appendix: Lesbian, gay, bisexual, and transgender health disparities: A policy position paper from the American College of Physicians. *Annals of Internal Medicine*, 163(2), [unpaginated].

de Vries, A. L. C. & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch Approach. *Journal of Homosexuality*, 59, 301–320.

de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134, 1–9.

de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine*, 8, 2276–2283.

de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry*, 52, 1195–1202.

de Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer- Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, 40, 930–936.

Delemarre-van de Waal, H. A., & Cohen- Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155 (suppl 1), S131–S137.

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Langström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE 6*(2), e16885.

Dhejne, C., Van Vlerken, R., Geylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry*, 28, 44–57.

Dhejneberg, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: Prevalence, incidence, and regrets. *Archives of Sexual Behavior*, 43, 1535–1545.

Donnelly, L. (2019, Dec. 12). Children's transgender clinic hit by 35 resignations in three years as psychologists warn of gender dysphoria 'over-diagnoses'. *The Telegraph*. Retrieved from https://www.telegraph.co.uk/news/2019/12/12/childrens-transgender-clinic-hit-35-resignations-three-years/?WT.mc_id=tmg_share_em

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow up study of girls with gender identity disorder. *Developmental Psychology*, 44, 34–45.

Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56, 116–123.

Finland Ministry of Social Affairs and Health, Council for Choices in Health Care. (2020, June 11). *Medical treatment methods for dysphoria associated with variations in gender identity in minors—Recommendation.* Retrieved from https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474

Finland Ministry of Social Affairs and Health, Council for Choices in Health Care. (2020, June 16). *Medical treatments for gender dysphoria that reduces functional capacity in transgender people—Recommendation.* Retrieved from https://palveluvalikoima.fi/documents/1237350/22895838/Summary+transgender.pdf/2cc3f053-2e34-39ce-4e21-becd685b3044/Summary+transgender.pdf?t=1592318543000

Freeman, A., Mergl, R., Kohls, E., Székely, A., Gusmao, R., Arensman, E., Koburger, N., Hegerl, U., & Rummel-Kluge, C. (2017). A cross-national study on gender differences in suicide intent. *BMC Psychiatry, 17,* 234.

Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality.* New Haven, CT: Yale University Press.

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, T. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/ gender-incongruent persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism*, 102, 3869–3903.

Hepp, U., Kraemer, B., Schnyder, U., Miller, N., & Delsignore, A. (2005). Psychiatric comorbidity in gender identity disorder. *Journal of Psychosomatic Research, 58*, 259–261.

Hisle-Gorman, E., Schvey, N. A., Adirim, T. A., Rayne, A. K., Susi, A., Roberts, T. A., & Klein, D. A. (2021). Mental healthcare utilization of transgender youth before and after affirming treatment. *The Journal of Sexual Medicine, 18,* 1444–1454.

Holt, V., Skagerberg, E., & Dunsford, M. (2016). Young people with features of gender dysphoria: Demographics and associated difficulties. *Clinical Child Psychology and Psychiatry, 21*, 108–118.

Jacobs, L. A., Rachlin, K., Erickson-Schroth, L., & Janssen, A. (2014). Gender dysphoria and co-occurring autism spectrum disorders: Review, case examples, and treatment considerations. *LGBT Health, 1*, 277–282.

Janssen, A., Busa, S., Wernick, J. (2019). The complexities of treatment planning for transgender youth with co-occurring severe mental illness: A literature review and case study. *Archives of Sexual Behavior, 48*, 2003–2009.

Janssen, A., Huang, H., & Duncan, C. (2016). Gender variance among youth with autism spectrum disorders: A retrospective chart review. *Transgender Health, 1*, 63–68.

Kalin, N. H. (2020). Reassessing mental health treatment utilization reduction in transgender individuals after gender-affirming surgeries: A comment by the Editor on the process. *American Journal of Psychiatry, 177,* 765.

Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., & Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health, 9*, 9.

Kaltiala, R, Heino, E., Työläjärvi, & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry, 74,* 213–219.

Kaltiala, R., Heino, E., Työläjärvi, & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry, 74,* 213–219.

Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender- affirming hormone therapy. *Pediatrics, 145*, e20193006.

Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a raid onset of gender dysphoria. *PLoS ONE, 13*(8), e0202330.

Marsh, S. (2020, Sept. 20). NHS to hold review into gender identity services for children and young people. *The Guardian.* Retrieved from https://www.theguardian.com/society/2020/sep/22/nhs-to-hold-review-into-gender-identity-services-for-children-and-young-people

May, T., Pang, K., & Williams, K. J. (2016). Gender variance in children and adolescents with autism spectrum disorder from the National Database for Autism Research. *International Journal of Transgenderism, 18*, 7–15.

McCall, B. (2021, October 7). Psychiatrists shift stance on gender dysphoria, recommend therapy. *Medscape Psychiatry.* Retrieved from www.medscape.com/viewarticle/960390?src=soc_tw_share

McNeil, J., Ellis, S. J., & Eccles, F. J. R. (2017). Suicide in trans populations: A systematic review of prevalence and correlates. *Psychology of Sexual Orientation and Gender Diversity, 4,* 341–353.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*, 674–697.

Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/ role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology, 4*, 29–41.

Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health, 100*, 2426–2432.

Nainggolan, L. (2021, May 12). Hormonal Tx of youth with gender dysphoria stops in Sweden. Medscape Psychiatry. Retrieved from www.medscape.com/viewarticle/950964?src=soc_tw_share

National Health Service (NHS). (2020, Sept. 22). NHS announces independent review into gender identity services for children and young people. United Kingdom. Retrieved from https://www.england.nhs.uk/2020/09/nhs-announces-independent-review-into-gender-identity-services-for-children-and-young-people/

National Institute for Health and Care Excellence (NICE). (2020, Oct. 14). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. Retrieved from https://arms.nice.org.uk/resources/hub/1070905/attachment

Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics, 137*, e20153223.

Orange, R. (2020, Feb 22). Teenage transgender row splits Sweden as dysphoria diagnoses soar by 1,500%: New health report and TV debates highlight backlash against gender reassignment. *The Guardian.* Retrieved from https://www.theguardian.com/society/2020/feb/22/ssweden-teenage-transgender-row-dysphoria-diagnoses-soar

Pediatric Endocrine Society & Endocrine Society. (2020, December 15). *Transgender health.* Retrieved from www.endocrine.org/advocacy/position-statements/transgender-health.

Pediatric Endocrine Society. (Online). About PES. Retrieved from https://pedsendo.org/about-pes/

Rae, J. R., Gülgoz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science, 30*, 669–681.

Rafferty, J., AAP Committee on psychosocial aspects of child and family health, AAP Committee on adolescence, AAP Section on lesbian, gay, bisexual, and transgender health and wellness. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics, 142*(4), e20182162

Rayner, G. (2018, Sept. 16). Minister orders inquiry into 4000 percent rise in children wanting to change sex. *The Telegraph.* Retrieved from https://www.telegraph.co.uk/politics/2018/09/16/minister-orders-inquiry-4000-per-cent-rise-children-wanting/

Reisner, S. L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *Journal of Adolescent Health, 56(3)*, 274–279.

Reuter, T. R., Sharp, C., Kalpakci, A. H., Choi, H. J., & Temple, J. R. (2016). Sexual orientation and Borderline Personality Disorder features in a community sample of adolescents. *Journal of Personality Disorders, 30,* 694–707.

Rodriguez-Seiljas, C., Morgan, T. A., & Zimmerman, M. (2021). A population-based examination of criterion-level disparities in the diagnosis of Borderline Personality Disorder among sexual minority adults. *Assessment, 28,* 1097–1109.

Safer, J. D., Tangpricha, V. (2019). In the clinic: Care of the transgender patient. *Annals of Internal Medicine, 171*(1), ITC1–ITC6.

Schumm, W. R., & Crawford, D. W. (2020). Is research on transgender children

what it seems? Comments on recent research on transgender children with high levels of parental support. *The Linacre Quarterly, 87,* 9–24.

Schumm, W. R., Crawford, D. W., Fawver, M. M., Gray, N. K., Niess, Z. M., & Wagner, A. D. (2019). Statistical errors in major journals: Two case studies used in a basic statistics class to assess understanding of applied statistics. *Psychology and Education—An Interdisciplinary Journal, 56,* 35–42.

Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. *Frontiers in Psychiatry*, 12, 632784.

Skagerberg, E., Parkinson, R., & Carmichael, P. (2013). Self-harming thoughts and behaviors in a group of children and adolescents with gender dysphoria. *International Journal of Transgenderism, 14*, 86–92.

Skelly, A. C., Dettori, J. R., & Brodt, E. D. (2012). Assessing bias: The importance of considering confounding. *Evidence-based Spine-Care Journal, 3,* 9–12.

Spack, N. P. (2013). Management of transgenderism. *Journal of the American Medical Association, 309,* 478–484.

Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics, 129,* 418–425.

Steensma, T. D., Cohen-Kettenis, P. T., & Zucker, K. J. (2018). Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988–2016). *Journal of Sex & Marital Therapy, 44,* 713–715.

Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*, 582–590.

Strang, J. F., Kenworthy, L., Dominska, A., Sokoloff, J., Kenealy, L. E., Berl, M., ... Wallace, G. L. (2014). Increased gender variance in autism spectrum disorders and attention deficit hyperactivity disorder. *Archives of Sexual Behavior, 43*, 1525–1533.

Strang, J. F., Meagher, H., Kenworthy, L., de Vries, A. L., Menvielle, E., Leibowitz, S., ... Anthony, L. G. (2016). Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *Journal of Clinical Child and Adolescent Psychology, 47*, 105–115.

Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU). (2019, Sept. 6). Gender dysphoria in children and adolescents: An inventory of the literature. A systematic scoping review. Retrieved from https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/

Swedish Agency of Health Technology Assessment and Assessment of Social Services. (2019). *Gender dysphoria in children and adolescents: An inventory of the literature.* Retrieved from: www.sbu.se/en/publications/sbu-bereder/gender-

dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/

Swedish National Board of Health and Welfare (NBHW). (2020, Feb. 22). Uppdaterade rekommendationer för hormonbehandling vid könsdysfori hos unga. [*Updated recommendations for hormone therapy for gender dysphoria in young people.*] Author: Socialstyrelsen. Retrieved from https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdaterade-rekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/

Tetelepta, B. (2021, Feb 27). More research is urgently needed into transgender care for young people: 'Where does the large flow of children come from?' [translated]. Algemeen Dagblad. Retrieved from www.ad.nl/nijmegen/dringend-meer-onderzoek-nodig-naar-transgenderzorg-aan-jongeren-waar-komt-de-grote-stroom-kinderen-vandaan~aec79d00/?referrer=https%3A%2F%2Ft.co%2F.

Thrower, E., Bretherton, I., Pang, K. C., Zajac, J. D., & Cheung, A. S. (2020). Prevalence of Autism Spectrum Disorder and Attention-Deficit Hyperactivity Disorder amongst individuals with Gender Dysphoria: A systematic review. *Journal of Autism and Developmental Disorders*, 50, 695–706.

Turban, J. (2021, March 16). Trans girls belong on girls' sports teams. *Scientific American*. www.scientificamerican.com/article/trans-girls-belong-on-girls-sports-teams/

United Kingdom National Health Service (NHS), National Institute for Health and Care Excellence, (2021, March 11). *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria.* Retrieved from www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3ffrom%3d2020-01-01%26q%3dgender%2bdysphoria%26sp%3don%26to%3d2021-03-31

van der Miesen, A. I. R., Steensma, T. D., de Vries, A. L. C., Bos, H., Popma, A. (2020). Psychological functioning in transgender adolescence before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health, 66*, 699–704.

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*, 1413–1423.

Wallien, M. S., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*, 1307–1314.

Warrier, V., Greenberg, D. M., Weir, E., Buckingham, C., Smith, P., Lai, M.-C., Allison, C., & Baron-Cohen, S. (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature Communications, 11,* 3959.

Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Block, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). *Acta Psychiatrica Scandinavica, 141,* 486–491.

Wiepjes, C. M., Nota, N. M., de Bok, C. J. M., Klaver, M., de Vries, A. L. C., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M-B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels B. P. C., & den Heijer, M. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine, 15*, 582–590.

Wood, H., Sasaki, S., Bradley, S. J., Singh, D., Fantus, S., Own-Anderson, A., Di Giacomo, A., Bain, J., & Zucker, K. J. (2013). Patterns of referral to a gender identity service for children and adolescents (1976–2011): Age, sex ratio, and sexual orientation. *Journal of Sex & Marital Therapy, 39,* 1–6.

Zanarini, M. C., Magni, L. R., Temes, C. M., Hein, K. E., Aguirre, B. A., & Goodman, M. (2021). Sexual orientation and gender of intimate relationship partners among adolescents with BPD and psychiatrically healthy adolescents. *Journal of Personality Disorders, 35 (Suppl. B),* 1–7.

Zucker, K. J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior, 48,* 1983–1992.

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (2012). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy, 38,* 151–189.

Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*, 90–97.

APPENDICES

Appendix 1

Curriculum Vita

Appendix 2

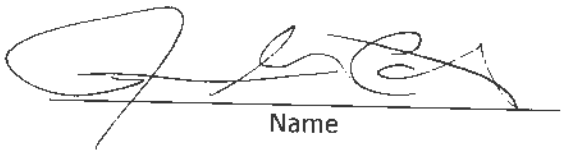
Peer-reviewed article:

Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy, 46,* 307–313. doi: 10.1080/0092623X.2019.1698481

Appendix 3

The Outcomes Studies of Childhood-Onset Gender Dysphoria

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed on 30 April, 2022.



Name

James M. Cantor, PhD

Toronto Sexuality Centre
2 Carlton Ave., suite 1820
Toronto, Ontario, Canada M5B 1J3

[redacted]

EDUCATION

Postdoctoral Fellowship Jan., 2000–May, 2004
Centre for Addiction and Mental Health • Toronto, Canada

Doctor of Philosophy Sep., 1993–Jun., 2000
Psychology • McGill University • Montréal, Canada

Master of Arts Sep., 1990–Jan., 1992
Psychology • Boston University • Boston, MA

Bachelor of Science Sep. 1984–Aug., 1988
Interdisciplinary Science • Rensselaer Polytechnic Institute • Troy, NY
Concentrations: Computer science, mathematics, physics

EMPLOYMENT HISTORY

Director Feb., 2017–Present
Toronto Sexuality Centre • Toronto, Canada

Senior Scientist (Inaugural Member) Aug., 2012–May, 2018
Campbell Family Mental Health Research Institute
Centre for Addiction and Mental Health • Toronto, Canada

Senior Scientist Jan., 2012–May, 2018
Complex Mental Illness Program
Centre for Addiction and Mental Health • Toronto, Canada

Head of Research Nov., 2010–Apr. 2014
Sexual Behaviours Clinic
Centre for Addiction and Mental Health • Toronto, Canada

Research Section Head Dec., 2009–Sep. 2012
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Psychologist May, 2004–Dec., 2011
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

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

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

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

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

ACADEMIC APPOINTMENTS

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

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

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

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

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

PUBLICATIONS

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

10.1177/1079063215612444

15. Stephens, S., Cantor, J. M., Goodwill, A. M., & Seto, M. C. (2017). Multiple indicators of sexual interest in prepubescent or pubescent children as predictors of sexual recidivism. *Journal of Consulting and Clinical Psychology, 85,* 585–595. doi: 10.1037/ccp0000194
16. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2017). Evidence of construct validity in the assessment of hebephilia. *Archives of Sexual Behavior, 46,* 301–309. doi: 10.1007/s10508-016-0907-z
17. Walton, M. T., Cantor, J. M., & Lykins, A. D. (2017). An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior. *Archives of Sexual Behavior, 46,* 721–733. doi: 10.1007/s10508-015-0606-1
18. Cantor, J. M., Lafaille, S. J., Hannah, J., Kucyi, A., Soh, D. W., Girard, T. A., & Mikulis, D. J. (2016). Independent component analysis of resting-state functional magnetic resonance imaging in pedophiles. *Journal of Sexual Medicine, 13,* 1546–1554. doi: 10.1016/j.jsxm.2016.08.004
19. Cantor, J. M., & McPhail, I. V. (2016). Non-offending pedophiles. *Current Sexual Health Reports, 8,* 121–128. doi: 10.1007/s11930-016-0076-z
20. Cantor, J. M. (2015). Milestones in sex research: What causes pedophilia? In J. S. Hyde, J. D. DeLamater, & E. S. Byers (Eds.), *Understanding human sexuality* (6th Canadian ed.) (pp. 452–453). Toronto: McGraw-Hill Ryerson.
21. Cantor, J. M. (2015). Pedophilia. In R. Cautin & S. Lilienfeld (Eds.), *Encyclopedia of clinical psychology.* Malden, MA: Wiley-Blackwell. doi: 10.1002/9781118625392.wbecp184
22. Nunes, K. L., & Cantor, J. M. (2015). Sex offenders. In P. Whelehan & A. Bolin (Eds.), *International encyclopedia of human sexuality.* Malden, MA: Wiley-Blackwell.
23. Cantor, J. M., Lafaille, S., Soh, D. W., Moayedi, M., Mikulis, D. J., & Girard, T. A. (2015). Diffusion Tensor Imaging of pedophilia. *Archives of Sexual Behavior, 44,* 2161–2172. doi: 10.1007/s10508-015-0599-9
24. Cantor, J. M., & McPhail, I. V. (2015). Sensitivity and specificity for the phallometric test of hebephilia. *Journal of Sexual Medicine, 12,* 1940–1950. doi: 10.1111/jsm12970
25. Dyshniku, F., Murray, M. E., Fazio, R. L., Lykins, A. D., & Cantor, J. M. (2015). Minor physical anomalies as a window into the prenatal origins of pedophilia. *Archives of Sexual Behavior, 44,* 2151–2159. doi: 10.1007/s10508-015-0564-7
26. Fazio, R. L., & Cantor, J. M. (2015). Factor structure of the Edinburgh Handedness Inventory versus the Fazio Laterality Inventory in a population with established atypical handedness. *Applied Neuropsychology, 22,* 156–160. doi: 10.1080/23279095.2014.940043
27. Lykins, A. D., Robinson, J. J., LeBlanc, S., & Cantor, J. M. (2015). The effects of common medications on volumetric phallometry. *Journal of Sexual Aggression, 21,* 385–393. doi: 10.1080/13552600.2014.900121
28. Sutton, K. S., Stratton, N., Pytyck, J., Kolla, N. J., & Cantor, J. M. (2015). Patient characteristics by type of hypersexuality referral: A quantitative chart review of 115 consecutive male cases. *Journal of Sex and Marital Therapy, 41,* 563−580. doi: 10.1080/0092623X.2014.935539
29. Cantor, J. M. (2014). Gold star pedophiles in general sex therapy practice. In Y. M. Binik and K. Hall (Eds.), *Principles and practice of sex therapy* (5th ed.) (pp. 219–234). New York: Guilford.

30. Cantor, J. M., & Sutton, K. S. (2014). Paraphilia, gender dysphoria, and hypersexuality. In P. H. Blaney & T. Millon (Eds.), *Oxford textbook of psychopathology* (3rd ed.) (pp. 589–614). New York: Oxford University Press.
31. Chivers, M. L., Roy, C., Grimbos, T., Cantor, J. M., & Seto, M. C. (2014). Specificity of sexual arousal for sexual activities in men and women with conventional and masochistic sexual interests. *Archives of Sexual Behavior, 43,* 931−940. doi: 10.1007/s10508-013-0174-1
32. Fazio, R. L., Lykins, A. D., & Cantor, J. M. (2014). Elevated rates of atypical-handedness in paedophilia: Theory and implications. *Laterality, 19,* 690−704. doi: 10.1080/1357650X.2014.898648
33. Lykins, A. D., & Cantor, J. M. (2014). Vorarephilia: A case study in masochism and erotic consumption. *Archives of Sexual Behavior, 43,* 181–186. doi: 10.1007/s10508-013-0185-y
34. Cantor, J. M., Klein, C., Lykins, A., Rullo, J. E., Thaler, L., & Walling, B. R. (2013). A treatment-oriented typology of self-identified hypersexuality referrals. *Archives of Sexual Behavior, 42,* 883–893. doi: 10.1007/s10508-013-0085-1
35. Blanchard, R., Kuban, M. E., Blak, T., Klassen, P. E., Dickey, R., & Cantor, J. M. (2012). Sexual attraction to others: A comparison of two models of alloerotic responding in men. *Archives of Sexual Behavior, 41,* 13–29. doi: 10.1007/s10508-010-9675-3
36. Cantor, J. M. (2012). Brain research and pedophilia: What it says and what it means [Invited article]. *Sex Offender Law Report, 13,* 81–85.
37. Cantor, J. M. (2012). Is homosexuality a paraphilia? The evidence for and against. *Archives of Sexual Behavior, 41,* 237–247. doi: 10.1007/s10508-012-9900-3
38. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010). Sexual arousal to female children in gynephilic men. *Sexual Abuse: A Journal of Research and Treatment, 22,* 279–289. doi: 10.1177/1079063210372141
39. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010). The relation between peak response magnitudes and agreement in diagnoses obtained from two different phallometric tests for pedophilia. *Sexual Abuse: A Journal of Research and Treatment, 22,* 42–57. doi: 10.1177/1079063209352094
40. Cantor, J. M., Blanchard, R., & Barbaree, H. E. (2009). Sexual disorders. In P. H. Blaney & T. Millon (Eds.), *Oxford textbook of psychopathology* (2nd ed.) (pp. 527–548). New York: Oxford University Press.
41. Barbaree, H. E., Langton, C. M., Blanchard, R., & Cantor, J. M. (2009). Aging versus stable enduring traits as explanatory constructs in sex offender recidivism: Partitioning actuarial prediction into conceptually meaningful components. *Criminal Justice and Behavior: An International Journal, 36,* 443–465. doi: 10.1177/0093854809332283
42. Blanchard, R., Kuban, M. E., Blak, T., Cantor, J. M., Klassen, P. E., & Dickey, R. (2009). Absolute versus relative ascertainment of pedophilia in men. *Sexual Abuse: A Journal of Research and Treatment, 21,* 431–441. doi: 10.1177/1079063209347906
43. Blanchard, R., Lykins, A. D., Wherrett, D., Kuban, M. E., Cantor, J. M., Blak, T., Dickey, R., & Klassen, P. E. (2009). Pedophilia, hebephilia, and the DSM–V. *Archives of Sexual Behavior, 38,* 335–350. doi: 10.1007/s10508-008-9399-9.
44. Cantor, J. M. (2008). MRI research on pedophilia: What ATSA members should know

[Invited article]. *ATSA Forum, 20*(4), 6–10.

45. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2008). Cerebral white matter deficiencies in pedophilic men. *Journal of Psychiatric Research, 42,* 167–183. doi: 10.1016/j.jpsychires.2007.10.013
46. Blanchard, R., Kolla, N. J., Cantor, J. M., Klassen, P. E., Dickey, R., Kuban, M. E., & Blak, T. (2007). IQ, handedness, and pedophilia in adult male patients stratified by referral source. *Sexual Abuse: A Journal of Research and Treatment, 19,* 285–309. doi: 10.1007/s11194-007-9049-0
47. Cantor, J. M., Kuban, M. E., Blak, T., Klassen, P. E., Dickey, R., & Blanchard, R. (2007). Physical height in pedophilia and hebephilia. *Sexual Abuse: A Journal of Research and Treatment, 19,* 395–407. doi: 10.1007/s11194-007-9060-5
48. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2006). Interaction of fraternal birth order and handedness in the development of male homosexuality. *Hormones and Behavior, 49,* 405–414. doi: 10.1016/j.yhbeh.2005.09.002
49. Blanchard, R., Kuban, M. E., Blak, T., Cantor, J. M., Klassen, P., & Dickey, R. (2006). Phallometric comparison of pedophilic interest in nonadmitting sexual offenders against stepdaughters, biological daughters, other biologically related girls, and unrelated girls. *Sexual Abuse: A Journal of Research and Treatment, 18,* 1–14. doi: 10.1007/s11194-006-9000-9
50. Blanchard, R., Cantor, J. M., & Robichaud, L. K. (2006). Biological factors in the development of sexual deviance and aggression in males. In H. E. Barbaree & W. L. Marshall (Eds.), *The juvenile sex offender* (2nd ed., pp. 77–104). New York: Guilford.
51. Cantor, J. M., Kuban, M. E., Blak, T., Klassen, P. E., Dickey, R., & Blanchard, R. (2006). Grade failure and special education placement in sexual offenders' educational histories. *Archives of Sexual Behavior, 35,* 743–751. doi: 10.1007/s10508-006-9018-6
52. Seto, M. C., Cantor, J. M., & Blanchard, R. (2006). Child pornography offenses are a valid diagnostic indicator of pedophilia. *Journal of Abnormal Psychology, 115,* 610–615. doi: 10.1037/0021-843X.115.3.610
53. Zucker, K. J., Mitchell, J. N., Bradley, S. J., Tkachuk, J., Cantor, J. M., & Allin, S. M. (2006). The Recalled Childhood Gender Identity/Gender Role Questionnaire: Psychometric properties. *Sex Roles, 54,* 469–483. doi 10.1007/s11199-006-9019-x
54. Cantor, J. M., Blanchard, R., Robichaud, L. K., & Christensen, B. K. (2005). Quantitative reanalysis of aggregate data on IQ in sexual offenders. *Psychological Bulletin, 131,* 555–568. doi: 10.1037/0033-2909.131.4.555
55. Cantor, J. M., Klassen, P. E., Dickey, R., Christensen, B. K., Kuban, M. E., Blak, T., Williams, N. S., & Blanchard, R. (2005). Handedness in pedophilia and hebephilia. *Archives of Sexual Behavior, 34,* 447–459. doi: 10.1007/s10508-005-4344-7
56. Cantor, J. M., Blanchard, R., Christensen, B. K., Dickey, R., Klassen, P. E., Beckstead, A. L., Blak, T., & Kuban, M. E. (2004). Intelligence, memory, and handedness in pedophilia. *Neuropsychology, 18,* 3–14. doi: 10.1037/0894-4105.18.1.3
57. Blanchard, R., Kuban, M. E., Klassen, P., Dickey, R., Christensen, B. K., Cantor, J. M., & Blak, T. (2003). Self-reported injuries before and after age 13 in pedophilic and non-pedophilic men referred for clinical assessment. *Archives of Sexual Behavior, 32,* 573–581.

58. Blanchard, R., Christensen, B. K., Strong, S. M., Cantor, J. M., Kuban, M. E., Klassen, P., Dickey, R., & Blak, T. (2002). Retrospective self-reports of childhood accidents causing unconsciousness in phallometrically diagnosed pedophiles. *Archives of Sexual Behavior, 31,* 511–526.

59. Cantor, J. M., Blanchard, R., Paterson, A. D., Bogaert, A. F. (2002). How many gay men owe their sexual orientation to fraternal birth order? *Archives of Sexual Behavior, 31,* 63–71.

60. Cantor, J. M., Binik, Y. M., & Pfaus, J. G. (1999). Chronic fluoxetine inhibits sexual behavior in the male rat: Reversal with oxytocin. *Psychopharmacology, 144,* 355–362.

61. Binik, Y. M., Cantor, J., Ochs, E., & Meana, M. (1997). From the couch to the keyboard: Psychotherapy in cyberspace. In S. Kiesler (Ed.), *Culture of the internet* (pp. 71–100). Mahwah, NJ: Lawrence Erlbaum.

62. Johnson, M. K., O'Connor, M., & Cantor, J. (1997). Confabulation, memory deficits, and frontal dysfunction. *Brain and Cognition, 34,* 189–206.

63. Keane, M. M., Gabrieli, J. D. E., Monti, L. A., Fleischman, D. A., Cantor, J. M., & Nolan, J. S. (1997). Intact and impaired conceptual memory processes in amnesia. *Neuropsychology, 11,* 59–69.

64. Pilkington, N. W., & Cantor, J. M. (1996). Perceptions of heterosexual bias in professional psychology programs: A survey of graduate students. *Professional Psychology: Research and Practice, 27,* 604–612.

PUBLICATIONS

LETTERS AND COMMENTARIES

1. Cantor, J. M. (2015). Research methods, statistical analysis, and the phallometric test for hebephilia: Response to Fedoroff [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2499–2500. doi: 10.1111/jsm.13040
2. Cantor, J. M. (2015). In his own words: Response to Moser [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2502–2503. doi: 10.1111/jsm.13075
3. Cantor, J. M. (2015). Purported changes in pedophilia as statistical artefacts: Comment on Müller et al. (2014). *Archives of Sexual Behavior, 44,* 253–254. doi: 10.1007/s10508-014-0343-x
4. McPhail, I. V., & Cantor, J. M. (2015). Pedophilia, height, and the magnitude of the association: A research note. *Deviant Behavior, 36,* 288–292. doi: 10.1080/01639625.2014.935644
5. Soh, D. W., & Cantor, J. M. (2015). A peek inside a furry convention [Letter to the Editor]. *Archives of Sexual Behavior, 44,* 1–2. doi: 10.1007/s10508-014-0423-y
6. Cantor, J. M. (2012). Reply to Italiano's (2012) comment on Cantor (2011) [Letter to the Editor]. *Archives of Sexual Behavior, 41,* 1081–1082. doi: 10.1007/s10508-012-0011-y
7. Cantor, J. M. (2012). The errors of Karen Franklin's *Pretextuality* [Commentary]. *International Journal of Forensic Mental Health, 11,* 59–62. doi: 10.1080/14999013.2012.672945
8. Cantor, J. M., & Blanchard, R. (2012). White matter volumes in pedophiles, hebephiles, and teleiophiles [Letter to the Editor]. *Archives of Sexual Behavior, 41, 749–752.* doi: 10.1007/s10508-012-9954-2
9. Cantor, J. M. (2011). New MRI studies support the Blanchard typology of male-to-female transsexualism [Letter to the Editor]. *Archives of Sexual Behavior, 40,* 863–864. doi: 10.1007/s10508-011-9805-6
10. Zucker, K. J., Bradley, S. J., Own-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex and Marital Therapy, 34,* 287–290.
11. Cantor, J. M. (2003, Summer). Review of the book *The Man Who Would Be Queen* by J. Michael Bailey. *Newsletter of Division 44 of the American Psychological Association, 19*(2), 6.
12. Cantor, J. M. (2003, Spring). What are the hot topics in LGBT research in psychology? *Newsletter of Division 44 of the American Psychological Association, 19*(1), 21–24.
13. Cantor, J. M. (2002, Fall). Male homosexuality, science, and pedophilia. *Newsletter of Division 44 of the American Psychological Association, 18*(3), 5–8.
14. Cantor, J. M. (2000). Review of the book *Sexual Addiction: An Integrated Approach. Journal of Sex and Marital Therapy, 26,* 107–109.

EDITORIALS

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

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

FUNDING HISTORY

Principal Investigators:	Doug VanderLaan, Meng-Chuan Lai
Co-Investigators:	James M. Cantor, Megha Mallar Chakravarty, Nancy Lobaugh, M. Palmert, M. Skorska
Title:	*Brain function and connectomics following sex hormone treatment in adolescents experience gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Behavioural Sciences-B-2
Funds:	$650,250 / 5 years (July, 2018)
Principal Investigator:	Michael C. Seto
Co-Investigators:	Martin Lalumière , James M. Cantor
Title:	*Are connectivity differences unique to pedophilia?*
Agency:	University Medical Research Fund, Royal Ottawa Hospital
Funds:	$50,000 / 1 year (January, 2018)
Principal Investigator:	Lori Brotto
Co-Investigators:	Anthony Bogaert, James M. Cantor, Gerulf Rieger
Title:	*Investigations into the neural underpinnings and biological correlates of asexuality*
Agency:	Natural Sciences and Engineering Research Council (NSERC), Discovery Grants Program
Funds:	$195,000 / 5 years (April, 2017)
Principal Investigator:	Doug VanderLaan
Co-Investigators:	Jerald Bain, James M. Cantor, Megha Mallar Chakravarty, Sofia Chavez, Nancy Lobaugh, and Kenneth J. Zucker
Title:	*Effects of sex hormone treatment on brain development: A magnetic resonance imaging study of adolescents with gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Transitional Open Grant Program
Funds:	$952,955 / 5 years (September, 2015)
Principal Investigator:	James M. Cantor
Co-Investigators:	Howard E. Barbaree, Ray Blanchard, Robert Dickey, Todd A. Girard, Phillip E. Klassen, and David J. Mikulis
Title:	*Neuroanatomic features specific to pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$1,071,920 / 5 years (October, 2008)
Principal Investigator:	James M. Cantor
Title:	*A preliminary study of fMRI as a diagnostic test of pedophilia*
Agency:	Dean of Medicine New Faculty Grant Competition, Univ. of Toronto
Funds:	$10,000 (July, 2008)

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

KEYNOTE AND INVITED ADDRESSES

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

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

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

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

PAPER PRESENTATIONS AND SYMPOSIA

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

preferences. Symposium presented at the 37th annual meeting of the International Academy of Sex Research, Los Angeles, USA.

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

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

POSTER PRESENTATIONS

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

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

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

EDITORIAL AND PEER-REVIEWING ACTIVITIES

Editor-in-Chief

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

Editorial Board Memberships

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

Ad hoc Journal Reviewer Activity

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

GRANT REVIEW PANELS

2017–2021 Member, College of Reviewers, *Canadian Institutes of Health Research,* Canada.

2017 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2017 Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2016 Reviewer. National Science Center [*Narodowe Centrum Nauki*], Poland.

2016 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2015 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2015 Reviewer. *Czech Science Foundation,* Czech Republic.

2015 Reviewer, "Off the beaten track" grant scheme. *Volkswagen Foundation,* Germany.

2015 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada

2015 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2014 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2014 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada.

2014 Panel Member, Dean's Fund—Clinical Science Panel. *University of Toronto Faculty of Medicine*, Canada.

2014 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2013 Panel Member, Grant Miller Cancer Research Grant Panel. *University of Toronto Faculty of Medicine*, Canada.

2013 Panel Member, Dean of Medicine Fund New Faculty Grant Clinical Science Panel. *University of Toronto Faculty of Medicine,* Canada.

2012 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence (2nd round). *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2012 External Reviewer, University of Ottawa Medical Research Fund. *University of Ottawa Department of Psychiatry*, Canada.

