TRANSGENDER "TRANSITION" PROCEDURES PERFORMED ON MINORS
ANSWERS TO QUESTIONS AND INFORMATION FOR JOINT INTERIM COMMITTEE

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Part I - Evaluating the scope of the challenge

1. What is biological sex dysphoria?

Biological sex dysphoria is the feeling of discomfort or distress that might occur in people whose gender identity differs from their biological sex or sex-related physical characteristics.

"The medical diagnosis is gender dysphoria. A biological male feeling and believing himself to be a girl and the distress that accompanies these feelings and beliefs is an example of gender dysphoria (previously known as gender identity disorder).

There are billions of neurons that make the brain. Neurons are very specialized cells that transmit and store information. The control center, if you will, of every cell in the body is the nucleus, which contains DNA. The DNA is wound up into specialized units called chromosomes. There are 46 chromosomes in every human cell. Two of these are specialized chromosomes called sex chromosomes. Assuming normal development, females have two X chromosomes, and males have one X and one Y chromosome. These sex chromosomes are present in every cell in the body. They remain in the cells from conception until death and do not change." Michael K. Laidlaw, M.D.

Historically, biological sex dysphoria primarily affected a very small percentage of biologically male children who were first diagnosed at a very young age (generally, under the age of five). More recently, however, a growing number of pre-teen and early teen females (primarily) are experiencing what has come to be called Rapid Onset Gender Dysphoria (ROGD).

"In my clinical practice I find that social media, internet exposure to pornography, and childhood sexual abuse are often contributing factors to ROGD in my clients ages 10-13. For my client base, the "coming out" is linked to access to the internet or getting their own cell phone where when they google "feeling uncomfortable about your body" google will tell you all about gender dysphoria and being transgender. Other factors can include undiagnosed autistic spectrum and other learning disabilities causing social anxiety." Sheri Golden, Ph.D.

A distraction frequently raised in the context of this issue is the tiny percentage of people who suffer from disorders of sexual development (DSD), sometimes referred to as an intersex condition. Those in whom sexual anatomy is ambiguous or clearly conflicts with their chromosomal make-up are rare, estimated by one expert as "occurring in fewer than 2 out of every 10,000 live births." The vast majority of "transgender" individuals are not "intersexed."

Any proposed legislation would be carefully written and should not inhibit the normal and traditional treatment of these chromosomal birth defects.

2. How many Utah children experience biological sex dysphoria or Utah adolescents experience rapid onset gender dysphoria?

There are no medical records available that would show how many children see pediatricians because their parents express concerns about any gender confusion their child might be experiencing. Nor are there records that would show how many who do so are advised that that ambiguity in gender expression or feelings is fairly common in children, and that the wisest course is "watchful waiting" because the feelings will resolve themselves in most cases. Nor are there records that would show how many parents have concerns but never report those concerns to anyone. Even if records were available, it still would be particularly difficult to establish or estimate a number because a child's gender expression or emotional feelings about his or her biological gender are not fixed and can change over time.

Rapid onset gender dysphoria in teens is unquestionably a social phenomenon. Often driven by social media and the need to be noticed or to be "trendy," teens sometimes identify as a sexual or gender minority for a season. However, we have no research studies to follow how this changes over time. This very fluidity in identity is a fundamental feature of adolescence and illustrates the dangers of making life decisions based on what could well be a temporary enthrallment.

Reliable research on sexual or gender issues in children and adolescents – particularly in individual states like Utah – is essentially nonexistent. Further, identifying randomly selected subjects, employing reliable and reasonably accurate survey methodology, and following the research subjects over time would be extraordinarily difficult. In addition, for a number of reasons, an attempted survey of even a large sample of school-age children and adolescents could easily yield inaccurate or misleading results in either direction. Voluntary response rates would vary and likely would be considerably less than 100 percent even among the survey sample population, for reasons ranging from individual reluctance to parental objection.

We do know from other evidence (e.g. *Examining Health Outcomes for People Who Are Transgender*, 2019) that there has been an increase in adolescents reporting gender dysphoria of over 1,000 percent in the United States and 4,000 percent in Great Britain over the last decade. Another primary indicator is the number of gender clinics that have begun operation within the last five years. In Utah there has been a five-fold increase in the number of prescriptions for testosterone to girls under the age of 18 in the last five reporting years according to information in the Utah Controlled Substances Database. (As discussed further below, there is no medical reason to administer testosterone to girls; the only possible reason is for gender "transition.")

Evidently, an increasing number of physicians and mental health professionals believe there is money to be made by specializing in this area. New gender clinics are springing up almost overnight. For example, Planned Parenthood is now offering transgender services in the vast majority of its facilities, and has expanding its advertising from its traditional focus on abortion services to include "transgender" pharmaceutical and medical conversion therapies. This indicates that the problem affects a significant number of youth and is increasing.

3. How many Utah children and adolescents are undergoing various forms of "gender affirming" pharmaceutical or medical (surgical) conversion therapies?

Transgender "affirming" processes begin with social transition (changes in name, clothing, public presentation, etc.) and then progress to early pharmaceutical interventions – puberty blocking drugs – to stop normal adolescent development. The next transition phase is administering what are popularly called cross-sex hormones (boys receiving abnormally large doses of estrogen, or girls being injected with large doses of testosterone). The final phase is "sex reassignment" surgeries, in which healthy breasts are removed from females and healthy genitals from males, along with a variety of additional surgical procedures to construct artificial male or female genitalia to "reshape" the body to artificially resemble the body of an opposite-sex individual.

The unregulated nature of these experimental processes and the growing number of unregulated venues where these procedures are available make it impossible to know at what age, in what number, or to what degree gender conversion therapies are taking place in Utah.

a. Puberty blockers:

"Puberty blockers are gonadotropin releasing hormone agonists (GnRHa) which basically chemically castrate either sex at the level of the brain, thus suppressing ("blocking") the formation of either testosterone or estrogen. They are FDA approved for use in precocious (premature) puberty and for treatment of prostate cancer, both being disease states. They are not FDA approved for treatment of gender dysphoria, where their use in otherwise physically healthy minors is experimental, not proven safe, not proven effective, not proven to reduce suicides, and is something to which a minor does not have the competence to consent." Andre Van Mol, M.D.

