INTERNATIONAL FEDERATION FOR THERAPEUTIC & COUNSELLING CHOICE

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Dear Dr. Miguel Cardona, United States Secretary of Education,

I am Dr. Laura Haynes, psychologist, representing the International Federation for Therapeutic and Counselling Choice (iftcc.org) for which I am a General Board Member and the U.S.A. Country Representative. I have served as an expert on gender dysphoria research internationally for professional organizations of physicians and 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.

Thank you for the opportunity to express our deep concern that the United States Department of Education intends to expand Title IX that historically has prohibited discrimination based on sex to include prohibiting discrimination based on sexual orientation and gender identity. Our concerns with this change are many, but we will focus here on one. The expansion would promote radical gender identity ideology as mandated policy in our schools. In effect, it would require conformity to a viewpoint that discordant gender identity is like sex and skin color that are inborn and fixed traits, which we will show is not true. It would bizarrely prioritize a person's changeable perception of their sex, even when it is contrary to biological reality, over a person's inborn sex—who a person unchangeably is, and, in an ironic turning of the tables, discriminate against sex. Educators and children would be coerced to conform speech and behavior to this viewpoint on pain of punishment. The many millions of educators and children who cannot cooperate with the promotion of this viewpoint, because they do not believe it, or because they are morally, ethically, or religiously obligated to uphold

another viewpoint as more hopeful for gender incongruent children, will be subjected to efforts to silence and cancel them.

But is the viewpoint premise for Title IX scientifically valid? And if scientifically invalid, might it have unintended consequences, not only for the men and women, boys and girls in schools whose gender identity matches their sex, but importantly for the gender discordant children it is intended to support? Please consider the evidence we now present.

The "Global DSD [disorders of sex development] Consortium Consensus Statement Update 2016" by several endocrine societies around the world makes it clear that *a viewpoint that gender incongruence is an inborn biological trait or an intersex condition of the brain is not scientifically supported*. The Global Consensus Statement says there is no consistent evidence that the brains of gender incongruent people are different from the brains of gender congruent people. It says no biological marker—no biological thing—has been found that is gender identity that another person can find by looking at a person's brain or giving a biological test. It says feminine and masculine aspects of the brain develop "gradually" over time, that is, after birth, through the interaction of biological influences and psychological and social life experiences ("biopsychosocial" development) [23]. The American Psychiatric Association agrees. In its Diagnostic and Statistical Manual—Fifth Edition—Text Revision (DSM-5-TR, 2022), it says, "Overall, current evidence is insufficient to label gender dysphoria without a DSD as a form of intersexuality limited to the central nervous system." Further, it says, "Biological factors are seen as contributing, in interaction with social and psychological factors, to gender development." [1, pp. 511, 517]

What kinds of psychological factors may be causal influences in the development of incongruent gender identity? It is widely accepted that there is an association between gender discordance and high rates of mental health problems. Studies in at least 16 countries on 4 continents have found 50% to 89% of gender incongruent or gender dysphoric adolescents and/or adults had psychiatric conditions and/or suicidality. [19,18] Most of these studies, however, do not tell us which came first—the gender discordance or the mental health problems, and mere association cannot tell us the direction of causation. Nevertheless, it has regularly been assumed that the higher prevalence of mental health problems is a result of discrimination or lack of access to physical interventions. Some of these studies, however, do tell us which came

first. In each case, the mental health problems preceded onset of gender discordance. Robust international research in the United States, Finland, and Canada has found that high rates of psychiatric disorders, neurodevelopmental disabilities, self-injuring behavior, and suicidality, as well as peer bullying for reasons other than gender, commonly existed *prior to onset* of gender incongruence or distress and seldom began secondary to it [3,20,4], therefore may be predisposing causes for gender incongruence or dysphoria. Conditions and experiences that precede gender discordance cannot be caused by failure to affirm it.

What is leading to these high rates of psychiatric conditions? It is generally accepted, including by the United States government's Centers for Disease Control, that adverse childhood experiences contribute to the development of psychiatric disorders and suicidality. [9] In a study of children ages 8-15 and their families who presented at an Australian hospital gender clinic over 5 years, 89% of the children had psychiatric disorders. Nearly all the families, 98%, reported a developmental history of adverse childhood experiences, mostly in the family, on average 5 of the following: mother mental illness, father mental illness, parent incarceration, family conflict, loss by separation from a parent or grandparent, exposure to domestic violence, bullying, and maltreatment in the forms of physical, emotional, and/or sexual abuse. It was in this unstable context that the children and adolescents developed their psychiatric disorders and discordant gender identity. [21] It seems far more likely that such severe contexts led to gender discordance than that gender discordance led to such severe contexts. Sensitive children who grow up in troubled families and perceive or experience serious maltreatment based on sex or gender may come to believe they would feel more secure or valued as another sex. [42, pp. 262-264] Incongruent gender identity is not inborn, and it may have treatable adverse psychological causes.