2012 External Reviewer, Behavioural Sciences—B. *Canadian Institutes of Health Research*, Canada.

2011 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

TEACHING AND TRAINING

PostDoctoral Research Supervision
Law & Mental Health Program, Centre for Addiction and Mental Health, Toronto, Canada

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

Doctoral Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

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

Masters Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

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

Undergraduate Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

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

Clinical Supervision (Doctoral Internship)
Clinical Internship Program, Centre for Addiction and Mental Health, Toronto, Canada

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

TEACHING AND TRAINING

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

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

PROFESSIONAL SOCIETY ACTIVITIES

OFFICES HELD

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

PROFESSIONAL SOCIETY ACTIVITIES

MEMBERSHIPS

2017–2021 Member • *Canadian Sex Research Forum*

2009–Present Member • *Society for Sex Therapy and Research*

2006–Present Member (elected) • *International Academy of Sex Research*

2006–Present Research and Clinical Member • *Association for the Treatment of Sex Abusers*

2003–2006 Associate Member (elected) • *International Academy of Sex Research*

2002 Founding Member • CPA Section on Sexual Orientation and Gender Identity

2001–2013 Member • *Canadian Psychological Association* (CPA)

2000–2015 Member • *American Association for the Advancement of Science*

2000–2015 Member • *American Psychological Association* (APA)

APA Division 12 (Clinical Psychology)

APA Division 44 (Society for the Psychological Study of LGB Issues)

2000–2020 Member • *Society for the Scientific Study of Sexuality*

1995–2000 Student Member • *Society for the Scientific Study of Sexuality*

1993–2000 Student Affiliate • *American Psychological Association*

1990–1999 Member, American Psychological Association of Graduate Students (APAGS)

CLINICAL LICENSURE/REGISTRATION

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

AWARDS AND HONORS

2017 Elected Fellow, Association for the Treatment of Sexual Abusers

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

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

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

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

1995 Dissertation Research Grant
Society for the Scientific Study of Sexuality

1994–1996 McGill University Doctoral Scholarship

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

MAJOR MEDIA

(Complete list available upon request.)

Feature-length Documentaries

Vice Canada Reports. *Age of Consent.* 14 Jan 2017.
Canadian Broadcasting Company. *I, Pedophile.* Firsthand documentaries. 10 Mar 2016.

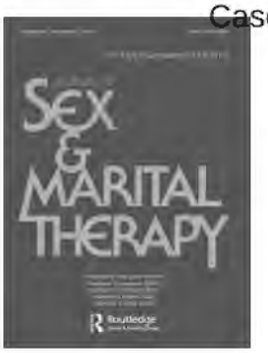
Appearances and Interviews

11 Mar 2020. Ibbitson, John. It is crucial that Parliament gets the conversion-therapy ban right. *The Globe & Mail.*
25 Jan 2020. Ook de hulpvaardige buurman kan verzamelaar van kinderporno zin. *De Morgen.*
3 Nov 2019. Village of the damned. *60 Minutes Australia.*
1 Nov 2019. HÅKON F. HØYDAL. Norsk nettovergriper: – Jeg hater meg selv: Nordmannen laster ned overgrepsmateriale fra nettet – og oppfordrer politiet til å gi amnesti for slike som ham.
10 Oct 2019. Smith, T. Growing efforts are looking at how—or if—#MeToo offenders can be reformed. *National Public Radio.*
29 Sep 2019. Carey, B. Preying on Children: The Emerging Psychology of Pedophiles. *New York Times.*
29 Apr 2019. Mathieu, Isabelle. La poupée qui a troublé les Terre-Neuviens. *La Tribune.*
21 Mar 2019. Pope Francis wants psychological testing to prevent problem priests. But can it really do that? *The Washington Post.*
12 Dec 2018. Child sex dolls: Illegal in Canada, and dozens seized at the border. Ontario Today with Rita Celli. *CBC.*
12 Dec 2018. Celli, R. & Harris, K. Dozens of child sex dolls seized by Canadian border agents. *CBC News.*
27 Apr 2018. Rogers, Brook A. The online 'incel' culture is real–and dangerous. *New York Post.*
25 Apr 2018. Yang, J. Number cited in cryptic Facebook post matches Alek Minassian's military ID: Source. *Toronto Star.*
24 Ap 2018 Understanding 'incel'. *CTV News.*
27 Nov 2017. Carey, B. Therapy for Sexual Misconduct? It's Mostly Unproven. *New York Times.*
14 Nov 2017. Tremonti, A. M. The Current. *CBC.*
9 Nov2017. Christensen, J. Why men use masturbation to harass women. *CNN.* http://www.cnn.com/2017/11/09/health/masturbation-sexual-harassment/index.html
7 Nov 2017. Nazaryan, A. Why is the alt-right obsessed with pedophilia? *Newsweek.*
15 Oct 2017. Ouatik, B. Déscouvre. Pédophilie et science. *CBC Radio Canada.*
12 Oct 2017. Ouatik, B. Peut-on guérir la pédophilie? *CBC Radio Canada.*
11 Sep 2017. Burns, C. The young paedophiles who say they don't abuse children. *BBC News.*
18 Aug 2017. Interview. *National Post Radio.* Sirius XM Canada.
16 Aug 2017. Blackwell, Tom. Man says he was cured of pedophilia at Ottawa clinic: 'It's like a weight that's been lifted': But skeptics worry about the impact of sending pedophiles into the world convinced their curse has been vanquished. *National Post.*
26 Apr 2017. Zalkind, S. Prep schools hid sex abuse just like the catholic church. *VICE.*
24 Apr 2017. Sastre, P. Pédophilie: une panique morale jamais n'abolira un crime. *Slate France.*
12 Feb 2017. Payette, G. Child sex doll trial opens Pandora's box of questions. *CBC News.*
26 Nov 2016. Det morke uvettet ["The unknown darkness]". *Fedrelandsvennen.*
13 July 2016. Paedophilia: Shedding light on the dark field. *The Economist.*

1 Jul 2016. Debusschere, B. Niet iedereen die kinderporno kijkt, is een pedofiel: De mythes rond pedofilie ontkracht. *De Morgen.*
12 Apr 2016. O'Connor, R. Terence Martin: The Tasmanian MP whose medication 'turned him into a paedophile'. *The Independent.*
8 Mar 2016. Bielski, Z. 'The most viscerally hated group on earth': Documentary explores how intervention can stop pedophiles. *The Globe and Mail.*
1 Mar 2016. Elmhirst, S. What should we do about paedophiles? *The Guardian.*
24 Feb 2016. The man whose brain tumour 'turned him into a paedophile'. *The Independent.*
24 Nov 2015. Byron, T. The truth about child sex abuse. *BBC Two.*
20 Aug 2015. The Jared Fogle case: Why we understand so little about abuse. *Washington Post.*
19 Aug 2015. Blackwell, T. Treat sex offenders for impotence to keep them out of trouble, Canadian psychiatrist says. *National Post.*
2 Aug 2015. Menendez, J. BBC News Hour. *BBC World Service.*
13 Jul 2015. The nature of pedophilia. *BBC Radio 4.*
9 Jul 2015. The sex-offender test: How a computerized assessment can help determine the fate of men who've been accused of sexually abusing children. *The Atlantic.*
10 Apr 2015. NWT failed to prevent sex offender from abusing stepdaughter again. *CBC News.*
10 Feb 2015. Savage, D. "The ethical sadist." In Savage Love. *The Stranger.*
31 Jan 2015. Begrip voor/van pedofilie [Understanding pedophilia]. *de Volkskrant.*
9 Dec 2014. Carey, B. When a rapist's weapon is a pill. *New York Times.*
1 Dec 2014. Singal, J. Can virtual reality help pedophiles? *New York Magazine.*
17 Nov2014. Say pedófile, busco aydua. *El Pais.*
4 Sep 2014. Born that way? *Ideas, with Paul Kennedy.* CBC Radio One.
27 Aug 2014. Interrogating the statistics for the prevalence of paedophilia. BBC.
25 Jul 2014. Stephenson, W. The prevalence of paedophilia. *BBC World Service.*
21 Jul 2014. Hildebrandt, A. Virtuous Pedophiles group gives support therapy cannot. *CBC.*
26 Jan 2014. Paedophilia a result of faulty wiring, scientists suggest. *Daily Mail.*
22 Dec 2013. Kane, L. Is pedophilia a sexual orientation? *Toronto Star.*
21 Jul 2013. Miller, L. The turn-on switch: Fetish theory, post-Freud. *New York Magazine.*
1 Jul 2013. Morin, H. Pédophilie: la difficile quête d'une origine biologique. *Le Monde.*
2 Jun 2013. Malcolm, L. The psychology of paedophilia. *Australian National Radio.*
1 Mar 2013. Kay, J. The mobbing of Tom Flanagan is unwarranted and cruel. *National Post.*
6 Feb 2013. Boy Scouts board delays vote on lifting ban on gays. *L.A. Times.*
31 Aug 2012. CNN Newsroom interview with Ashleigh Banfield. *CNN.*
24 Jun 2012. CNN Newsroom interview with Don Lemon. *CNN.*

LEGAL TESTIMONY, PAST 5 YEARS

2022	Hersom & Doe v WVa Health & Human Services	Southern District, West Virginia
2022	BPJ v WVa Board of Education	Southern District, West Virginia
2021	Cross et al. v Loudoun School Board	Loudoun, Virginia
2021	Allan M. Josephson v Neeli Bendapudi	Western District of Kentucky
2021	Re Commitment of Michael Hughes (Frye Hearing)	Cook County, Illinois
2019	US vs Peter Bright	Southern Dist. of New York, NY
2019	Probate and Family Court (Custody Hearing)	Boston, Massachusetts
2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, Illinois
2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, New York
2018	Re Commitment of Fernando Little (Frye Hearing)	Utica, New York
2018	Canada vs John Fitzpatrick (Sentencing Hearing)	Toronto, Ontario, Canada



Routledge
Taylor & Francis Group

Journal of Sex & Marital Therapy

ISSN: 0092-623X (Print) 1521-0715 (Online) Journal homepage: https://www.tandfonline.com/loi/usmt20

Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

James M. Cantor

To cite this article: James M. Cantor (2020) Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy, Journal of Sex & Marital Therapy, 46:4, 307-313, DOI: 10.1080/0092623X.2019.1698481

To link to this article: https://doi.org/10.1080/0092623X.2019.1698481

JOURNAL OF SEX & MARITAL THERAPY
2020, VOL. 46, NO. 4, 307–313
https://doi.org/10.1080/0092623X.2019.1698481

Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

James M. Cantor

Toronto Sexuality Centre, Toronto, Canada

ABSTRACT

The American Academy of Pediatrics (AAP) recently published a policy statement: *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping gender diverse (GD) children, the AAP statement instead rejected that consensus, endorsing *gender affirmation* as the only acceptable approach. Remarkably, not only did the AAP statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its citations, which repeatedly said the very opposite of what AAP attributed to them.

The American Academy of Pediatrics (AAP) recently published a policy statement entitled, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, 2018). These are children who manifest discontent with the sex they were born as and desire to live as the other sex (or as some alternative gender role). The policy was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping transgender and gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only *gender affirmation*. That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition. With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy, however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.

The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in the aggregate—It was merely disappeared. (The list of all existing studies appears in the appendix.) As they make clear, *every* follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition. AAP is, of course, free to establish whatever policy it likes on

CONTACT James Cantor jamescantorphd@gmail.com Toronto Sexuality Centre, 2 Carlton Street, suite 1820, Toronto, Ontario M5B 1J3, Canada.

whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.

AAP divided clinical approaches into three types—conversion therapy, watchful waiting, and gender affirmation. It rejected the first two and endorsed *gender affirmation* as the only acceptable alternative. Most readers will likely be familiar already with attempts to use conversion therapy to change sexual orientation. With regard to gender identity, AAP wrote:

> "[C]onversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. ... Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42]

The citations were:

38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol.* 1994;62(2):221–227.

29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 2012;51(9):957–974.

39. Byne W. Regulations restrict practice of conversion therapy. *LGBT Health.* 2016;3(2):97–99.

40. Cohen-Kettenis PT, Delemarrevan de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med.* 2008;5(8):1892–1897.

41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Soc Policy.* 2006;3(3):23–39.

42. World Professional Association for Transgender Health. *WPATH De-Psychopathologisation Statement.* Minneapolis, MN: World Professional Association for Transgender Health; 2010.

AAP's claims struck me as odd because *there are no studies of conversion therapy for gender identity.* Studies of conversion therapy have been limited to *sexual orientation,* and, moreover, to the sexual orientation *of adults,* not to gender identity and not of children in any case. The article AAP cited to support their claim (reference number 38) is indeed a classic and well-known review, but it is a review of sexual orientation research *only.* Neither gender identity, nor even children, received a single mention in it. Indeed, the narrower scope of that article should be clear to anyone reading even just its title: "The practice and ethics of *sexual orientation* conversion therapy" [italics added].

AAP continued, saying that conversion approaches for GD children have already been rejected by medical consensus, citing five sources. This claim struck me as just as odd, however—I recalled associations banning conversion therapy for sexual orientation, but not for gender identity, exactly because there is no evidence for generalizing from adult sexual orientation to childhood gender identity. So, I started checking AAP's citations for that, and these sources too pertained only to sexual orientation, not gender identity (specifics below). What AAP's sources *did* repeatedly emphasize was that:

A. Sexual orientation of adults is unaffected by conversion therapy and any other [known] intervention;
B. Gender dysphoria in childhood before puberty desists in the majority of cases, becoming (cis-gendered) homosexuality in adulthood, again regardless of any [known] intervention; and
C. Gender dysphoria in childhood persisting after puberty tends to persist entirely.

That is, in the context of GD children, it simply makes no sense to refer to externally induced "conversion": The majority of children "convert" to cisgender or "desist" from transgender

regardless of any attempt to change them. "Conversion" only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that "gender identity is not synonymous with 'sexual orientation'" (Rafferty et al., 2018, p. 3), they went ahead to treat them as such nonetheless.

To return to checking AAP's fidelity to its sources: Reference 29 was a practice guideline from the Committee on Quality Issues of the American Academy of Child and Adolescent Psychiatry (AACAP). Despite AAP applying this source to *gender identity*, AACAP was quite unambiguous regarding their intent to speak to sexual orientation and *only* to sexual orientation: "Principle 6. Clinicians should be aware that there is no evidence that *sexual orientation* can be altered through therapy, and that attempts to do so may be harmful. There is no established evidence that change in a predominant, enduring *homosexual* pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter *homosexuality*. Psychiatric efforts to alter *sexual orientation* through 'reparative therapy' *in adults* have found little or no change in *sexual orientation*, while causing significant risk of harm to self-esteem" (AACAP, 2012, p. 967, italics added).

Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP's actual view was decidedly neutral, noting the lack of evidence: "Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed" (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: "In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood" (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP's actual view.

Next, in reference 39, Byne (2016) also addressed only sexual orientation, doing so very clearly: "Reparative therapy is a subset of conversion therapies based on the premise that *same-sex attraction* are reparations for childhood trauma. Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing *same-sex attractions*" (Byne, 2016, p. 97). Byne does not say this of gender identity, as the AAP statement misrepresents.

In AAP reference 40, Cohen-Kettenis et al. (2008) did finally pertain to gender identity; however, this article never mentions conversion therapy. (!) Rather, in this study, the authors presented that clinic's lowering of their minimum age for cross-sex hormone treatment from age 18 to 16, which they did on the basis of a series of studies showing the high rates of success with this age group. Although it did strike me as odd that AAP picked as support against conversion therapy an article that did not mention conversion therapy, I could imagine AAP cited the article as an example of what the "mainstream of traditional medical practice" consists of (the logic being that conversion therapy falls outside what an 'ideal' clinic like this one provides). However, what this clinic provides is the very *watchful waiting* approach that AAP rejected. The approach

espoused by Cohen-Kettenis (and the other clinics mentioned in the source—Gent, Boston, Oslo, and now formerly, Toronto) is to make puberty-halting interventions available at age 12 because: "[P]ubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved" (Cohen-Kettenis et al., 2008, p. 1894).

Reference 41 presented a very interesting history spanning the 1960s–1990s about how feminine boys and tomboyish girls came to be recognized as mostly pre-homosexual, and how that status came to be entered into the DSM at the same time as homosexuality was being *removed* from the DSM. Conversion therapy is never mentioned. Indeed, to the extent that Bryant mentions treatment at all, it is to say that treatment is entirely irrelevant to his analysis: "An important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the DSM and not unique to GIDC)" (Bryant, 2006, p. 35). How this article supports AAP's claim is a mystery. Moreover, how AAP could cite a 2006 history discnssing events of the 1990s and earlier to support a claim about the *current* consensus in this quickly evolving discussion remains all the more unfathomable.

Cited last in this section was a one-paragraph press release from the World Professional Association for Transgender Health. Written during the early stages of the American Psychiatric Association's (APA's) update of the DSM, the statement asserted simply that "The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide." Very reasonable debate can (and should) be had regarding whether gender dysphoria should be removed from the DSM as homosexuality was, and WPATH was well within its purview to assert that it should. Now that the DSM revision process is years completed however, history has seen that APA ultimately retained the diagnostic categories, rejecting WPATH's urging. This makes AAP's logic entirely backwards: That WPATH's request to depathologize gender dysphoria was *rejected* suggests that it is *WPATH's* view—and therefore the AAP policy—which fall "outside the mainstream of traditional medical practice." (!)

AAP based this entire line of reasoning on their belief that conversion therapy is being used "to prevent children and adolescents from identifying as transgender" (Rafferty et al., 2018, p. 4). That claim is left without citation or support. In contrast, what is said by AAP's sonrces is "delaying affirmation should *not* be construed as conversion therapy or an attempt to change gender identity" in the first place (Byne, 2016, p. 2). Nonetheless, AAP seems to be doing exactly that: simply relabeling any alternative approach as equivalent to conversion therapy.

Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP's stated claim about the existing science on gender identity at all, never mind gender identity of children.

AAP also dismissed the watchful waiting approach out of hand, not citing any evidence, but repeatedly calling it "outdated." The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling watchful waiting the current standard. According to AAP:

> [G]ender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47]

The citations from AAP's reference list are:

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. *Int J Transgend.* 2018;19(2):251–268

47. Olson KR. Prepubescent transgender children: what we do and do not know. *J Am Acad Child Adolesc Psychiatry.* 2016;55(3):155–156.e3

I was surprised first by the AAP's claim that watchful waiting's delay to puberty was somehow "arbitrary." The literature, including AAP's sources, repeatedly indicated the pivotal importance of puberty, noting that outcomes strongly diverge at that point. According to AAP reference 29, in "*prepubertal* boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance" (Adelson & AACAP, 2012, p. 963, italics added), whereas "when gender variance with the desire to be the other sex is present *in adolescence*, this desire usually does persist through adulthood" (Adelson & AACAP, 2012, p. 964, italics added). Similarly, according to AAP reference 40, "Symptoms of GID *at prepubertal ages* decrease or even disappear in a considerable percentage of children (estimates range from 80–95%). Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting *into early puberty* appears to be highly persistent" (Cohen-Kettenis et al., 2008, p. 1895, italics added). That follow-up studies of prepubertal transition differ from postpubertal transition is the very meaning of non-arbitrary. AAP gave readers exactly the reverse of what was contained in its own sources. If AAP were correct in saying that puberty is an arbitrarily selected age, then AAP will be able to offer another point to wait for with as much empirical backing as puberty has.

Next, it was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim. The people in such programs often receive substantial support during this period. Also unclear is on what basis AAP could already know exactly which treatments are "critical" and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: It is only if one were already pre-convinced that gender affirmation is the only acceptable alternative that would make watchful waiting seem to withhold critical support—What it delays is gender affirmation, the method one has already decided to be critical.

Although AAP's next claim did not have a citation appearing at the end of its sentence, binary notions of gender were mentioned both in references 45 and 47. Specifically, both pointed out that existing outcome studies have been about people transitioning from one sex to the other, rather than from one sex to an in-between status or a combination of masculine/feminine features. Neither reference presented this as a reason to reject the results from the existing studies of complete transition however (which is how AAP cast it). Although it is indeed true that the outcome data have been about complete transition, some future study showing that partial transition shows a different outcome would not invalidate what is known about complete transition. Indeed, data showing that partial transition gives better outcomes than complete transition would, once again, support the watchful waiting approach which AAP rejected.

Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot.

Reference 47 was a one-and-a-half page commentary in which the author off-handedly mentions criticisms previously made of three of the eleven outcome studies of GD children, but does not provide any analysis or discussion. The only specific claim was that studies (whether early or late) had limited follow-up periods—the logic being that had outcome researchers lengthened the follow-up period, then people who seemed to have desisted might have returned to the clinic as

cases of "persistence-after-interruption." Although one could debate the merits of that prediction, AAP instead simply withheld from the reader the result from the original researchers having tested that very prediction directly: Steensma and Cohen-Kettenis (2015) conducted another analysis of their cohort, by then ages 19–28 (mean age 25.9 years), and found that 3.3% (5 people of the sample of 150) later returned. That is, in long-term follow-up, the childhood sample showed 66.7% desistence instead of 70.0% desistance.

Reference 45 did not support the claim that watchful-waiting is "outdated" either. Indeed, that source said the very opposite, explicitly referring to watchful waiting as the *current* approach: "Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model *favored by the standards,* we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5" (Ehrensaft et al., 2018, p. 255). Moreover, Ehrensaft et al. said there are cases in which they too would still use watchful waiting: "When a child's gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child" (p. 259). Ehrensaft et al. are indeed critical of the watchful waiting model (which they feel is applied too conservatively), but they do not come close to the position the AAP policy espouses. Where Ehrensaft summaries the potential benefits and potential risks both to transitioning and not transitioning, the AAP presents an ironically binary narrative.

In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all. AAP claimed, "This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population"; however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, "Current available research and expert opinion from clinical and research leaders ... will serve as the basis for recommendations" (pp. 1–2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion.

AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with Rafferty, however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence.

Disclosure statement

No potential conflict of interest was reported by the author.

References

Rafferty, J., AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics, 142*(4), e20182162 doi:10.1542/peds.2018-2162

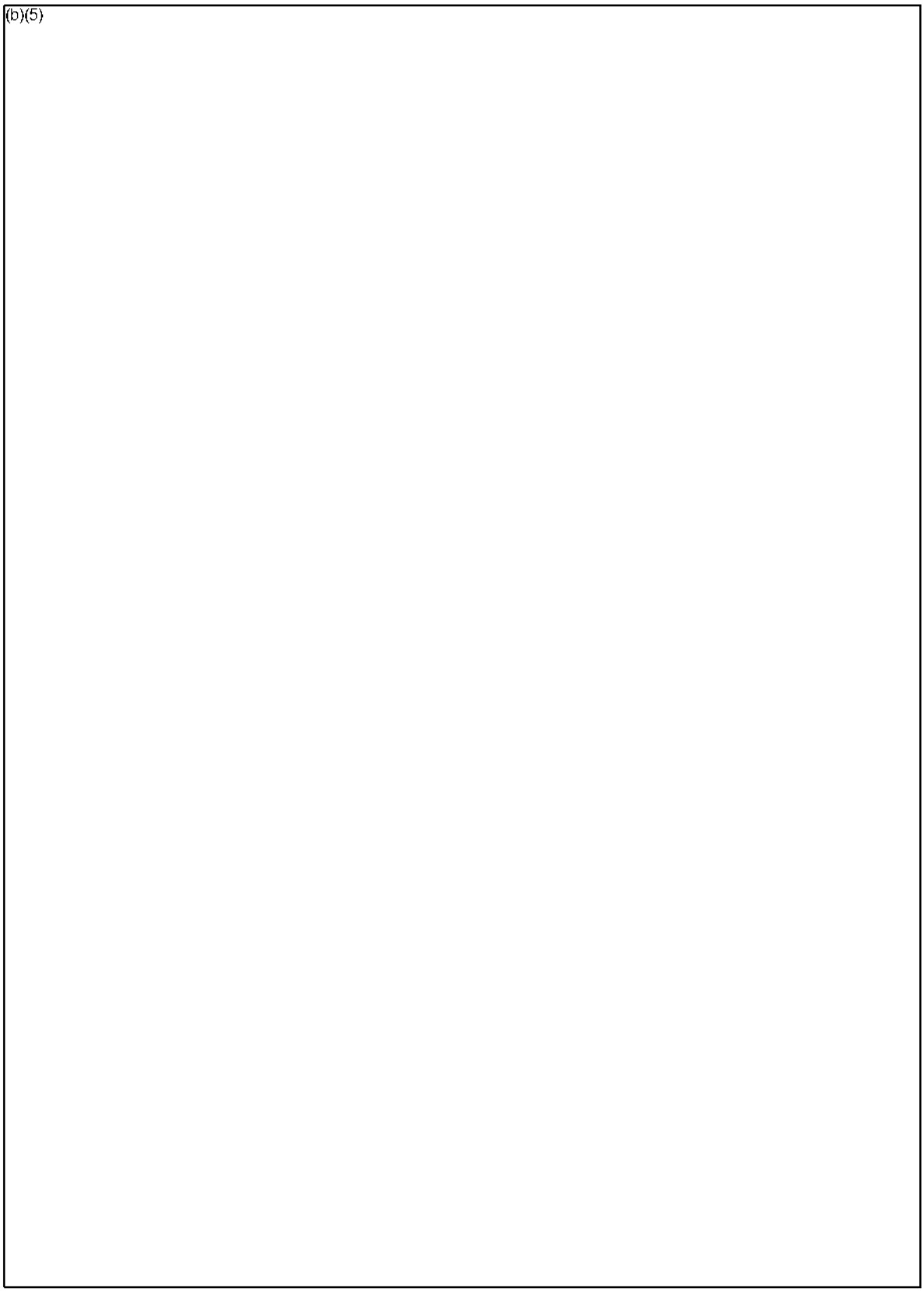
Steensma, T. D., & Cohen-Kettenis, P. T. (2015). More than two developmental pathways in children with gender dysphoria? *Journal of the American Academy of Child and Adolescent Psychiatry, 52*, 147–148. doi:10.1016/j.jaac.2014.10.016

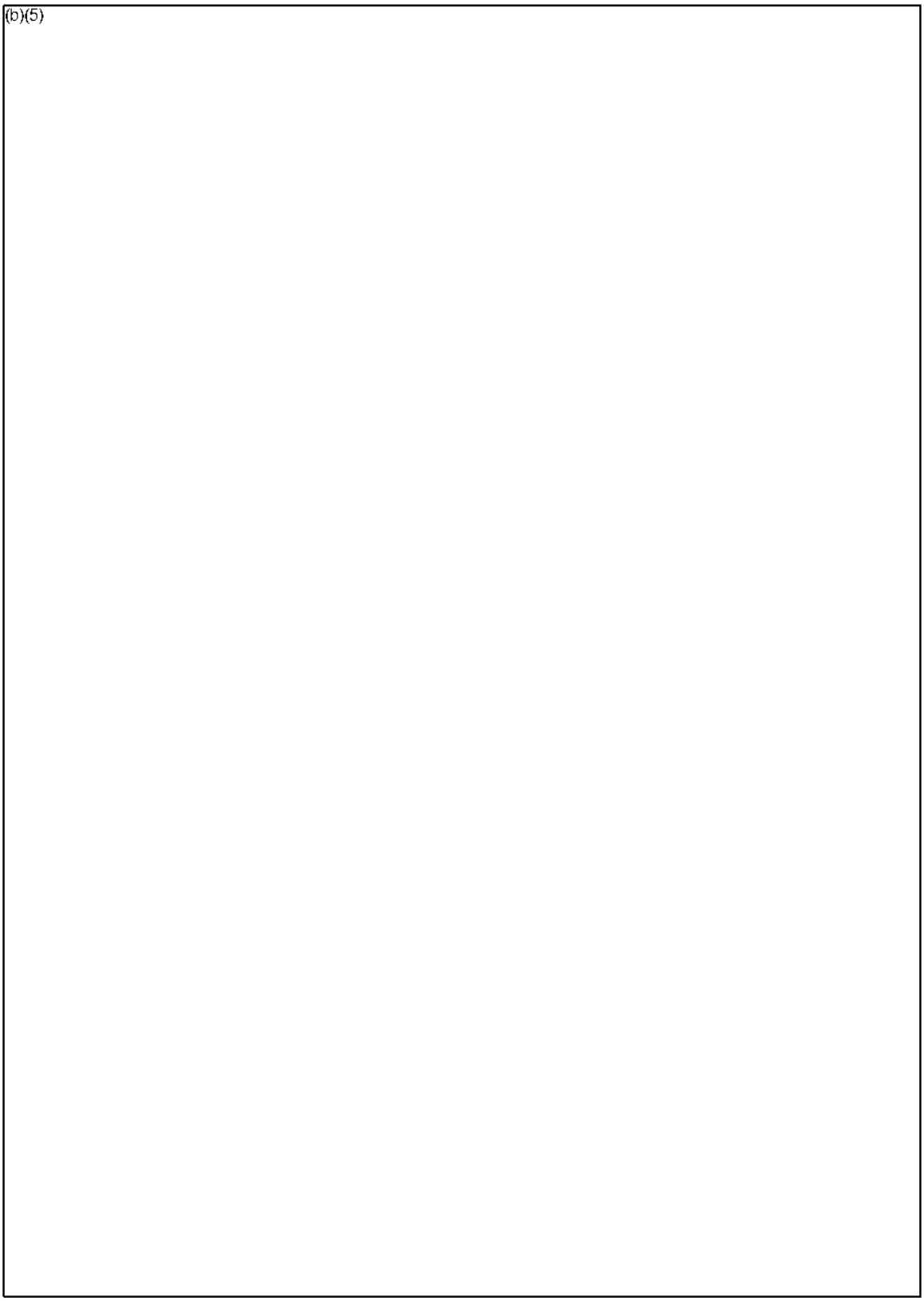
Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 1413–1423. doi:10.1097/CHI.0b013e31818956b9

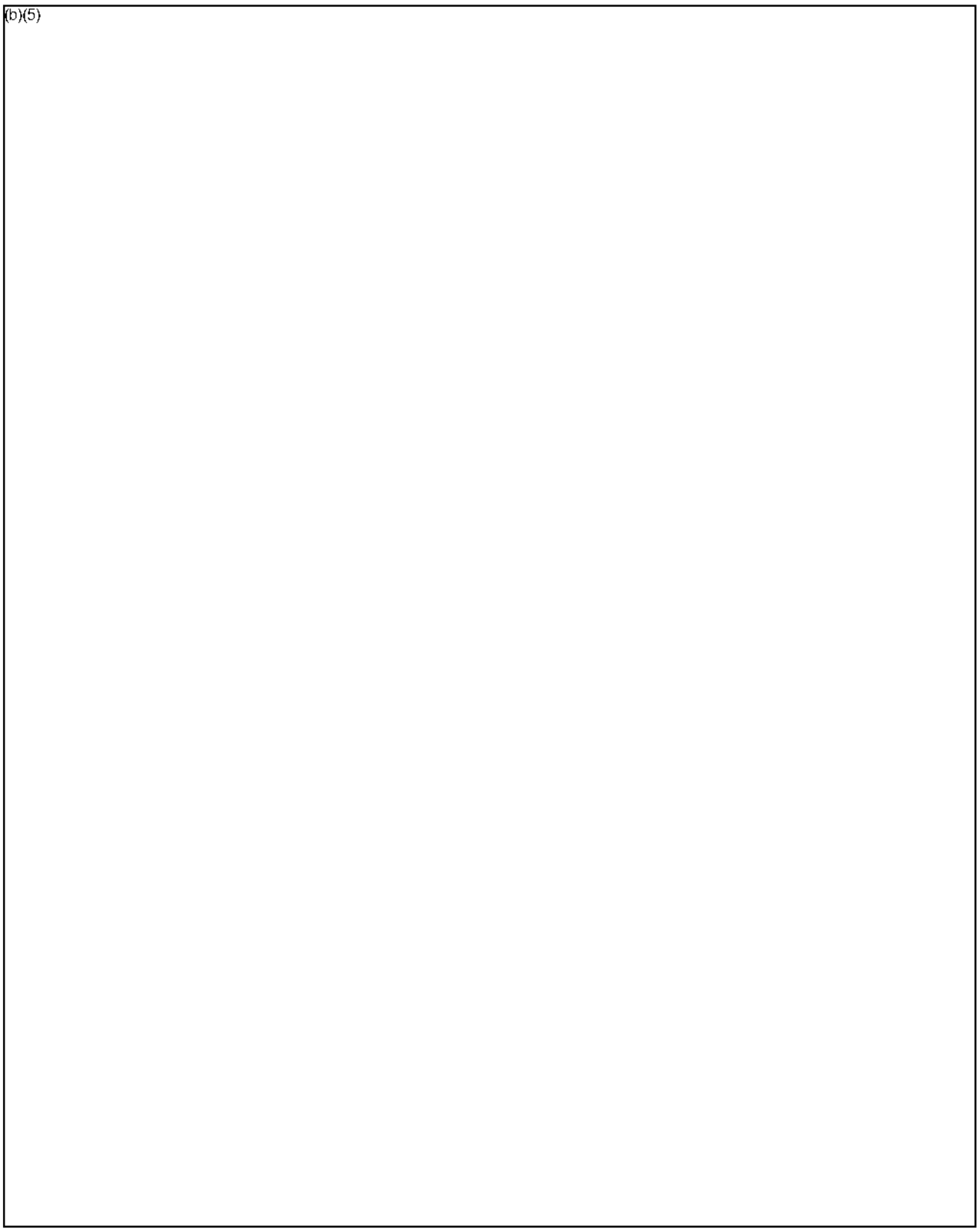
Appendix

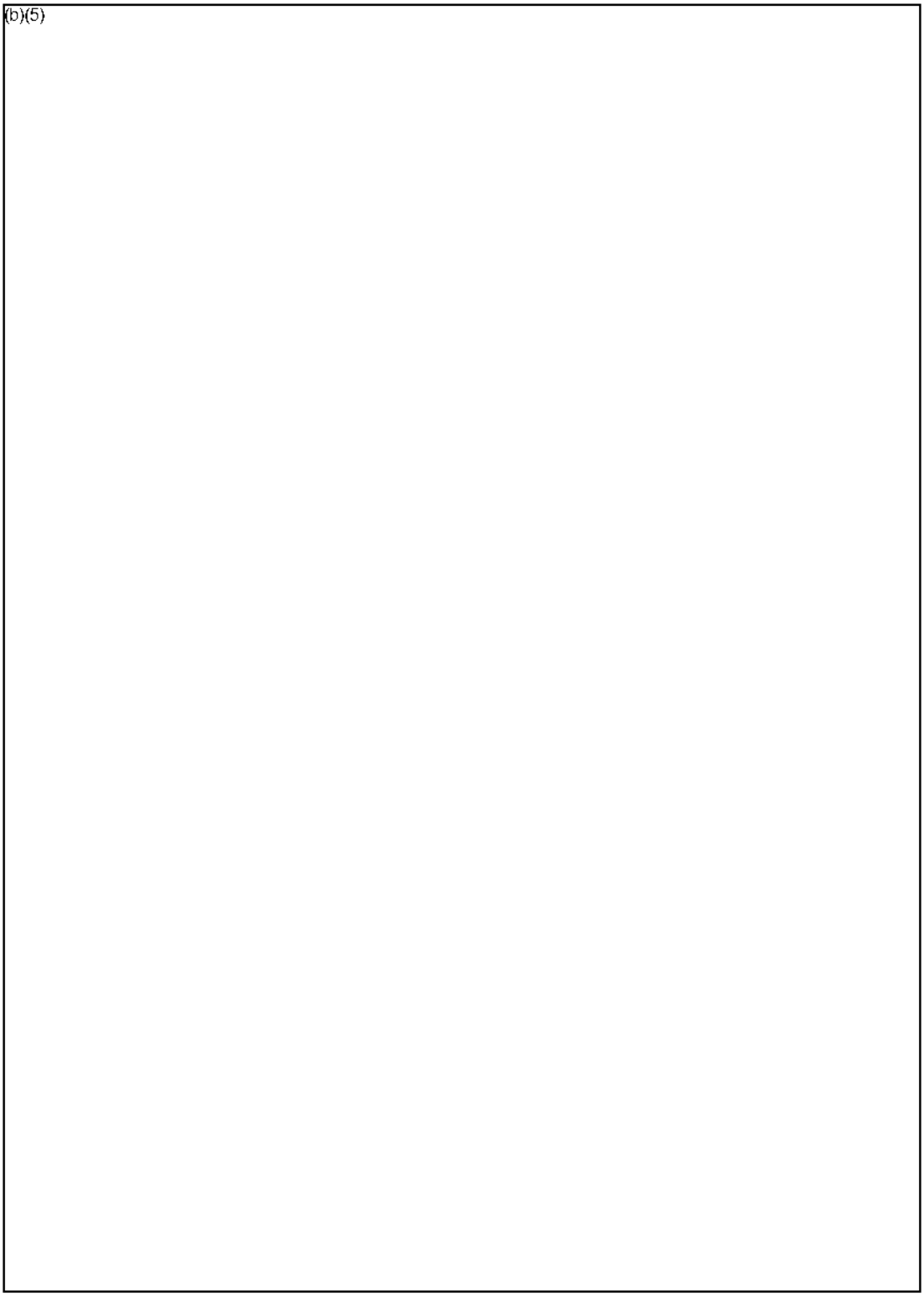
Count	Group	Study
2/16 4/16 10/16	gay* trans-/crossdress straight*/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
2/16 2/16 12/16	trans- uncertain gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19,* 363–369.
0/9 9/9	trans- gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
2/45 10/45 33/45	trans-/crossdress uncertain gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
1/10 2/10 3/10 4/10	trans- gay uncertain straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,* 511–517.
1/44 43/44	trans- cis-	Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality.* New Haven, CT: Yale University Press.
0/8 8/8	trans- cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
21/54 33/54	trans- cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
3/25 6/25 16/25	trans- lesbian/bi- straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44,* 34–45.
17/139 122/139	trans- cis-	Singh, D. (2012). *A follow-up study of boys with gender identity disorder.* Unpublished doctoral dissertation, University of Toronto.
47/127 80/127	trans- cis-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.