There are proper medical and FDA-approved uses for puberty blockers with children in certain rare cases such as precocious puberty, idiopathic short stature, endometriosis, or sex hormone-stimulated cancers. (The most common puberty blockers are gonadotropin-releasing hormone agonists (GnRHa) such as Lupron.) The legislation being suggested includes express exceptions for all of the known medical conditions for which these drugs are proper FDA-approved treatment.

"By current protocol, children with gender dysphoria are given these powerful hormones at around age eleven. This is too young for them to understand the implications of what will happen to their minds and bodies. Time is required for maturity of the developing adolescent mind, and hormones play an important role in this development." Michael K. Laidlaw, M.D.

For children experiencing biological sex dysphoria (transgender feelings), there is nothing under current law restricting or limiting physicians, psychiatrists, licensed physician assistants, and even nurse practitioners from prescribing puberty blockers to stop the normal developmental process. Under current law, GnRHa and similar drugs are not controlled substances. There is no mandatory reporting system for prescriptions filled for these drugs.

b. Cross-sex hormones ("masculinizing" or "feminizing" drugs)

By "masculinizing" drugs, we understand the question to refer to administration of testosterone or other androgens to minor females. By "feminizing" drugs, we understand the question to refer to administration of estrogen or compounds with estrogenic effect to minor males.

The next step in "affirming" gender transition of minors for those who first took puberty blockers is the administration of cross-sex hormones. The male hormone testosterone is given to biological females who wish to present themselves as male, in order to give them more masculine physical characteristics (such as facial and body hair and deepening of the voice). The female hormone estrogen is given to biological males who wish to present themselves as female, in order to give them more feminine characteristics such as enlarged breasts. In effect, the cross-sex hormones are used to initiate an artificial partial puberty corresponding to the desired gender identity. In this situation, there may be pressure to start cross-sex hormones at even younger ages, so that the child does not remain in an artificial pre-pubescent state while his or her peers are continuing to develop more adult sexual characteristics.

"*There is no such thing as 'trans puberty.' What happens is that [an] abnormal, pathologic state . . . is induced*." Michael K. Laidlaw, M.D.

Testosterone is a Schedule III controlled substance. (Utah Code Ann. § 58-37-4(2)(c)(vi)(Z).) Consequently, every retail, institutional, and outpatient hospital pharmacy, and every in-state and out-of-state mail order pharmacy, is legally required to report every dispensing of this substance to the Utah Controlled Substance Database (CSD). (Utah Code Ann. § 58-37f-203(3).) The CSD is not accessible by the public. However, we understand from a former legislator who obtained the information from the CSD that more than 550 prescriptions for testosterone issued to minor females were filled in 2019, and that this number is more than a five-fold increase over 5 years before. There is no medical reason to prescribe testosterone to a female other than to facilitate gender "transition."

Estrogen is not a controlled substance, and there is no mandatory reporting system for prescriptions filled for estrogen. Therefore, the number of minor males for whom estrogen was prescribed to facilitate gender "transition" is unknown.

c. Sex reassignment surgeries

"Sex reassignment surgery" is a massive misrepresentation of what these operations actually do. You can't change a person's sex. All that is happening is that the patient is undergoing an intentional mutilation in order to create a counterfeit appearance of the other sex. Nearly 100% of children who are enrolled in "gender clinics" are pushed along from puberty blockers, to wrong sex hormones, to top surgery, and then to bottom surgery, because at each step, the hoped for resolution of their anxiety only finds temporary effect, so the next step is encouraged." Patrick Lappert, M.D.

There are a variety of medical procedures and surgeries that are undertaken in an attempt to make female bodies appear more male, and male bodies to appear more female. Healthy bodies are declared to be "wrong" and are treated as mere material to be mastered and reshaped. These range from the actual removal of healthy breasts and genitals to plastic surgery to construct a more masculine or feminine sounding or appearing body.

"Typically, surgery turning a male into a trans-female involves dissecting the penis, turning the skin inside out, and placing it into a surgically created cavity to create a false vagina. After surgery, a dilator has to be placed in this artificial vagina to keep it from collapsing. Since he still has a small child-sized penis (because of puberty blockers), he does not have enough skin to line the false vagina. Potential remedies include sewing in a section of intestine along with the penis skin to make the false vagina. Once he has surgery to remove his testicles he will be forever infertile, with no chance to produce biological offspring." Michael K. Laidlaw, M.D.

While we have no reporting requirements that would show how many of these various procedures are taking place in Utah, or the age of the patients on whom they are performed, the Internet is replete with the pictures and stories of minor children who have undergone these procedures.

4. How many Utah minors who begin treatment for biological sex dysphoria with puberty blocking drugs subsequently move on to cross-sex hormones and sex reassignment surgeries?

Transgender "affirming" advocates and clinics outline in their publications and websites a step-by-step process that begins with social transitioning, moves to drug and hormone treatment, and concludes with surgical procedures. If one accepts the worldview that an individual can be born as a male with a female brain or as a female with a male brain (*i.e.*, transgender is something you are and not just a dysphoria about biological sex that you experience), then advancing toward becoming your authentic self is the logical goal. Current research from Great

Britain and Sweden suggests that individuals who are socially affirmed in a new transgender identity and begin puberty blockers almost always proceed to cross-sex hormones and surgical transition.

The entire transgender affirming process is so new, so medically experimental, so irreversible in its effects, and so lacking in longitudinal (long term) research that much of the eventual consequences of this socially-driven phenomenon are completely unknown. That is precisely why it is so potentially harmful. Regardless of the number of Utah children affected, be it 5 or 50 or 500, every child and adolescent should be protected from these "adults only" procedures.

