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EXPERT OPINION ON THE CONSTITUTIONAL MEANING OF "SEX" AND MEDICAL GENDER AFFIRMING TREATMENT in case no. No6 of 2021 Submitted by the International Federation for Therapeutic and Counselling Choice 19 June 2021 (Updated 2 July 2021[1])

The IFTCC is submitting this expert opinion on the subject of Constitutional Case No. 6 of 2021 in the hope that it may aid the Court in making decisions on the admitted question based on the Request of the General Assembly of the Civil Chamber of the Supreme Court of Cassation of the Republic of Bulgaria for the purpose of interpreting Case No. 2/2020 of the General Chamber of the Supreme Court of Cassation and Justice, namely : "How should the term "gender" be understood, used by the Constitution, and whether it has a meaning other than biological sex?".

The term 'sex" refers to the reproductive biological trait of being male or female that is determined at conception and can never change. The term "gender" has recently evolved, under the influence of an ideological movement, to have a meaning different from its historical meaning as a synonym for biological sex. Instead, it is increasingly being promoted that "gender" refers to a person's subjective perception of their sex that may differ from their body sex. A person's so-called "gender", it is being asserted, is more essentially who a person is than the material reality of their body sex. Increasingly, we see dangerous pressure on governments and members of societies to abandon the concept that the material reality of biological sex represents the real world better than some individuals' subjective and sometimes changing perceptions. We believe the proposed new definition of "gender" leads to confusion and is dangerous.

[1] There was insufficient time to incorporate updates in the English version into the Bulgarian translation submitted to courts. The updates consisted chiefly of the addition of the second full paragraph and a limited number of other small changes.

Societal affirmation of the new definition of "gender" is scientifically invalid and harmful, as may be explained by the scientific invalidity and harm of medical affirmation of gender identity. In redefining "gender", governments are being asked to coerce societal affirmation of "gender" identities and of harmful "gender" affirming medical treatments for individuals who perceive their sex as different from the sex of their body. Incongruent gender identity is not simply an inborn trait. It both develops and can change throughout the lifespan from experiences in the social environment. Rigorous research points to treatable underlying psychological conditions that medical and mental health professionals help people decrease, resolve, or manage every day. Harmful puberty blockers, toxic cross sex hormones, mastectomies of healthy breasts, and sterilizing sex surgeries do not heal underlying psychiatric conditions or reduce high rates of suicides, as the best research shows. Long term, these risky medical gender affirmative treatments can lead to serious medical complications, fatal diseases, and ongoing significantly higher rates of completed suicides. The safest treatment is already existing, noninvasive, psychological and psychiatric treatments for underlying conditions that may be causing the distress some people feel about their sex. Half a century of dramatically increasing societal affirmation and medical affirmation of some individuals' sex rejection has led to little or no change in their higher rates of psychiatric disorders and suicides.

We believe government should retain clarity that "gender" means "sex" in law. Other terms may refer to subjective perceptions.

INCONGRUENT GENDER IDENTITY IS NOT INBORN

1. A discussion of gender affirming treatment requires the understanding of some terms.

1. "Gender" has historically been a synonym for "sex", but recently it has been used to refer to a person's subjectively perceived sex. Some people perceive their sex to be different from the sex of their body. They may perceive themselves to be the opposite sex from the sex of their body, both male and female sexes, neither male nor female, fluid or changing sex from one time to the next, or something else.

2. "Transgender" can refer to people who perceive they are the opposite sex of their biological sex, but it is also used to refer to all people who have various perceptions of their sex that do not match their body sex.

3. "Nonbinary gender identity" refers to a perception that one's sex is not solely male and not solely female.

4. "Gender dysphoria" is a term that means a feeling of distress some people may feel because their perceived sex does not match their body sex.

5. "Gender expression": Some people may present in appearance or behaviour as a gender identity that does not match their sex, but they may or may not have a gender incongruent identity.

6. "Gender incongruent" can describe any diverse gender identity and/or gender expression that does not match a person's sex.

7. "Gender congruent": People who perceive their sex to be the sex of their body are gender congruent, also recently referred to as "cisgender".

2. **We know of no professional organization that says transgender identity, gender expression, or gender dysphoria is inborn or solely biologically determined, for example by genes, epigenetics, prenatal hormones, maternal factors, or brain structures. We know many professional organisations that say that biological factors alone do not explain gender incongruity. They say experiences in the individual's social environment are always influences as well. Some professional organisations that hold this view are:** the Endocrine Society and 6 organisations that co-sponsored its Guideline: the American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Paediatric Endocrinology, European Society of Endocrinology, Paediatric Endocrine Society, World Professional Association for Transgender Health (Hembree et al., 2017). Additional organisations are those that published a highly respected Gobal Consensus statement: the Asian Pacific Paediatric Endocrine Society, Japanese Society of Paediatric Endocrinology, Sociedad Latino-Americana de Endocrinologia Paediatrica, Chinese Society of Paediatric Endocrinology and Metabolism (also again the European Society for Paediatric Endocrinology and the Pediatric Endocrine Society) (Lee et al., 2016). More organisations are the American Psychiatric Association (DSM-5, 2013, p. 457), American Psychological Association (Bockting 2014, vol. 1, p. 743), American Academy of Paediatricians (Rafferty, 2018, p. 4), and British Psychological Society (2012, p. 25).

3. **A highly respected Global Consensus statement of endocrine societies around the world said that transgender identity is not caused by having the brain of the opposite sex.** The consensus statement explains that there is no consistent evidence that brain structures are different for gender *incongruent* people and gender *congruent* people. Even if at some time in the future it became possible to find such a difference in adult brains, it is unlikely gender incongruence could be predicted from the brains of newborns, because masculine or feminine aspects of the brain largely develop gradually (after birth),

and the brain develops in interaction with psychological, social, and cultural experiences in the environment. The endocrine societies that published this Global Consensus view are the European Society for Paediatric Endocrinology, the Paediatric Endocrine Society, the Asian Pacific Paediatric Endocrine Society, the Japanese Society of Paediatric Endocrinology, the Sociedad Latino-Americana de Endocrinologia Paediatrica, the Chinese Society of Paediatric Endocrinology and Metabolism. (Lee et al., 2016).