*For brevity, the list uses "gay" for "gay and cis-", "straight" for "straight and cis-", etc.

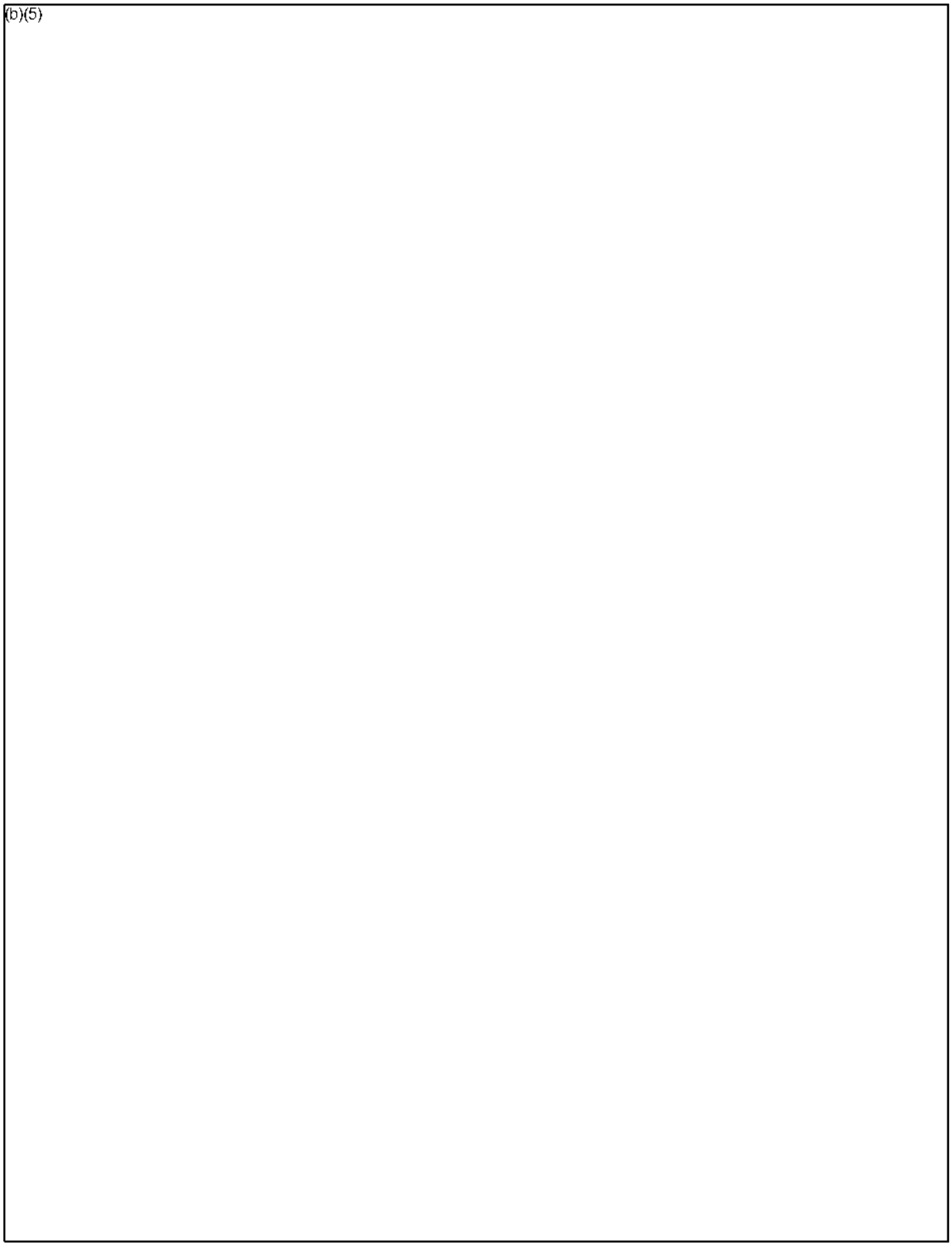

(b)(5)
(b)(5)

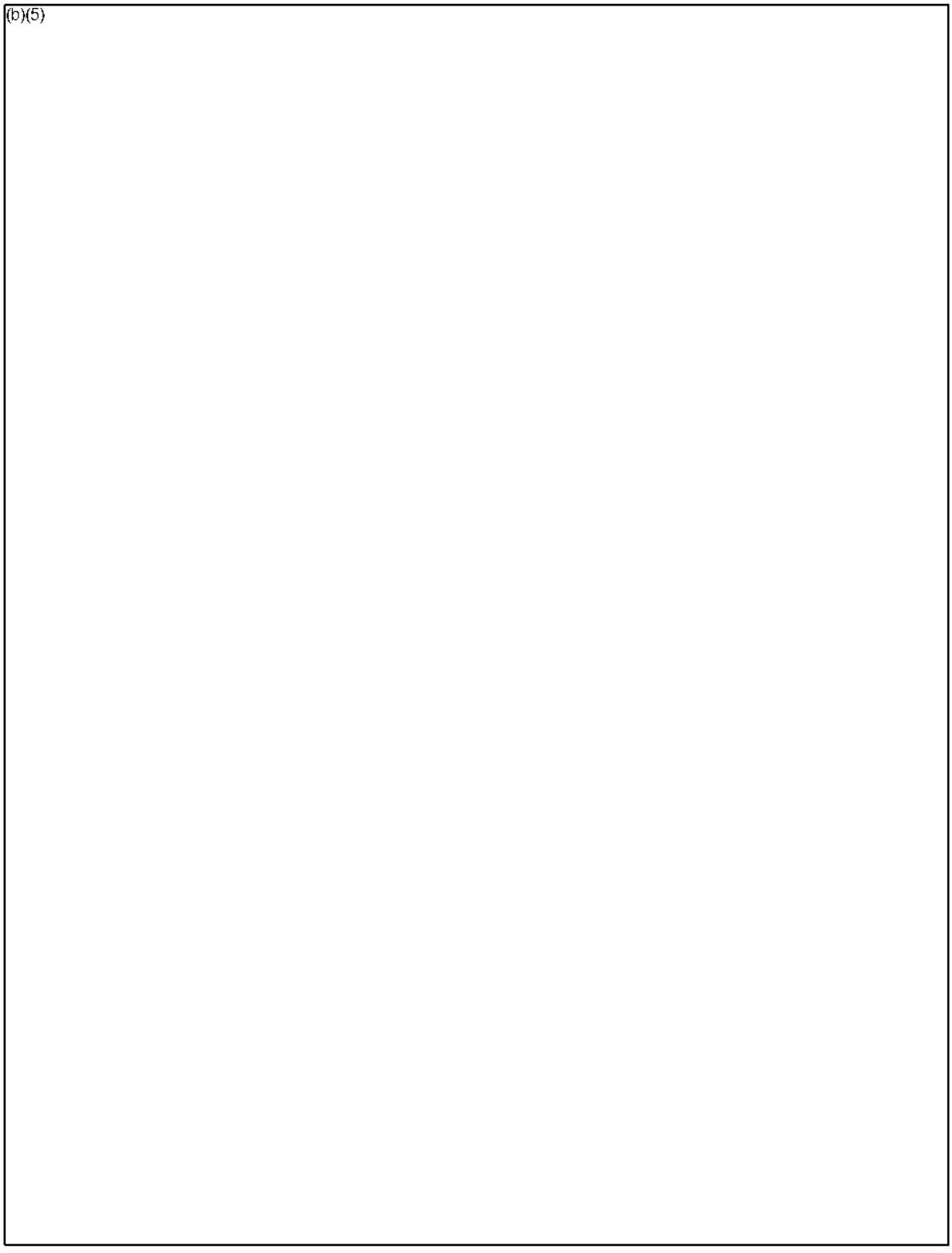

(b)(5)

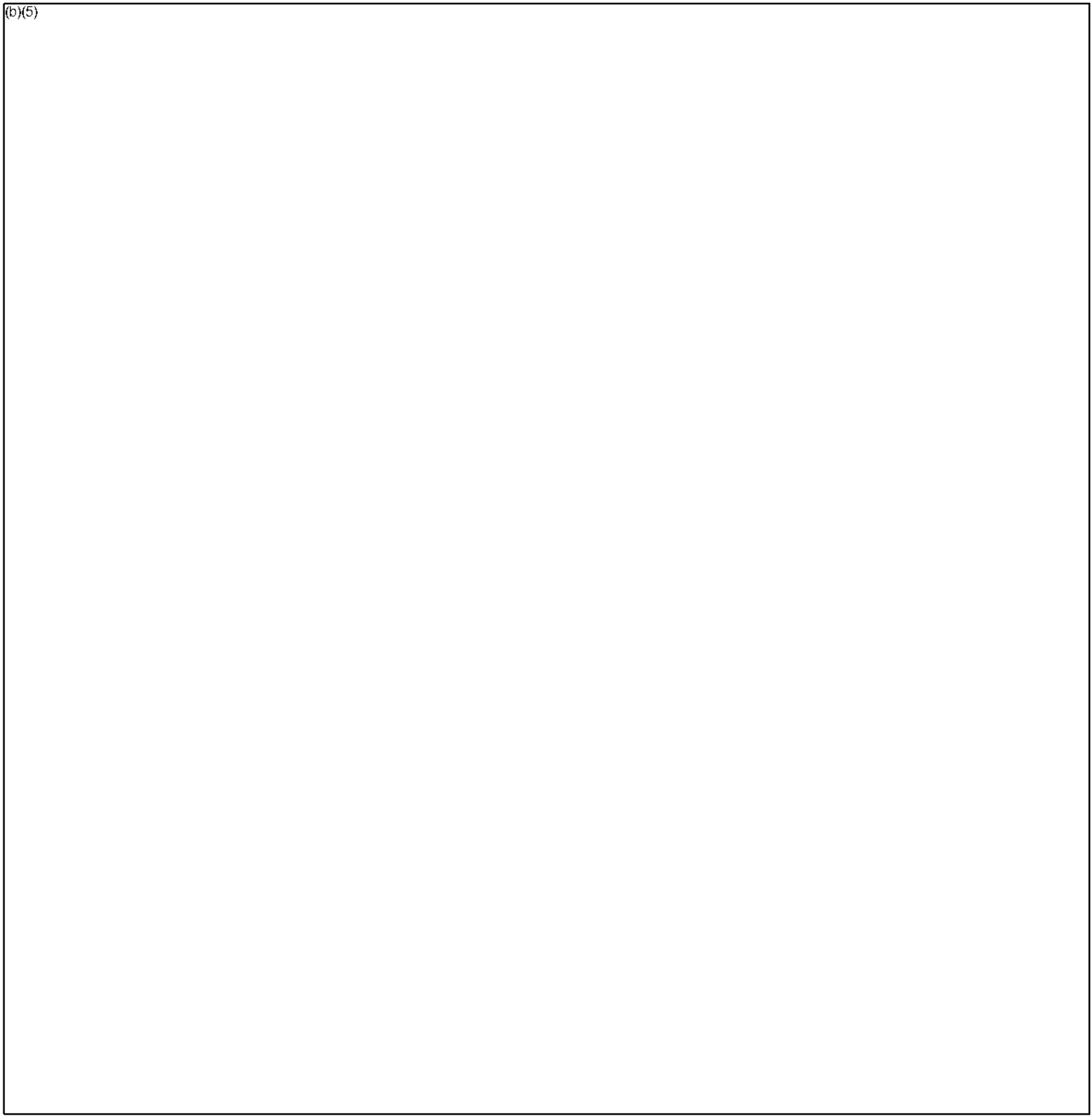

(b)(5)


(b)(5)

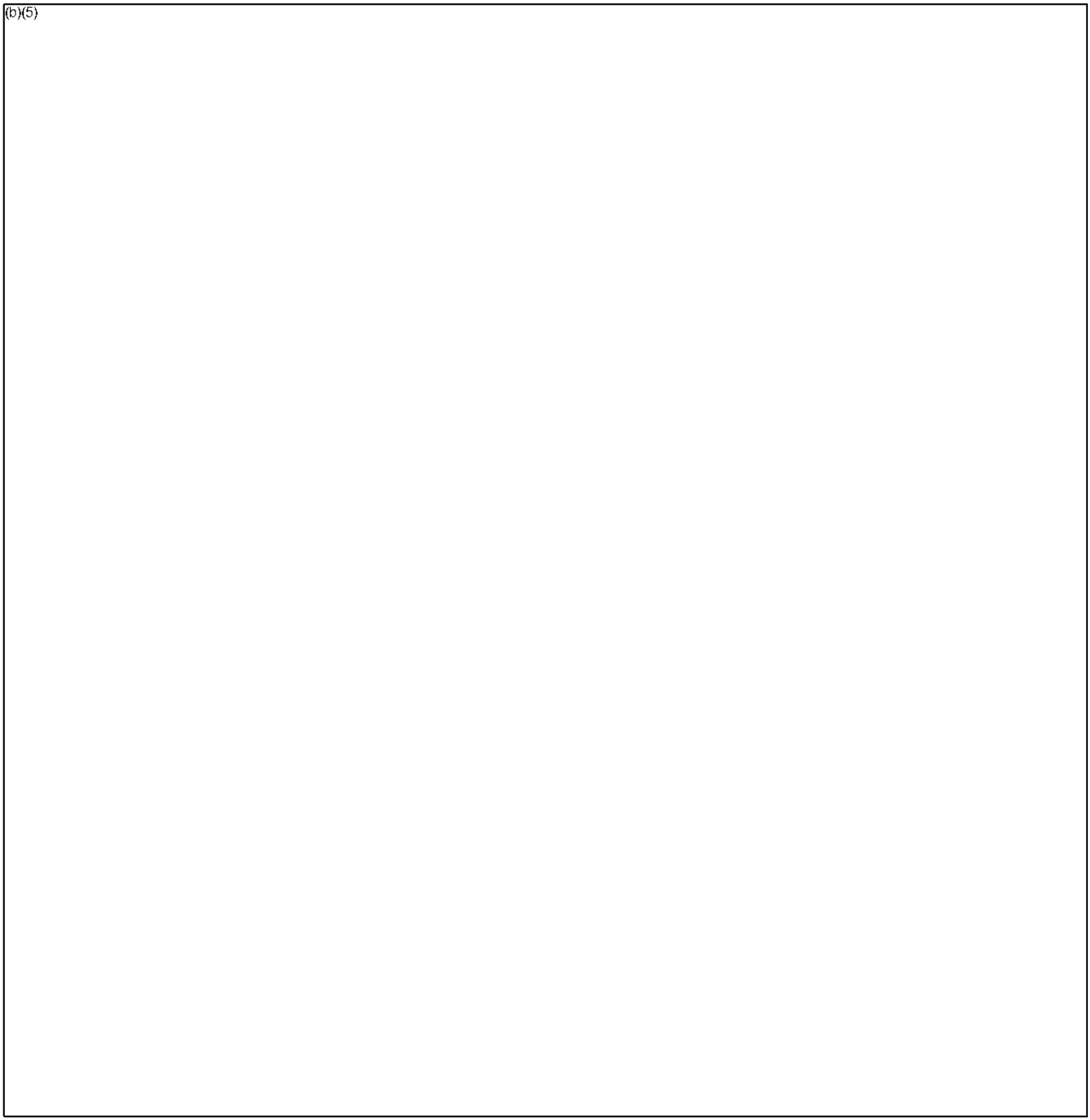
(b)(5)

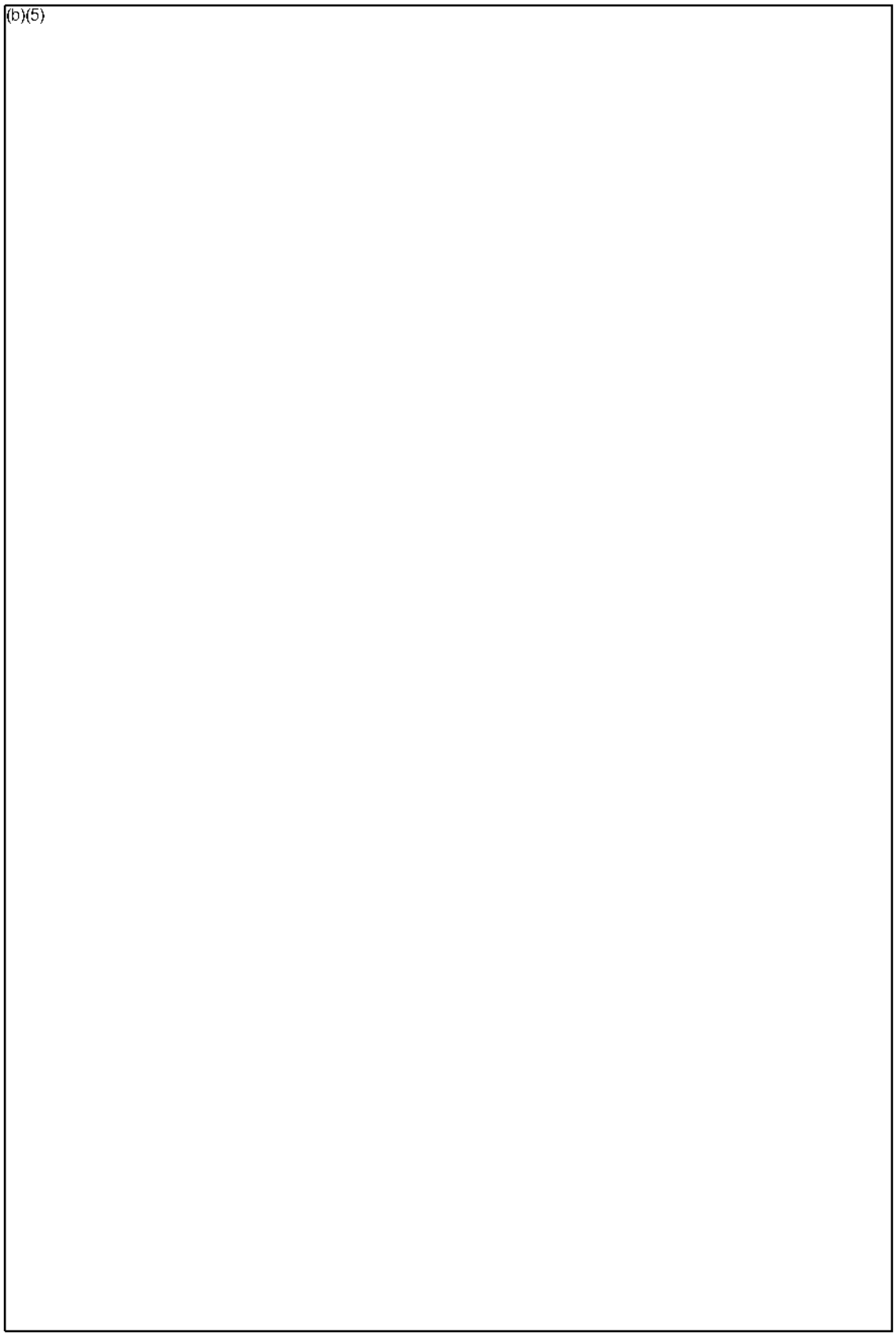

(b)(5)


(b)(5)

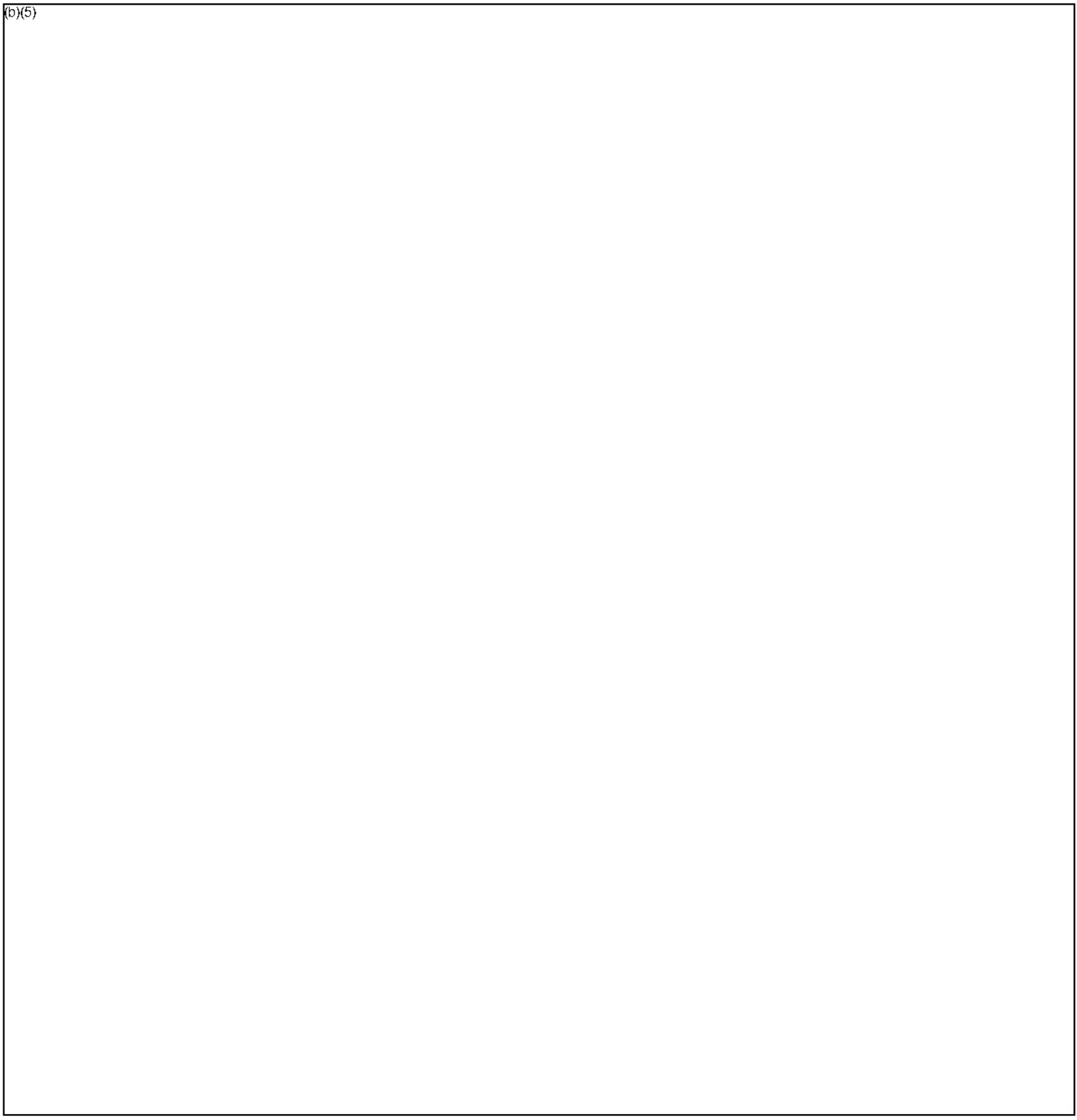

(b)(5)

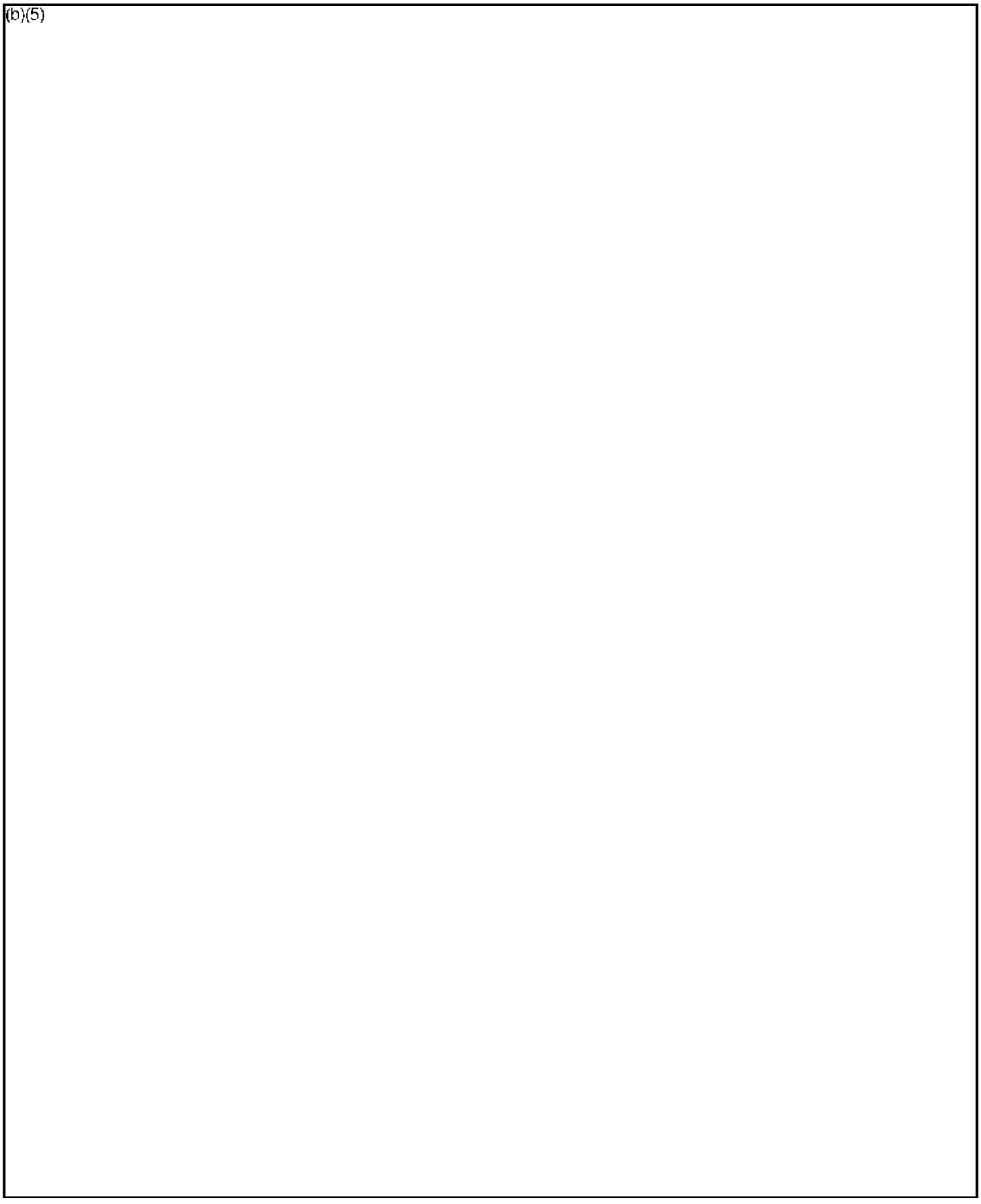
(b)(5)


(b)(5)

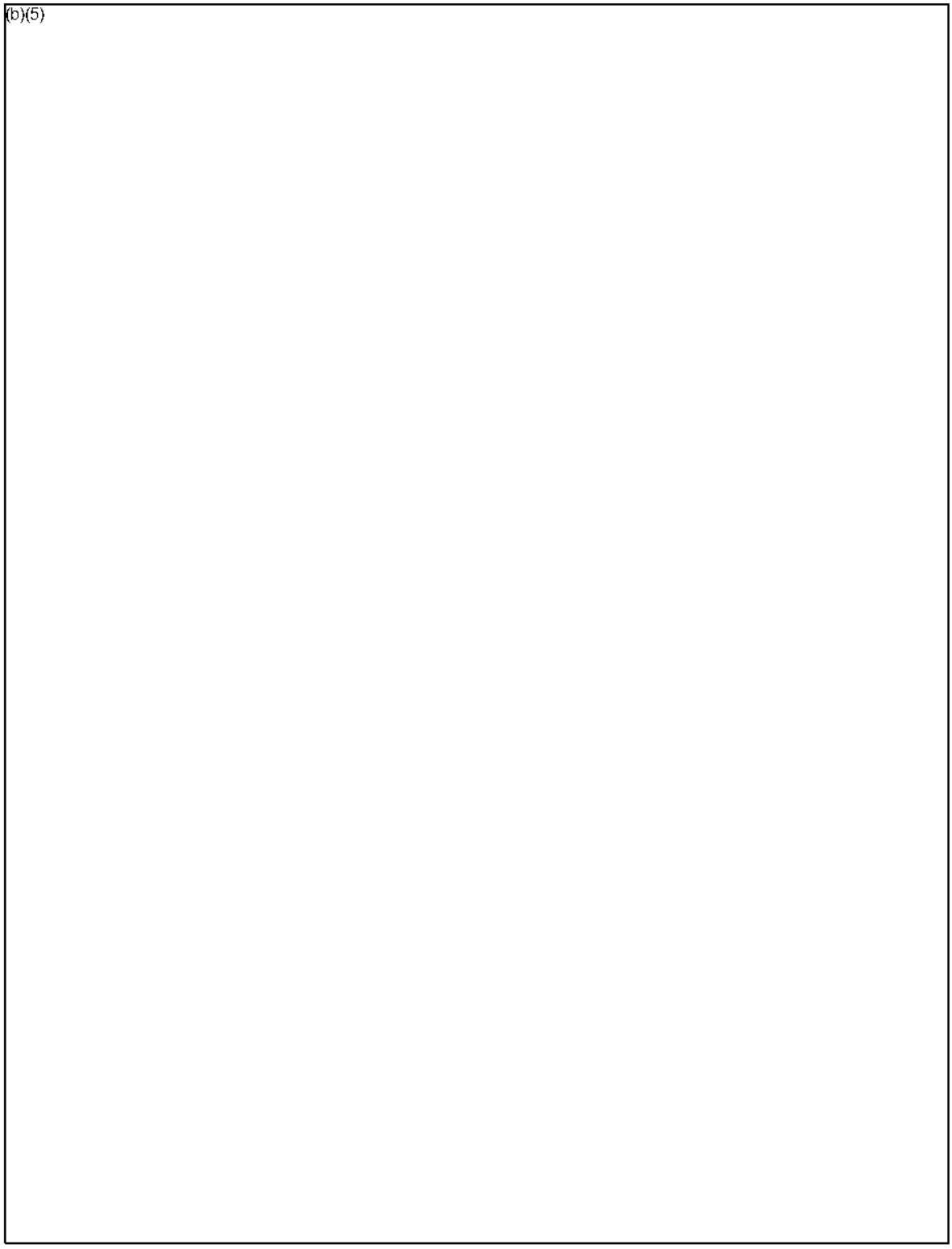

(b)(5)

(b)(5)

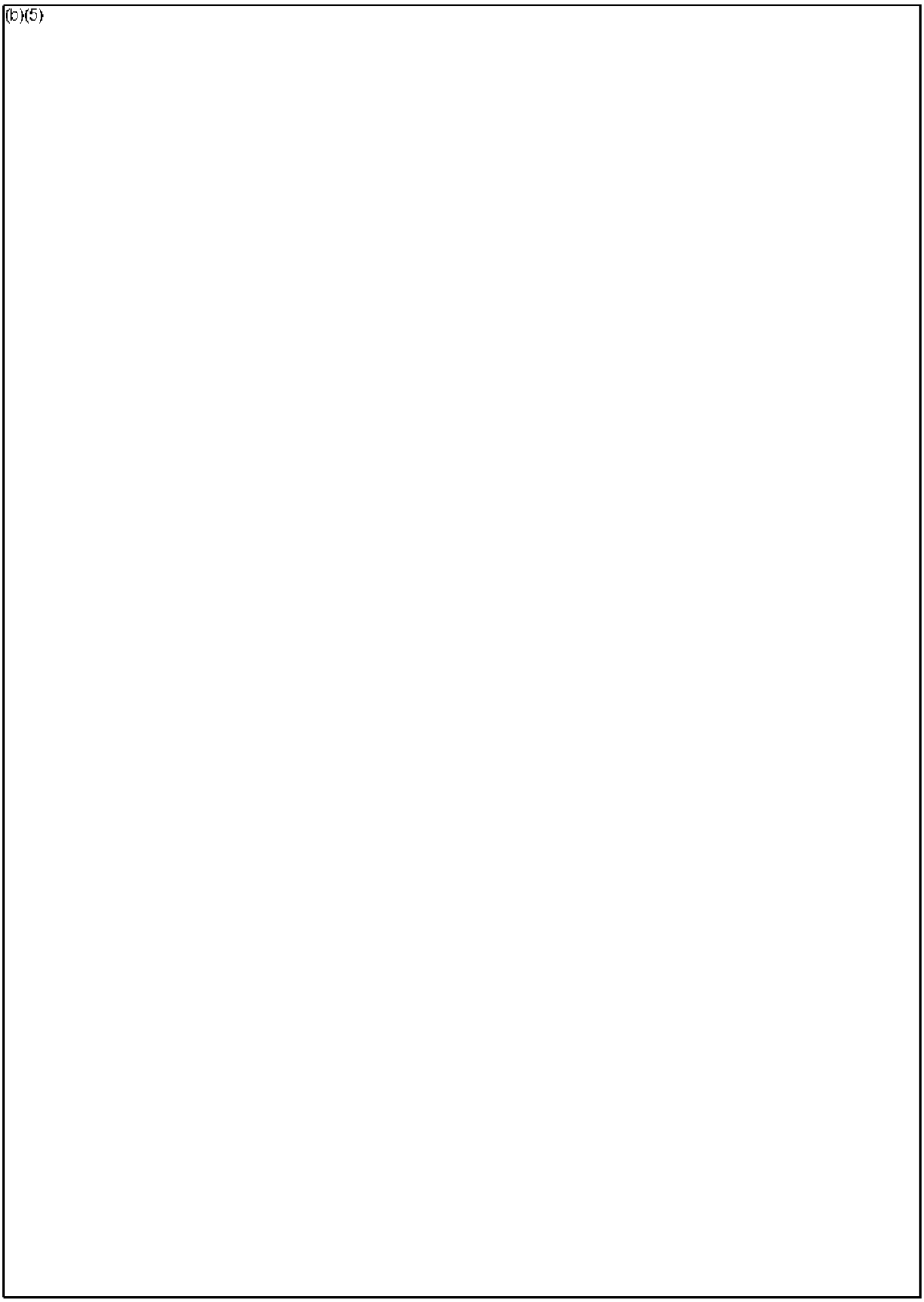

(b)(5)