5. How are social awareness, population growth, and the evolving understanding of appropriate treatment for gender dysphoria likely to affect the estimates above?

Different parties have vastly different views on what constitutes "appropriate treatment for gender dysphoria." As a nation-wide (and world-wide) social phenomenon, public and even professional awareness is changing rapidly.

We believe the appropriate treatment for children and adolescents is competent and caring counseling by an adept mental health professional. Medical professionals in the United Kingdom, Finland, and most recently Sweden have declared that the permanent, irreversible chemical or surgical damage to the healthy bodies of minors cannot be justified as a wise or sensible approach to what is scientifically a mental health issue. We hope that this growing awareness and Utah's willingness to protect vulnerable children and adolescents will be the foundation for an "evolving understanding of appropriate treatment."

"As a family therapist for over 25 years, as well as educating on gender identity development for nearly 20 years, I have found that when children are confused about their gender, there are usually underlying factors that need to be addressed. Offering to change a child's body, instead of addressing his or her mind, completely ignores the underlying issues. Hormones and amputation of body parts are neither safe, nor effective solutions. However, individual and family therapy (talk therapy) have been shown to be effective with many of these children. Not only is this a safer option, but it addresses the deeper issues." Julie Hamilton, Ph.D., LMFT

Professional perception of what constitutes appropriate treatment for biological sex dysphoria depends primarily on the professional's "worldview" of the issue. Transgenderism is based on the idea that a person can be born into the "wrong body" (*i.e.*, that someone born male can have a "female brain," and vice versa). "Affirming" mental health professionals and physicians accept and advocate that position. Consequently, they favor drug, hormonal, and surgical interventions to try to re-fashion the body to align with internally-perceived gender. However, there is no scientific evidence for this underlying proposition. There is no evidence that there is anything different about a transgender female's brain or body from that of any other male. There is no evidence that there is anything different about a transgender male's brain or body from that of any other female. Persons experiencing biological sex dysphoria are having a

mental or emotional experience—albeit a very painful and difficult and often persistent one—which may arise from any of a number of causes or contributing factors particular to the individual.

It is for this reason that medical professionals are becoming more reluctant to undertake medical procedures on people whose bodies do not present medical issues. Mental health and medical professionals who do not accept transgenderism's underlying assumption—which is an ideological proposition, not a scientific fact or evidence-based scientific hypothesis—believe that these emotional challenges should be addressed through therapeutic counseling procedures.

Part II – Assessing the treatment options

1. **What are the short- and long-term potential benefits and harms of addressing gender dysphoria in minors with medical intervention?**

    a. Puberty blockers:

"Puberty blockers (GnRHa or PB) cause infertility (blocking sperm and egg development) as long as they are used, and their reversibility after discontinuation is not assured. If puberty blockers are followed by cross-sex hormones, sterility is assured. Puberty blockers inhibit and compromise bone density development precisely during life's greatest period of increase for such. This may lead to early osteoporosis. Genitalia are arrested in an underdeveloped stage and sexual dysfunction is also noted (for males: erectile, orgasmic and ejaculatory impairment; for females: a menopausal-like state is induced).

The Lupron package insert warns of mood swings, depression, suicidal ideation and attempts. Brain development milestones are hindered with unknown long-term effects, and the puberty time frame shared with peers is forever sacrificed. Numerous studies show that initiation of puberty blockers selects persistence of gender dysphoria over its natural desistance. Therefore, puberty blockers are not "buying time" or "pause buttons" to "wait and see," but are gateway drugs to cross sex hormones and possible gender reassignment surgery, along with all of their shortcomings.

Their use in otherwise physically healthy minors is experimental, not proven safe, and not proven effective. Thus ruled the United Kingdom's High Court in Bell v Tavistock (Dec 2020), which led to the NHS amending service specifications for Gender Identity Development Services for children and adolescents. Likewise, Sweden's famed Karolinska Hospital issued a similar policy change effective April 1, 2021. Puberty blockade will no longer be allowed for minors under 16, and only under court order (UK) or in a closely monitored clinical trial (Sweden) for those under 18." Andre Van Mol, M.D.

The legislation being suggested includes express exceptions for all of the known medical conditions for which these drugs are the proper FDA-approved treatment. The FDA has not approved use of puberty blockers for treatment of biological sex dysphoria. Use of GnRHa for this purpose is still highly experimental.

Current Utah law does nothing to protect children from physicians, physician assistants, or even nurse practitioners from prescribing these drugs, even though the medical practitioner may have little or no experience or specialty training in the physical or psychological consequences of prescribing these drugs, or knowledge of the current medical research.

Delaying puberty in a child who has confused or dysphoric feelings about his or her biological sex may bring a very temporary perception of relieved stress in delaying physical development that the child thinks he or she does not want, and with which the child is, in the immediate moment, uncomfortable. However, if the confused feelings don't actually represent reality—in other words, if a child with confused feelings has not actually been "born into the wrong body"—prescribing medications can only "mask" or distract from the exploration of underlying problems or sources of the confused feelings.

Transgender activists argue that use of puberty blockers is harmless. They say that their effects are fully reversible if a minor stops taking them. Making any such claims for experimental treatments about which there is little longitudinal medical research is speculative at best and irresponsible at worst. Notably, last year the United Kingdom's National Health Service (NHS) backed away from previous categorical statements that effects of puberty blockers are fully reversible; new NHS statements are much more cautious.

The biggest concern, however, is that in the overwhelming majority of cases, children who are socially transitioned and placed on puberty blockers progress to the next phase of "transition," that is, the administration of cross-sex hormones.

b. Cross-sex hormones

Cross-sex hormones – large doses of feminizing hormones (estrogen) given to biological boys places them at increased risk for blood clots, high triglycerides, cardiovascular disease, high blood pressure, and diabetes. Large doses of masculinizing hormones (testosterone) given to biological girls places them at increased risk for high red blood cells, high cholesterol, cardiovascular disease, high blood pressure, diabetes, and destabilization of certain psychiatric disorders.