4. **We can see from identical twin research that biological factors may contribute to transgender identity to a degree, but do not determine it.** Identical twins (imperfectly) share biological factors—genes, epigenetic elements, prenatal hormones, and maternal prenatal factors. We know identical twins are the same sex in 100% of twin pairs. Sex is biologically determined and can never change. By contrast, a study found that if one twin lives as another sex or intends to do so, the other twin usually does not. Only in about 28% of pairs does the other twin also live as another sex. (M. Diamond, 2013)

5. **What biological theories actually propose is that biological factors such as genes, prenatal hormones, or maternal prenatal factors may lead to a boy being born less masculine or a girl being born more masculine. Most individuals who have these traits do not identity as transgender, however,** and what is more, many who do identify as transgender do not have these traits, according to the American Psychological Association's *APA Handbook of Sexuality and Psychology*. (Bockting, 2014, vol. 1, pp. 743-744) There have to be more factors for a gender atypical person to develop a gender-sex discordant identity.

6. **What may not be sufficiently considered is that biologically influenced traits may lead to significant psychological or social experiences, and it may actually be such life experiences that influence some people with atypical gender traits to develop gender incongruent identity.** A boy who is less masculine or a girl who is more masculine may be subjected to social experiences, such as rejection or bullying by peers of their own sex or by opposite sex peers, difficulties in a parent-child relationship, or gender or sexual trauma or abuse. Some individuals who were transgender and who came to accept their sex have said it was social experiences such as these that led them to feel that being a member of their own sex was not a good or safe option for them. Some say they reported to therapists such adverse experiences that they feel led to rejecting their sex and taking another gender identity, but their therapists ignored the possibility that life experiences could lead to gender incongruent identity. Instead, their therapists referred them to gender services without evaluating for or discussing options for treatment for potentially causal adverse life experiences. (Heyer, 2018; SexChangeRegret.com)

7. **Psychological influences on the development of incongruent gender identity can begin very early in life.** There are published cases that illustrate that cross sex behaviour can have psychosocial causes as early as age 2 and rapidly resolve in children when therapy addresses family relationships. (Kosky, 1987)

INCONGRUENT GENDER IDENTITY BOTH DEVELOPS AND CAN CHANGE LIFELONG THROUGH LIFE EXPERIENCES

8. **Gender dysphoria can change throughout the lifespan through life experience.** The British Psychological Society Guideline says, "Gender dysphoria can fluctuate over years, not infrequently increasing or decreasing in mid-life and it is not unusual for people to present for therapeutic discussion and support later in life…." (p. 25)

9. **Childhood gender dysphoria overwhelmingly resolves through life experience by late adolescence or adulthood, in about 85 to 95 percent of cases, when children are not affirmed to dress and live as another sex and are supported to go through puberty with their peers and experience the sex hormones that are natural to and congruent with their sex.** This is the consensus of at least nine European and U.S. professional organisations (Endocrine Society and 6 co-sponsoring U.S. and European organisations: Hembree et al., 2017; American Psychiatric Association, 2013, p. 455; American Psychological Association: Bockting, 2014, vol. 1, p. 744) and numbers of research studies (Singh, Bradley, & Zucker, 2021; Cohen-Kettenis et al., 2008; research review: Zucker, 2018). **A recent challenge to this consensus has been rebutted** (Zucker, 2018), **and recent research, the largest study to date, confirms this rate of change** (Singh, Bradley, & Zucker, 2021).

10. **Life experiences change the brain.** People are not born with a brain that is fixed from birth. The brain develops largely after birth and continues to change lifelong in interaction with life experiences. Life experiences even change the epigenome (the chemical environment around the genes) and, as a result, modify genes themselves, especially genes in the brain, enabling memory, learning, and adaption to the environment lifelong. (Charney, 2012; Jordan-Young, 2010)

11. **Psychotherapy changes the brain.** Impressive research has found that both the development of trauma and effective trauma treatments cause epigenome-wide changes in the brain, thus modifying genes. (Vinkers et al., 2019)

12. **Culture influences the development of incongruent gender identity and in some countries has created a fad during the period of adolescent identity exploration.** In 2013, the American Psychiatric Association's Diagnostic and Statistical Manual said the prevalence of transgender identity in adults was 2 to

14 thousands of one percent (0.002% to 0.014%). Only 4 years later in California in the United States, in 2017, 27% of adolescents ages 12 to 17 identified as gender incongruent to some degree. (UCLA, 2017) Referrals to transgender clinics in a Northern California private health maintenance organization rose 504% in 3 years (from 2015 to 2018) (Handler et al., 2019) and rose 880% in the state of Georgia in the U.S. in the same time period. (Roblin, et al., 2016) In Britain, referrals to the national Tavistock clinic rose 1,460% for boys and 5,337% for girls in less than a decade (from 2009/10 to 2018/19). This evidence points to a cultural fad during the time of adolescent identity exploration, cognitive immaturity, impulsivity, and limited judgement for how they may feel in the future as an adult about loss of fertility, loss of sexual function, or potentially decreased sexual pleasure. The United Kingdom (Transgender Trend, 2019), Sweden (Karolinska, 2021), The Netherlands (de Vries et al., 2012), and Finland (COHERE, 2020) have restricted gender affirming treatments for children and adolescents, providing much needed protection.

RESEARCH AND PROFESSIONAL ORGANIZATION GUIDELINES REFUTE THAT THERE IS A CONSENSUS THAT GENDER INCONGRUENCE IS INVARIABLY NORMAL

13. **There is not a consensus of *professional organizations* that gender incongruence is invariably normal.** Some professional organizations, even some that say gender incongruence is normal, do not say that it is invariably normal, but rather that it may be caused by mental disorders.