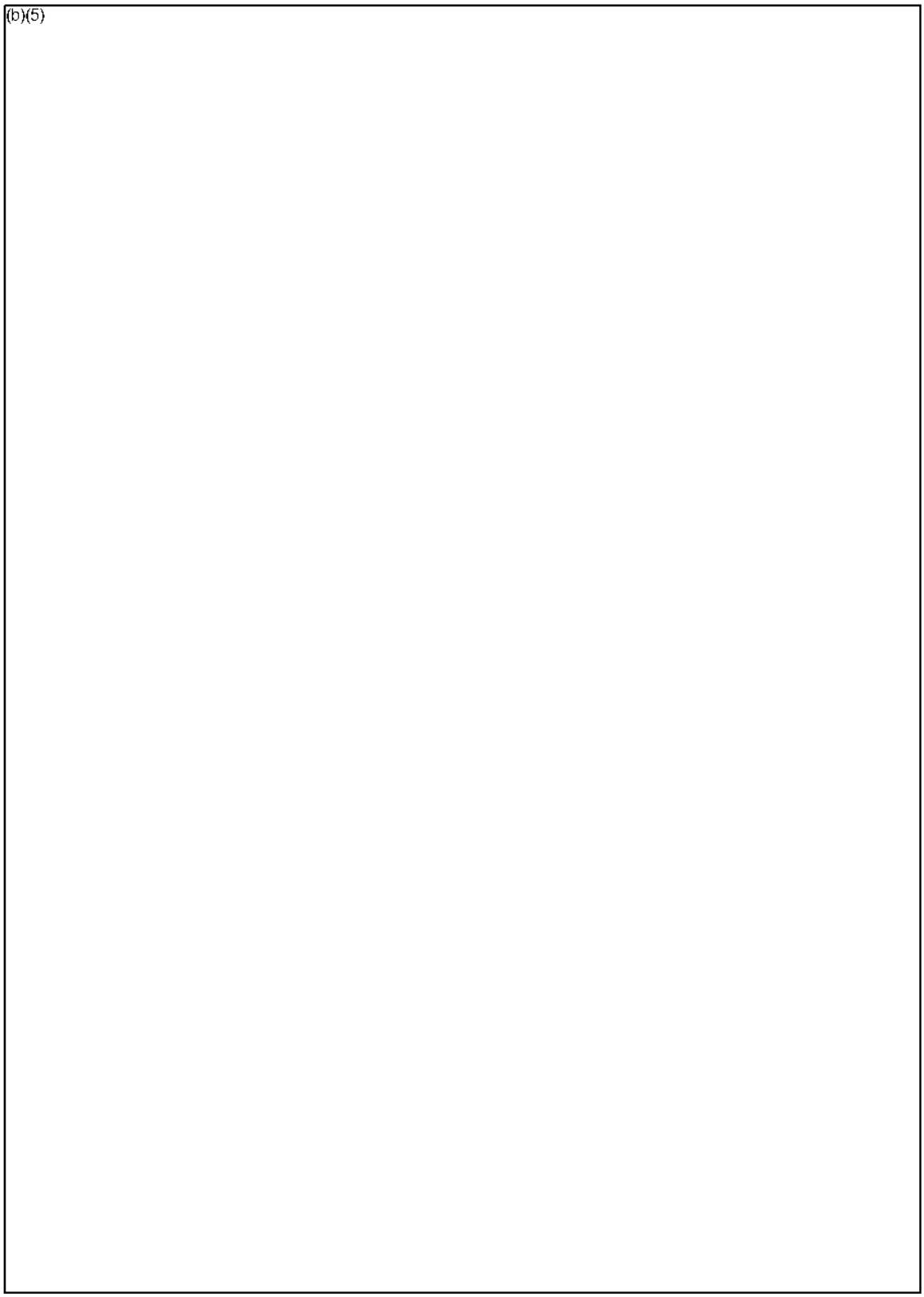

(b)(5)

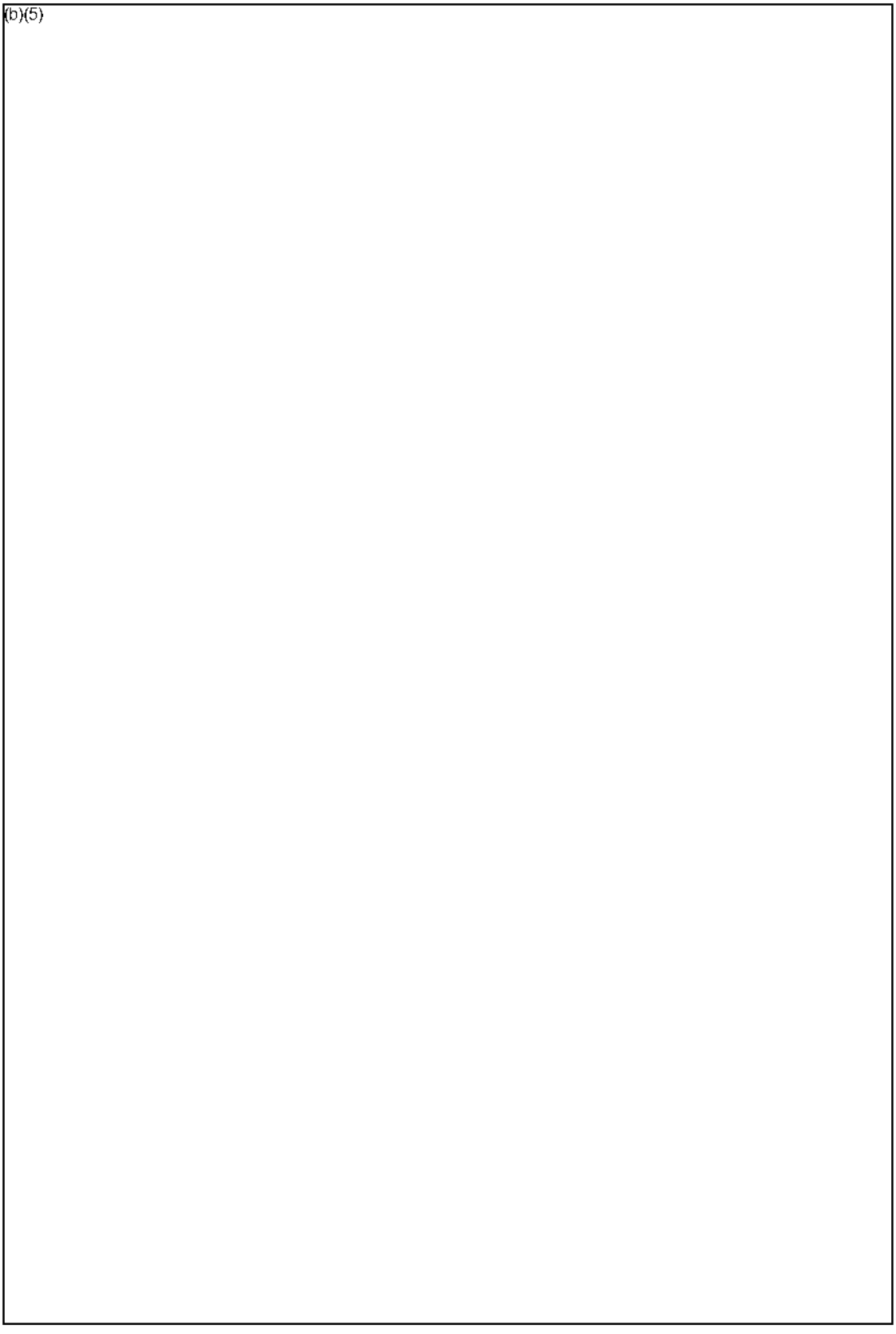
(b)(5)

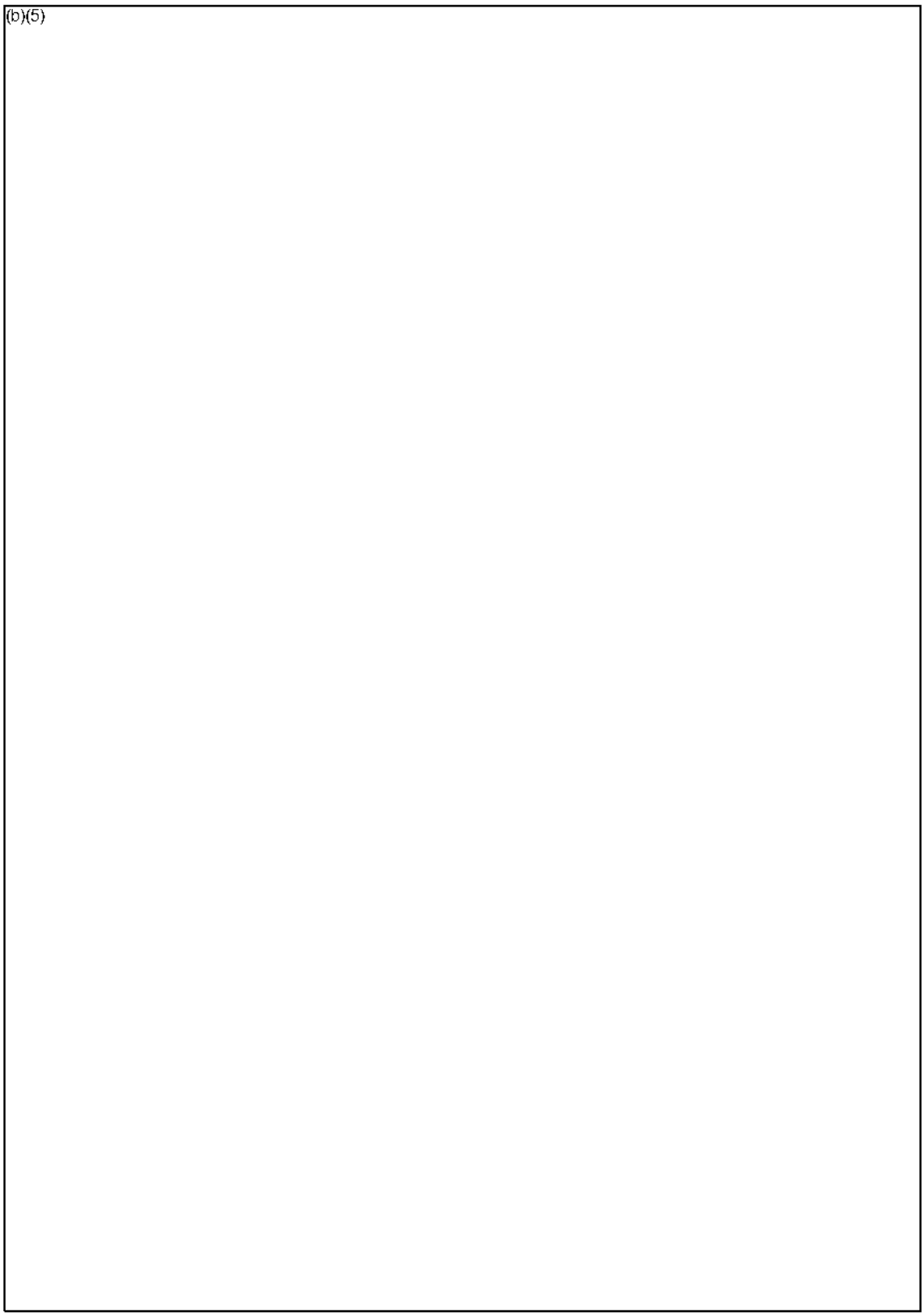

(b)(5)

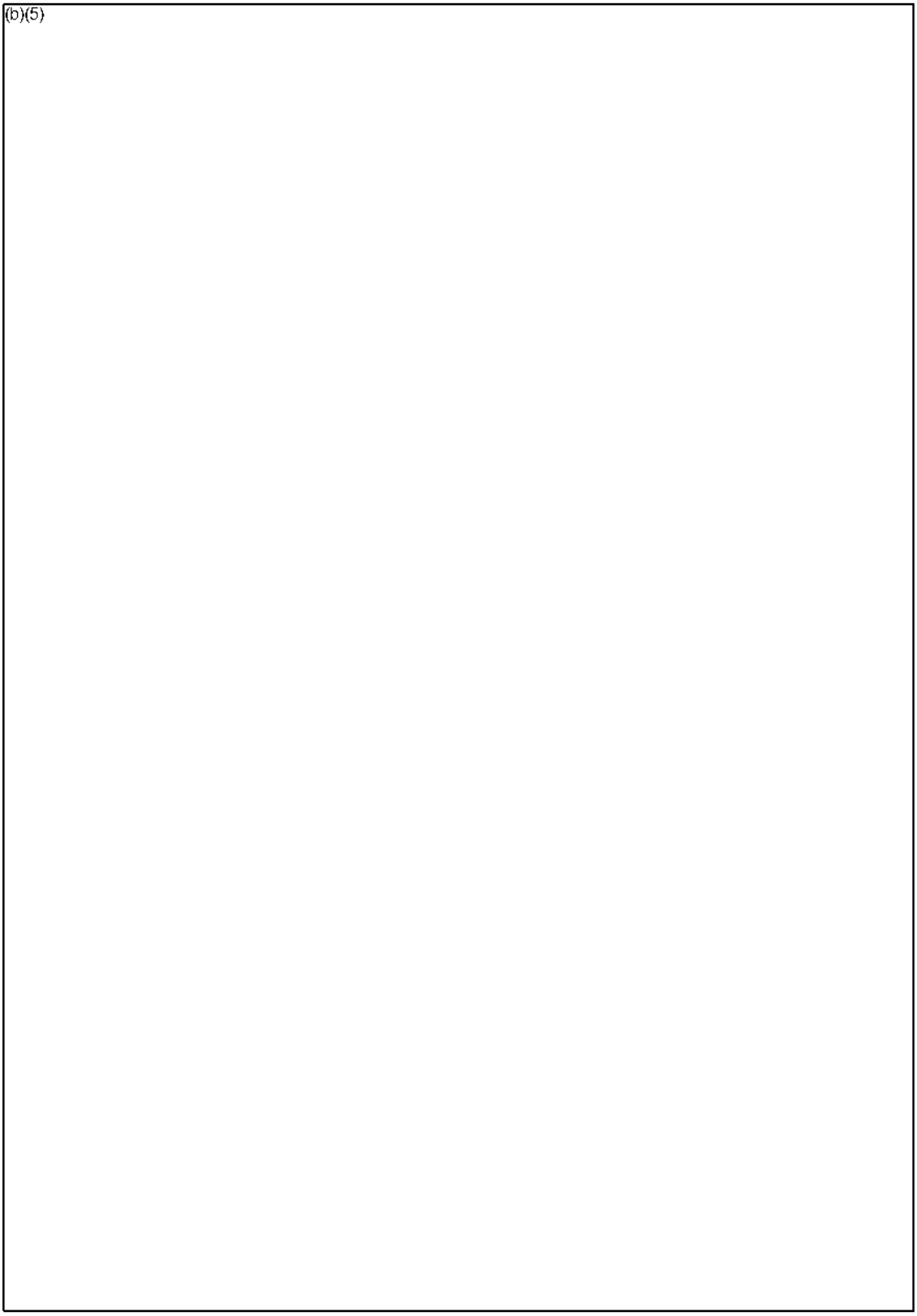
(b)(5)

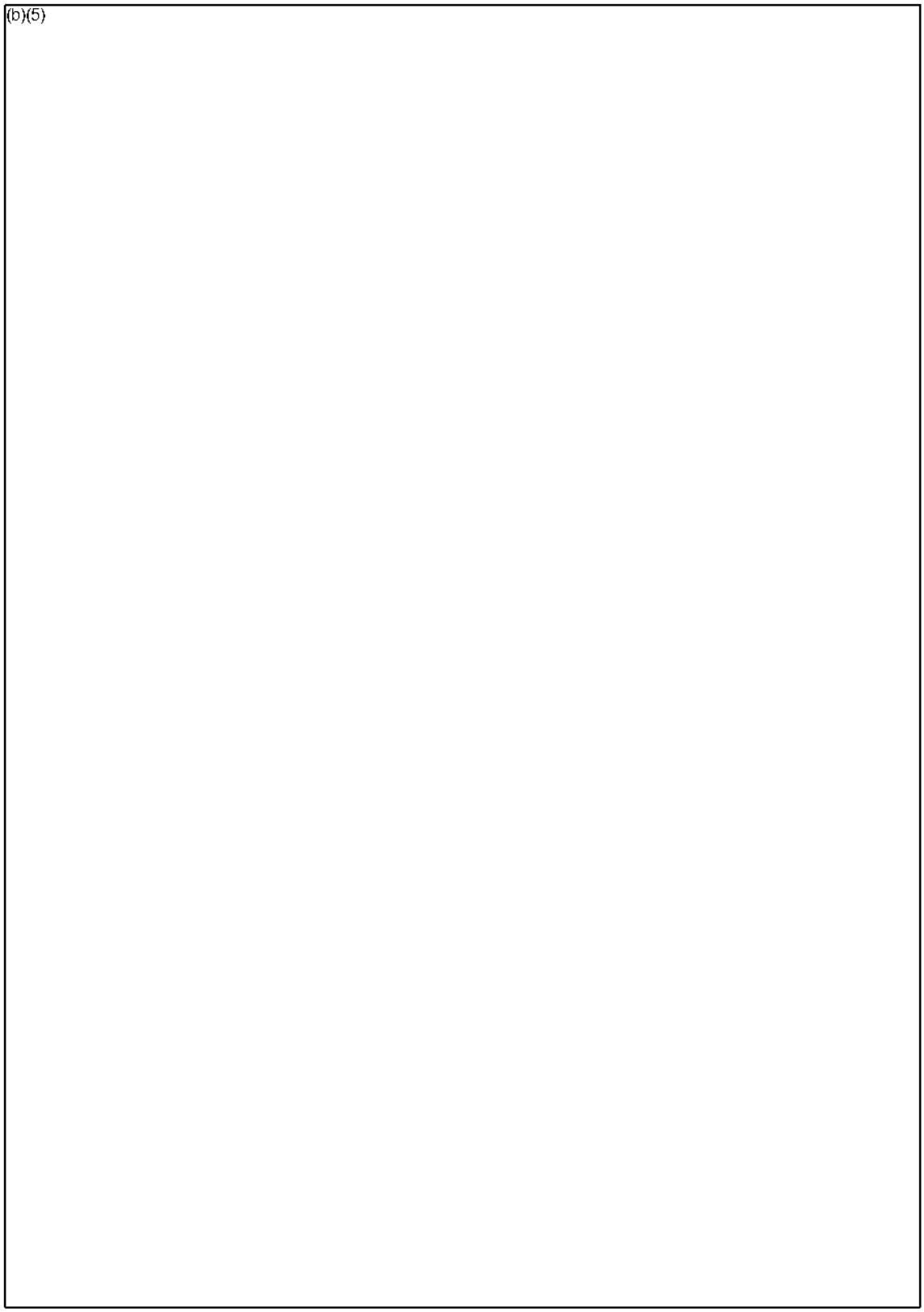

(b)(5)

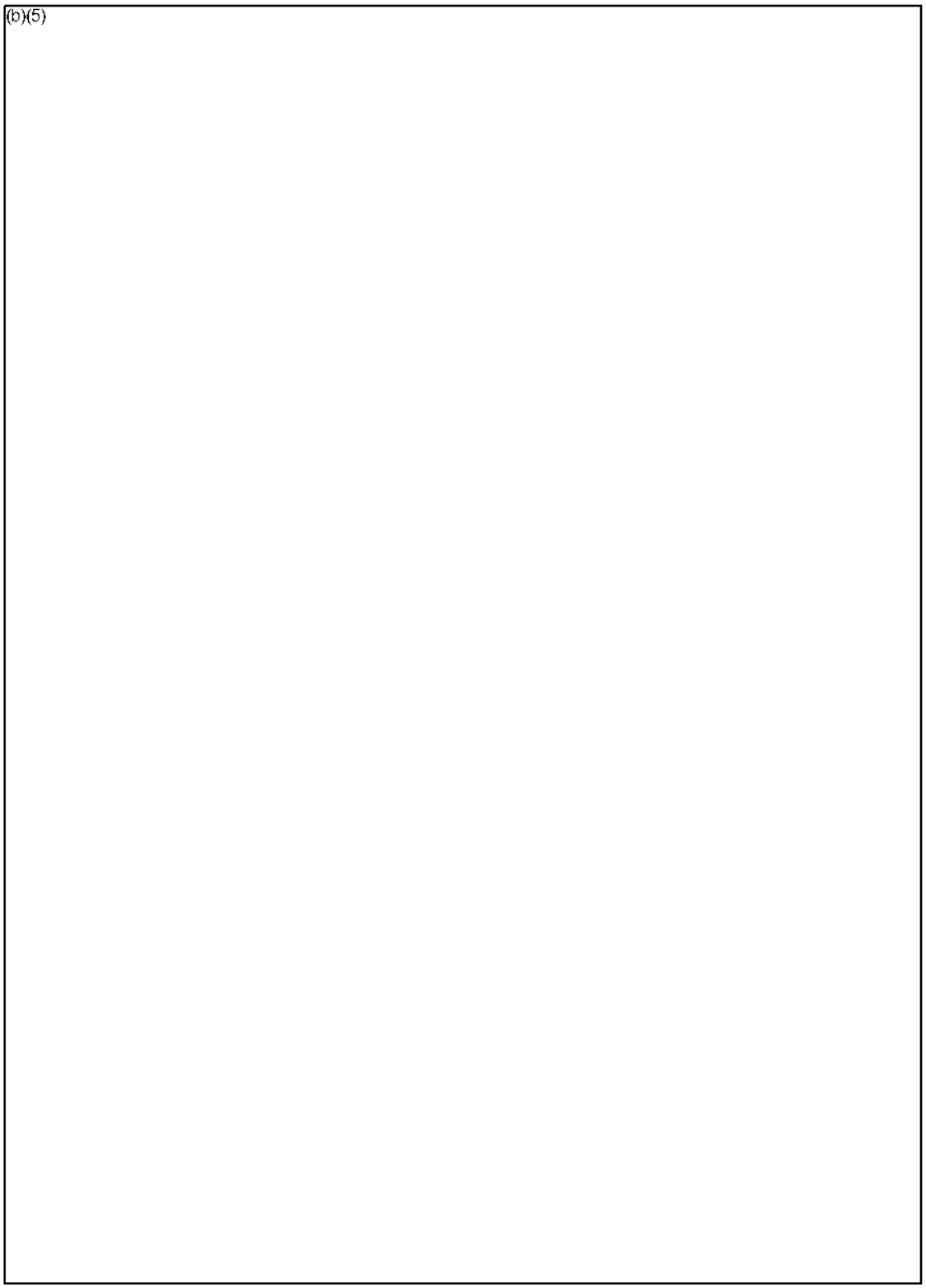

(b)(5)

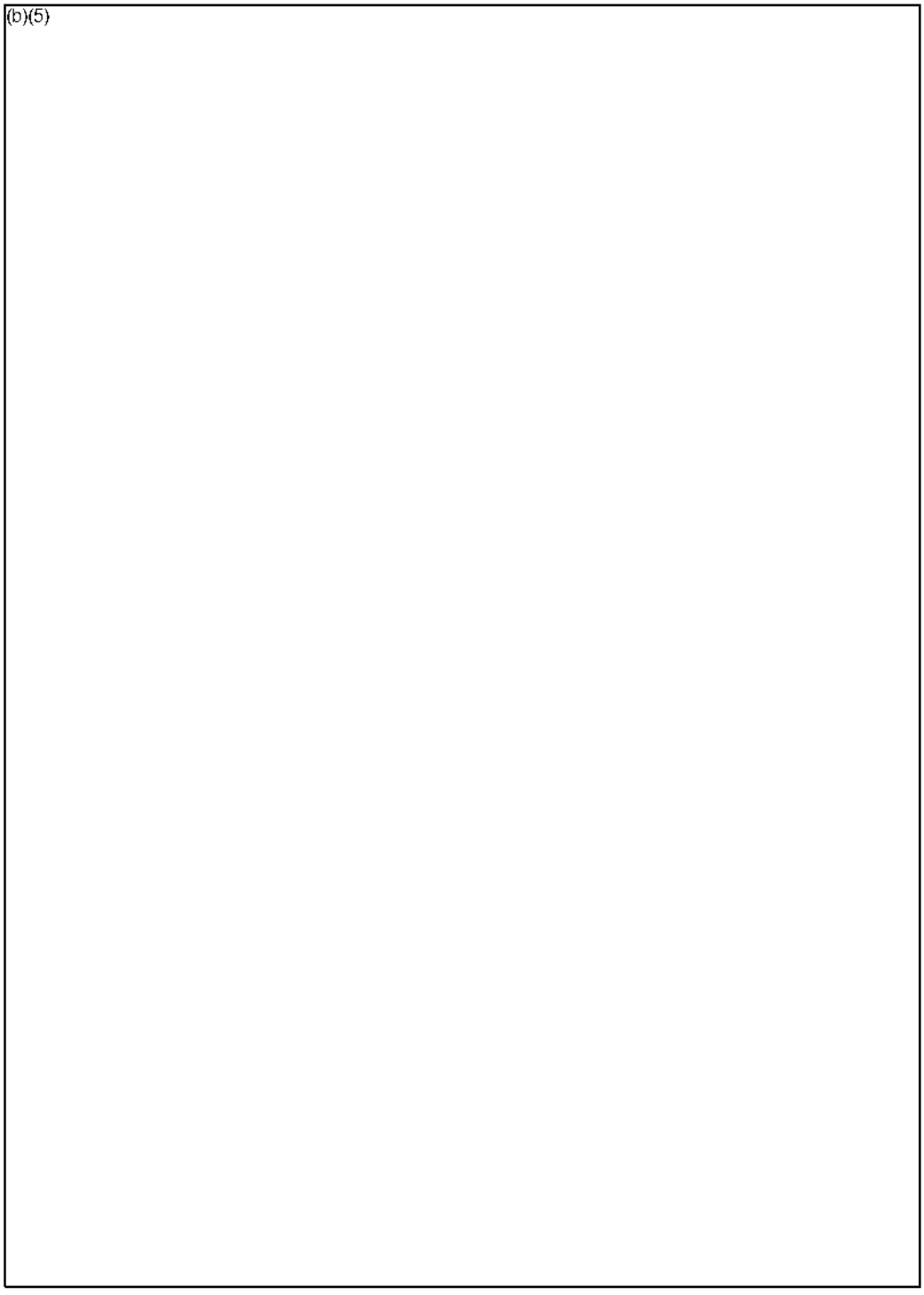

(b)(5)

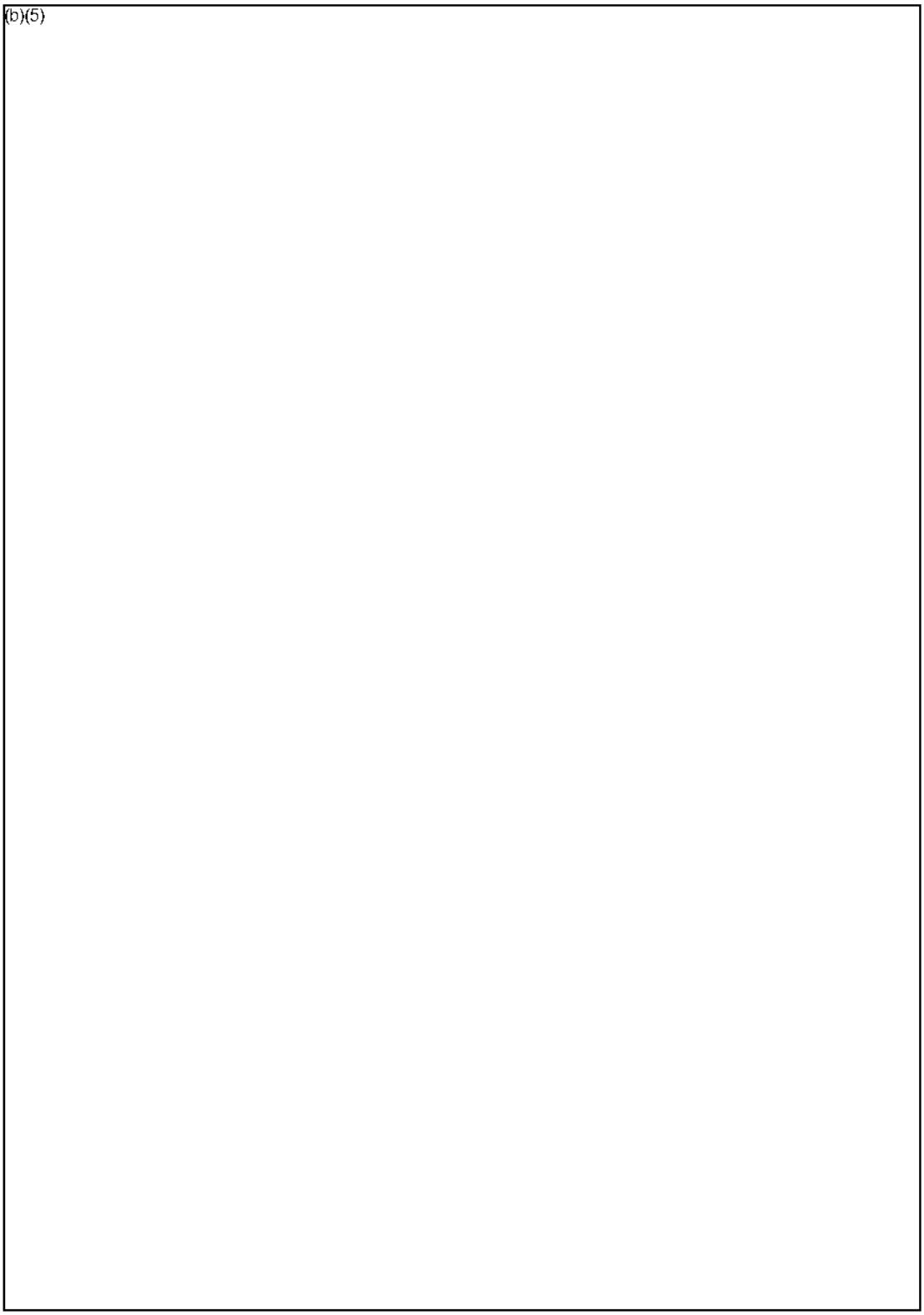

(b)(5)

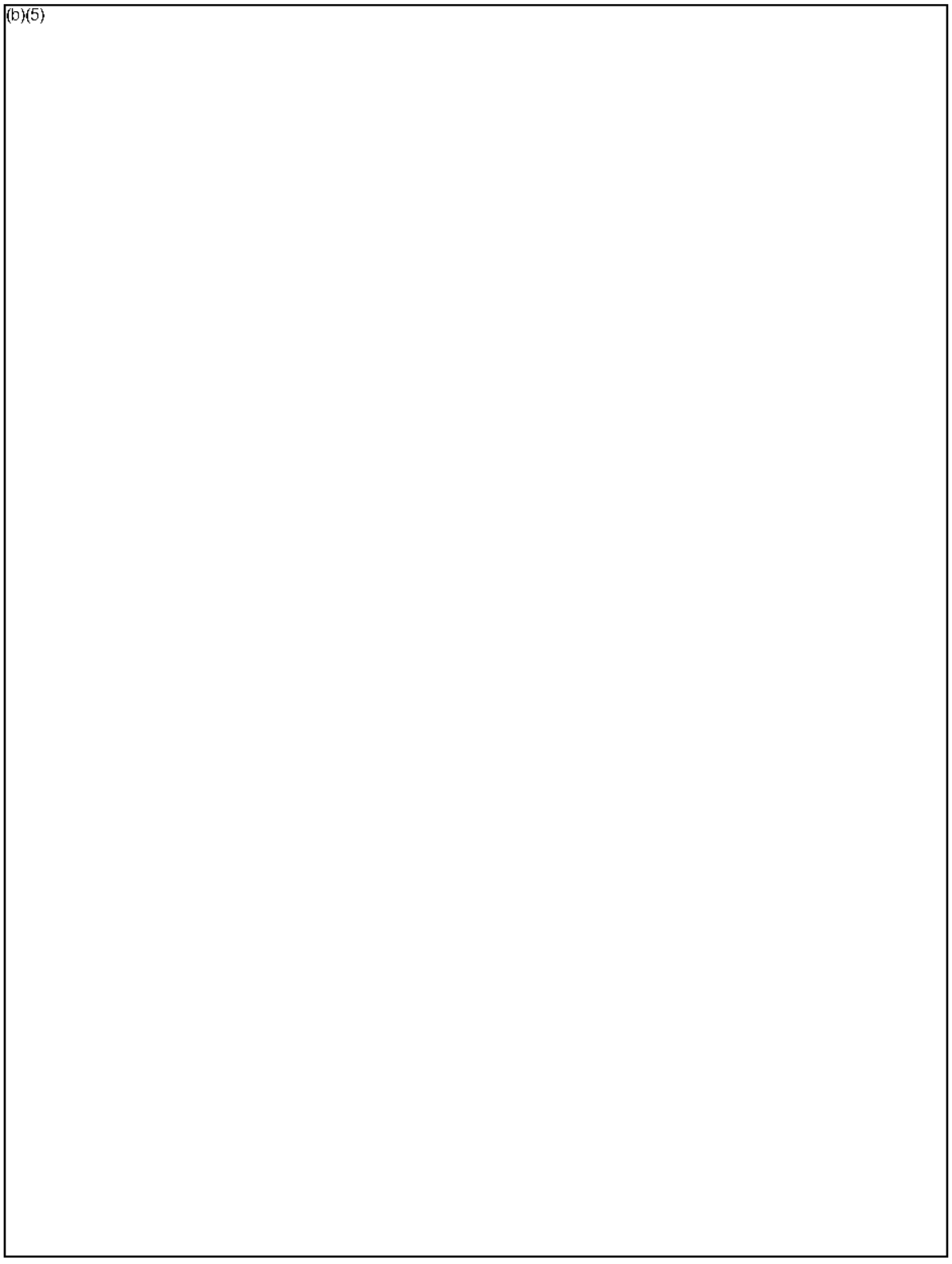

(b)(5)