It also may change throughout the lifespan through maturation and life experience. Eleven out of eleven studies have come to the same conclusion, that the vast majority of children outgrow gender distress by late adolescence or adulthood—about 85%. [42,35,36] Attempts to dismiss this have been rebutted [41], and the American Psychiatric Association's latest version of its Diagnostic and Statistical Manual just out this year (DSM-5-TR, 2022) continues to accept it. [1] These are rates of resolution if nothing is done or if children are treated for psychiatric conditions, supported to go through puberty, and not socially

or medically affirmed as the discordant gender they perceive themselves to be or strongly wish to be.

In stark contrast, a recent study found, among gender dysphoric children who were socially affirmed with cross sex clothing, hairstyles, names, and pronouns for about 5 years, only 2.5% resolved gender distress. If some of the children who discontinued participation in the study 2 years before it ended did so because they returned to identifying with their sex, the rate of resolving gender dysphoria may have been up to 11% (10.7%). [31] Social transition has been found to be a strong and unique predictor of persisting gender dysphoria. [42,39,31]

Children who do not resolve gender incongruence may be directed to receive puberty blockers. The label for the puberty blocker used in the United States, Lupron, warns providers, “Monitor for development or worsening of psychiatric symptoms." [25] This is for a population of minors that already has a high prevalence of psychiatric conditions before onset of gender dysphoria.

Once gender discordant children are put on puberty blockers, zero to 6% come to embrace and identify with their body sex. [6,7,13,22] There is qualitative research evidence that experiencing the sex hormones that are natural to a child’s body—with the consequent body changes, first experience of falling in love, and first feelings of sexual attraction—are critical in gender identity development and in gender dysphoria resolution [39], and the 2022 guidelines from the Swedish National Board of Health and Welfare explicitly accept this. [37, p. 1]

Typically, children who are deprived of their natural puberty continue on to a medical protocol of high dose, toxic, wrong sex hormones that lead to infertility and loss of sexual function and pleasure for life, removal of healthy breasts [yes, this is really being done on minors: 32,17,34], and, potentially, surgeries that destroy sex organs. Can children who have not experienced falling in love consent to never having full sexual pleasure, never procreating a child, and never breast-feeding a child?

Population based studies have found that these profound body harms have led to a nearly 3 times higher rate of deaths from chronic diseases. Hospitalizations for psychiatric disorders continued unchanged at a 3 times higher rate, and completed suicides were 19 times higher compared to matched peers in the general population. [14] Rates of treatment for depression and anxiety and hospitalizations following

suicide attempts were no different for gender dysphoric people who did or did not have hormones or surgeries to appear as another sex. [5] Finland's government Recommendation says, "Since reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment." [12, chapter 6]

Comprehensive government research reviews in Sweden [37,27,28,16], the United Kingdom [29,30] and the United States [10] have consistently concluded research on the safety or efficacy of medical gender interventions is of uncertain quality and cannot support these interventions, therefore these are being restricted. Transgender "affirmation" is not transgender health, and it is not suicide prevention in the long term. Can children, especially a population of children who have a high prevalence of psychiatric conditions, consent to this "affirmation"?

Yet, even after sustaining irreparable body harms, emerging research is revealing that people from ages 13 to 64 have detransitioned to identify with their sex. They transitioned on average at about age 18 and detransitioned on average 4 years later at about age 22, but by then, what is gone is gone. [40] The distress of a second transition back to identifying with their sex may be substantial and more stressful than initially transitioning was. [40,39] Yet they demonstrate that gender dysphoria can change throughout the life span. [40,24] People can come to embrace who they innately are, even against the enormous obstacles caused by well-meaning "affirmation" of trauma symptoms and mismatched perceptions in the form of discordant gender identity.

"Affirmation" changes gender identity outcomes and has serious consequences. It causes far-reaching bodily losses and missed opportunity for timely emotional healing. Does the U.S. Department of Education want to be responsible for this? Schools that do not allow children to get an aspirin without parental consent must now "affirm" children to undergo profoundly harmful social and medical interventions without parental consent?