    1. **The British Psychological Society,** in its Guidelines says, “In some cases the reported desire to change sex may be symptomatic of a psychiatric condition for example psychosis, schizophrenia or a transient obsession such as may occur with Asperger’s syndrome….” (BPS, 2012, p. 26)

    2. **The World Professional Association for Transgender Health** (WPATH)**,** in its Standards of Care, said gender dysphoria may be “secondary to or better accounted for by other diagnoses.” In that case, the WPATH standards of care did not recommend body altering interventions. (Coleman et al., 2012, p. 180) Psychotherapy to decrease or resolve gender dysphoria is much needed.

    3. **The American Psychiatric Association** Task Force on the Treatment of Gender Identity Disorder noted gender dysphoric adolescents should be “screened for trauma as well as for any disorder (such as schizophrenia, mania, psychotic depression) that may produce gender confusion.**”** (Byne et al., 2012)

4. **The American Psychological Association's** *APA Handbook of Sexuality and Psychology* considers the possibility that there may be pathological psychodynamic or family causes. "Research on the influence of family of origin dynamics has found some support for separation anxiety among gender-nonconforming boys and psychopathology among mothers…." Thus, the American Psychological Association's *APA Handbook of Sexuality and Psychology* expressed openness to a possibility of psychopathology having an influence on or causal role in transgender identity. (Bockting 2014, vol. 1, p. 743)

14. ***Research,* also, does not support that gender incongruence is invariably normal.** Rather, research indicates that psychiatric disorders are *associative* and potentially *causal* for gender incongruence for many gender dysphoric adolescents and adults.

15. **Researchers in at least 10 countries report that gender incongruence is *associated* with neurodevelopmental and psychiatric disorders for adolescents and adults. This is generally accepted and not controversial.** Research establishes internationally that adolescents and adults who experience gender incongruence have prevalence rates of psychiatric disorders (frequently including neurodevelopmental disorders) that are very high, often at rates around 75 percent and higher in several countries: **in 6 European countries: The Netherlands, Belgium, Germany, Norway** (Heylens et al., 2014), **Finland** (Kaltiala-Heino, 2015), **Sweden (**Salmi, 2020); **the U.S.** (Becerra-Culqui, 2018; Hanna et al., 2019; Littman, 2018; Rider et al., 2018); **Canada** (Bechard et al, 2017); **Australia** (Strauss et al., 2017); **and Iran** (Meybodi et al., 2014a, 2014b).

16. **There is evidence that neurodevelopmental and psychiatric disorders are not only associative, but potentially *causal*, for gender incongruence.** Many of the just referenced studies do not tell us whether these disorders or gender incongruence came first. Two of them, however, do, as follows.

    1. **A rigorous, longitudinal, 8 year U.S. study looked at the *complete* electronic medical records of an *entire cohort*** of 8.8 million members of a large private health care organisation, at its sites in Georgia, northern California, and southern California in the United States, from 2006 to 2014. Medical records of all members identified 1,333 gender nonconforming children and adolescents (588 MtF and 745 FtM) in the entire health care organization. All were included in the study. The study did not rely on people who were volunteers. People who volunteer to be in a study could be different from people who do not volunteer to be in a study, making the results not representative of people in general. Participants were not limited to individuals who were applying for or who had been approved for gender affirming medical services or who were in

required pre-operative therapy (that they may not have wanted) for gender affirmative services. Also, the study did not rely on recruits from either transgender affirming organizations or organizations that provide therapy support for individuals who wish to become comfortable with their bodies and embrace their sex. It is possible recruits from such organisations may have an interest in presenting themselves in particular ways. Methods were not limited to self-report; they included diagnoses given by health care professionals in real time, not retrospectively. There were controls consisting of 10 matched biological males and 10 matched biological females who were gender conforming for each gender nonconforming child or adolescent. (Becerra-Culqui et al., 2018) **The researchers found:**

2. **Among children ages 3-9, *lifetime* rates of having 1 or more psychiatric disorders *before* first medical record evidence of gender nonconformity were 34 percent for biological girls and 32 percent for biological boys.** Comparable lifetime rates of having 1 or more psychiatric disorders for sex accepting peers were 5 percent for girls and 3 percent for boys.

3. **Among children ages 3-9, psychiatric disorders children manifested *before* first medical record evidence of gender nonconformity were:** anxiety disorders, attention deficit disorders, autism spectrum disorders, conduct and/or disruptive disorders, depressive disorders, and eating disorders.

4. **Among adolescents ages 10-17, *lifetime* rates of having 1 or more psychiatric disorders *before* first medical record evidence of gender nonconformity were 75 percent for biological girls and 71 percent for biological boys.** Comparable lifetime rates of having 1 or more psychiatric disorders for sex accepting peers were 4 percent for girls and 3 percent for boys.

5. **Among adolescents ages 10-17, psychiatric disorders they manifested *before* first medical record evidence of gender nonconformity were:** anxiety disorders, attention deficit disorders, autism spectrum disorders, bipolar disorders, conduct and/or disruptive disorders, depressive disorders, eating disorders, psychoses, personality disorders, schizophrenia spectrum disorders, self-inflicted injuries, substance use disorders, and suicidal ideation.

6. **Compared to peers who accepted their sex, gender-sex discordant adolescents ages 10 to 17 had <u>these higher rates of distress</u> during the <u>6 months *before*</u> first medical record evidence of gender nonconformity:**

    1. **Depression was up to 23 to 24 times higher.**
    2. **Suicidal ideation was up to 45 to 54 times higher.**
    3. **Self-inflicted injuries were up to 70 to 144 times higher.**

17. **A study in Finland also found, "Severe psychopathology preceding onset of gender dysphoria was common." (Kaltiala-Heino et al., 2015, abstract)**

    1. **The research looked at a *complete cohort* of adolescent applicants for "sex reassignment" services in Finland from 2011 to 2013.** Methods used were a "Structured quantitative retrospective chart review and qualitative analysis of case files of all SR [sexual reassignment] applicants who entered the assessment by the end of 2013." (Abstract)

    2. **"Seventy-five percent** of the applicants (35 of 47 applicants) had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria when they sought referral to SR assessment, and two more were contacted with general adolescent psychiatric services soon after entering the SR assessment." (p. 5)

    3. **Evidence suggests bullying prior to gender incongruence contributed to both suicidality and to gender incongruence in some of these adolescents**. Of the applicants, 57% had been significantly bullied at school. **Of those who had been bullied, 92% had been bullied *before* they questioned their gender identity** (72 percent before, 19 percent *both before* and after, 8 percent only after). About three-quarters, **73 percent, were bullied for reasons unrelated to gender presentation or gender identity. In nearly half the cohort (49 percent), persistent experiences of bullying *before* thoughts about gender was found to be associated with peer isolation, anxiety, depression, self-harm, and suicidal preoccupation, if not attempts.** As applicants for gender services, these adolescents had "very high expectations" that gender medical procedures "would solve their problems in social, academic, occupational and mental health domains" (pp. 4-6).