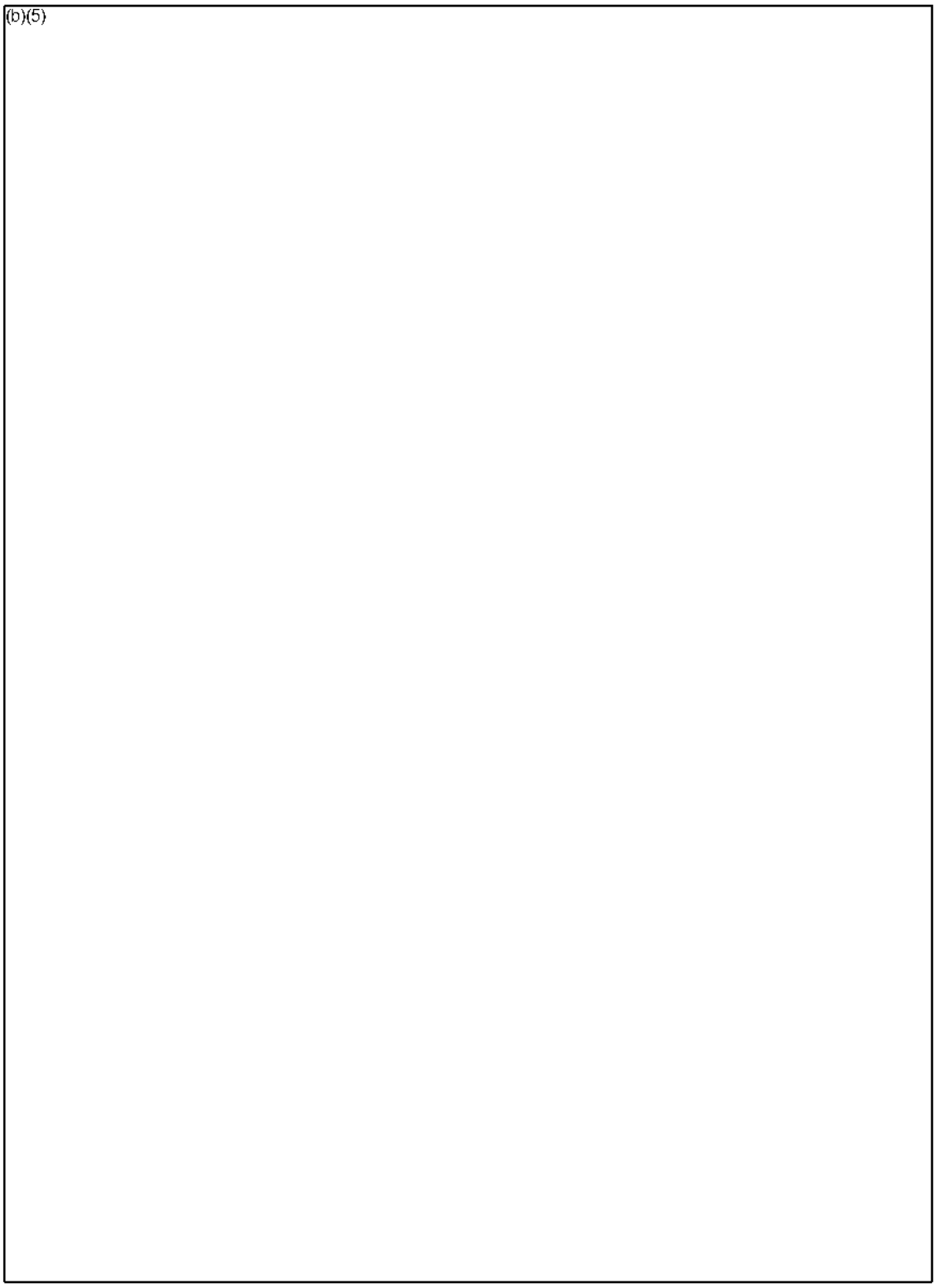

(b)(5)

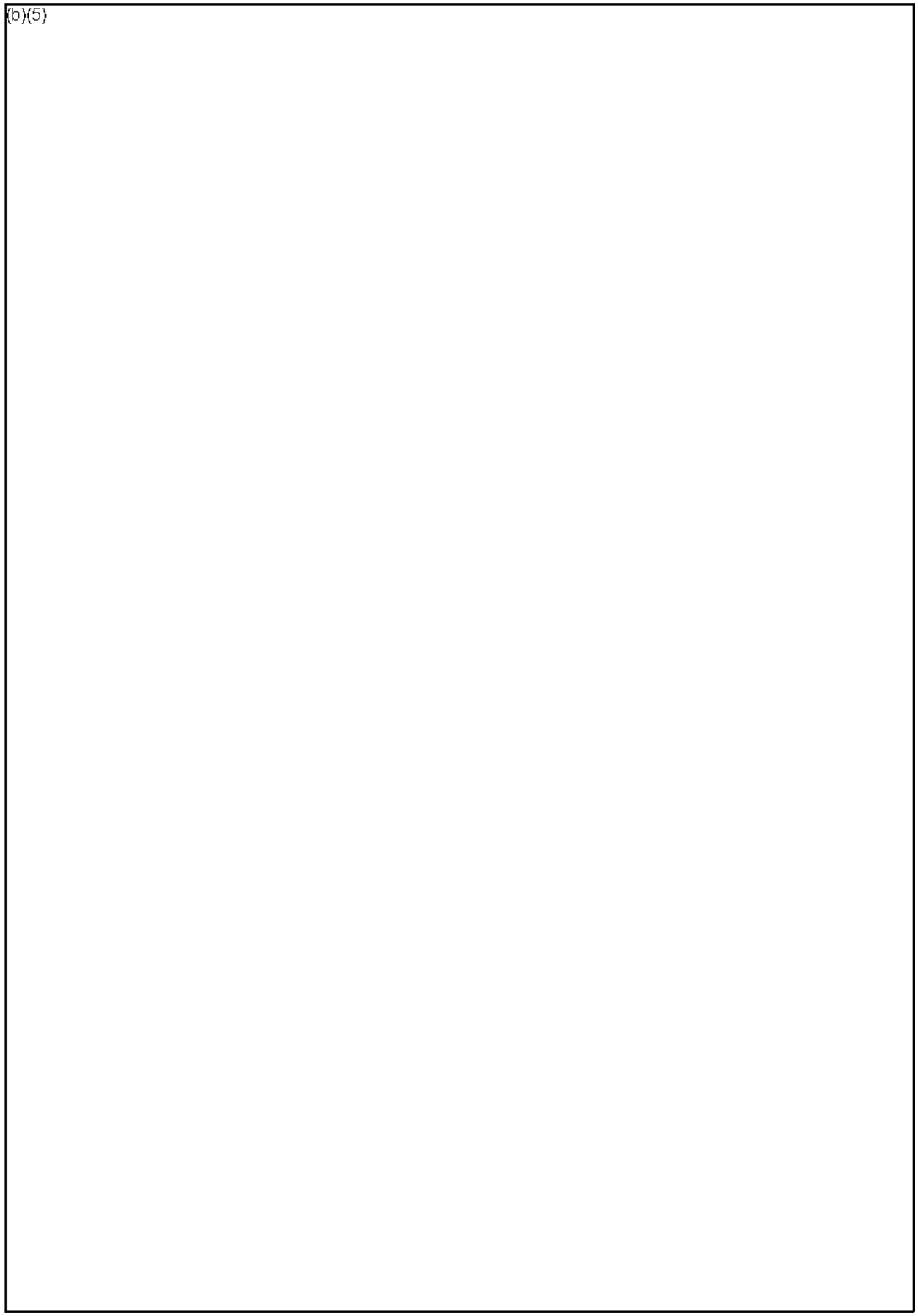

(b)(5)

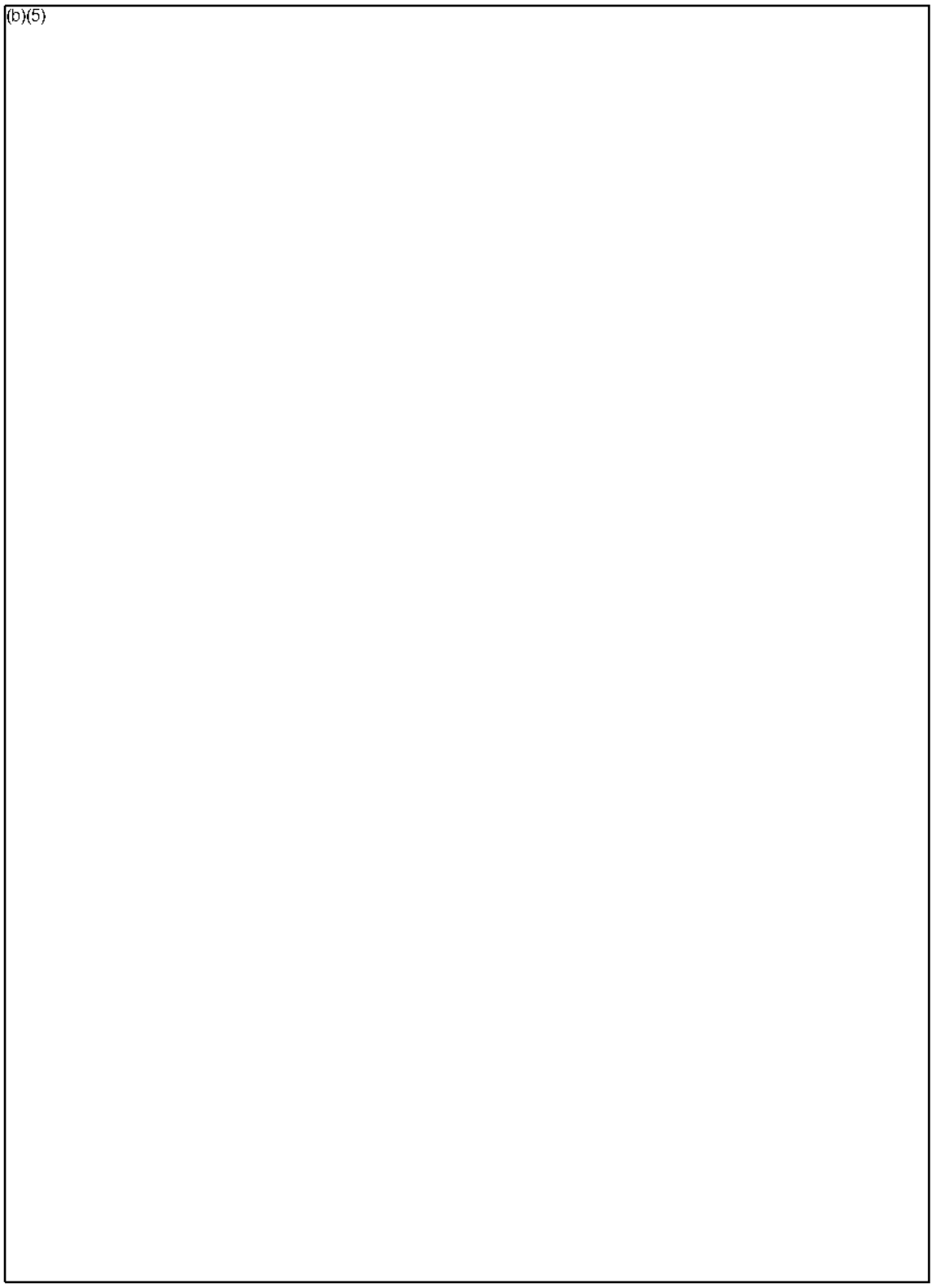

(b)(5)

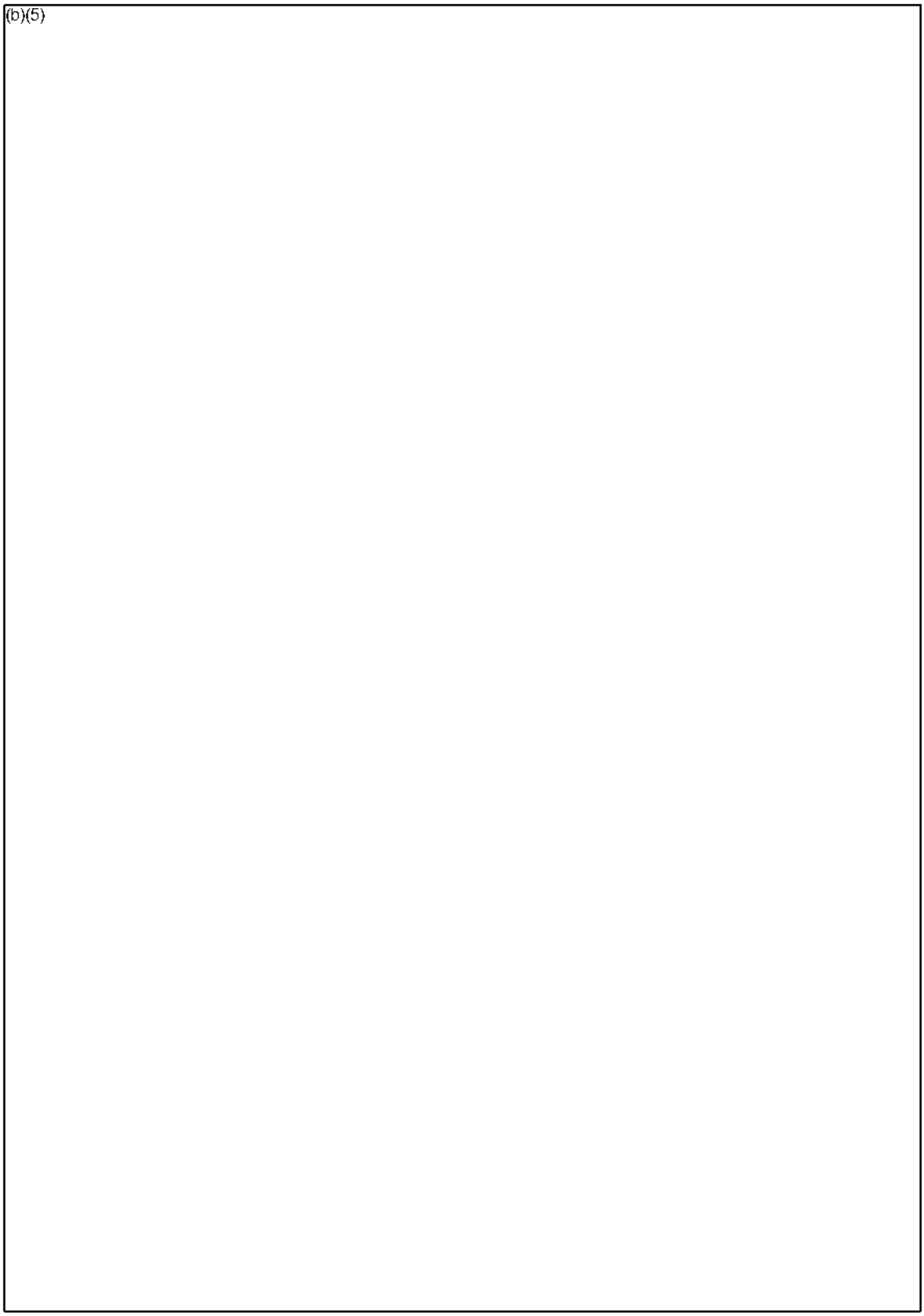

(b)(5)

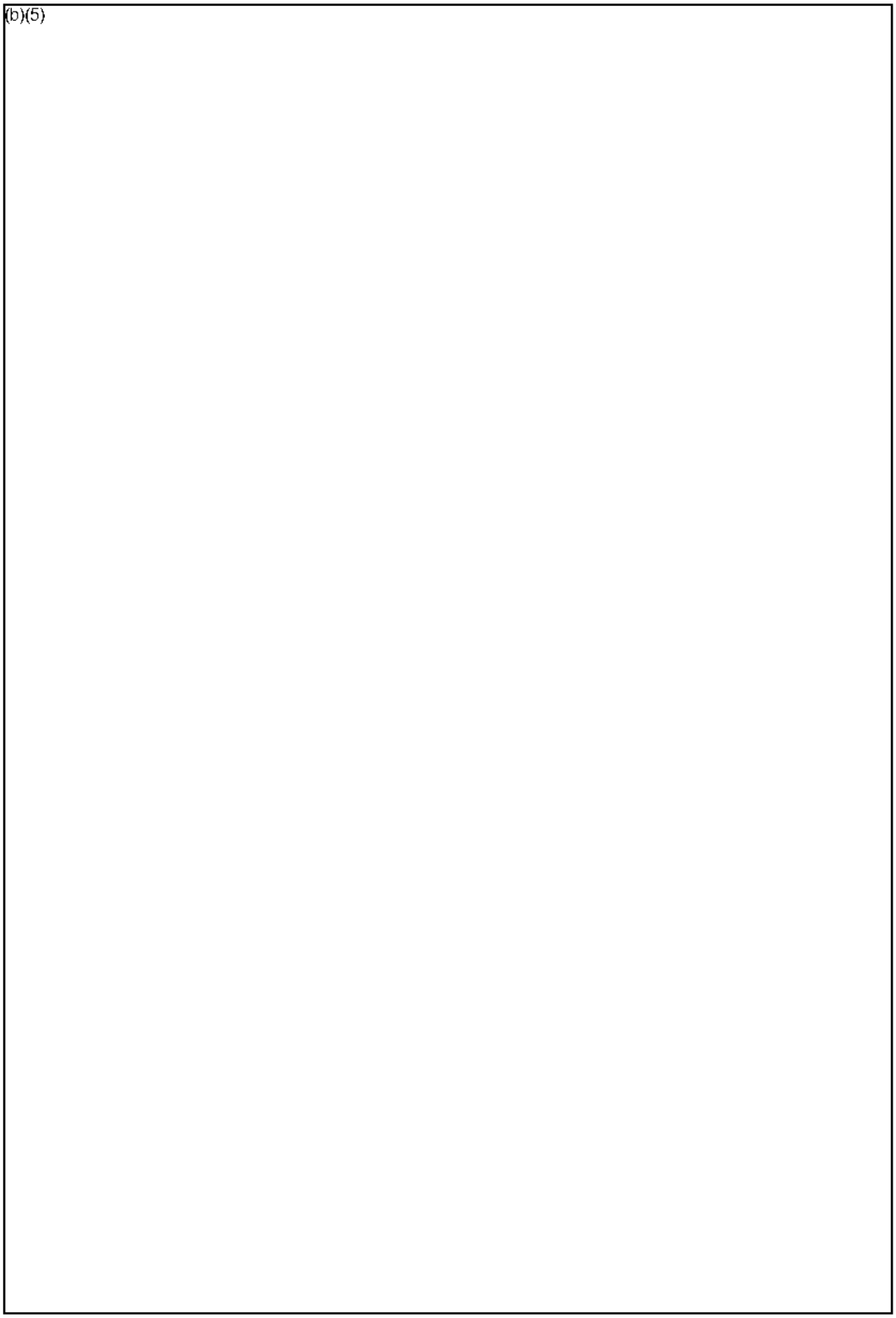

(b)(5)

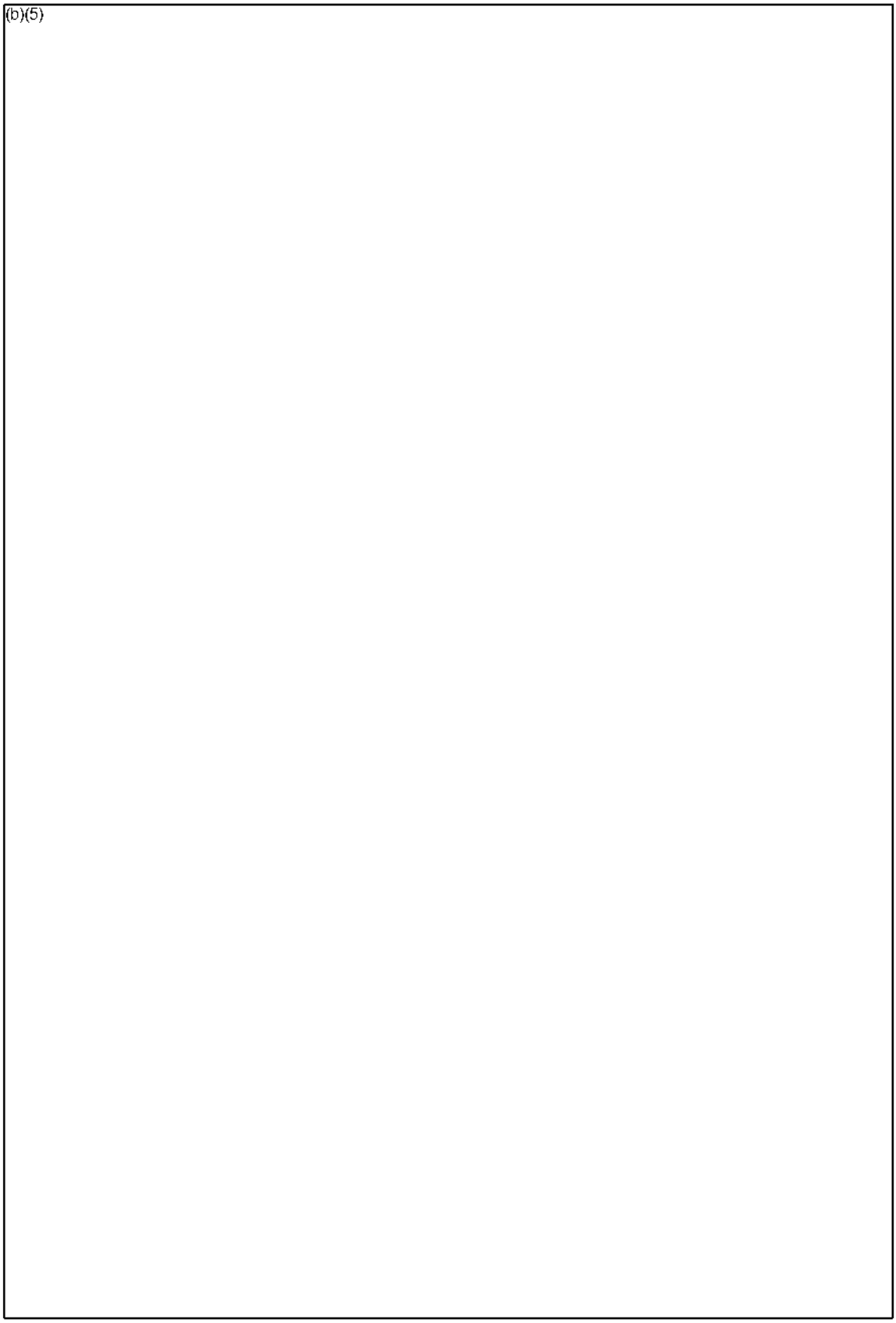

(b)(5)

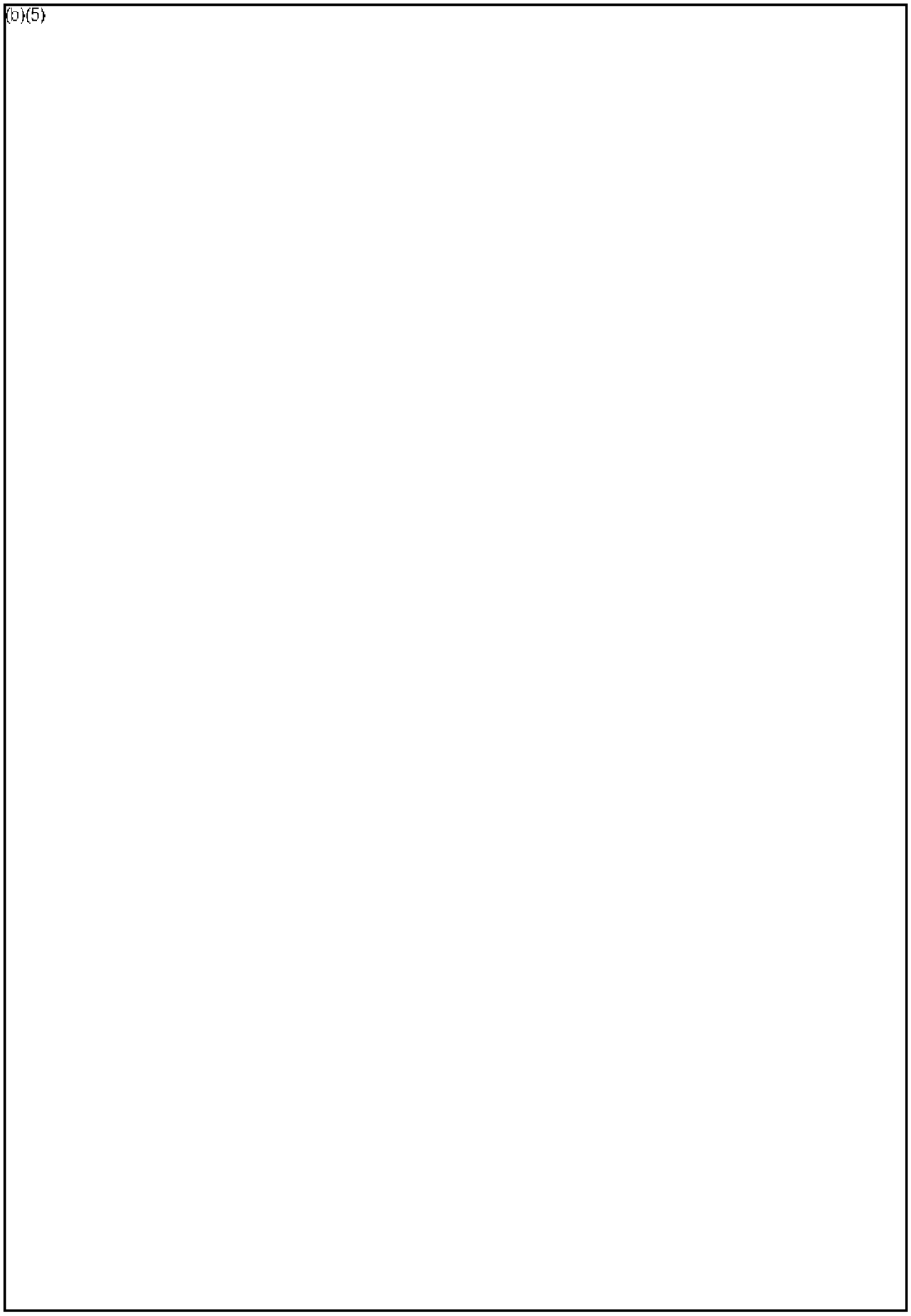

(b)(5)

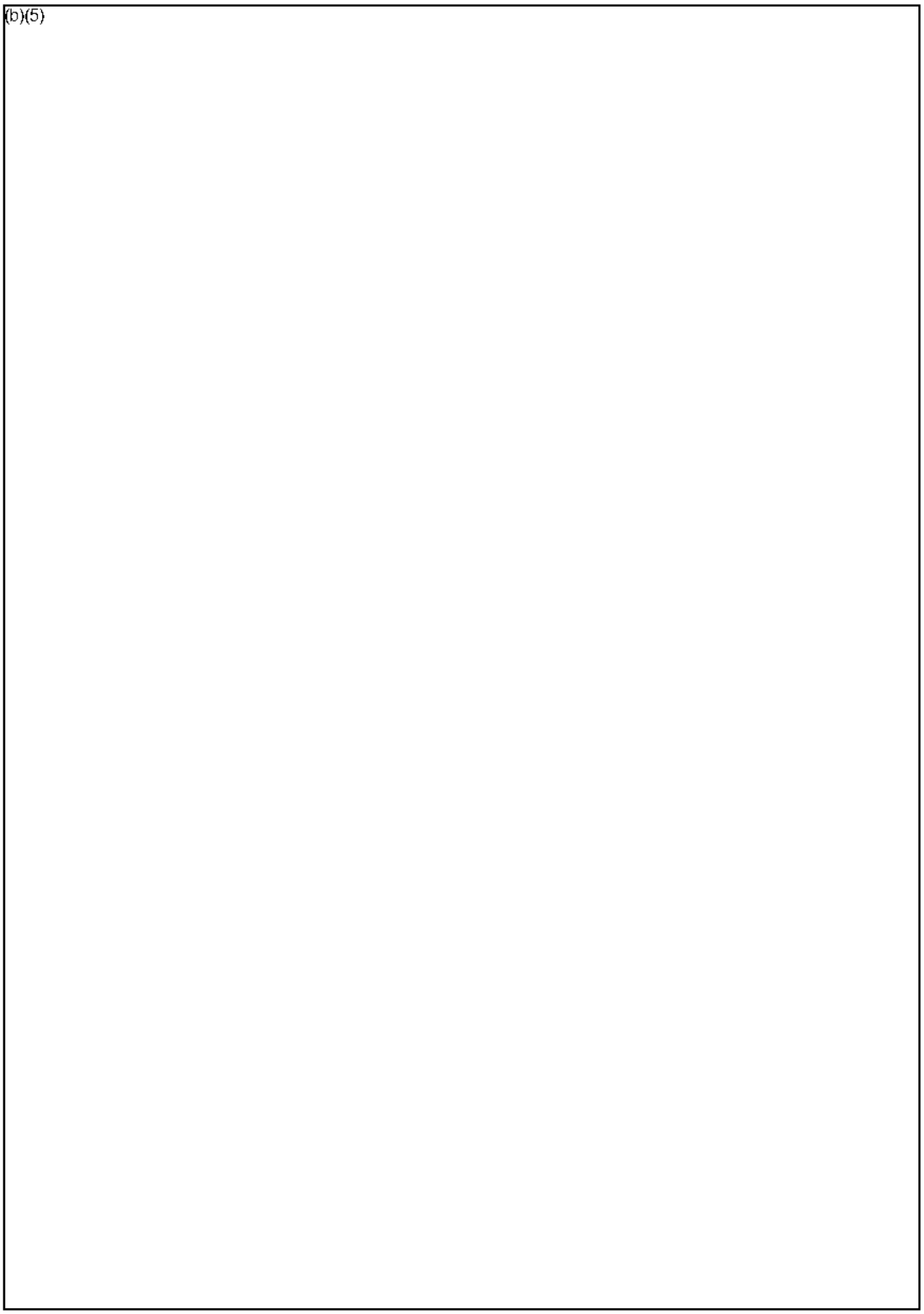

(b)(5)


(b)(5)

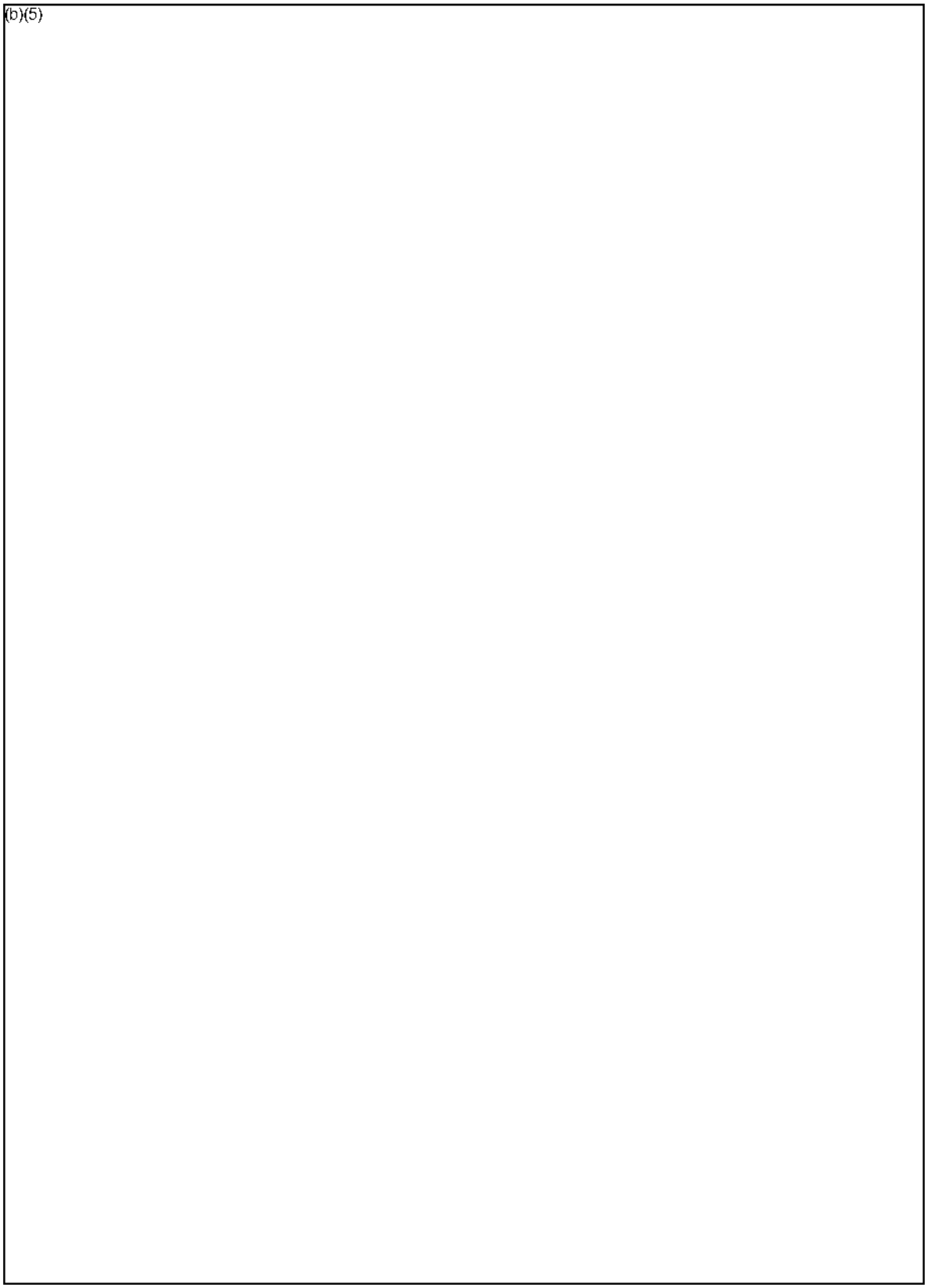

(b)(5)