Does the expansion of Title IX require informing teachers, children, and adolescents that affirmation may lead to profound regret? Does this expansion provide funding for minors who regret sterilization and other injuries to their health and who may one day sue the government for reparation?

The first line recommendation for treating gender distress from Finland's government and from the United Kingdom's Secretary of Health is that gender distress in minors should be addressed by treating underlying psychiatric conditions or causes, not by medical affirmation [12,33]. A United Kingdom review process is moving treatment away from previous monolithic pressure on providers to medically affirm. [2,8,29,30] The Swedish government also is prioritizing psychotherapy for minors. It now says it would only consider medical intervention under restricted circumstances and then only if the children were made subjects of experiments, if there were any experiments. [37,27] The National Academy of Medicine in France is following Sweden in recommending great caution about affirmation [26]. If the U.S. expanded Title IX, it would be requiring educators and school counselors to go in the opposite direction of countries with far longer and more robust experience delivering and researching treatment of gender discordance. This is absurd. Societal affirmation which the Title IX expansion would compel deprives gender distressed people from knowing what may really help them.

Nationally representative studies in the liberal countries of Sweden and the Netherlands have found that increasing societal and medical affirmation over nearly half a century has made little to no change in the higher rates of psychiatric disorders, attempted suicides, and completed suicides of gender incongruent people over the long term of their lives. [41,14,5] Studies of young people cannot tell us long term outcomes, because young people, by definition, have not lived long enough.

The proposed Title IX change would coerce teachers and students to tell gender distressed people a lie, that their condition is who they really are, like being a member of a race, further preventing them from seeking help to understand their conflict between their innate body and their changeable feelings and the distress they may feel about this conflict. Increasingly, gender discordant people are regretting the social and medical affirmation that has failed them, that has not heard them and their deep underlying stress. They are detransitioning in growing numbers and making their voices of protest heard online [40,24]. Title IX affirmation will increase their number. [39,42]

There is no scientific justification for misleading suffering gender incongruent people. The additional cost of erasing biological women and girls and their rights in K-12 school private places and sports will not likely increase much needed empathy for gender incongruent people in

schools. Educators and children who cannot cooperate with this viewpoint will be mistreated. This proposed ordinance is in the end a lose-lose for everyone.

Respectfully,

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International Federation for Therapeutic and Counselling Choice (iftcc.org)

References:

[1] American Psychiatric Association (2022). “Gender Dysphoria”. In *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR*). Washington, D.C., American Psychiatric Association, pp. 511-520. See especially pp. 511, 517.

[2] [Andersson, J. & Rhoden-Paul, A. (28 July 2022). NHS to close Tavistock child gender identity clinic. https://www.bbc.com/news/uk-62335665]

[3] Becerra-Culqui T. et al. (USA) (2018). Mental health of transgender and gender nonconforming youth compared with their peers. *Pediatrics, 141(5)*, e20173845. https://doi.org/10.1542/peds.2017-3845

[4] Bechard, M. et al. (Canada) (2017). Psychosocial and psychological vulnerability in adolescents with gender dysphoria: A “Proof of Principle” study. *Journal of Sex and Marital Therapy, 43(7)*, 678–688. https://doi.org/10.1080/0092623X.2016.1232325

[5] Branstrom, R. & Pachankis, J. (2020). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study. With correction addendum and correction statement at end. *American Journal of Psychiatry 177(8),* 727-734. https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2019.19010080

[6] Brik, T., Vrouenraets, L., de Vries, M., Hannema, S. (2020). Trajectories of Adolescents Treated with Gonadotropin-Releasing

Hormone Analogues for Gender Dysphoria. *Archives of Sexual Behaviour, 49*, 2611-2618. https://doi.org/10.1007/s10508-020-01660-8

[7] Carmichael, P., Butler, G., Masic, U., Cole, T., De Stavola, B., Davidson, S., Skageberg, E., Khadr, S., & Viner, R. (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. PLoS ONE 16(2), e0243894. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0243894

[8] Cass, H., Chair, Independent Review into GIDS for Children and Young People. (Feb. 2022). The Cass review: Independent review of gender identity services for children and young people: Interim report. https://cass.independent-review.uk/publications/interim-report/

[9] Centers for Disease Control and Prevention (U.S.) (Last updated April 10, 2020). Adverse Childhood Experiences Resources. National Center for Injury Prevention and Control, Division of Violence Prevention, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/aces/resources.html?