18. **Disorders that PRECEDE gender incongruence may be *causes* of gender congruence. (Becerra-Culqui, 2018; Kaltialo-Heino, 2015)**

19. **It is not possible that mental disorders or suicidality that individuals experience *before* gender incongruence are caused because they did not**

get puberty blockers, cross sex hormones, mastectomies, sex change surgeries, or social affirmation for being gender incongruent. It is also not possible that these psychiatric conditions that pre-existed gender incongruence were caused by therapy to resolve gender incongruence.

RESEARCH DOCUMENTS THAT THERE ARE SERIOUSLY HARMFUL CONSEQUENCES OF GENDER AFFIRMING TREATMENT

20. **Therapy that affirms the rejection of one's own body sex is a path that often leads to a harmful medical protocol** of experimental (NICE, 2020; Hembree et al., 2017; Gagliano-Juca et al., 2018;) puberty-blockers known to increase depression and psychiatric disorders (Lupron label; Biggs 2019a; 2019b; Weipjes, 2020; Brik et al., 2020), risky (Hembree, 2017, Coleman, 2012) high dose, toxic (Coleman, 2012: pp. 190-197, 205-207) cross-sex hormones, potentially permanent infertility, potential loss of sexual function and pleasure, medical dependency for life, healthy breasts removal, and potentially surgical destruction of reproductive organs (Coleman, 2012) assuring sterility and a long term 2-2.5 times higher rate of deaths from heart attacks, strokes, and chronic diseases including cancers and a 19 times higher rate of completed suicides, even in an affirming society. (Dhejne et al., 2012).

21. **To be clear, "gender affirming" medical treatments sterilise children.** A parent consent form at the Children's Hospital Los Angeles, California, United States tells parents, "If your child starts puberty blockers in the earliest stages of puberty, and then goes on to gender affirming hormones, they will not develop sperm or eggs. This means that they will not be able to have biological children." (Children's Hospital Los Angeles, 2016, p. 32) (See also Olson-Kennedy et al., 2016; Fenway Health, 2019, no date "a"; no date "b")

22. **Some professional organizations caution against affirming children to live as another sex, because doing so may increase the number of children who go on to be sterilized and have higher health risks for life instead of naturally resolving their gender dysphoria through life experience.**

    1. **The *APA Handbook on Sexuality and Psychology* (APA, 2014) cautions that social transition may lock a child into transgender identity who otherwise would have resolved naturally. "Premature labeling of gender identity should be avoided.** Early social transition (i.e., change of gender role, such as registering a birth-assigned boy in school as a girl) should be approached with caution to avoid foreclosing this stage of (trans)gender identity development." If there is early social transition, "the stress associated with possible reversal of this decision has been shown to be substantial…" (Bockting, 2014, vol. 1, p. 744).

2. **The Endocrine Society and 6 medical organizations that co-sponsor its "Guideline" concur that social affirmation to live as another sex may foreclose natural resolution of gender dysphoria.** The co-sponsoring organizations of the "Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline" are: The American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health. (Hembree et al., 2017)

3. **The *APA Handbook* warns, affirmation may neglect psychological problems and result in a difficult transition back again.** "This approach runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist…" (Bockting, 2014, vol. 1, p. 750).

23. **Puberty blockers do not buy time to decide whether to go further with medical gender treatments. Rather, puberty blockers are the "entry drug", so to speak, that leads to cross sex hormones and consequent permanent loss of fertility and potential loss of sexual function.** Two studies found 98% (Carmichael et al., 2021) to 100% (de Vries et al., 2011) of children who receive puberty blockers go on to be sterilised with cross sex hormones.

24. **Affirming parents do not improve the children's mental health when transitioning, contrary to claims.** Schumm and Crawford found that, "Whereas Olson et al. (2016) and Durwood, McLaughlin, & Olson (2017) concluded that transgender children with strong parental support had, at worst, only slightly higher levels of anxiety with no differences in self-worth or depression; a reanalysis of their findings suggests otherwise, with slightly higher levels of depression but significantly and substantively meaningful differences in anxiety and self-worth, and with results favoring cisgender children, even when the transgender children had high levels of parental support for their gender transitioning." (Schumm & Crawford, 2019, re Olson et al., 2016, Durwood et al., 2017.)

25. **United Kingdom: The National Institute for Health and Care Excellence (NICE) in England found no proof that hormone blockers are effective or safe on several factors including "psychosocial impact"**. It reviewed research that looked at the safety and effectiveness, of gonadotrophin releasing hormone (GnRH) analogues (commonly referred to as puberty blockers) from 2000 through 14 October 2020. The government review concluded the quality of the best available research is of "very low certainty". (p. 4)

26. United States: An example of a study with very low certainty is one published by Turban and colleagues (2020). It is often used to claim that adolescents who did not get puberty blockers in adolescence had a higher rate of suicidality. The study has many fatal flaws that will not be detailed here and did not as a whole support the claim.