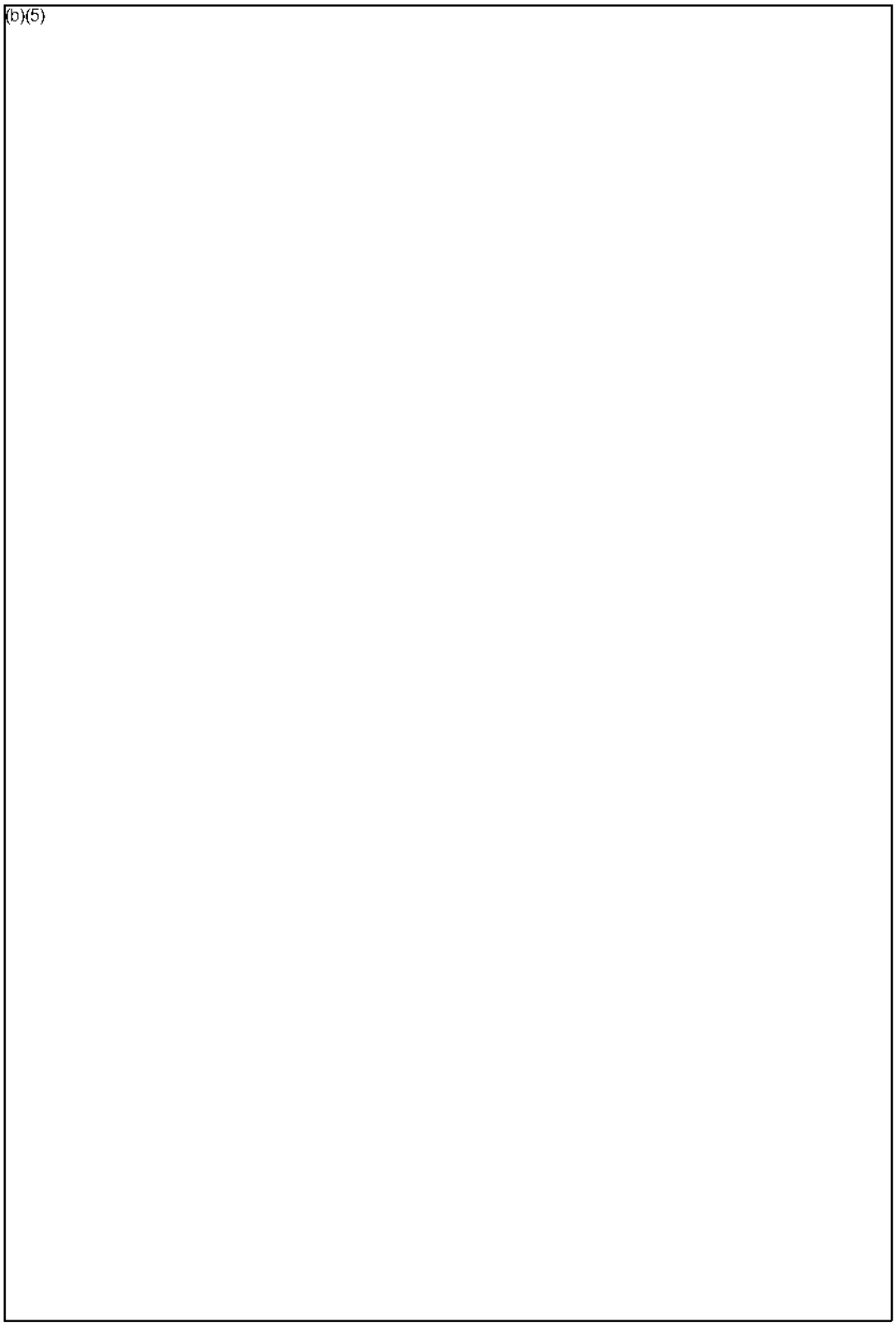

(b)(5)

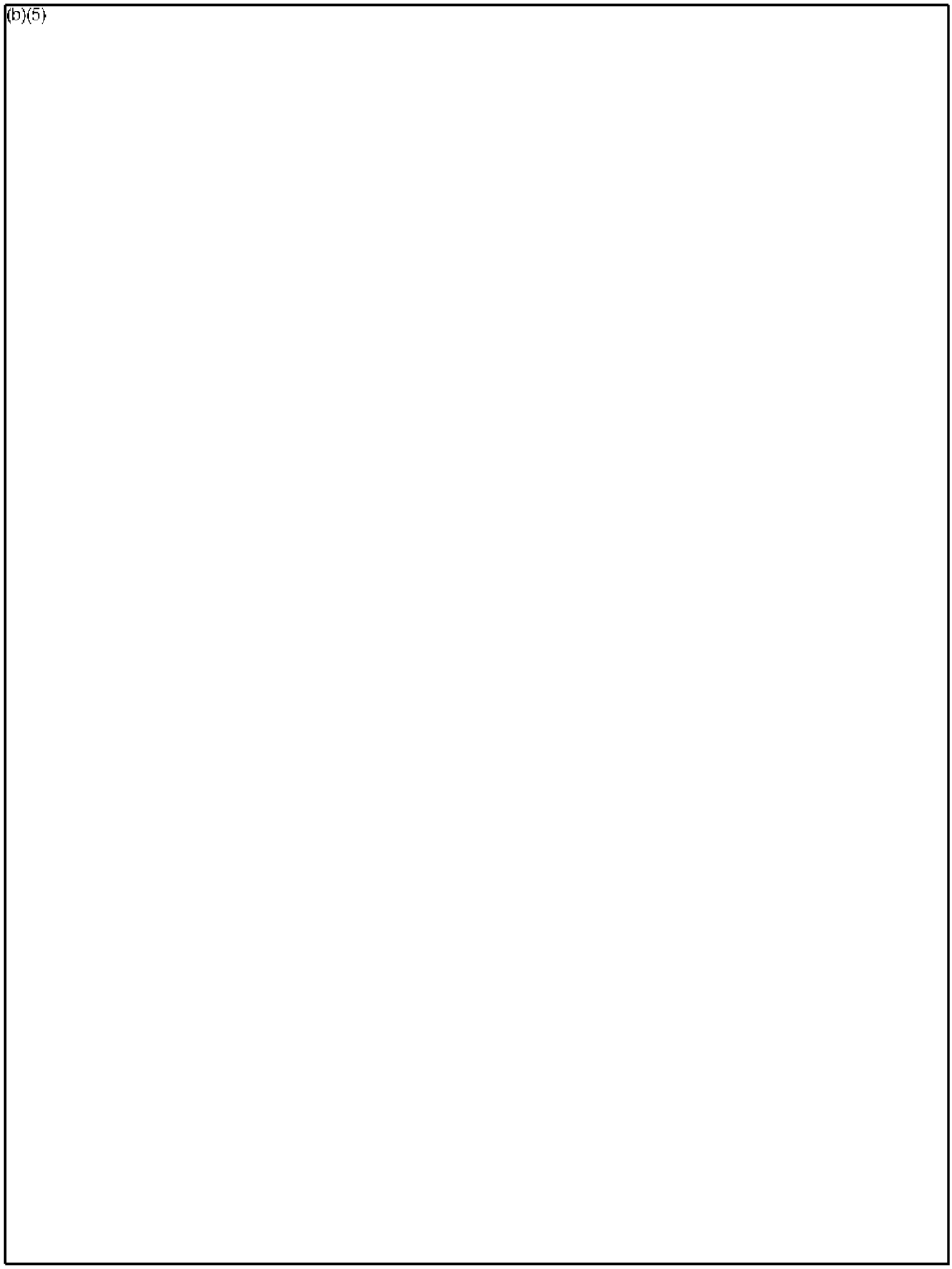

(b)(5)

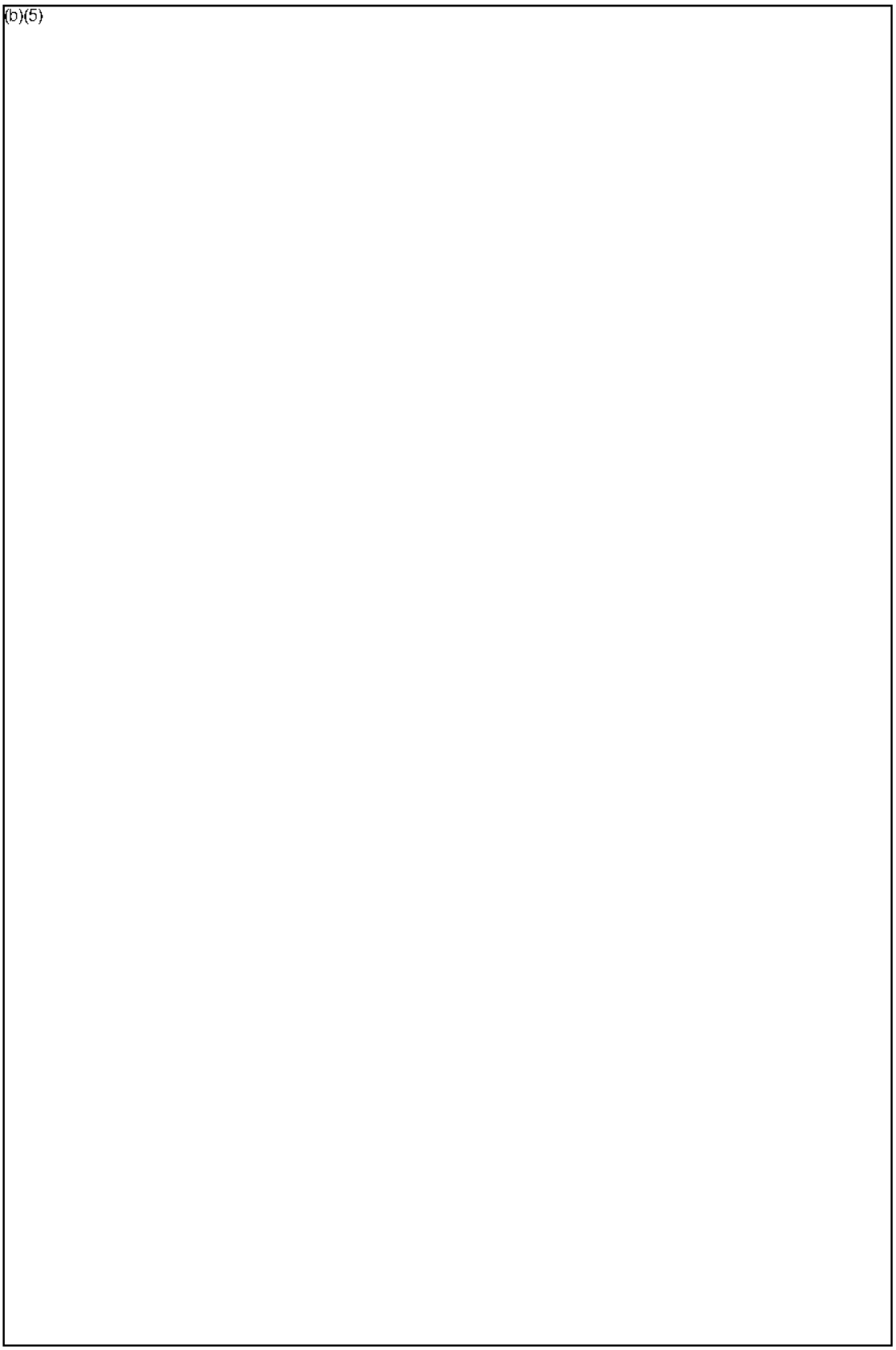

(b)(5)

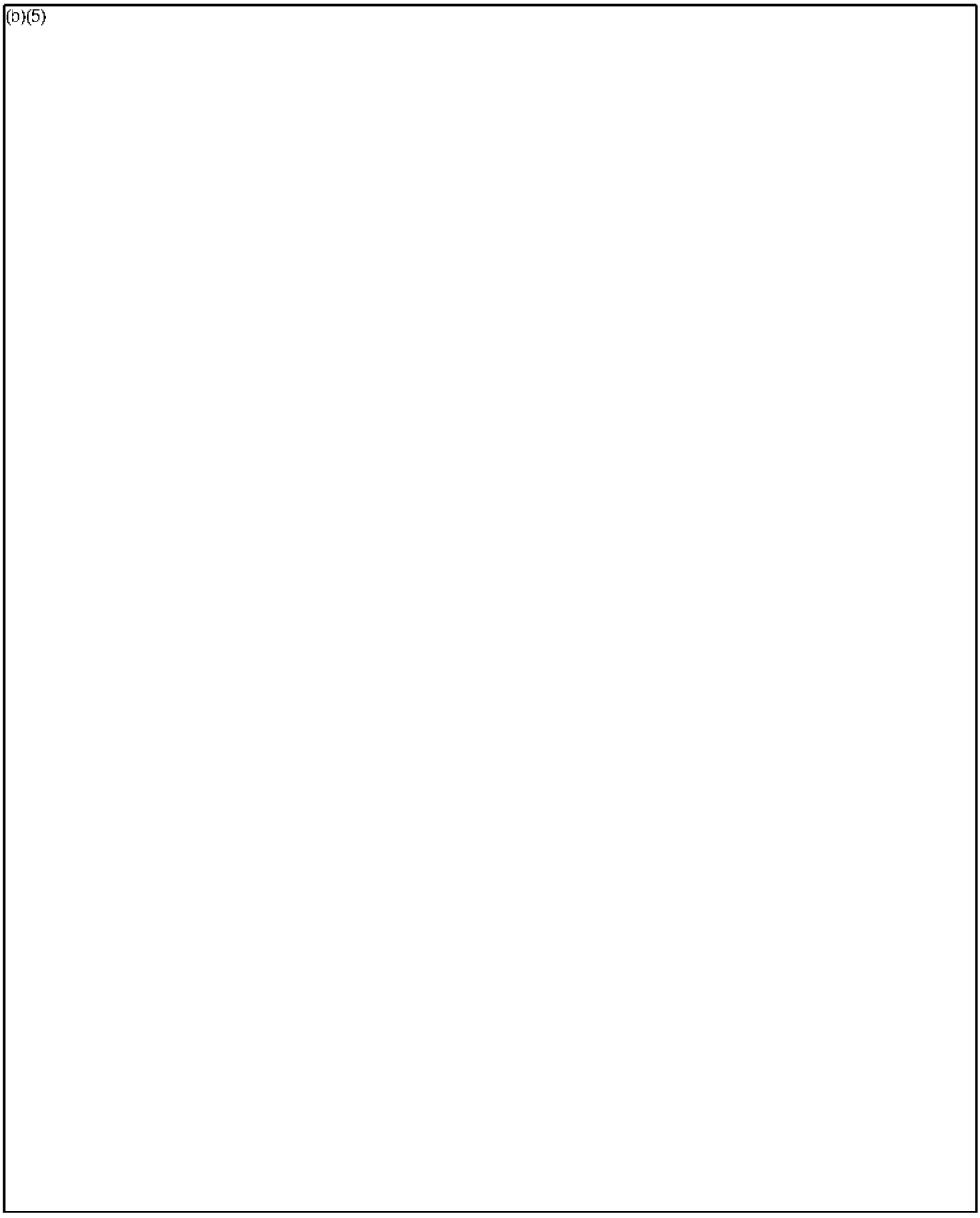
(b)(5)

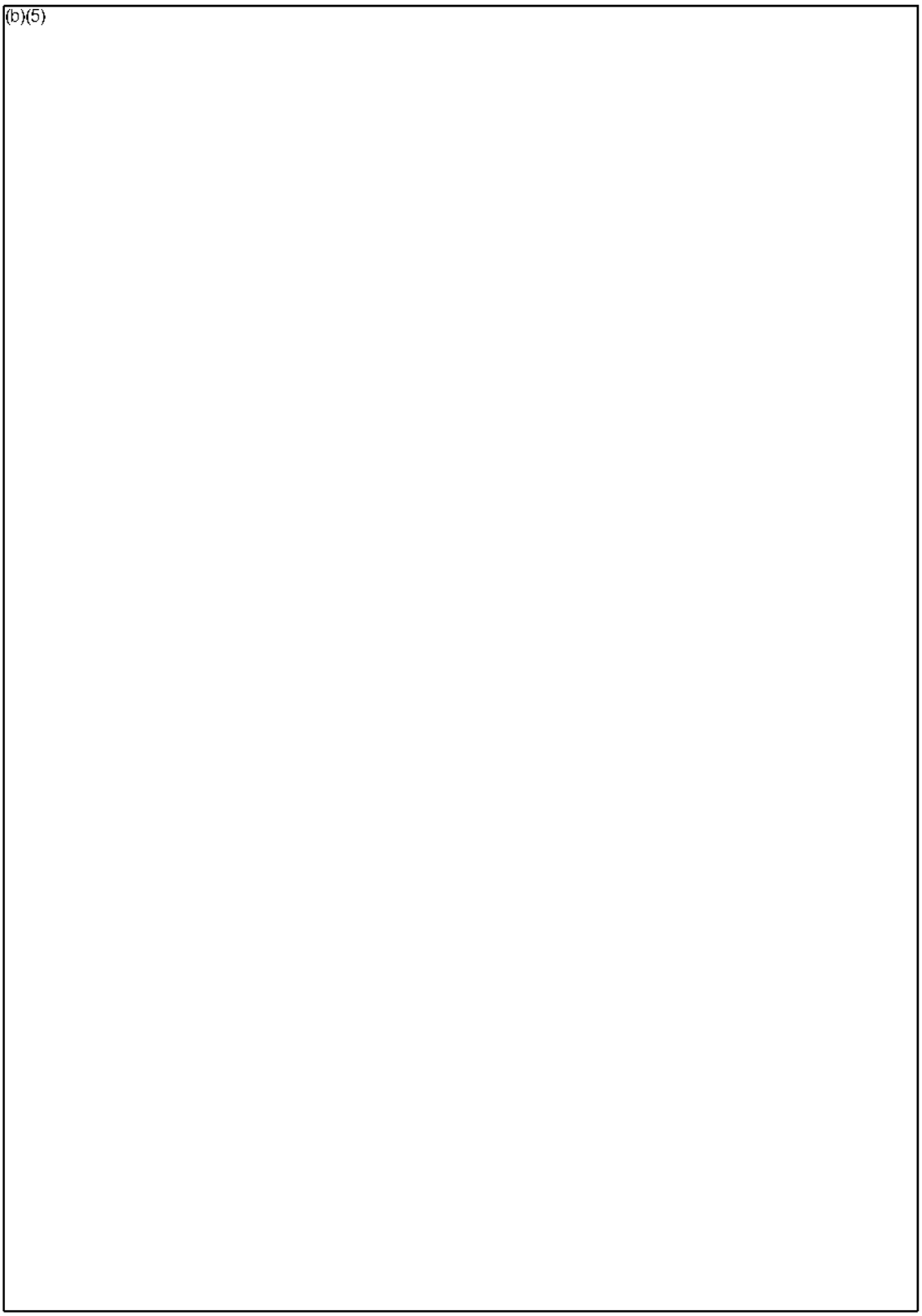

(b)(5)

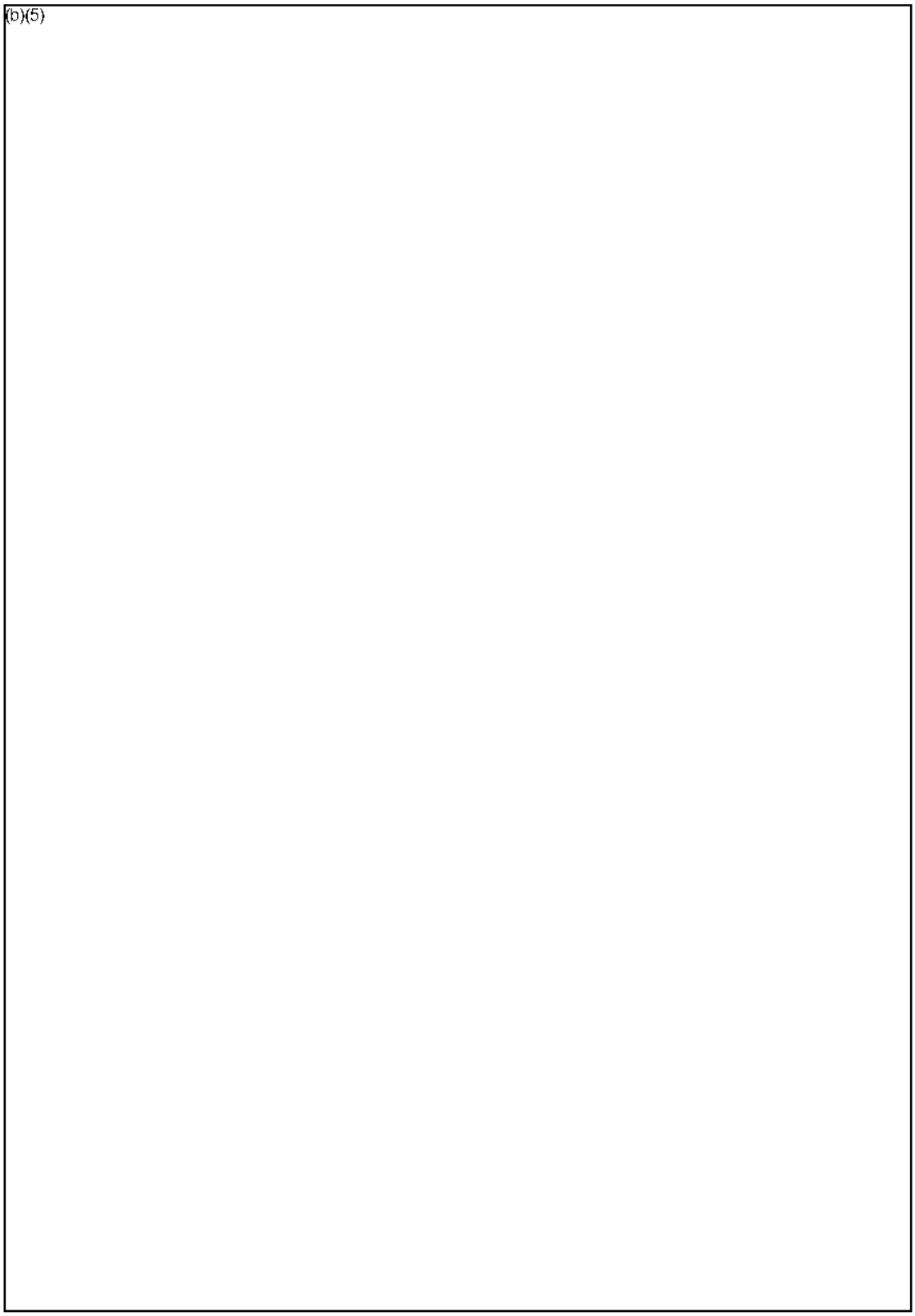

(b)(5)

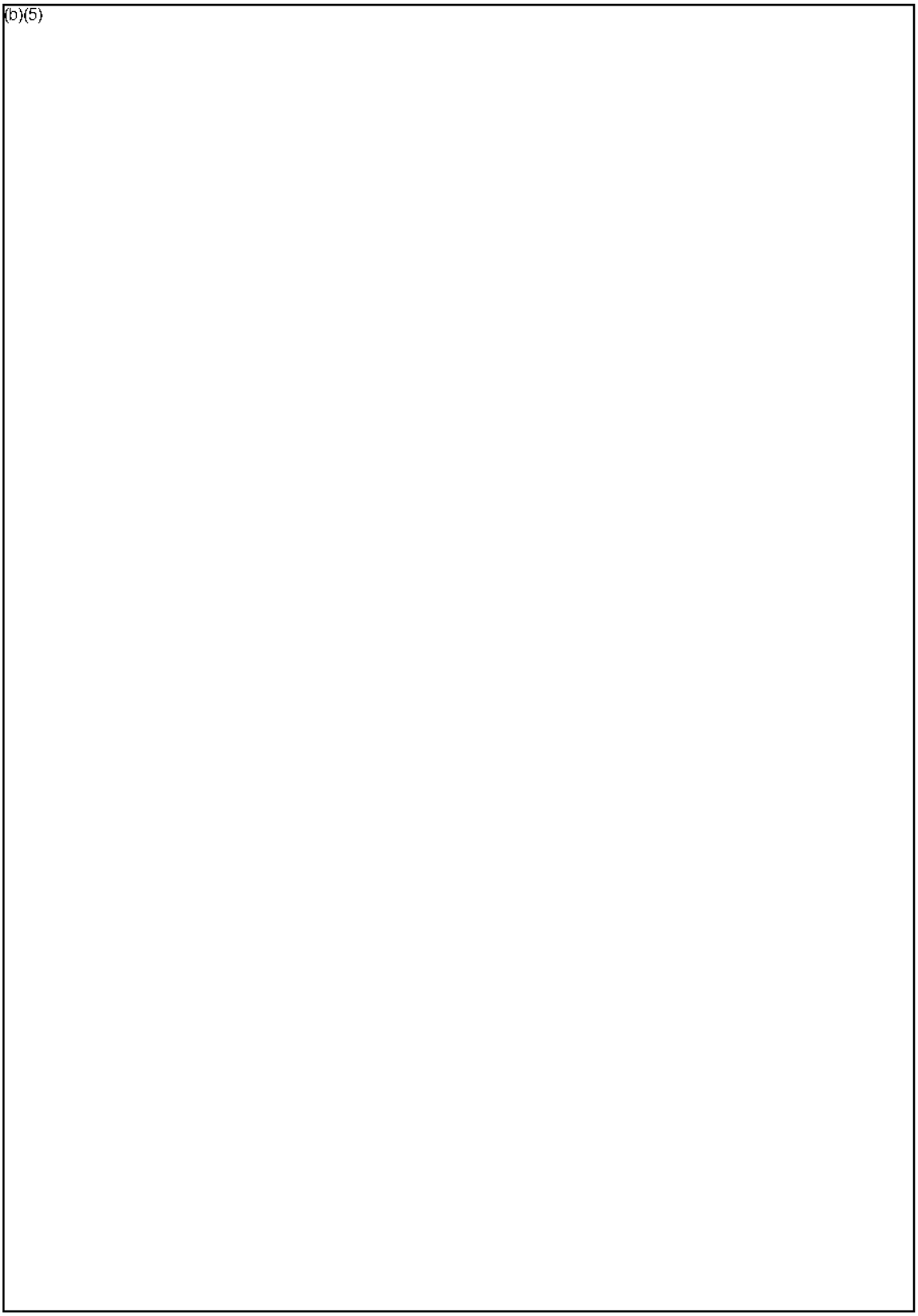

(b)(5)

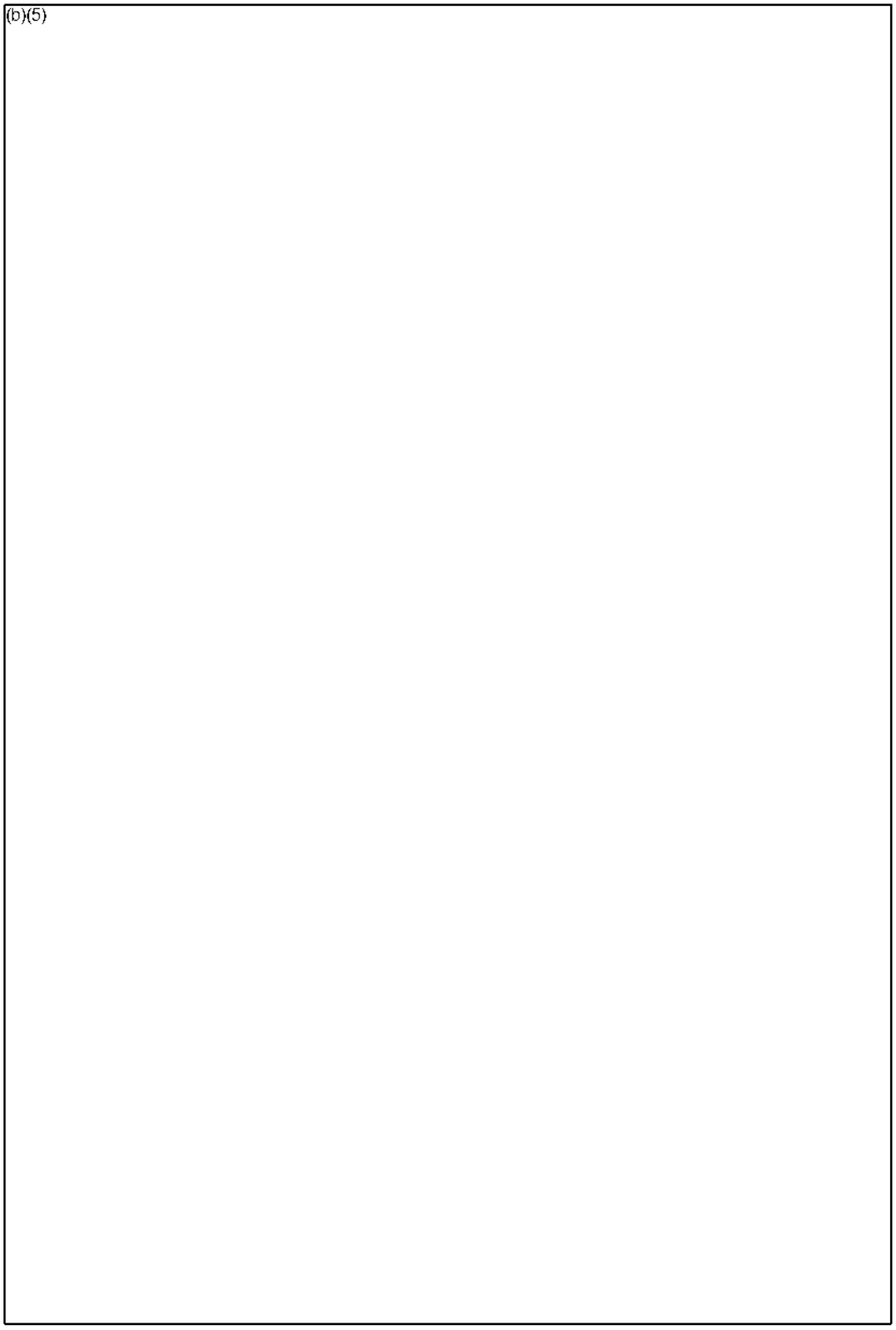

(b)(5)

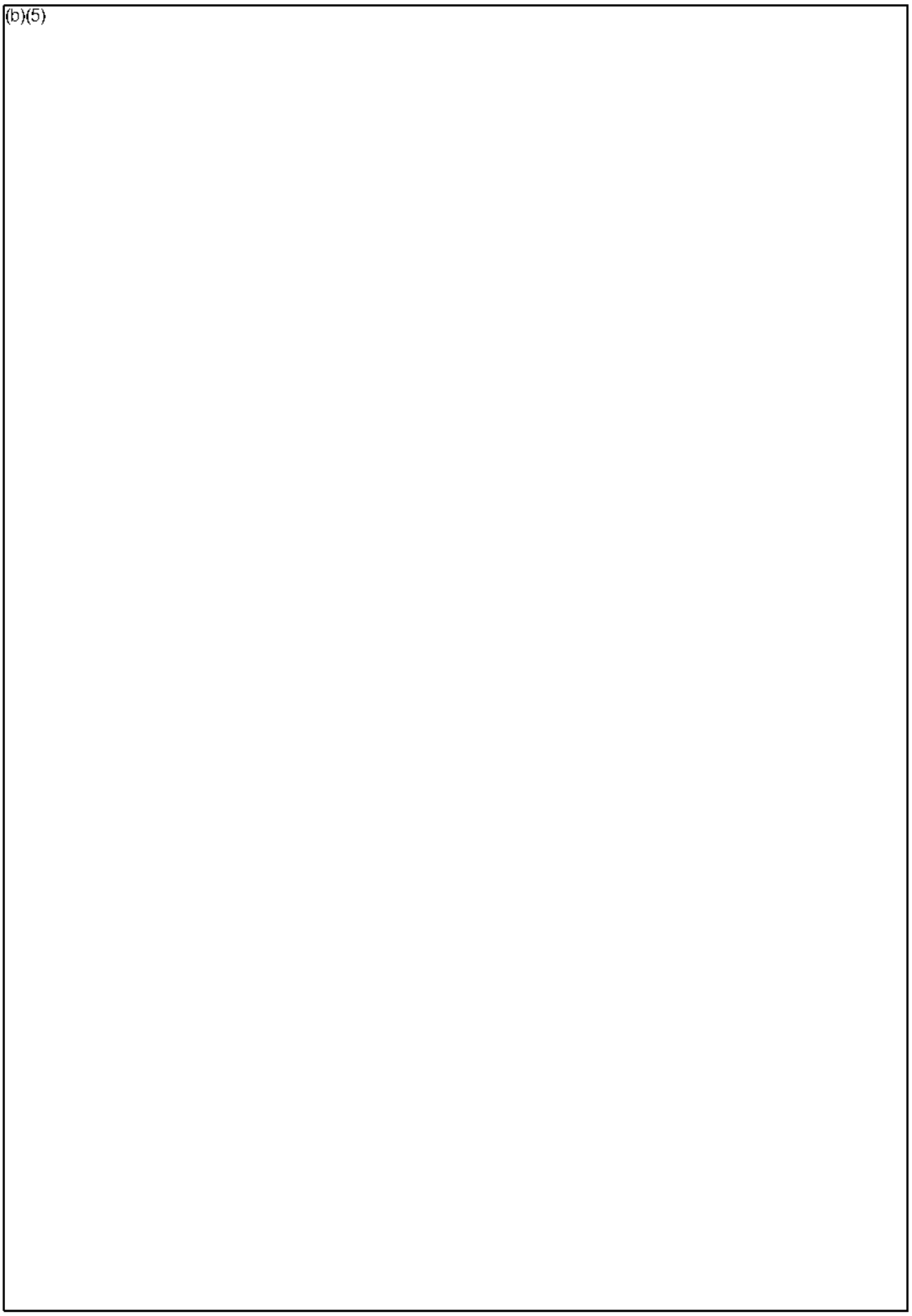

(b)(5)