The effect of administering cross-sex hormones after puberty blockers is permanent sterilization. A young person who has taken puberty blockers will have already prevented the development of the reproductive system to the point where viable sperm or eggs would be produced in the first place. Indeed, the medical disclosure forms patients or their parents are required to sign before these treatments can proceed emphasize this.

Individuals who have already undergone natural puberty will generally be rendered infertile, at least temporarily, by the administration of cross-sex hormones, which inhibit ovulation in biological females and the production of sperm in biological males. While claims that either puberty blockers or cross-sex hormones alone are "fully reversible" are questionable, the use of both amounts to what some have called "chemical castration."

c. Sex reassignment surgery

It is very important to understand the reality of attempted sex-change surgical procedures. For females, this involves mastectomies, hysterectomies, removal of the ovaries, chest and facial masculinization procedures, and construction of artificial male genitalia from other tissues. For males, attempted sex-change surgery involves orchiectomy (removal of the testes); reduction and reconstruction of the penis to form an artificial clitoris; construction of an artificial vagina and artificial vulva; breast augmentation surgery, and facial feminization procedures. These procedures are irreversible and cause permanent sterilization.

Life-long pharmaceutical treatment and very often repeated medical interventions will be necessary because of the extreme nature of these hormonal and surgical procedures.

"Elective mastectomy to masculinize a young woman's chest (sometimes as young as 13-year-old girls) is the intentional removal of normal tissue in hopes of satisfying a disordered subjective feeling. It cannot be equated to the removal of normal breast tissue in a girl with abnormally large breasts because this latter case is based upon the diagnosis of an orthopedic problem (neck, back, and shoulder pain limiting physical activity). There is an objective medical condition, and 3rd party payment requires reporting of the weights of the specimens in order to confirm the mechanical effects of the weight of the breast, and to distinguish this operation from a cosmetic procedure to make the girl look better. In the case of boys having breast tissue removed, here again we have an objective medical diagnosis of gynecomastia (breast glandular tissue in a boy is not normal).

In the case of transgender masculinization, the diagnosis is subjective, the diagnosis is made by the child, and the doctor has no way of confirming or refuting the diagnosis, and has no way of predicting if the child will benefit. There are no peer reviewed publications to support the procedure, only small studies, typically single center, with massive self-selection bias, and no long term follow up to show benefit. The best studies, which are longitudinal population based studies show that persons who have completed transition surgeries, when followed long term, have a 19-fold higher incidence of completed suicide.

Mastectomy is irreversible. All that can be offered to the ever growing population of females with transition regret is the construction of breast mounds. They will never be able to breast feed (so they have lost a human capacity) and in most cases will have lost erotic sensibility. They will always have large chest scars in most cases." Patrick Lappert, M.D.

Again, there is no medically defensible reason to cut off or mutilate healthy body parts or destroy healthy body functions in response to what is actually an emotional or mental health issue. None of these procedures address the underlying causes of the confused feelings for the individual involved. As with administration of cross-sex hormones, performing these procedures on a minor who does not have the maturity or judgment to make such life-long irreversible decisions for himself or herself is not justifiable.

In short, from a medical perspective, all of these procedures are only harmful and damaging.

The only arguable benefit from this damage is a perception of continued partial relief from distressed and conflicted feelings. How long such perceived relief lasts will vary according to the individual case because the underlying causes of the confused feelings will go unaddressed.

This is especially true for minors, who are at an age at which conflicted emotions on any number of issues are common, and for whom the emotional maturation and developmental processes are not complete. To permanently sterilize a minor at this stage of life, when the minor does not have the maturity and judgment to make the decision for himself or herself, is unjustifiable.

2. What are the short- and long-term potential benefits and harms of addressing gender dysphoria in minors with non-medical (counseling and support) interventions?

Children and adolescents experiencing either biological sex dysphoria or later-occurring rapid onset gender dysphoria are experiencing authentic confusion and distress. Ignoring these genuine symptoms of angst is risky and potentially dangerous. A process of acknowledgement, counseling, evaluation, and support directed by competent mental health professionals is the appropriate approach.

"In young children, for example, parents can be taught how to genuinely "affirm," i.e., learn to recognize their child's innate goodness and communicate their delight in his or her being. In time affirmation by others helps one to affirm oneself as one is, and as one has the potential to be(come). Family and parental therapy may be a tremendous help for enabling parents to affirm their child as s/he is now, even if s/he is discordant about his/her biological sex and how s/he would like to live as a gendered being. Fundamentally, parents can learn to unconditionally love their child." Philip Sutton, Ph.D.

Experiences of biological sex dysphoria in teens are taking place in a developmental season where incidents of childhood trauma, normal identity exploration, peer influence and various emotional conflicts or intellectual misunderstandings (to cite just a few examples) can effect an evolving sense of self. Understanding and evaluating these potential developmental factors requires both time and professional competence. There should be no rush to reach hypothetical and premature psychological conclusions, or to move toward experimental and

dangerous medical interventions which are clearly life-changing and irreversible.

"The research indicates that approximately 90% of dysphoric patients resolve dysphoria by their late 20s. Past peer reviewed research has shown that dysphoria in children can be resolved via psychotherapy, which indicates dysphoria is environmentally based. And yet…many medical doctors and therapists approve of and perform permanent removal of healthy body parts in order to supposedly relieve dysphoria. The research is already showing increased transgender treatment regret in some areas of the world. But the damage to their bodies is permanent in operative cases. Authentic and compassionate psychotherapy treatments must be adopted by our professions." David Pickup, LMFT

Since research clearly demonstrates that a very high percentage of children experiencing biological sex dysphoria will resolve their confusion in favor of their biological sex by the time they reach adulthood, surely a counseling approach makes more sense and does not foreclose "transition" opportunities for adults who eventually pursue a medical option.