1. **The survey found that, on 8 out of 9 measures of suicidality and mental health, there was no statistically significant difference between transgender adults who had or did not have puberty suppression. Those factors for which there was no difference were suicidality past 12 months in the forms of ideation, ideation with plan, ideation with plan and attempt, and attempt resulting in inpatient care, as well as lifetime suicidal attempts, past-month severe psychological distress, past-month binge drinking, and lifetime illicit drug use.**

2. **The one statistically significant finding was a difference in lifetime suicidal ideation but not lifetime suicidal attempts. A trend close to significance in the unpredicted direction was that those who *received* puberty suppression were nearly three times (OR 2.8) *more* likely to attempt suicide resulting in inpatient care.**

3. These results as a whole do not present a resounding case for puberty suppression.

27. United States: A government research review (CMS, 2016) concluded that "there is not enough high-quality evidence to determine whether gender reassignment surgery improves health outcomes." Participants in the best studies "did not demonstrate clinically significant changes" after surgery. It said one of the strongest studies was the Dhejne et al. (2011) research that found a 19 times higher rate of completed suicide among Swedes who had had gender affirming surgery. This U.S. government review of 33 studies spanning over 36 years may be one of the most comprehensive ever conducted. Although the reviewers were responsible to draw a conclusion only for older adults who were eligible for government healthcare, the studies appear not to have made distinctions in outcomes among adults based on age. (CMS, 2016; Sprigg, 2018)

28. Netherlands: Patients who received national gender affirming services between 2013 and 2017 *completed suicide* at a rate 3 to 4 times higher than the general Dutch population. Patients completed suicide at every stage of gender affirming treatment. Researchers who reported the concerning situation neglected to make pre-existing and continuing psychiatric disorders a focus in their discussion on possible causes. (Wiepjes et al., 2020, abstract, pp. 3-4)

29. **Netherlands: Social stigma is not a sufficient explanation for transgender suicides. In the Netherlands, change in cultural acceptance over nearly a half century has made little to no difference in suicide rates,** suggesting stigma is not a sufficient explanation for suicides. During a *45 year period* from 1972 to 2017, the rate of suicides from year to year decreased slightly for those who received feminizing treatments and did not change for those who received masculinizing treatments. (Wiepjes et al., 2020, pp. 3-4)

30. **Sweden: Individuals who received national gender affirming services between 1973 and 2003 *completed suicide* at a rate 19 times higher than matched individuals of either biological sex who identified with their sex.** The *30 year follow up* study found suicide *attempts* were 4.9 times higher, and hospitalizations for psychiatric disorders other than gender dysphoria continued to be 2.8 times higher. The researchers only considered recommending treatment for psychiatric disorders *after* gender treatments. (Dhejne, et al., 2011) The U.S. government research review in 2016 said these Swedish statistics were from the best available research (CMS 2016).

31. **Swedish lead author of a research review:** The lead author of the above Swedish study, Dhejne, and colleagues reported that, internationally, people seeking medical gender interventions have higher psychiatric disorders. They claimed the studies they reviewed showed these decrease or go down to the level of the general population after the interventions, but they acknowledge that many of the studies were "methodologically weak." (Dhejne et al., 2016) Studies were either too short to show long term outcomes (only 3 months to 5 years) or had too many participants drop out. No conclusions can be drawn. Disappearing participants could be suicides or people who were avoiding reporting to the gender clinic personnel that the outcome was poor for them.

32. **Sweden: The suicides of gender incongruent people may actually be caused by their high rates of psychiatric disorders.** A Swedish government report said, **"**people with gender dysphoria who commit suicide have a very high rate of co-occurring serious psychiatric diagnoses, which in themselves sharply increase risks of suicide. Therefore, it is not possible to ascertain to what extent gender dysphoria alone contributes to suicide,**"** researchers concluded. This is according to a study published by the National Board of Health and Welfare. (Salmi, 2020; English translation is unpublished.)

33. **Sweden: Neither cross sex hormones nor surgeries decrease psychiatric disorders or suicidality.** Branstrom and Pachankis (2019) reported there was still a lack of research support for long term benefit from gender affirming treatment as of 2019. They said, "Despite professional recommendations to consider gender-affirming hormone and surgical interventions for transgender

individuals experiencing gender incongruence, the long-term effect of such interventions on mental health is largely unknown." (Abstract) To fill this important gap, they conducted the first population-based study on gender affirmative medical interventions by using national records on the entire Swedish population. They found that, "among individuals who received a diagnosis of gender incongruence (i.e., transsexualism or gender identity disorder) between 2005 and 2015 (N=2,679)," affirmative hormone treatment did not reduce "mood and anxiety disorder health care visits, antidepressant and anxiolytic prescriptions, and hospitalization after a suicide attempt", but gender affirming surgeries did. However, when the researchers re-analyzed their data using an appropriate control group, they found that "gender affirming surgeries" also did not reduce the utilization of such mental health services. (Branstrom & Pachankis, 2020)

34. Neglecting to acknowledge, evaluate for, and potentially treat underlying mental health disorders and their *potential causal links* to gender dysphoria may lead to ongoing mental health problems and completed suicides.

1. **Worldwide: 90 percent** of people who committed suicide had unresolved mental health disorders, according to global research. The researchers' number one recommendation for preventing suicide is treating mental disorders (Cavanagh et al., 2003).

2. **U.S: 96 percent of adolescents** who experience suicidal thoughts, plans, or attempts have at least one psychiatric disorder, according to a nationally representative study. (Nock et al., 2013)

3. **U.S: "psychopathological problems are almost always involved" in suicide,** according to the Centers for Disease Control. (O'Carroll, & Potter, 1994)

35. In conclusion, according to *research* on puberty blockers and according to robust national cohort or population-based studies on cross sex hormones and surgeries, the view that medical gender affirming treatment improves transgender mental health and reduce suicides is not supported.

36. There is not a *professional organization* consensus that there is empirical support for gender affirming treatment (GAT).

