INTERNATIONAL FEDERATION FOR
THERAPEUTIC & COUNSELLING CHOICE

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EO 12866 Meeting
Nondiscrimination in Health Programs and Activities
RIN: 0945-AA17
Re: HHS (Health and Human Services) Section 1557 Proposed Amendment
To: OIRA (Office of Information and Regulatory Affairs) of the White House OMB (Office of Management and Business)
Attendees: Representatives of OMB/OIRA, OMB/HD (health division), OMB/OGC (office of general counsel), HHS/OCR (office for civil rights), HHS/IOS (immediate office of the secretary)

TESTIMONY OF LAURA HAYNES, PH.D.
International Federation for Therapeutic and Counseling Choice

Thank you hearing our concerns today regarding a proposed amendment to HHS Section 1557.

I am Dr. Laura Haynes, psychologist, representing the International Federation for Therapeutic and Counselling Choice for which I am the USA Country Representative and a General Board Member. I have presented on gender dysphoria internationally to physicians, psychotherapists, Parliamentarians, European courts, United Nations delegates, and high-level government officials. Our organization supports *physicians* as well as psychotherapists and counsellors in about 25 nations including the *United States*.

We are concerned to learn from Roger Severino at the Ethics and Public Policy Center that a proposed HHS rule will try to smuggle in a dangerous new gender identity standard of medical care under the cover of nondiscrimination. It would force physicians to conduct experimental gender treatments and surgeries. [7] We believe coercing such interventions would be *unscientific* and *harmful for patients and our physicians*. Please consider the evidence.

There is no consensus that incongruent gender identity is simply biologically determined. The American Psychiatric Association's *Diagnostic and Statistical Manual, Fifth Edition*, says gender dysphoria is not an intersex condition of the brain. [1] A consensus statement by several endocrine societies around the world agrees. [11] Many professional organizations agree that gender dysphoria likely develops from an interaction of biological, psychological, and social influences. [1,11] What kinds of psychological influences may be causal?

Studies in many countries report high rates of other psychiatric conditions in gender incongruent adolescents and adults. This association is widely accepted and not controversial. [2,9,17]

Most studies, however, do not tell us which came first—psychiatric conditions or gender dysphoria, but some do. Rigorous studies have found internationally that lifetime psychiatric conditions at high rates often come first, before gender incongruence or gender dysphoria, therefore psychiatric conditions may predispose to, or be a causal influence for, gender dysphoria. [2,9]

A rigorous U.S. study of 8.8 million members of a health maintenance organization in California and Georgia over 8 years found that a third of children and about three-quarters of adolescents had lifetime psychiatric conditions *before* first electronic medical record evidence of gender incongruence in comparison to only about 3 to 6% of matched gender congruent peers. Psychiatric conditions studied included psychiatric disorders, neurodevelopmental disabilities such as autism spectrum disorder, suicidality, and self-harming behavior. Medical records were kept in real time. The 1,333 gender incongruent children and adolescents in this study were an entire 8-year cohort, not recruited volunteers. [2]

Another study similarly found three-quarters of adolescents applying at one of Finland's two centralized gender clinics, at a university hospital, had previously been treated for other psychiatric conditions. The researchers found that severe psychiatric conditions and bullying for reasons other than gender commonly began before onset of gender dysphoria and seldom began secondary to gender dysphoria. [9]

The government Recommendation of the Council for Choices in Health Care in Finland says, "The *first-line treatment* for gender dysphoria is psychosocial support and, as necessary*, psychotherapy and treatment of possible comorbid psychiatric disorders…. In adolescents, psychiatric disorders and developmental difficulties may predispose a young person to the onset of gender dysphoria*." [5, see section 7; emphasis added]

Updated guidelines from the Swedish National Board for Health and Welfare now also *prioritize psychotherapy*. The new guidelines emphasize that identity formation is an evolving process in youth. Experiencing natural puberty is a vital step for development of gender identity and overall identity. The National Board said guidelines for young adults, 18 to 25, are needed, because they also are still in process of brain development and maturation, and they are reporting detransition and transition-related regret. [12]

Research reviews by the government equivalents of HHS in the United Kingdom and Sweden have determined research for *puberty blockers and cross sex hormones* for minors is inconclusive. [13,14,12,15] Follow up research at one of Finland's two centralized gender clinics found cross sex hormones did not resolve psychiatric conditions in gender dysphoric adolescents. Depression and anxiety may have decreased some, but psychiatric conditions overall did not decrease and even worsened for some. [10] Finland's government Recommendation says, "As far as minors are concerned, there are no medical treatment[s] [sic.] that can be considered evidence based." [5]

Comprehensive government research reviews in Sweden and the United States found research for gender *surgeries* was inconclusive. The United States Centers for Medicare and Medicaid Services *declined* to issue a National Coverage Determination for Medicare. Yet now the US government wants to coerce these treatments as the standard of care? [8,3,4]

In Sweden and the Netherlands, large studies, some covering decades of follow-up, taken together covering nearly half a century, based on national populations and national treated cohorts, not recruited volunteers, have found that, long term, gender medical interventions for adults do not reduce their higher rates of psychiatric conditions, suicide attempts, and completed suicides. [6,3,16]

There is *no medical consensus* for prioritizing expensive and body-harming medical interventions over psychiatric treatment and psychotherapy to relieve patients of gender dysphoria. Under the proposed HHS 1557 amendment, the United States government *remarkably* would declare *what Finland's and Sweden's tolerant governments recommend as first line treatment to be gender discriminatory and unlawful. This is absurd*. [5,12]

There is *no scientific justification* for steering gender dysphoric *patients* down a single, expensive, risky path of hormones and surgeries and failing to offer them the alternative option of psychotherapy and psychiatric treatment that governments with more experience now prioritize. There is *no scientific justification* for coercing *physicians* to engage in medical speech and perform medical acts against their medical judgment, ethics, conscience, or religious beliefs. Such *unprecedented forced labor would have a chilling effect*, driving physicians from practice and repelling potential physicians from entering practice, *reducing* access to gender dysphoria services and medical services broadly.

The proposed amendment to HHS section 1557 is a *disaster*. It should just not happen.

Laura Haynes, Ph.D., Psychologist, U.S.A. Country Representative, General Board Member, International Federation for Therapeutic and Counselling Choice (iftcc.org)

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