3. How should potential harms and benefits be weighed in treatment decisions?

As a matter of general principle, of course, potential harms and benefits should be weighed in any treatment decision. But inherent in that is the imperative necessity of an accurate and truthful understanding, and honest and logical analysis, of the factors involved. In addition, we must consider the ability of children and adolescents to understand these potential harms and benefits and offer truly "informed consent".

"During the past decade, research on neurological maturity shows that the human brain is not finally "mature" until the mid-20's (25 is often given as the average.) It is simply not possible for pre-pubescent and pubescent girls and boys to truly understand the serious short and long-term (life-long) consequences of taking puberty blockers and cross-sex hormones. These boys and girls are simply humanly unable to understand the gravity of such decisions. This is even more true for the amputation of primary and secondary sexual organs. " Philip Sutton, Ph.D.

We must keep the following in mind:

There is no scientific or medical evidence to clearly establish any biological explanation for biological sex dysphoria. We are left to conclude that this is a very real emotional and psychological condition. This is a mental health, not a medical, condition.

Experimental, life-altering pharmaceutical and surgical procedures are a decision to artificially alter the body to meet a mental image the individual may have of himself or herself and to regulate challenging emotions. This process will require life-long medical treatments to force the natural body to accept these synthetically-imposed alterations.

Both a decision to go forward with or to postpone medical "transition" may have emotional consequences. The difference is that children and adolescents who postpone medical interventions and pursue the family and mental health counseling route can always pursue medical interventions as adults should they choose to do so for themselves. Children and adolescents who are permitted by adults to pursue medical transition can never "un-ring the bell." They can never really undo the damage to their body that these procedures will do.

Sadly, parents are sometimes misinformed about the long-term consequences to their children of medical interventions, or receive inadequate support from mental health professionals to assist their children while they pursue a "supportive counseling" approach.

Sometimes parents are misled into believing that a failure to support childhood biological sex transition processes will lead to an increased suicide risk for those they love. They need to know that there is no reliable research to support the idea that these medical transition procedures prevent suicide. While there may be some evidence that biological sex dysphoria increases distress in certain individuals, there is absolutely no research that demonstrates that children who follow a counseling process for their dysphoria are any more suicidal than those who follow a medical transition process. Experts agree that suicide is most likely to be associated with some form of ongoing mental illness.

"Ninety percent of suicides are associated with a psychiatric condition. The risk of suicide coincides of course with the high prevalence of mental illness in this group of people. Depression, for example, is present in at least 50 percent of those who commit suicides." Michael K. Laidlaw, MD

In fact

"Using quotes from the following studies done through NIH/NCBI to answer these concerns.

*'Approximately 58% of transgender patients had at least one DSM-5 diagnosis, most frequently Major Depressive Disorder. (13.6% cisgender) * NIH/NCBI November 2020.' Clearly this is a population at risk and in need of therapeutic counseling and perhaps medication to address these illnesses. Any type of medical transitioning will complicate diagnostic evaluation and treatment. Therefore, rather than reducing suicide risk, medical procedures involving hormone therapy and surgery have the potential to increase the risk because of missed diagnosis and complications of medications.*

*It seems that transitioning in and of itself is does not remove the risk of suicide in this population. As found in the study from *NIH/NCBI June 2020, "Suicide risk in transgender people is higher than in the general population and seems to occur during every stage of transitioning." Therefore the act of transitioning does not prevent the risk of suicide."* Steven Johnson, Ph.D. and Dale Johnson, M.S.

4. **To what extent have long-term outcomes, including physical health, mental health, satisfaction, and regret, been tracked in individuals receiving various treatments for gender dysphoria? What do those studies indicate?**

Again, the entire transgender "affirming" process is so new, so medically experimental, so irreversible in its effects, and lacking in longitudinal (long term) research that much of the eventual consequences of this socially driven phenomenon are completely unknown. That is precisely why it is so potentially harmful and exactly why we should not be preforming these irreversible pharmaceutical and medical conversion therapies on minors.

Part III – Clinical Guidelines

1. **Are the guidelines published by the World Professional Association for Transgender Health and the Endocrine Society and other published information adequate to guide professionals in their care of minors experiencing biological sex dysphoria?**

Twelve years ago a review of more than 100 international medical studies of post-operative transgender patients by the University of Birmingham Aggressive Research Intelligence Facility found "no robust scientific evidence that gender reassignment surgery is clinically effective . . . Research from the US and Holland suggests that up to a fifth of patients regret changing sex."

In regards to children and adolescents there are almost no scientific outcome studies whatsoever.

We must again return to the concern that there has been too little longitudinal research for scientifically-minded organizations to offer authoritative guidelines for either medical or mental health professionals. For example, even when small studies have been conducted, the results are often based on a minority of the participants because, as *The Guardian* newspaper in Great Britain reported, "The results of many gender reassignment studies are unsound because researchers lost track of more than half of the participants. For example, in a five-year study of 727 post-operative transsexuals published, 495 people dropped out for unknown reasons."

Additionally, how do you set medical guidelines without understanding the many psychological conditions that may be affecting the emotional stability of the client? According to one study (*Psychiatric Axis I Comorbidities among Patients with Gender Dysphoria*, 2014) Fifty-seven (62.7%) patients had at least one psychiatric comorbidity. Major depressive disorder (33.7%), specific phobia (20.5%), and adjustment disorder (15.7%) were the three most prevalent disorders. Consistent with most of earlier research, the majority of patients with gender dysphoria had psychiatric Axis I comorbidity.

The Endocrine Society Guidelines published in 2017 advocated for "watchful waiting" as the standard of care for gender dysphoria. The Society noted, "In some forms of Gender dysphoria/ gender incongruence, psychological interventions may be useful and sufficient."

Taking a conservative approach to treatment is justified because, as Professor Kenneth Zucker (of the Toronto Gender Clinic) notes, ". . . the field suffers from a vexing problem: There are no randomized controlled trials of different approaches, so the front-line clinician has to rely on lower-order levels of evidence in deciding on what optimal approach to treatment might be."