1. **The British Psychological Society (2012), in its Guidelines, said of gender affirmative body changing treatments, "It is important to note that the treatment of Gender Identity Disorder (APA, 2000a) in young people is largely experimental" (p. 35).**

2. **The Endocrine Society Guideline rated the quality of research in support of 23 of its 24 recommendations as "low," "very low," and "none." It rated the quality of the research in support of 1 recommendation as "moderate," and rated research support as "high" for none of its recommendations (Hembree, 2017; Sprigg, 2020). The Endocrine Society Guideline is co-sponsored by 6 additional organizations:** The American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health. (Hembree et al., 2017)

3. **Several professional organizations express strong reservations against gender affirming medical treatments for minors who experience gender dysphoria.**

    1. Royal College of General Practitioners
    2. Swedish Pediatric Society
    3. Royal Australian College of Physicians
    4. Society for Evidence Based Gender Medicine (international)
    5. Pediatric and Adolescent Gender Dysphoria Working Group (international)

PROFESSIONAL ORGANISATIONS AND EMERGING RESEARCH SUPPORT THERAPY CONVERSATIONS TO HELP GENDER INCONGRUENT INDIVIDUALS BECOME COMFORTABLE WITH THEIR SEX

37. **Many professional *organisations* have either not opposed sex acceptance therapy for gender dysphoric individuals or have affirmatively supported it.**

    1. **The Royal College of Psychiatrists chose not to take a position in opposition to sex acceptance therapy for gender identity.**

    2. **Many medical and mental health professional organizations have opposed bans on therapy that is open to a client's goal of change for an unwanted gender identity or expression and/or supported the right of clients to such therapy (https://iftcc.org/?s=organisations):**

        - International Federation for Therapeutic and Counseling Choice (iftcc.org)
        - International Federation of Catholic Medical Associations (FIAMC) — **has 62 member organizations around the world**

- American Association of Physicians and Surgeons (https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf ; https://aapsonline.org/california-proposes-bills-to-outlaw-self-determination-in-medical-therapy/)
- American College of Pediatricians (https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf ; https://acpeds.org/position-statements/psychotherapy-for-unwanted-homosexual-attraction-among-youth)
- Christian Medical and Dental Associations (U.S.A.) (https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf ; https://cmda.org/position-statements/)
- Catholic Medical Association (U.S.A.) (https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf ; https://www.cathmed.org/resources/cma-protests-california-bill/)
- Society of Catholic Social Scientists
- Alliance for Therapeutic Choice and Scientific Integrity (https://docs.wixstatic.com/ugd/ec16e9_1d6108cfa05d4a73921e0d0292c0bc91.pdf)
- Association of Christians in Health and Human Services (ACHHS)
- American Association of Christian Counselors (AACC Code of Ethics, 2014, 1-120f, 1-330, 1-340, https://www.aacc.net/code-of-ethics-2/)

38. **Emerging research is encouraging for therapy conversations that are open to a client's goal of sex acceptance. The Appendix is a chart presenting some of these studies. (American College of Pediatricians, 2021)** Research on such therapy is in its infancy. In early stages of research into psychotherapy for a particular goal, it is common for research design to include clinical case reports. Research studies such as those presented in the Appendix provide evidence that some people become able to feel comfortable identifying with their body sex through therapeutic support. Due to the early stage of the research, however, the evidence does not reach the level of proof. More and better research is needed but difficult to conduct due to the small number of potential participants. The American Psychological Association identifies the components of "evidence based practice in psychotherapy" as use of the best available research, clinical expertise, and attention to patient characteristics, culture, and preferences. (APA, 2021) We believe standard therapies applied toward a client's goal of sex acceptance can meet these criteria and is warranted and much needed in light of the evidence of harm from medical gender affirming treatments, the best evidence that shows medical gender treatment does not reduce psychiatric conditions or reduce suicides, the desirability of reducing the suffering of gender dysphoria, and emerging

research that some can benefit from such client-initiated, non coercive, and non aversive care that does not harm bodies.

RESEARCH DOES NOT SHOW THAT THERAPY CONVERSATIONS FOR BECOMING COMFORTABLE WITH ONES BODY ARE HARMFUL

39. Some who seek to censor therapy conversations that support a client's goal of becoming comfortable with their body call such therapy conversations "gender identity change efforts" or "GICE." These opponents generally take a position that therapy conversations, or GICE, are harmful and ineffective, while body altering treatments are safe, effective, and should be a core part of affirmative treatment.

40. There is no research that meets scientific standards that shows GICE are unsafe or harmful.

41. A study by Turban and colleagues admitted that up to 2019, there has been no research that proves harm from GICE. Efforts to censor GICE have had no scientific basis. The survey by Turban and colleagues, however, does not change that status due to fatal flaws.

42. Inapplicable studies have been used to claim GICE are unsafe or ineffective. As an example, the British Psychological Society Guidelines invalidly asserted that psychotherapy to resolve gender dysphoria is harmful based on studies of preoperative psychotherapy required as a condition for getting sex surgery, hence coerced on participants who were not seeking it, and a study of psychotherapy conducted for unstated therapy goals. (BPS, 2012)

43. Studies that claim GICE are associated with harms, and therefore should be censored, use invalid methods. Some examples (Turban 2019; Green et al., 2020) are that they:

1. Survey only people who currently identify as transgender and therefore automatically omit people who changed gender identity to cisgender and would say they benefited from GICE.
2. Ask biased, pejorative key questions such as, "Did someone try to *make* you change?" that do not accurately represent noncoercive, client-directed sex accepting therapy.
3. Disqualify participants from the study who say they experienced change-supportive therapy but did not experience coercion.
4. Give cues as to the researcher's preferred views and potentially preferred participant responses—for example, reveal the researchers represent an activist organization or ask biased and pejorative key questions.

5. Mix together participants' reports of GICE from different kinds of providers--professional therapists, pastoral counselors, or "counselors" not further defined—thereby mixing different levels and kinds of training and experience—so we do not know what was researched.
6. Do not sufficiently define what is meant by GICE. Participants could be referring to any experience they perceived as non affirming, such as a therapist telling them the potential risks and benefits of medical gender affirming treatments. Participants could be referring to experiences other than therapy, such as a psychological evaluation that was conducted before deciding appropriate treatment plans.
7. Do not assess levels of mental health problems or suicidality *both before* and after GICE in order to see whether these levels worsened, remained the same, or actually improved after GICE.
8. Use unreliable retrospective reports.
9. Apply statistical methods to a survey of self-selected participant transgenders as though they represent all transgenders.
10. Infer from an association between psychiatric conditions (examples: depression, anxiety, suicidal attempts) and GICE that GICE caused these conditions and ignore the possibilities that these conditions existed before the transgender identity or GICE or that therapists did not affirm transgender identity in patients they diagnosed as severely mentally ill.