[10] Centers for Medicare & Medicaid Services (CMS) (August 30, 2016). Decision memo for gender dysphoria and gender reassignment surgery (CAG-00446N), (See especially p. 62.) https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282

[11] Children's Hospital Los Angeles (CHLA) (2016). Children's Hospital Los Angeles Assent to Participate in Research Study. https://drive.google.com/file/d/1Q-zJCivH-QW7hL25idXT_jITfJZUUm1w/view?usp=sharing

[12] Council for Choices in Health Care in Finland (PALKO/COHERE Finland) (2020). 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. https://palveluvalikoima.fi/en/recommendations#genderidentity . UNOFFICIAL English translation: https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf

[13] de Vries, A., Steensma, T., Doreleijers, T., Cohen-Kettenis, P. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine, 8(8),* 2276-2283. https://pubmed.ncbi.nlm.nih.gov/20646177/

[14] Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A., La ̊ngstro ̈m, N., Landén, M. (2011) Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE 6(2),* e16885. https://pubmed.ncbi.nlm.nih.gov/21364939/

[15] Evans, S. & Evans, M. (2021). *Gender Dysphoria: A Therapeutic Model for Working with Children, Adolescents and Young Adults.* Bicester, Oxfordshire, U.K.: Phoenix Press. https://www.amazon.com/Gender-Dysphoria-Therapeutic-Children-Adolescents/dp/1912691787

[16] Georgas, K., Beckman, U., Bryman, I., Elander, A., Jivegård, L., Mattelin, E., Olsen Ekerhult, T., Persson, J., Sandman, L., Selvaggi, G., Stadig, I., Vikberg Adania, U., Strandell, A. (2018). Gender affirmation surgery for gender dysphoria-effects and risks. [Könskonfirmerande kirurgi vid könsdysfori - effekter och risker]. Göteborg: Västra Götalandsregionen, Sahlgrenska University Hospital, HTA-centrum.Regional activity based HTA 2018:102. https://mellanarkiv-offentlig.vgregion.se/alfresco/s/archive/stream/public/v1/source/available/sofia/su4372-1728378332-373/native/2018_102%20Rapport%20Könsdysfori.pdf

[17] Handler, T., et al. (2019). Trends in referrals to a pediatric transgender clinic. *Pediatrics, 144(5*), e20191368. https://www.semanticscholar.org/paper/Trends-in-Referrals-to-a-Pediatric-Transgender-Handler-Hojilla/e20b61969f8e6602cde7f3982225efc960acb36d

[18] Haynes, L. (2022 and periodically updated). “Dear Legislator” Letter/Fact Sheet. TherapyEquality.org/HarmsOfTherapyBans.

[19] Haynes, L. (2021). International Federation for Therapeutic and Counselling Choice expert opinion on the constitutional meaning of “sex” and “gender”: Medical gender affirming treatment, Case no. 6 of 2021,

Bulgarian Constitutional and Casian Courts. https://d3uxejw946d7m5.cloudfront.net/wp-content/uploads/2021/07/IFTCC-Brief-for-Cassian-Constitutional-Courts-in-Bulgaria-on-Gender-2021-6-19-FINAL-Full-edits-English-Post-2021-7-2-.pdf?x28941

[20] Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., and 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*:4-6. https://doi.org/10.1186/s13034-015-0042-y

[21] Kozlowska, K. McClure, G., Chudleigh, C., Maguire, A., Gessler, D., Scher, S., Ambler, G. (2021). Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. *Human Systems: Therapy, Culture and Attachments, 1(1),* 70-95. https://journals.sagepub.com/doi/pdf/10.1177/26344041211010777

[22] Kuper, L., Stewart, S., Preston, S., Lau, M. & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. *Pediatrics, 145 (4),* e20193006, 1-9. https://pediatrics.aappublications.org/content/145/4/e20193006

[23] Lee, P.A., Nordenström, A., Houk, C.P., Ahmed, S.F., Auchus, R., Baratz, A., Dalke, K.B., Liao, L, Lin-Su, K., Looijenga, L.H.J., Mazur, T., Meyer-Bahlburg, H.F.L., Mouriquand, P., Quigley, C.A., Sandberg, D.E., Vilain, E., Witchel, S., & the Global DSD Update Consortium (2016). Consensus Statement: Global disorders of sex development update since 2006: Perceptions, approach and care. *Hormone Research in Pediatrics, 85*, 158–180. https://doi.org/10.1159/000442975

[24] Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior.* https://doi.org/10.1007/s10508-021-02163-w