The so called "World Professional Association for Transgender Health," or WPATH, is simply a self-selected group individuals who are a political advocacy organization for "affirming" transgender procedures. WPATH is not a scientific or medical organization, and its membership is not restricted to medical or mental health professionals and scientists. No national government or international legal body officially appointed or recognizes WPATH. Nor is it accountable to any recognized body of scientists or medical researchers.

WPATH's views are by no means accepted objective standards, as demonstrated by the policies of the national medical associations in the United Kingdom, Sweden and Norway who oppose pharmaceutical and surgical procedures for children or young adolescents.

In simple terms, organizations who refuse to acknowledge the following concept have a divergent "worldview" that cannot be reconciled with those of us who do:

"Sex as defined by biology and reproductive function cannot be changed. While hormonal and surgical procedures may enable some individuals to "pass" as the opposite gender during some or all of their lives, such procedures carry with them physical, psychological, and social risks, and no procedures can enable an individual to perform the reproductive role of the opposite sex." Stephen B. Levine, M.D.

Part IV – Utah policy

1. **Should any particular treatments for gender dysphoria be limited to adults and emancipated minors? Why or why not?**

For reasons discussed above, cross-sex hormone treatments and surgical interventions for purposes of "transition" or attempted sex change should be limited to adults who have the maturity and judgment (and legal capacity) to make these decisions for themselves. As Stephen B. Levine, M.D. noted in his article published in the Journal of Sex & Marital Therapy, *Informed Consent for Transgendered Patients:*

> All of these patients should be helped by their clinicians to grapple with four relevant questions. Their answers provide the professional with a judgment about how realistic the patient is being:
> 1. What benefits do you expect that the consolidation of this identity, gender transition, hormones, or surgery will provide?

2. What do you understand of the social, educational, vocational, and psychological risks of this identity consolidation and gender role transition?
3. What do you understand about the common and rare, short- and long-term medical and health risks of hormone and surgical interventions?
4. What have you considered the nature of your life will be in 10 to 20 years?

Clearly children and adolescents cannot provide informed consent. The suggested legislation would apply only to procedures performed on minors. Adults are free to choose to undertake these procedures on their own bodies, regardless of whether other individuals personally would agree with that choice.

2. is there statutory, regulatory, or case law you believe the committee should be particularly mindful of?

Yes. In 2019, the Legislature enacted a law prohibiting female genital mutilation on minors (HB 430, Chapter 398 of the 2019 General Session). It was aimed at the practice of genital mutilation of young girls followed in some African Muslim cultures that has found its way to the United States.

Utah Code Ann. § 76-5-701(1) defines "female genital mutilation" comprehensively and with great specificity. Under paragraph (f), it includes "any other actions intended to alter the structure or function of the female genitalia for non-medical reasons." Female-to-male "bottom surgery" certainly alters the structure and function of female genitalia, in addition to involving specific procedures identified in some of the preceding paragraphs of that subsection. Subsection (2) provides that female genital mutilation is child abuse for mandatory reporting purposes under § 62A-4a-403.

Section 76-5-702(1) then makes performing a female genital mutilation on a minor female, giving permission for such a procedure on a minor female, or removing or facilitating the removal of a minor female from the state for the purpose of facilitating such a procedure a second degree felony. Subsection (2) provides that it is not a defense that the practice is required as a matter of religion or custom or that the girl's parent or guardian consented to it. Subsection (3) then provides that a surgical procedure is not a violation of the section defining female genital mutilation if it is necessary for medical reasons or if it is "requested for sex reassignment surgery by the person on whom it is performed."

Under subsection (4), a medical professional who is convicted of a violation will have his or her license revoked. Additionally, section 76-5-704 creates a civil right of action by the victim of female genital mutilation for damages.

Given that these sections apply only to procedures performed on minors, it appears that mutilating a minor girl's genitals as part of surgical "transition" (or consenting to or facilitating

such a procedure for that purpose) is exempt from the criminal sanctions as long as the minor girl requests the procedure.

The exception for sex reassignment surgery was in the bill as originally introduced. We have not been able to find any relevant legislative history regarding that exception. Given the apparent absence of discussion on the issue, it may be that the sponsors were looking at the "sex reassignment surgery" exception as a way to address the rare true "intersex" birth situation for which surgery may be medically appropriate. Or (without any offense to the sponsors or drafters intended) it could be that the provision was not well thought-through in the context of the bill's exclusive application to minors.

As a matter of public policy, it is difficult to understand why performing these procedures, or a parent's consenting to these procedures, is criminalized if it is for reasons of religious conviction, but it's OK if the minor girl is emotionally confused or delusional at the moment.

The version of the suggested legislation considered in the general session earlier this year would not have criminalized performing attempted sex-change surgery on a minor female (assuming the parents consented), but would have defined performing such procedures on a minor as unprofessional conduct that could lead to revoking the medical license of the surgeon performing the procedure. If a measure such as the suggested legislation is enacted, the exemption from criminal prosecution in section 76-5-702(3) could remain unchanged. However, to avoid ambiguity, the legislation should provide specifically for the possibility of professional discipline notwithstanding the exemption from criminal sanction. It should also provide that the private right of action in section 76-5-704 applies and that parental consent is not a defense to a private right of action.

We express appreciation to these noted professionals who contributed to this report:

Chauncey Adams, Ph.D. - Dr. Adams is a Clinical Psychologist with more than thirty years' experience in private practice, served as a psychology consultant in the Washington County school district, and as a the Behavioral Medicine Clinical Director, and former Chair of the Psychiatry Department at the IHC St. George Regional Medical Center. He is a graduate of Brigham Young University, a Member of the American Psychological Association, and a past Board Member of the Utah Psychological Association

Shirley E. Cox, D.S.W. – Dr. Cox has spent many years in private practice and 27 years as a social work educator at Weber State, University of Nevada, Las Vegas, and Brigham Young University. She has received numerous awards for her teaching and community practice including: the Liberal Arts

Outstanding Faculty Award, the Morris Committee on Excellence in Teaching Award, the NASW Nevada Chapter Social Worker of the Year. Her individual and jointly authored publications appear in outlets such as: The Journal of International Social Work and the Journal of Social Work Education.