2. **Opponents of GICE may assume minors are incapable of consenting to a goal of therapy conversations to accept their body. This assumption undermines the mature minor concept *that adolescents are capable of making health and mental health decisions for themselves. If it is assumed a minor cannot choose therapy conversations, then surely a minor cannot choose permanent body altering procedures.***

44. I**t is sometimes falsely inferred that the United Nations has taken a position in opposition to GICE**. A report of an independent expert individual does not represent the views of United Nations. Member States, in fact many, opposed his report and have said they don't recognize his mandate. (Example: OIC/CFM-43, 2016) In fact, there is no U.N. binding agreement regarding sexual orientation or gender identity at all.

COURT DECISIONS HAVE ALLOWED CHANGE-ALLOWING THERAPY CONVERSATIONS AND OPPOSED MEDICAL GENDER AFFIRMING TREATMENTS FOR MINORS

45. United States court decisions have overturned bans on change allowing therapy conversations.

1. **The Supreme Court of the United States (SCOTUS) rendered a decision that professional speech has the same right to freedom of speech as any other speech**. SCOTUS said it has never accepted a doctrine that professional speech is professional conduct and therefore can be censored. Otherwise, all the government would need to do to take away first amendment rights to freedom of speech from a group of people would be to license them. (National Institute of Family and Life Adovcates v. Becerra, 2018) This decision abrogated existing decisions of Circuit Courts. (Pickup et al. v. Brown, 2013; King v. Governor of the State of New Jersey, 2014)

2. **A decision of the U.S. 11th Circuit Court of Appeals found that the evidence submitted by the American Psychological Association against change-allowing therapy offered "assertions rather than evidence".** The Circuit Court said professional organisation opinion statements that oppose change supportive therapy "may hit the right mark—but they may also miss it. Sometimes by a wide margin too. It is not uncommon for professional organizations to do an about-face in response to new evidence or new attitudes…." The court struck down laws that banned "conversion therapy" (Otto et al. v. City of Boca Raton et al, 2020) based in part on the Supreme Court of the United States decision (NIFLA v City of Becerra, 2018).

46. A United Kingdom high court decision said minors cannot consent to medical gender affirmative treatments. A United Kingdom High Court in Bell vs. Tavistock (Dec. 12, 2020) ruled that gender affirming treatment in minors was experimental and could not, in most cases, be given to minors under 16 without court order, and that such was advisable for those 16-17. They added, "There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years." (Bell et al. v. GIDS, UK)

CONCLUSIONS

47. **Some nations with the longest experience with gender affirming treatment have restricted it for children and adolescents, providing them much needed protection.** Examples are the United Kingdom (Transgender Trend, 2019), Sweden (Karolinska, 2021), The Netherlands (de Vries et al., 2012), and Finland (COHERE, 2020).

48. **Psychiatric disorders have associative and potentially *causal* links to gender incongruence.**

49. **Treating a psychiatric disorder may resolve a symptom of a disorder.** In this case, treating a psychiatric disorder may potentially decrease or resolve gender incongruence or gender dysphoria**.**

50. **Even the World Professional Association for Transgender Health (WPATH) did not recommend gender affirming medical treatments when gender dysphoria is "secondary to or better accounted for by another diagnosis."** (Coleman, 2012, p. 180)

51. **Prohibiting therapy conversations to resolve gender dysphoria leaves these sufferers little help to resolve gender dysphoria.** This is dangerous and unjust. They could only be offered help to live with it.

52. **Neglecting to acknowledge, evaluate for, and potentially treat underlying mental health disorders and their *potential causal links* to gender dysphoria may lead to ongoing mental health problems and completed suicides. The denial of potential psychopathological causes has been dangerous.**

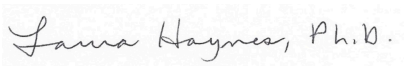
53. **Puberty blockers, cross sex hormones, mastectomies, and sex surgeries are opposed to a body's natural healthy functioning, inflict harm on a body, and increase deaths from diseases and completed suicides. On the other hand, there is no research that meets scientific standards that shows voluntary, client-initiated, non aversive, professional, therapy conversations to help people become comfortable in their body or manage their gender dysphoria is unsafe.**

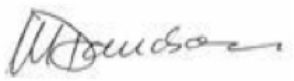
54. **Therapy conversations that treat potential underlying psychiatric conditions, such as psychiatric disorders, neurodevelopmental disabilities, or trauma, and their possible links to gender dysphoria are much needed therapy for gender dysphoria. Treatments for psychiatric disorders already exist and are continually developing over time.**

55. **Altering people's bodies to imitate the appearance of another sex is harmfully experimenting with people's bodies and lives. It is <u>not</u> transgender health, and it is <u>hardly</u> suicide prevention. It is wrong to sterililze children, adolescents, and adults and mutilate their bodies. This abuse must stop.**

56. **The best path for government is to clarify that "gender" means "biological sex" in law. Such a practice will help to prevent confusion and harm. Other terms may refer to subjective perceptions some individuals have of their sex.**