[25] Lupron Depot-PED (August 2022 last updated). Highlights of Prescribing Information. https://www.rxabbvie.com/pdf/lupronpediatric.pdf

[26] National Academy of Medicine, France (Feb. 25, 2022). Medical Care of Children and Adolescents with Transgender Identity. UNOFFICIAL translation. https://segm.org/sites/default/files/English%20Translation_22.2.25-Communique-PCRA-19-Medecine-et-transidentite-genre.pdf

[27] National Board of Health and Welfare (NBHW) (2022). Care of children and adolescents with gender dysphoria: Summary. Official English translation. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf

[28] National Board of Health and Welfare (Sweden) (February 2, 2022). Updated recommendations for hormone therapy for gender dysphoria in young people. Press release. RushTranslate (June 27, 2022), Certified English translation, Louisville, Kentucky. https://iftcc.org/wp-content/uploads/2022/07/Swedish-Health-Service-February-2022-Policy-Statement-Translated-and-Notarized.pdf-from-Brooks.pdf

[29] National Institute for Health and Care Excellence (NICE) (Oct. 2020a). Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria. https://arms.nice.org.uk/resources/hub/1070871/attachment

[30] National Institute for Health and Care Excellence (NICE) (Oct. 2020b). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. https://www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3ffrom%3d2020-01-01%26q%3dgender%2bdysphoria%26sp%3don%26to%3d2021-03-3

[31] Olson, K., Durwood, L., Horton, R., Gallagher, N., & Devor, A. (2022). Gender identity 5 years after social transition. *Pediatarics*, special article. https://pubmed.ncbi.nlm.nih.gov/35505568/

[32] Olson-Kennedy, J., Warus, J., Okonta,V., Belzer, M. & Clark, L. (2018). Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. JAMA Pediatrics, 172(5), 431-436.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5875384/?report=printable

[33] Osborne, S. (April 23, 2022). Inquiry into gender treatment for children to be launched by [UK] Health Secretary Sajid Javid. *Sky News.* https://news.sky.com/story/inquiry-into-gender-treatment-for-children-to-be-launched-by-health-secretary-sajid-javid-12596675

[34] Quinn, V., Nash, R., Hunkeler, E., Conteras, R., Cromwell, L., Becerra-Culqui, T., Getahun, D., Giammattei, S., Lash, T., Millman, A., Robinson, B., Roblin, D., Silverberg, M., Slovis,J., Tangpricha, V., Tolsma, D., Valentine, C., Ward, K., Winer, S., Goodman, M. (2017). Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people. BMJ Open, e018121. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5770907/

[35] Ristori, J. & Steensma, T. (2016). Gender dysphoria in childhood. *International Review of Psychiatry, 28(1)*, 13-20. https://www.tandfonline.com/doi/full/10.3109/09540261.2015.1115754

[36] Singh D., Bradley S., and Zucker K. (2021) A Follow-Up Study of Boys with Gender Identity Disorder. *Frontiers in Psychiatry, 12*, 632784. https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full

[37] Society for Evidence Based Gender Medicine (SEGM) (Feb. 27, 2022). SEGM Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW), February 2022 update. https://www.segm.org/segm-summary-sweden-prioritizes-therapy-curbs-hormones-for-gender-dysphoric-youth

[38] Steensma, T., Biemond, R., de Boer, F., & Cohen-Kettenis, P. (2010). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry, 16(4)*, 499-516. https://pubmed.ncbi.nlm.nih.gov/21216800/

[39] Steensma, T., McGuire, J., Kreukels, B., Beekman, A., & Cohen-Kettenis, P. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry, 52(6)*, 582-590. https://pubmed.ncb

[40] Vandenbussche, E. (2021). Detransition-Related Needs and Support: A cross-sectional online survey. *Journal of Homosexuality*, online. https://www.tandfonline.com/doi/pdf/10.1080/00918369.2021.1919479?needAccess=true

[41] Wiepjes, C., den Heijer, M., Bremmer, M., Nota, N., de Blok, C., Coumou, B. & Steensma, T. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). *Acta Psychiatrica Scandinavica*, 1-3. https://pubmed.ncbi.nlm.nih.gov/32072611/

[42] Zucker, K. (2018). The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018). *International Journal of Transgenderism.* https://www.tandfonline.com/doi/abs/10.1080/15532739.2018.1468293

[43] Zucker, K. & Bradley, S. (1995). *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*. New York: The Guilford Press. See summary on pp. 262-264.