Michelle Cretella, M.D. - Dr. Cretella received her medical degree from the University of Connecticut School of Medicine and she completed her internship and residency in pediatrics at the Connecticut Children's Medical Center. She practiced pediatrics with a special interest in behavioral health for 15 years and now serves as the Executive Director of the American College of Pediatricians (ACPeds). Dr. Cretella is a peer reviewer for the Journal of American Physicians and Surgeons, Issues in Law and Medicine, and the International Journal of Behavioural and Healthcare Research.

Sheri L. Golden, Ph.D. – Dr. Golden holds a PhD in Counselor Education and Supervision, and an MS in Human Services and Mental Health Counseling, with a specialization in Human Sexuality, from Capella University. Dr. Golden practices as a licensed professional counselor at Steeple Counseling LLC, and is the Director of Counselor Education at The Steeple Institute.

Julie Harren Hamilton, Ph.D. - Dr. Hamilton is a licensed marriage and family therapist with a private practice in south Florida. A graduate of Nova Southeastern University, she is a former Assistant Professor of Psychology in the Graduate Counseling Psychology Department of Palm Beach Atlantic University. She is a former president of the Palm Beach Association for Marriage and Family Therapy.

Geoffrey Heath, J.D., LL.M. – Mr. Heath graduated from the University of Utah, the University of Michigan Law School, and received an LL.M. degree from George Washington University. He is a former supervisory attorney and administrative judge of an Executive department of the Federal government.

Paul W. Hruz, M.D., Ph.D. – Dr. Hruz is an associate professor of pediatrics, endocrinology, and diabetes and an associate professor of cell biology and physiology at Washington University School of Medicine in St. Louis. A graduate of Marquette University, he received both his Ph.D. and his M.D. from the Medical College of Wisconsin.

Dale Johnson, M.S. - Received her undergraduate degree at Salisbury University and received a Master's degree in counseling from Johns Hopkins University. She worked for many years as a school counselor and served as the Department Chair for a staff of 15 where they served over 2000 "high risk" high schools students annually. Dale now acts as a Court Appointed Special Advocate.

Steve Johnson, Ph.D. – Dr. Johnson received his M.A. from the University of Nebraska at Omaha and his Ph.D. at the University of Illinois (dissertation on cognitive dissonance). He is a member of the National Register of Health Service Providers in Psychology and was in private practice in clinical psychology for almost 40 years. During those same years he served as a school psychologist specializing in emotionally and behaviorally disrupted adolescents, conducted cognitive and personality testing, parent and staff training and therapeutic groups. He has taught at George Mason and Western Maryland Universities.

Patrick Lappert, M.D. – Dr. Lappert has been practicing in the field of Plastic Surgery for over 25 years. He completed his undergraduate studies in Biology at the University of California, Santa Barbara, his medical degree at the Uniformed Services University School of Medicine and his general surgery residency at the Naval Hospital Oakland, and is Board Certified in General Surgery. Dr. Lappert completed his Plastic Surgery Residency at the University of Tennessee-Memphis and is Board Certified

by the American Board of Plastic Surgery. He was the former Chief of Plastic Surgery at the largest military hospital in the world (Naval Hospital Portsmouth, VA).

Michael K. Laidlaw, M.D. – Dr. Laidlaw is a board-certified physician in private practice for almost two decades specializing in Endocrinology, Diabetes, and Metabolism. He is a graduate of the University of Southern California School of Medicine, and is a member of the Endocrine Society and the National Board of Physicians and Surgeons.

Stephen B. Levine, M.D. – Dr. Levine earned his M.D. from Case Western Reserve University School of Medicine in and serves as a Clinical Professor of Psychiatry there. His clinical practice is with the University Hospitals of Cleveland Sexual Dysfunction Clinic (presently called The Center for Marital and Sexual Health). He received the Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research and is a Distinguished Life Fellow of the American Psychiatric Association.

Paul McHugh, M.D. – Dr. McHugh is a psychiatrist, researcher, educator and currently the University Distinguished Service Professor of Psychiatry at the Johns Hopkins University School of Medicine and the author, co-author, or editor of seven books in his field. He graduated from Harvard College and Harvard Medical School. He served as the Chairman of the Department of Psychiatry at the University of Oregon and as the Henry Phipps Professor of Psychiatry and the director of the Department of Psychiatry and Behavioral Science at the Johns Hopkins University. At the same time, he was psychiatrist-in-chief at the Johns Hopkins Hospital.

David H. Pickup, L.M.F.T. – Mr. Pickup holds a Master's Degree in Psychology and is a Doctoral Candidate in Psychology at California Southern University. He is a member of the American Psychological Association and the California Association of Marriage and Family Therapists and is in private practice with offices in California and Texas. He regularly speaks at regional, national, and international conferences on subjects related to human sexuality.

David Clarke Pruden, Sr., M.S. – Mr. Pruden graduated from the University of Utah and Utah State University in Family and Human Development. He is currently the Managing Editor of the Journal of Human Sexuality and an author and speaker on adolescent resilience and sexuality. He was a former adjunct faculty member at USU and Provo College and in his long career served as the Executive Director of the Utah Republican Party and the Director of the Utah Newspaper Association.

Philip M. Sutton, Ph.D. – Dr. Sutton is a licensed psychologist in Michigan, and a licensed marriage and family therapist and clinical social worker in Indiana. He earned his Master of Science in the clinical psychology program and Ph.D. in the marriage and family therapy program at Purdue University and earned a BA in philosophy at the University of Notre Dame. He has been in practice as a clinical psychologist for more than thirty years.