Respectfully submitted,





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APPENDIX *

Psychotherapeutic and behavioral approaches to treating gender dysphoria (including gender identity disorder & transsexualism) in adults and adolescents					
STUDY	DESIGN	N	POPULATION	INTERVENTION	OUTCOME
Barlow DH, Reynolds EJ, Agras WS. Gender Identity Change in a Transsexual. Archives of General Psychiatry. 1973;28:569-576.	Case series	1	Male age 17, diagnosed with transsexualism	Behavioral therapy (tied to stereotypes)	Success in treating his gender identity issues. He remained homosexual.
Barlow DH, Abel GG, Blanchard EB. Gender Identity Change in Transsexuals: Follow-up and Replications. Archives of General Psychiatry. 1979;36:1001-1007.	Case series	2	Two adult males	Behavioral therapy (tied to stereotypes)	Success. Also reports 6.5 years follow- up of 1973 case (Barlow et al 1973); that patient still doing fine.
Beigel HG. Three Transvestites under Hypnosis. The Journal of Sex Research. 1967;3:149-162.	Case series	3	Three adult males	Psychoanalysis and hypnosis	Success. All three reported no longer to have problems with transvestism.
Davenport CW, Harrison SI. Gender identity change in a female adolescent transsexual. Archives of Sexual Behavior. 1977;6:327-340.	Case report	1	Female age 14	Inpatient psychotherapy, recreational therapy, encouragement of female staff, etc. for 20 months	Success. At 2.5 years follow-up, the young woman was stable and content as a lesbian.
Dellaert R, Kunke T. Investigations on a Case of Male Transsexualism. Psychotherapy and Psychosomatics. 1969;17:89-107.	Case report	1	Male age 18	Psychotherapy and psychoanalysis	Success. Young man is happily married, not conflicted.
Hakeem A. Psychotherapy for gender identity disorders. Advances in Psychiatric Treatment. 2012;18:17-24.	Descriptive	82	Wide range of "trans" types. Comorbidities unclear.	Group psychotherapy	Unclear. Does not report outcomes specifically. Suggests that many patients now see that the transgender process wasn't necessary.
Keller AC, Althof SE, Lothstein LM. Group therapy with gender-identity patients--a four-year study.	Descriptive cohort	28	21 adult males, 7 adult females, 84% with significant comorbid psychopathology	Group psychotherapy (groups of 3-12), one male and one female therapist co-leading each group.	Mixed success. During the 4-year period, 8 patients carried on to transsexual

American Journal of Psychotherapy. 1982;36:223.					interventions; 8 “showed a lessening of character pathology”; 11 no longer wished to be transsexuals; one had psychotic break and kept changing his mind.
Kirkpatrick M, Freidmann CT. Treatment of requests for sex- change surgery with psychotherapy. American Journal of Psychiatry. 1976;133:1194-1196.	Case series	1	Male age 19, female age 18, diagnosed with gender identity disorder	Supportive psychotherapy 2x/week (male: 15 weeks; female: 2.5 years).	Success. Both desisted from their desire for sex change surgery. Both content as homosexuals.
Kronberg J, Tyano S, Apter A, Wijsenbeek H. Treatment of transsexualism in adolescence. Journal of Adolescence. 1981;4:177- 185.	Case report	1	Female age 15	Inpatient psychotherapy, recreational therapy, encouragement of female staff, etc. for "several" months	Success. Young woman stable and content as a female.
Lothstein LM. The adolescent gender dysphoric patient: an approach to treatment and management. Journal of Pediatric Psychology. 1980;5:93-109.	Case series	27	17 boys, mean age 16.5 years [12-19] and 10 girls, mean age 16.8 years [13-19], all diagnosed with gender identity disorder. Some on hormones, some prostituting. All presented in acute crisis with much family dysfunction and psychopathology.	Psychotherapy	Mixed success (14/27). 11 boys dropped out; status unknown. At 4-5 years, two young women and one young man had persisted and had transsexual surgeries. In one male who had been on hormones and "living as a woman" for 2 years, gender dysphoria resolved completely. At 4-5 years, the remaining 5 boys and 8 girls were still attending therapy or had desisted.
Lothstein LM, Levine SB. Expressive Psychotherapy with Gender Dysphoric Patients. Archives of General Psychiatry. 1981;38:924- 929.	Retrospective cohort with five cases highlighted	50	50 adults, adolescents and children. Breakdown by sex and age range not reported.	Expressive psychotherapy	Mixed success. 35/50 (70%) lost their desire to become transsexuals. 10 were still in therapy. Five received transsexual surgery.

Meyenburg B. Gender identity disorder in adolescence: Outcomes of psychotherapy. Adolescence. 1999;34:305-313.	Case series	3	Female (age 17), female (age 17), male (age 17), male (age 13), all demanding surgery, all "living as" opposite sex.	Psychotherapy, several months up to 2 years	Mixed success (2/3). One girl carried on and had "trans" surgeries. One girl stopped attending psychotherapy after several months; they later learned that she was in a lesbian relationship and living with her partner. One boy came to see himself as a flamboyant gay man. Younger boy's fetishism, which had arisen due to family issues and incipient borderline psychopathology, resolved.
Philippopoulos GS. A case of transvestism in a 17-year-old girl. Acta Psychother. 1964; 12:29-37.	Case report	1	Female age 17	Brief intense psychoanalysis and psychotherapy 3x-4x/week for 6 months	Success. At 5-year follow-up, young woman was stable and content as female.
Shtasel TF. Behavioral treatment of transsexualism: a case report. Journal of Sex & Marital Therapy. 1979;5:362-367.	Case report	1	Female age 25	Cognitive-behavioral therapy	Success. Patient accepted herself as a woman and as a lesbian. Important note: This is the only reported use of cognitive behavioral therapy (CBT) for alleviating gender identity issues. CBT came into the mainstream in the 1970s. By now, CBT-based approaches are the standard in treating much mental illness – including borderline and other personality disorders (many clinicians of the 1950s- 1980s observed borderline, narcissistic and/or histrionic traits in their patients with gender identity issues). Research should be conducted

					to assess the potential efficacy of CBT-based therapies in resolving gender dysphoria and other gender identity concerns. Since this study was published in 1979, there has not been a single additional study exploring the use of CBT-based therapies in treating gender dysphoria or any type of gender identity disturbance.
Wise TN. Psychotherapy of an aging transvestite. Journal of Sex & Marital Therapy. 1979;5:368-373.	Case report	1	Male age 43	Weekly psychotherapy for 16 months	Provisional success. Resolved for now. Patient no longer had desire for surgery. Clinician correctly notes the episodic nature of adult male transvestism and suggests that clinicians should remain available to help.

*Used by permission. American College of Pediatricians (2021). Psychotherapeutic and behavioral approaches to treating gender dysphoria (including gender identity disorder & transsexualism) in adults and adolescents. https://acpeds.org/assets/Psych-studies-gender-identity-final-17-June-2021.pdf