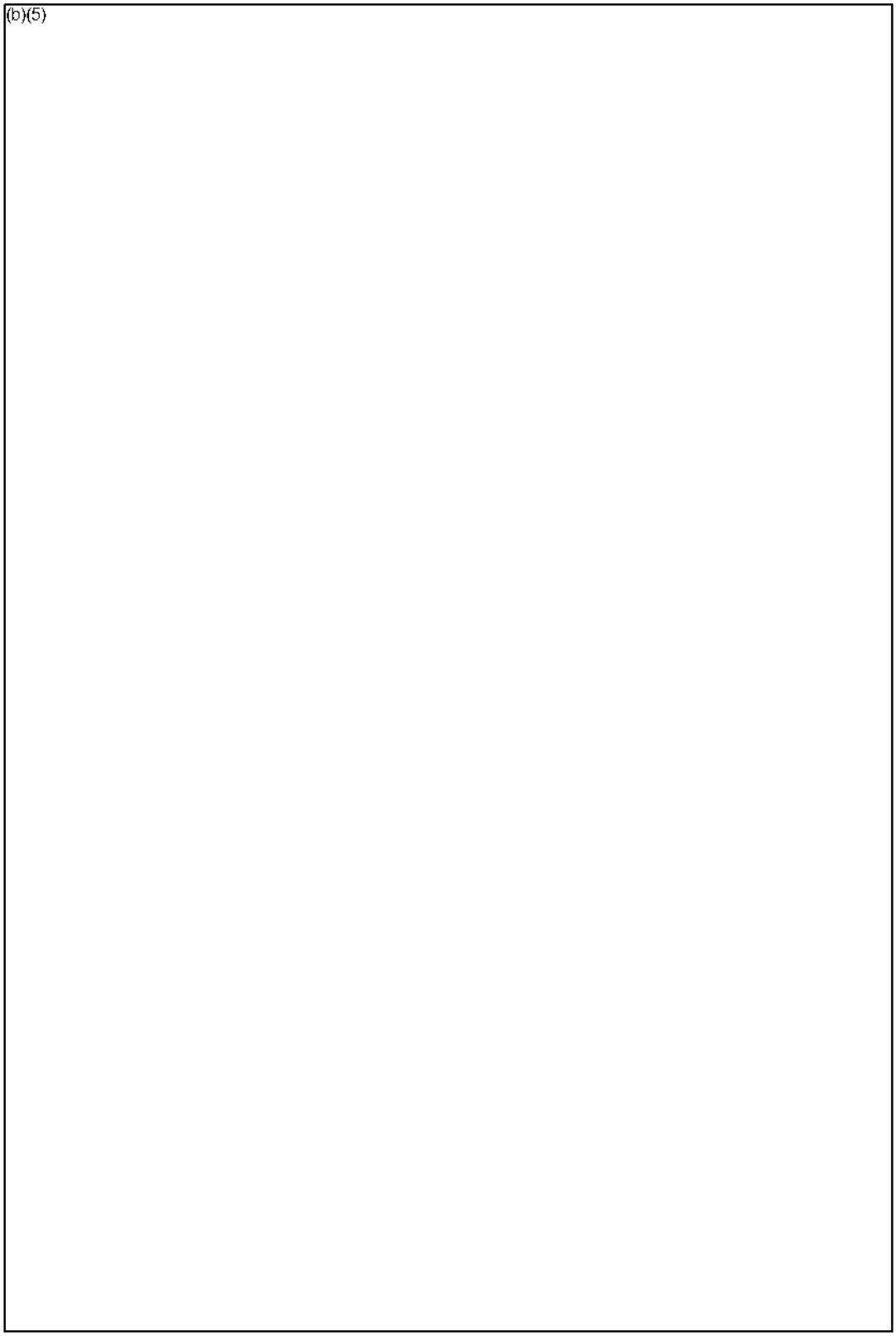

(b)(5)

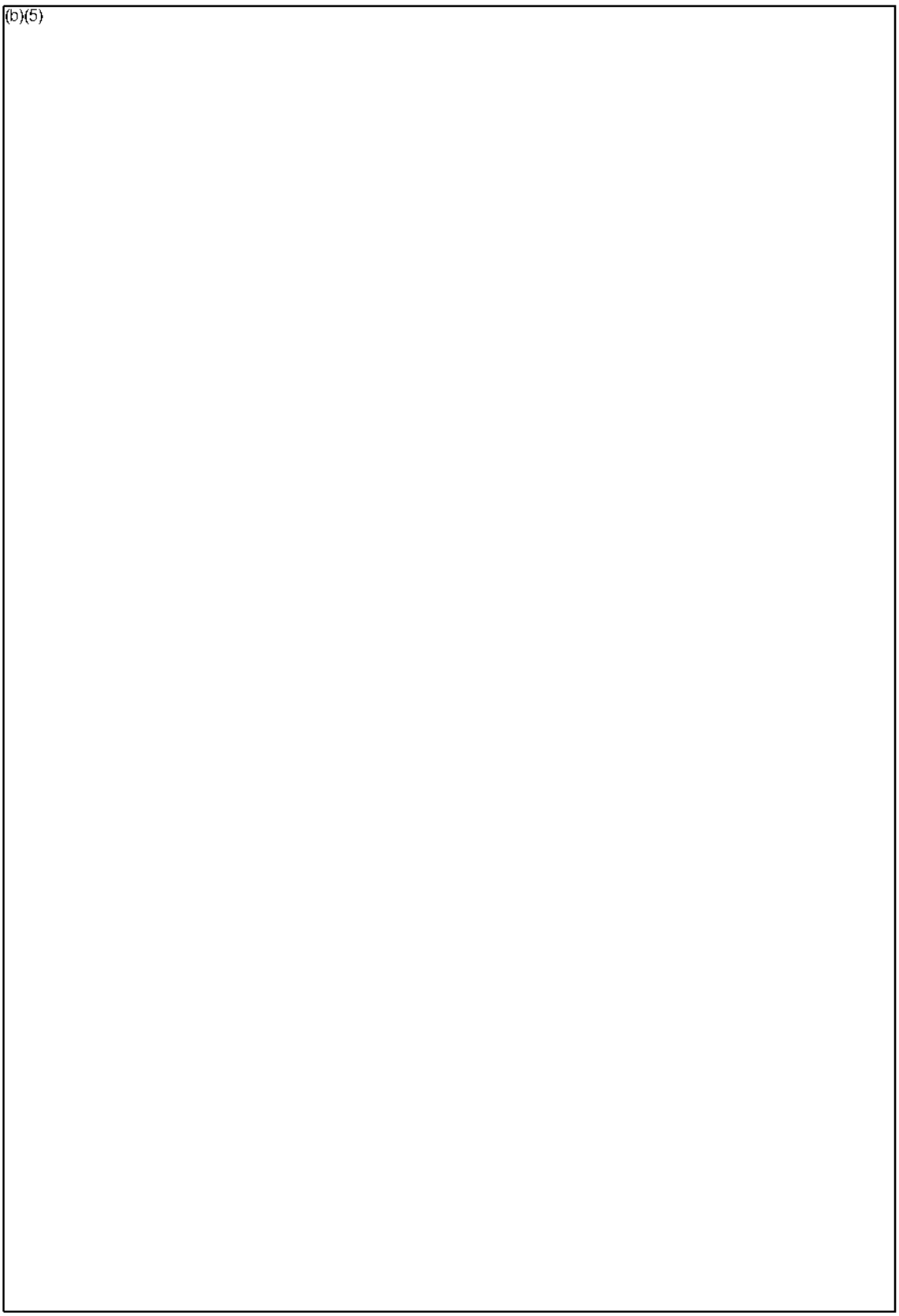

(b)(5)

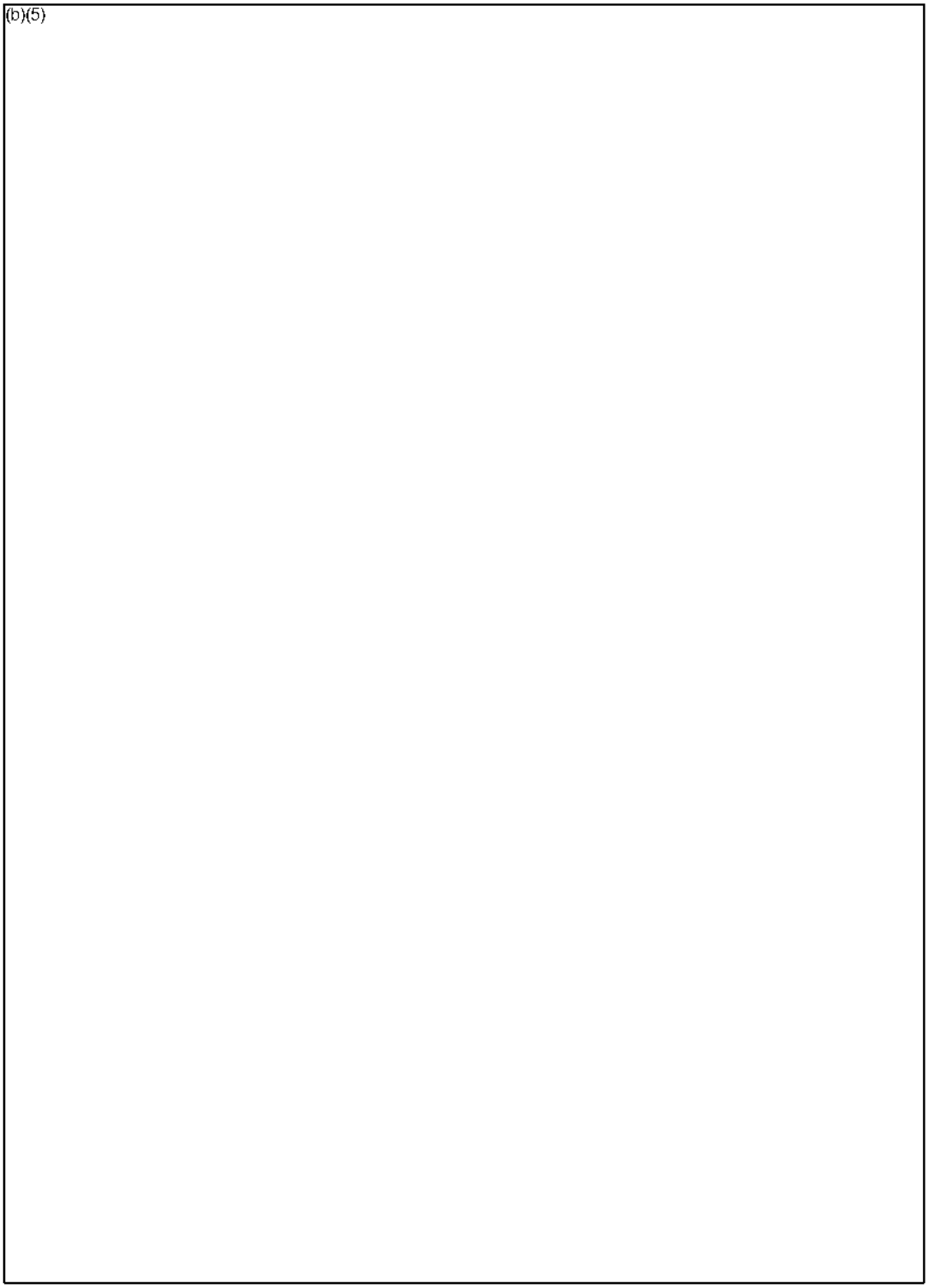

(b)(5)

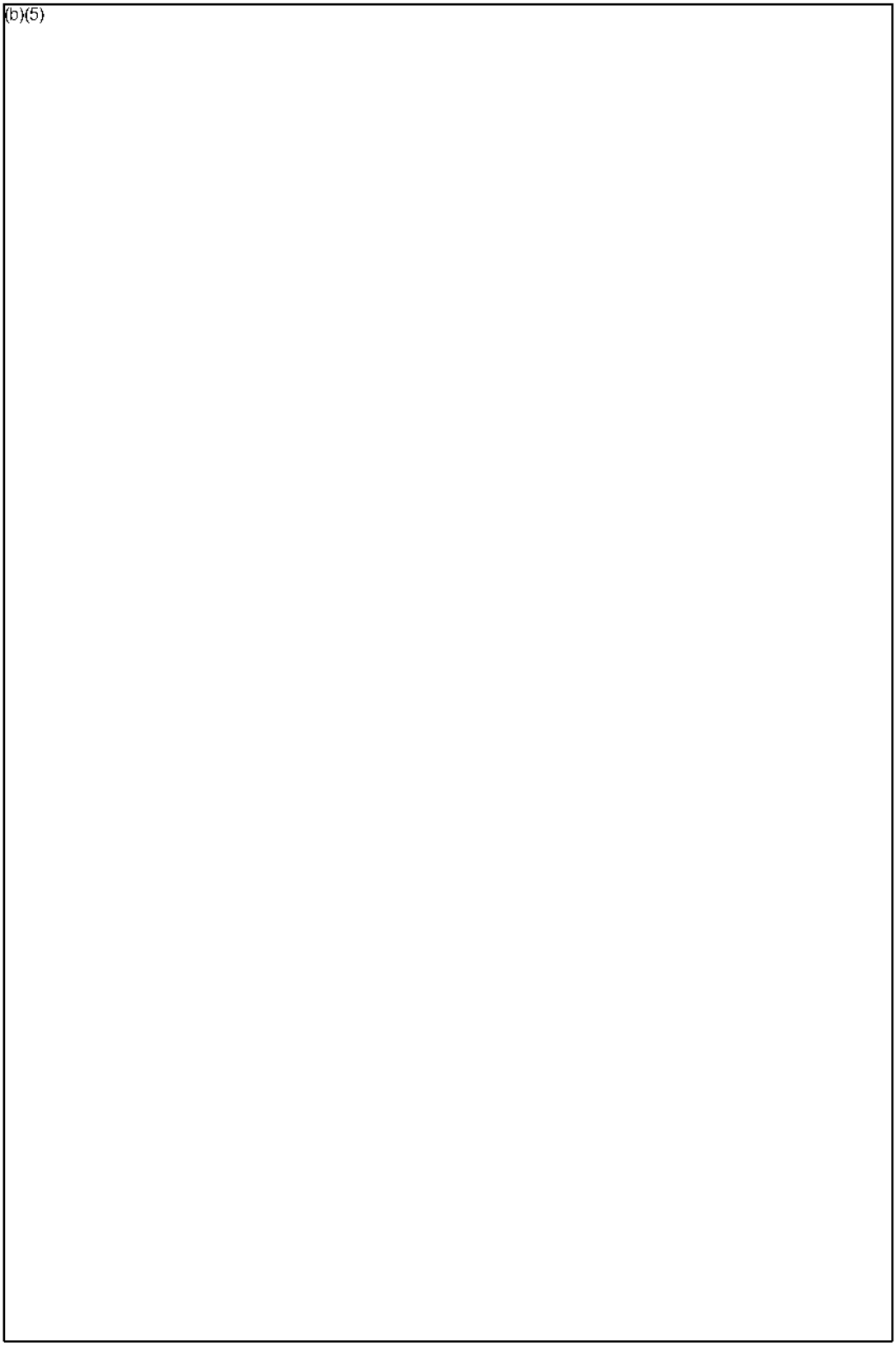

(b)(5)

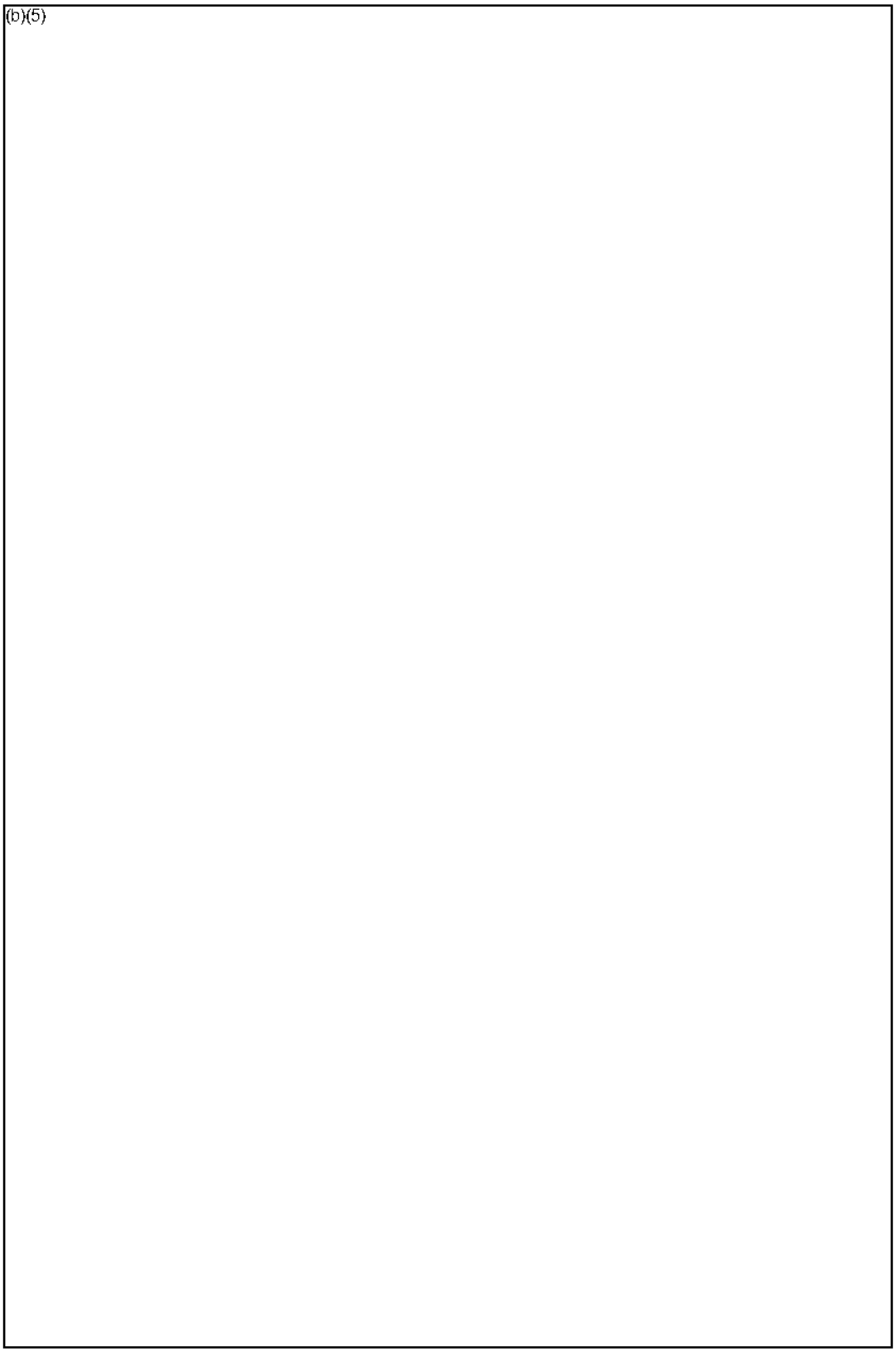

(b)(5)

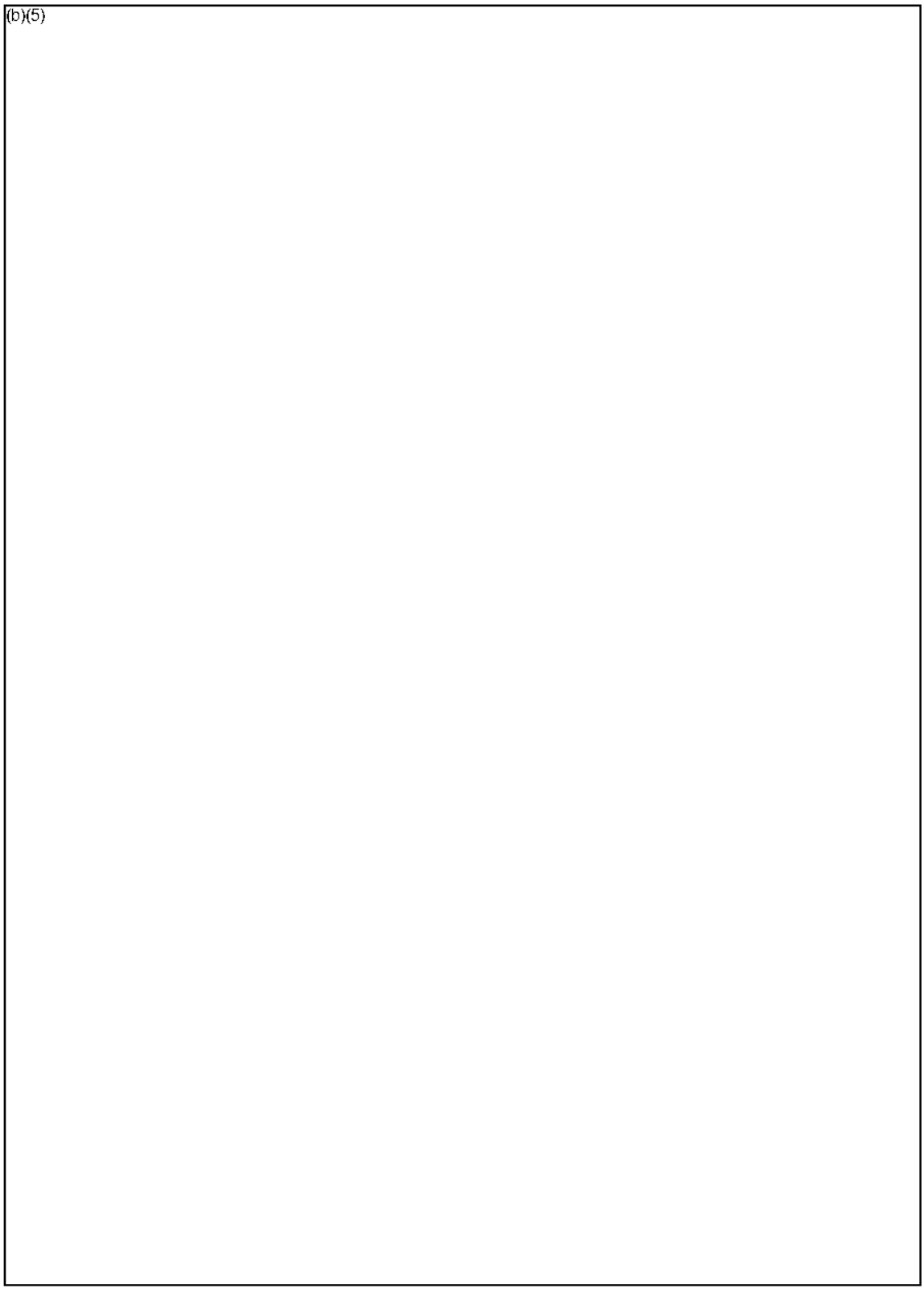

(b)(5)

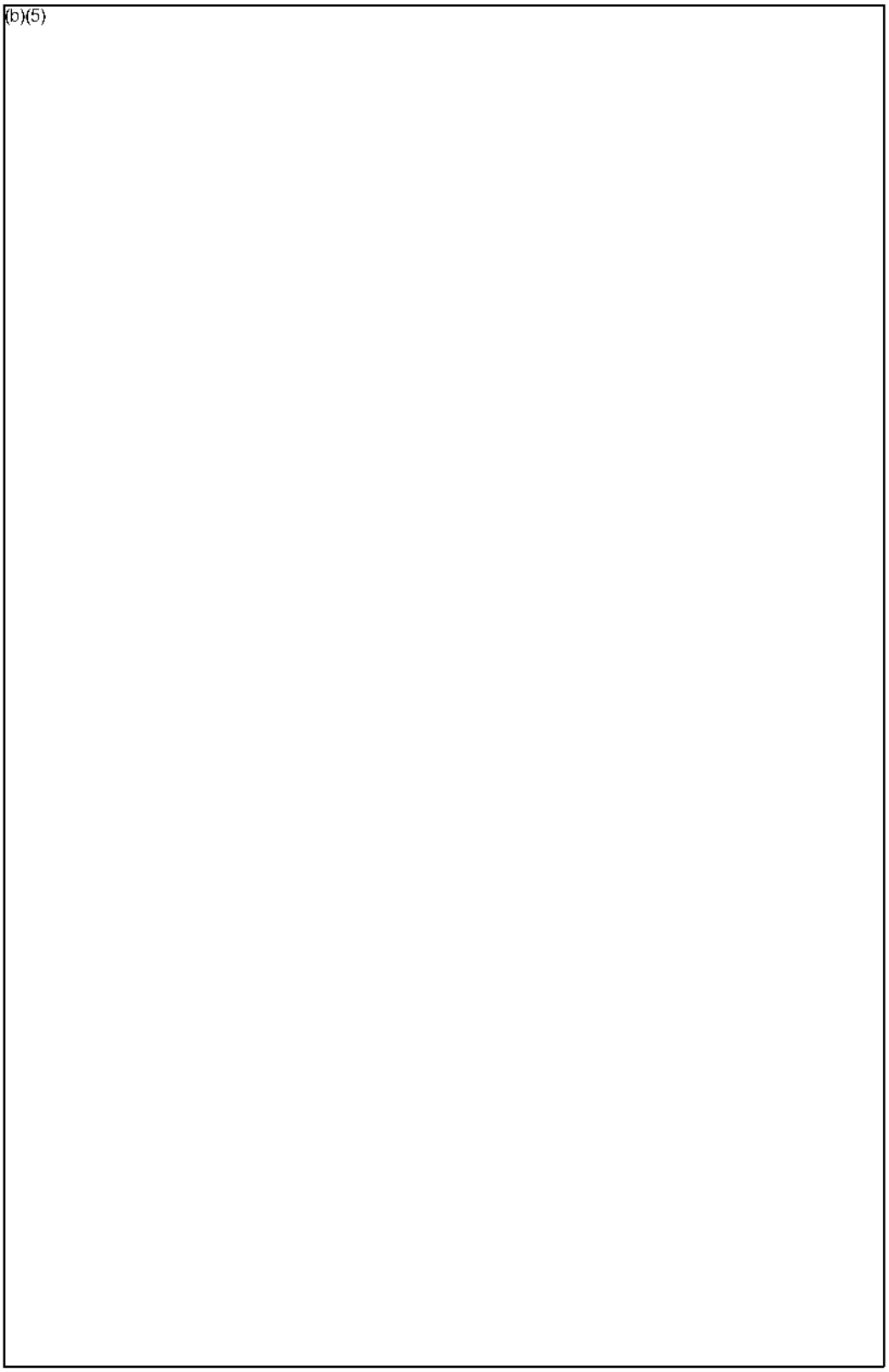

(b)(5)

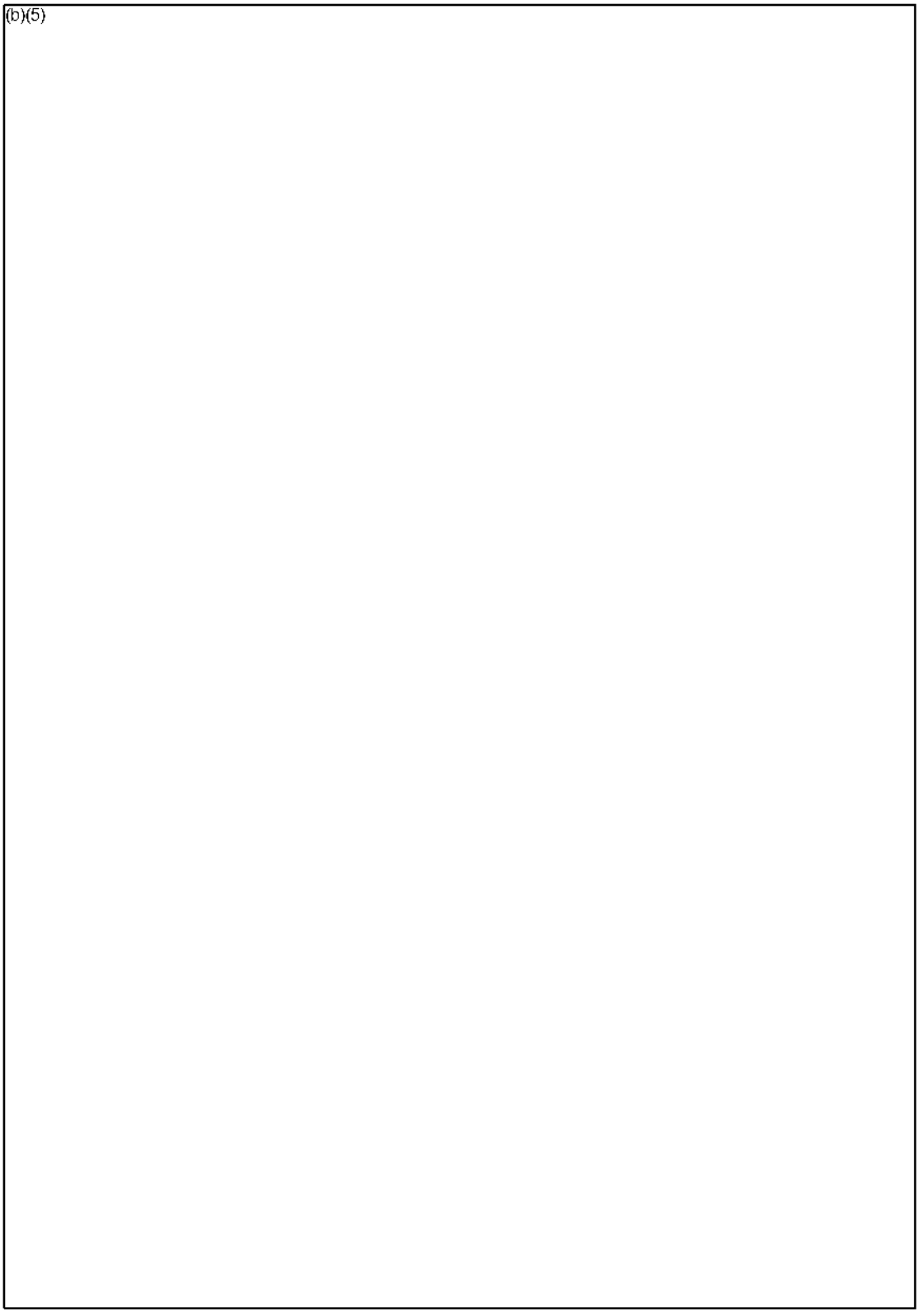

(b)(5)

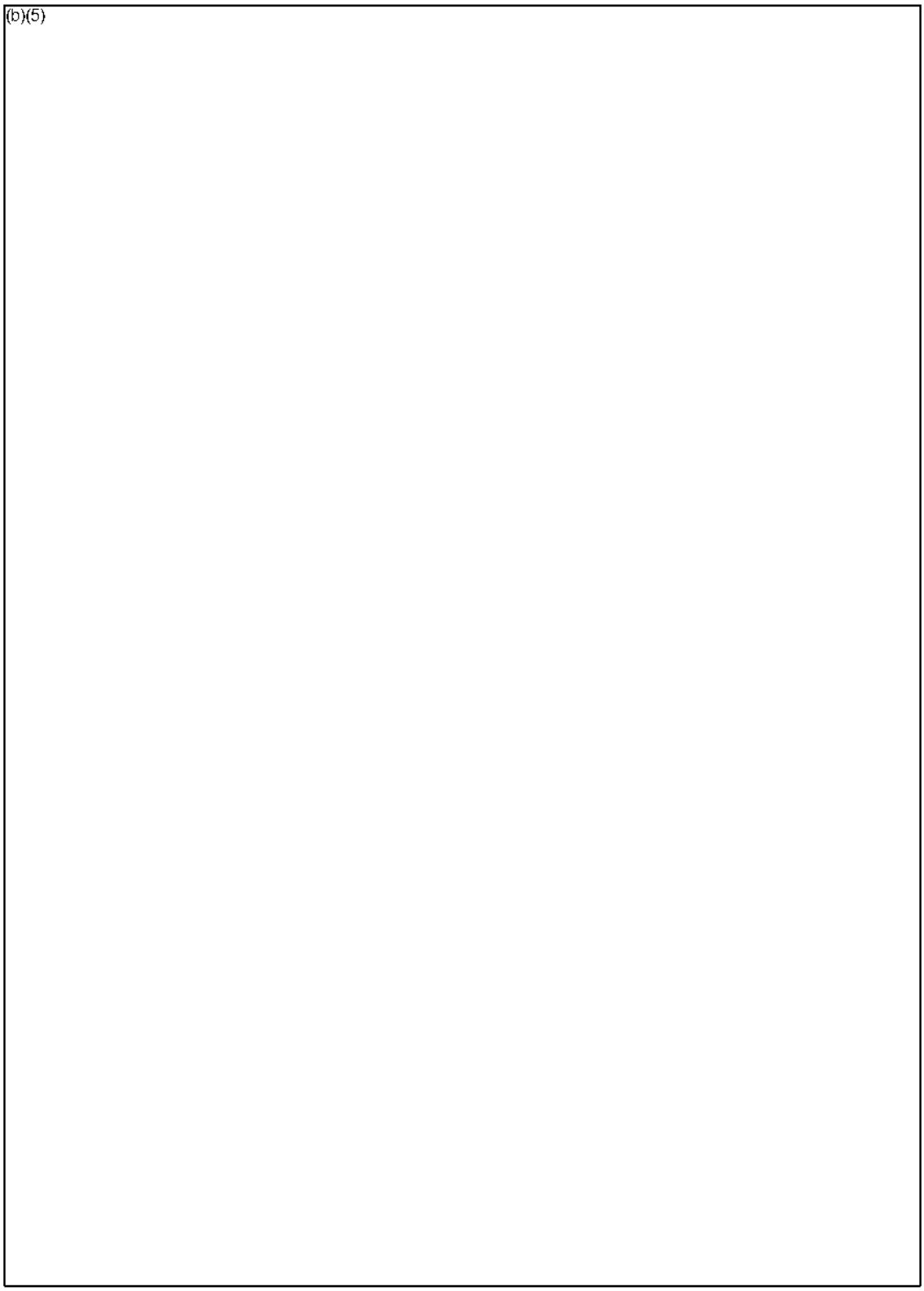

(b)(5)

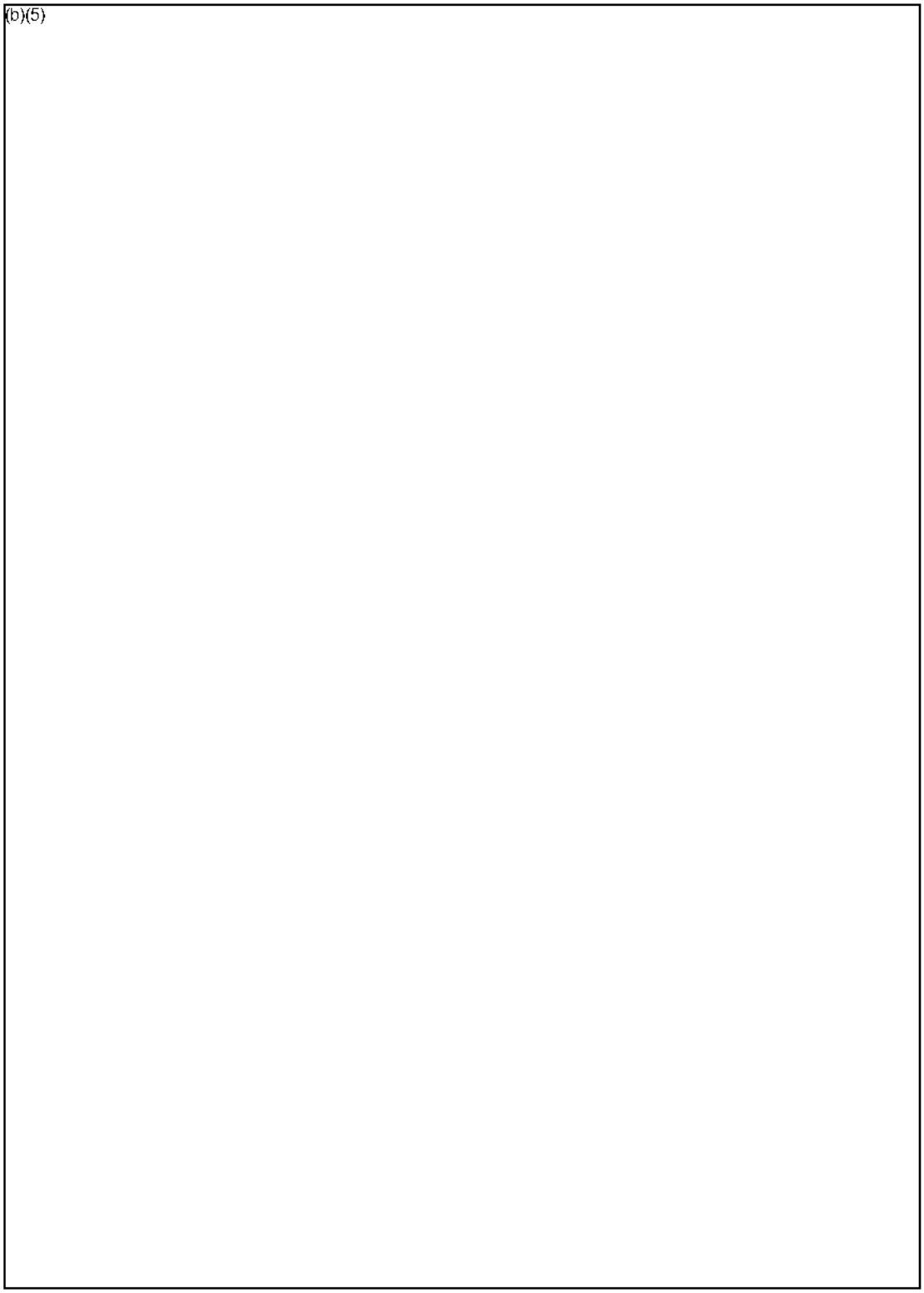

(b)(5)