Andre Van Mol, M.D. – Dr. Van Mol is a board-certified family physician with more than 20 years in private practice and is the co-chair of the American College of Pediatrician's Committee on Adolescent Sexuality. His education included the University of Southern California, the Medical College of Wisconsin, Charleston Naval Hospital, and the Naval Aerospace Medical Institute. He is a diplomate of the American Board of Family Practice.

Quentin Van Meter, M.D. – Dr. Van Meter graduated from the College of William and Mary, the Medical College of Virginia and completed his pediatric endocrinology fellowship at Johns Hopkins Hospital. After a 20-year career in the Navy Medical Corps he developed his own full-time private practice. He is an adjunct associate professor of Pediatrics at Emory University School of Medicine and an Associate Clinical Professor of Pediatrics at Morehouse Schools of Medicine.

Addendum A – Detransition Statements

Below is just a small sampling of stories among hundreds of examples you will find on the Internet. For example, go to YouTube and search "detransition" to listen to the many individuals speaking very candidly about their transition stories. To understand the scope of this growing problem, then consider the many more individuals who are too humiliated or traumatized to share their stories, or who just want to move on.

No matter where you are, there are aspects that are dangerous and terrifying about being a woman. And if we don't change that now, then we are just going to continue on this path of changing women and losing women to wanting to be a man because they cannot possibly survive in this society.

Pushing a person like myself in that direction and encouraging that person to take medical steps, I think was a very dangerous thing. Um, I was not told about much of the long-term effects from my therapist. After almost five years on testosterone, I started to experience liver and kidney failure. However, I was not prepared or told even that kidney and liver damage could be related to cross-sex hormones.

I felt like all these success stories were out there this whole time and why was I not doing it right? Why was everything out of control? Why was I not fixed? And when I was reading the stories of these detransition women, I realized it's because transitioning can't fix you.

Rachel Foster - See full interview at: https://youtu.be/w8taOdnXD6o

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I was about 17 when I had the word for transgender. I felt different before that but I didn't have like a particular word for it and I took intro to psych in high school and, you know, during that time, as a teenager, obviously, everybody goes through like changes and doesn't quite understand themselves. And I happened to be also autistic… A thing about autism is that, um, at least for high functioning, autism will tend to have like obsessions. So when they get into something it's like really into something, um, and they'll do all sorts of like research and, and it can like really, and they convince themselves also. And so I convinced myself that, uh, that I was absolutely trans, like that's what I needed to do…

I started seeing a gender therapist specifically because I'm really, um, resourceful with the internet. And so all I did was like Google gender therapist in Calgary and that was how that happened. After like three sessions I got my, um, permission slip or whatever for transitioning, medically for hormones. And so I started in 2013 on testosterone and it wasn't until 2015 or 2016, actually that I had any surgery. I had a top surgery and unfortunately I had a hysterectomy and oophorectomy, so, uh, I can't have babies. Top surgery I did in May of 2016 and the hysterectomy and oophorectomy I did in 2017. I ended up going through with it and, you know, really regretting it.

I think that up until recently there, haven't been like a lot of detransitoners speaking out, and I think it's important for the trans community, for people considering transitioning and for people who have like doubts in their minds who have already transitioned to hear our stories…

Ashira – See full Interview at: https://youtu.be/i0EFPv1_jdI

My first feelings of doubt. I can't really pinpoint the first thought that I ever had, but it was after my transition had finished. And that was when I changed all of my legal documents. And I felt like I could breathe after that, like I was done, let's live my life the way it was supposed to for the first time. And it was, there was a strong sense of relief in the, in the immediate, you know, and after four years of effort. I started having real doubts was in April of 2019 around my 21st birthday…

I've already done everything that I set out to do. And yet I still feel this dissonance and the dissonance was actually more apparent than the dissonance that I felt before my initial transition. And that was deeply, deeply concerning to me because transition is supposed to correct that initial dissonance. I hated my body now…

And when my voice started to change, I was elated when I got top surgery, I was elated. And so naturally because I was elated after each step, I thought, you know, this meant that I was going in the right direction. But when it was finished, I was left, incomplete, broken. I was suicidal. I couldn't even say the words. I regret my transition. I couldn't bear to hear myself say it. It was the, it was the unthinkable. It was my greatest nightmare.

Daisy – See full video at: https://youtu.be/R_KD46_Ophg

When I was 16 in high school, I thought that I might be a trans man so socially I transitioned about a year. And then when I was 17, I went on to a hormone replacement therapy and I was on that until I was 19. And then I got off of it and I detransitioned fully.

The therapist and the medical staff without being presented enough risks… like if they're not aware of a lot of detransitioners out there and the possibility of detransitioning, then they're going to just be like, oh, well, this person just has gender dysphoria so it's just allowed them to go and fully transitioned. If you've been on hormone replacement therapy you're going through your third puberty and that's kind of traumatic. It's very intense.

Willow – See full video at: https://youtu.be/d-z4H4NvGjw

Billy Burleigh took cross-sex hormones and getting surgeries to change his outward appearance after a difficult childhood and being sexually assaulted by his swim coach. He did his best to live as a woman but ultimately the truth of his biology won out. Billy hopes that by sharing his story, he will help others avoid the damaging and expensive procedures he endured.
https://youtu.be/55IR8taw2Ig

Sydney Wright started cross-sex hormones shortly after she turned 18 and almost died from the effects of testosterone. As she matured she realized she wanted to transition as a result of childhood trauma and internalized homophobia.
https://vimeo.com/481533780

Hacsi Horvath had a traumatic childhood and in a deep depression grabbed hold of the idea that he was actually a woman as a way to start a new life. After years on cross-sex hormones and genital mutilating surgery, he realized it was a mistake.
https://youtu.be/qbCX8XgvBMI

Laura Perry detransitioned after being on cross-sex hormones and having her breasts removed. She has spoken out widely about the harms of the gender industry.
https://www.youtube.com/watch?v=ucdLlJi8j50