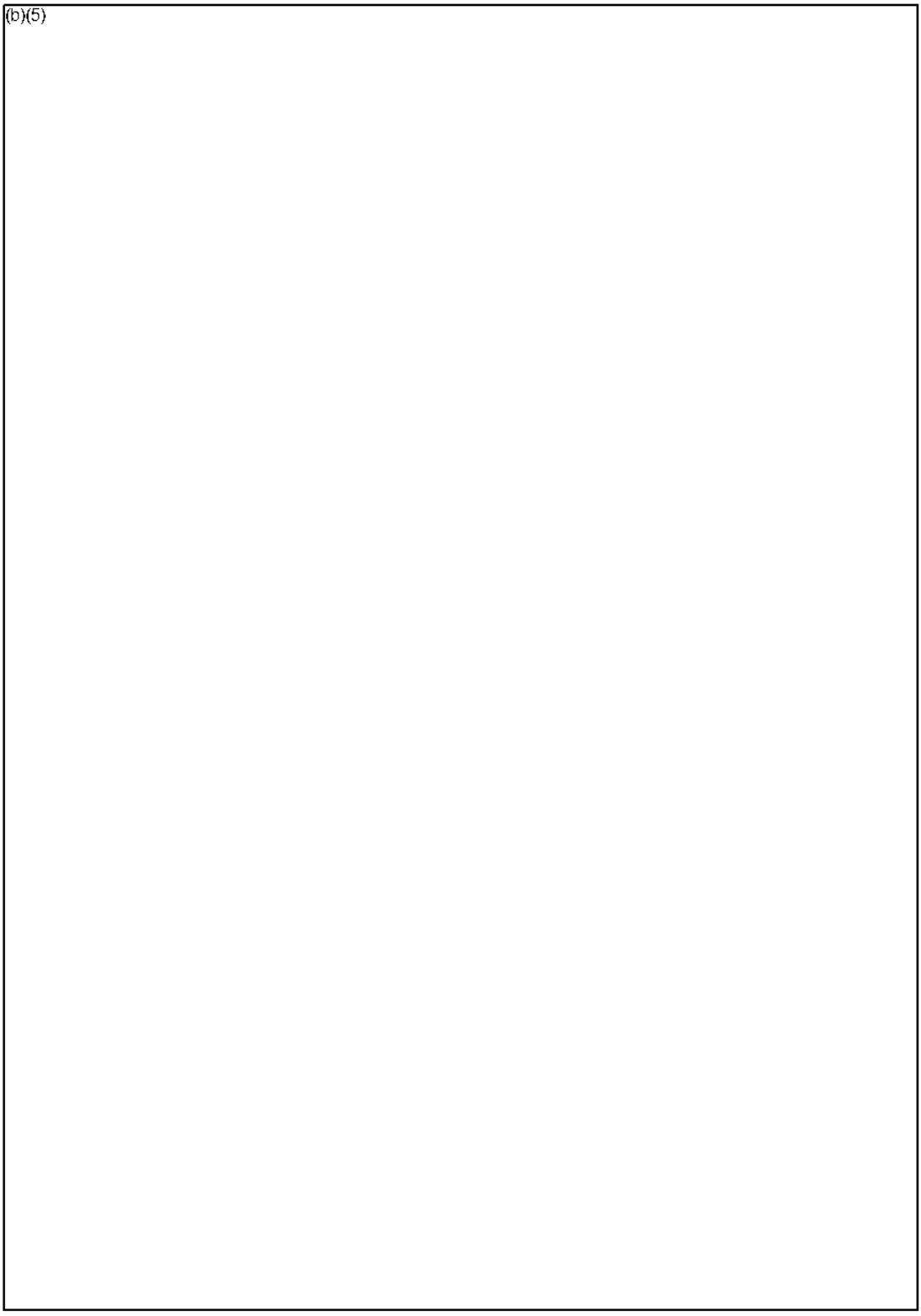

(b)(5)

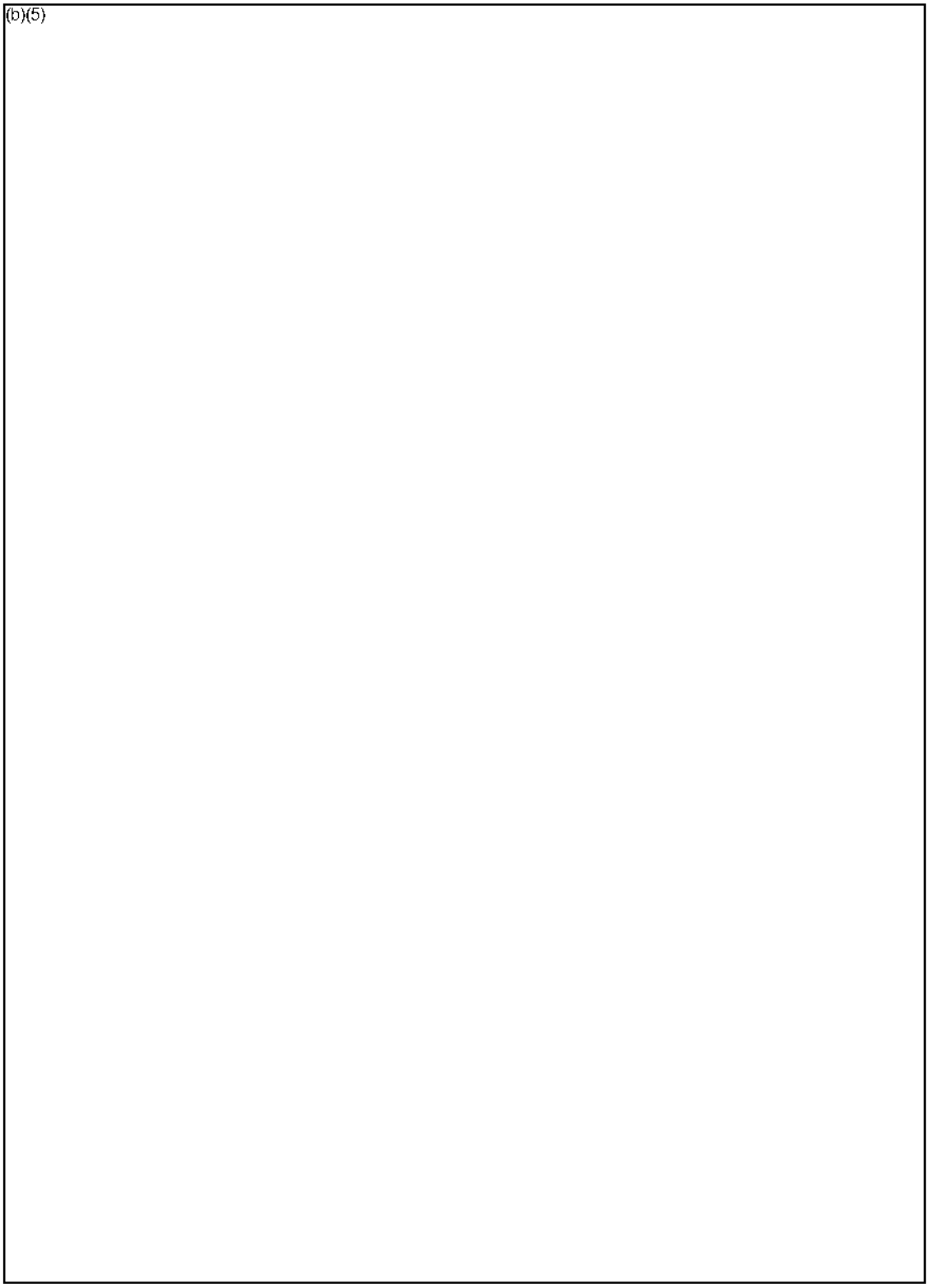

(b)(5)

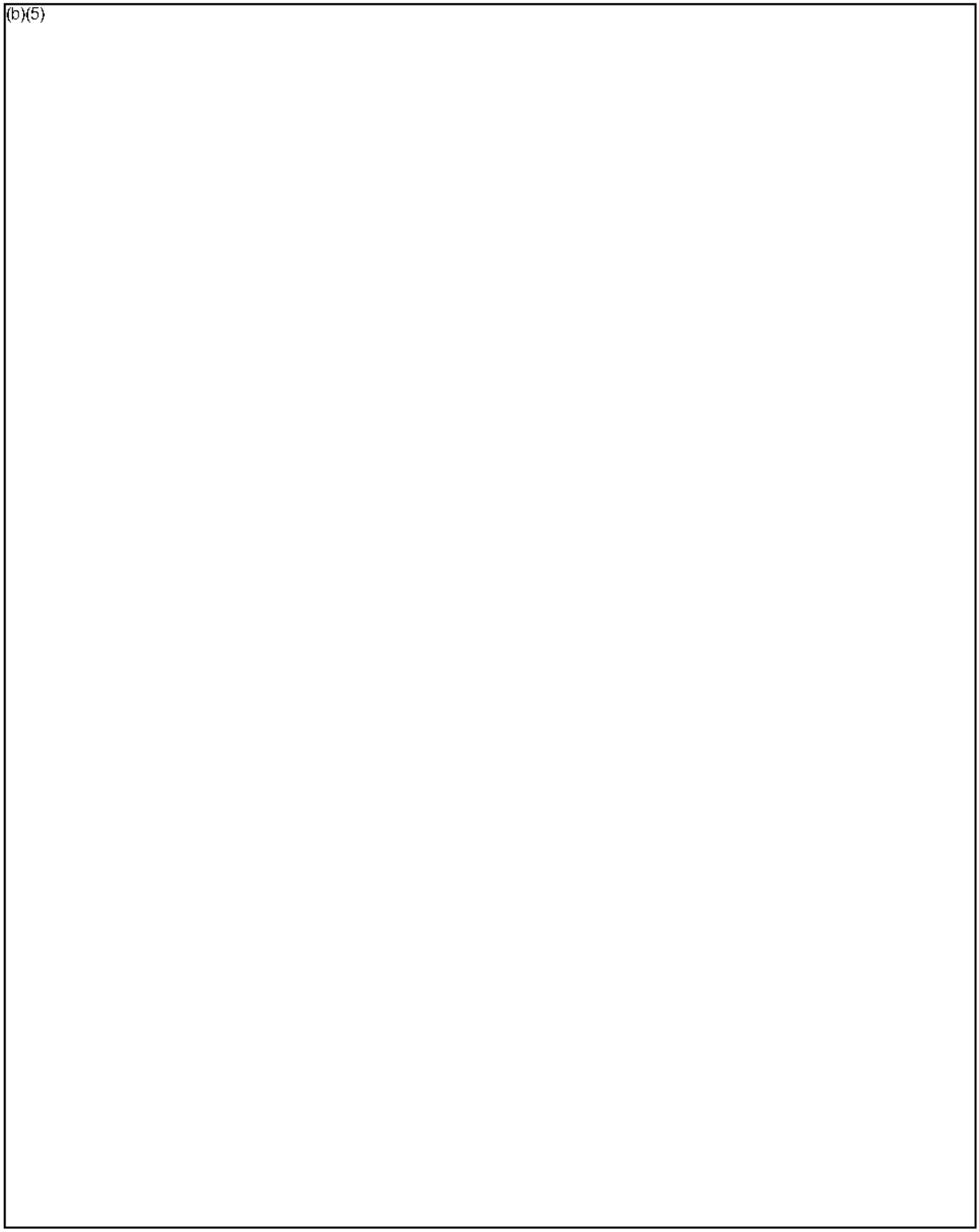

(b)(5)

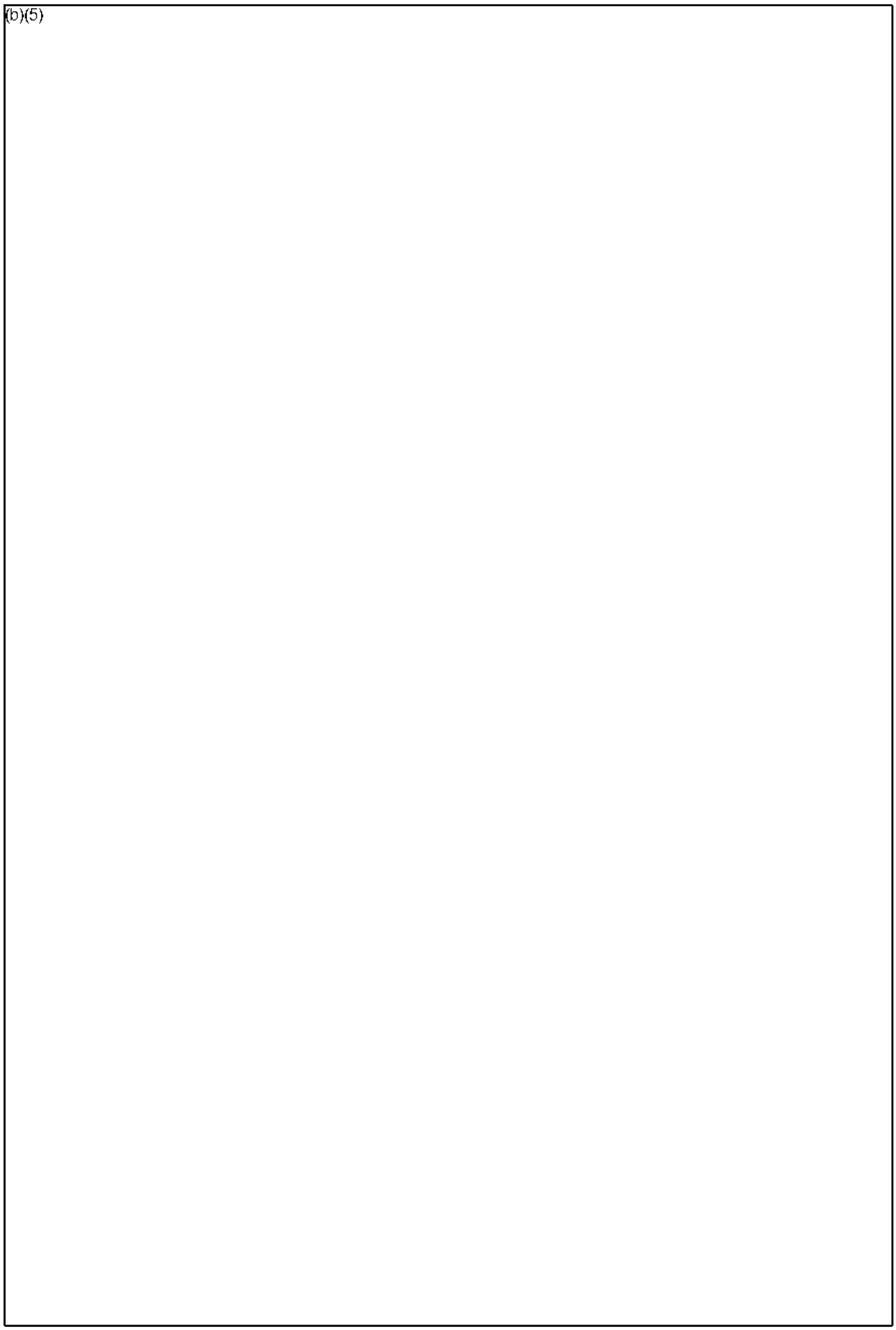

(b)(5)

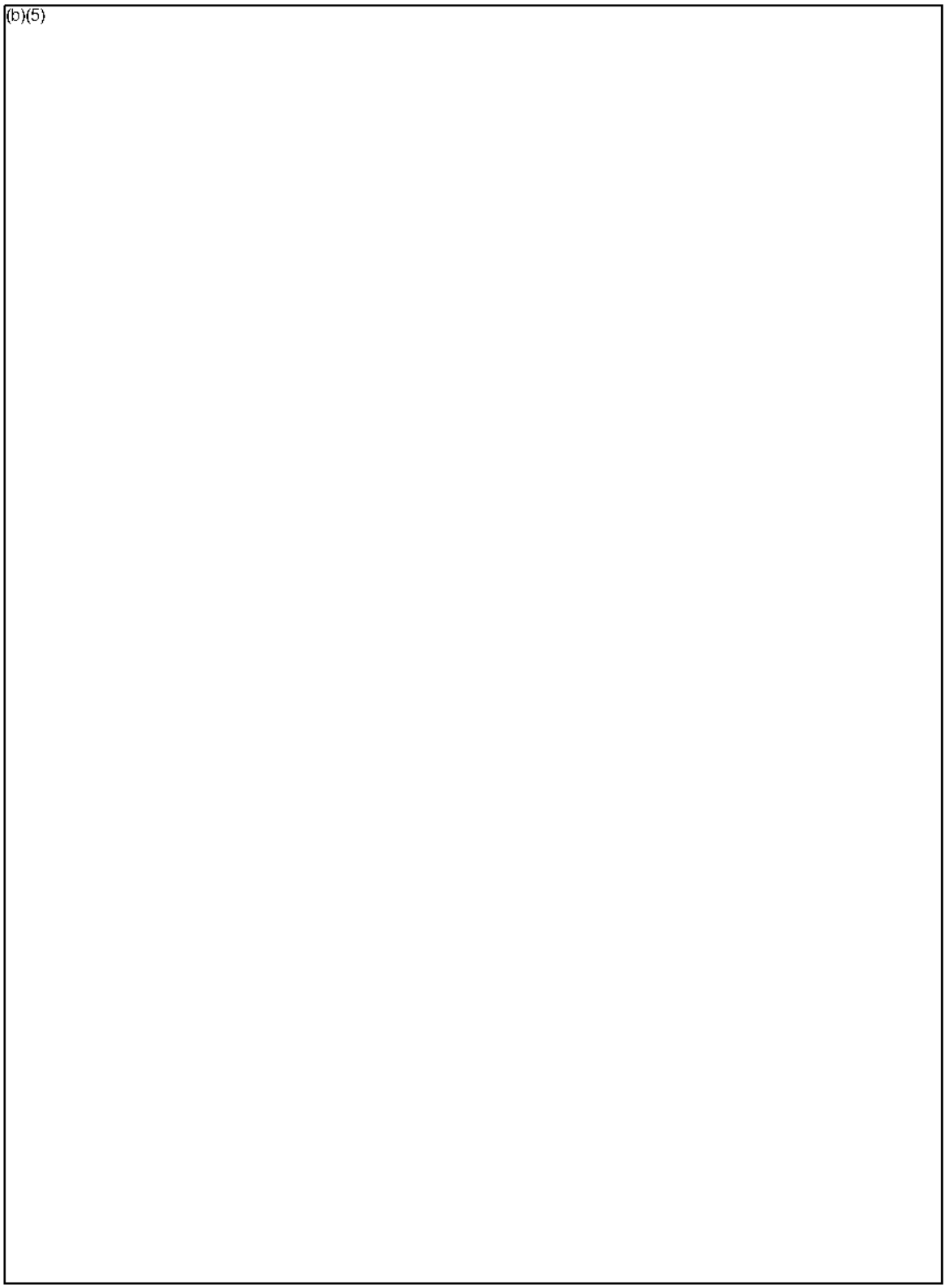

(b)(5)

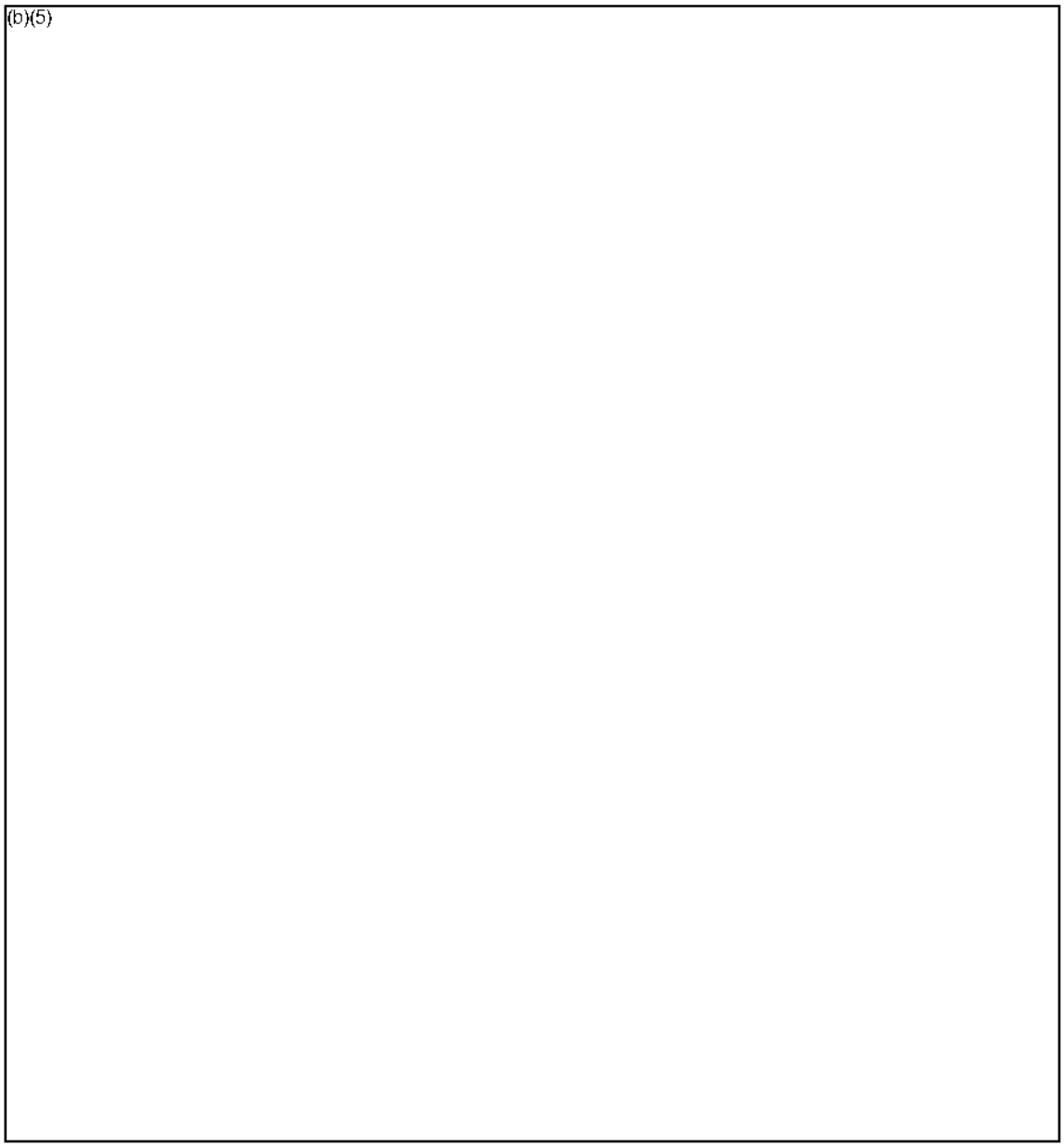

(b)(5)

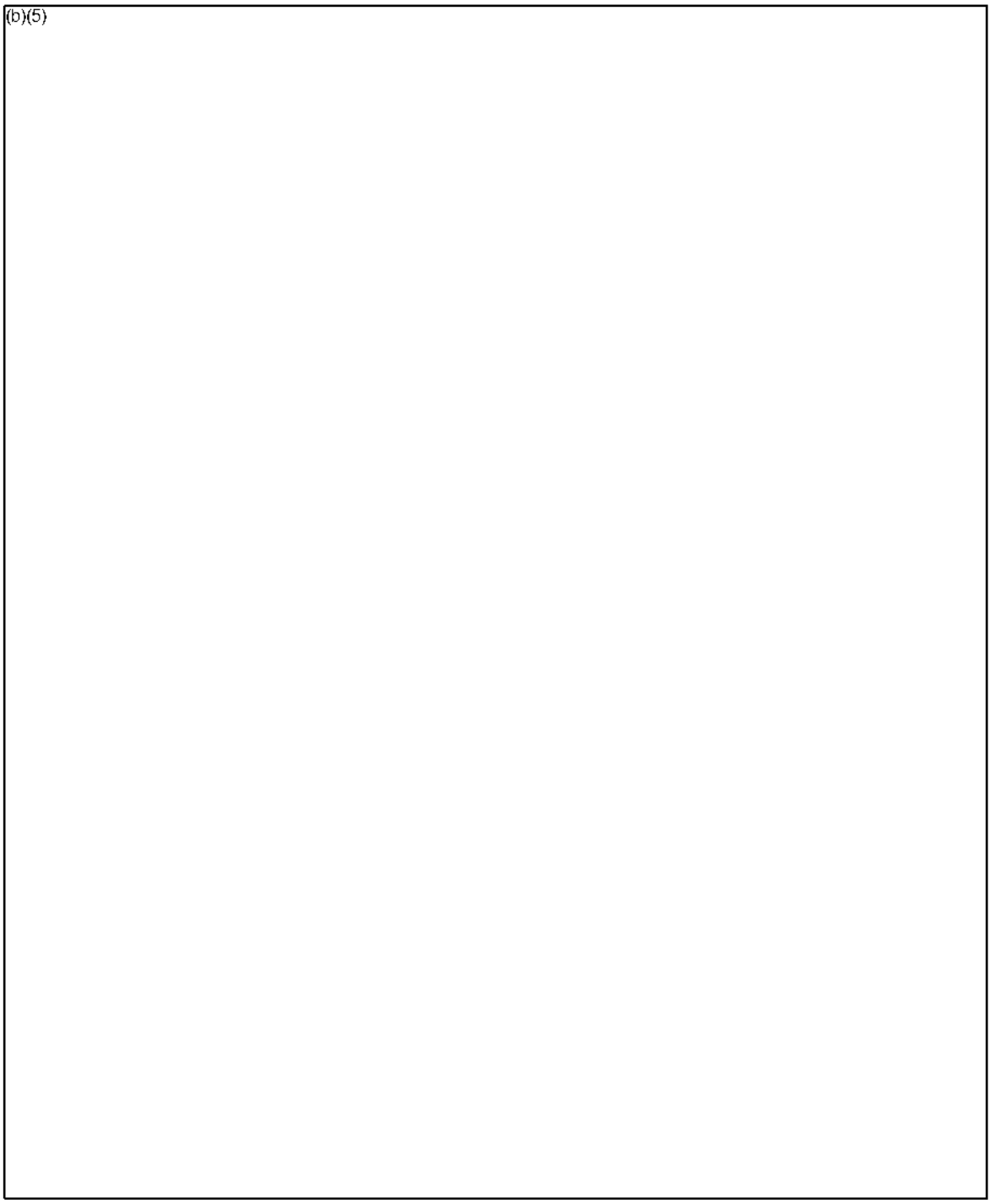

(b)(5)

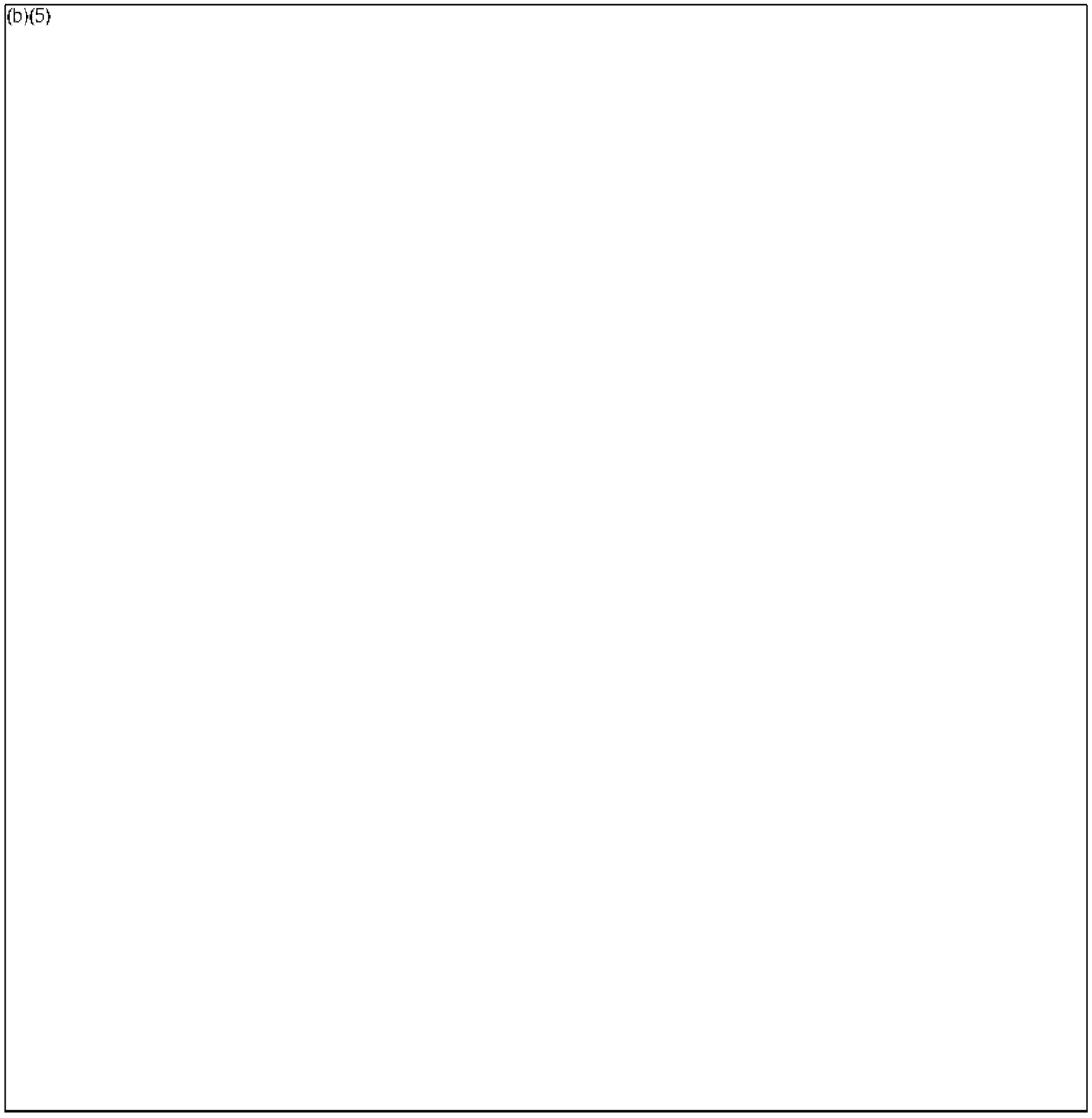

(b)(5)

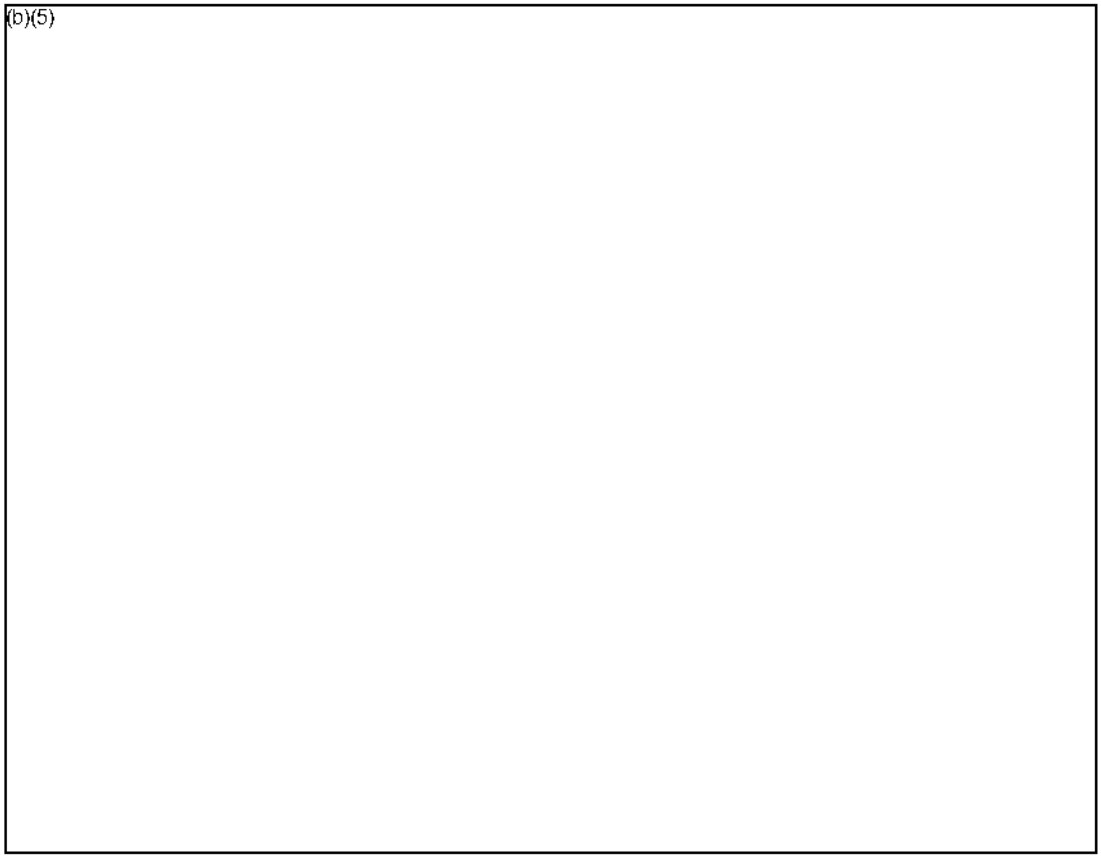

(b)(5)


(b)(5)


(b)(5)


(b)(5)


(b)(5)


(b)(5)