**2023 HOUSE HUMAN SERVICES**

**HB 1301**

# 2023 HOUSE STANDING COMMITTEE MINUTES

**Human Services Committee**
Pioneer Room, State Capitol

HB 1301
1/24/2023

Relating to prohibiting medical gender transitioning procedures on a minor; to provide a penalty; and to declare an emergency.

Chairman Weisz called the meeting to order at 6:16 PM.

Chairman Robin Weisz, Vice Chairman Matthew Ruby, Reps. Karen A. Anderson, Mike Beltz, Clayton Fegley, Kathy Frelich, Dawson Holle, Dwight Kiefert, Carrie McLeod, Todd Porter, Brandon Prichard, Karen M. Rohr, Jayme Davis, and Gretchen Dobervich. All present.

**Discussion Topics:**

- Sister bill to HB 1254
- Civil code
- Impact of bill on state healthcare providers

Rep. Prichard introduced HB 1301 with supportive testimony (#16197).

Danial Sturgill, PhD Psychology, testified in opposition to HB 1301, testimony (#16237).

**Additional written testimony:**

(#14808), (#14855), (#14864), (#14876), (#14901), (#14920), (#14939), (#14951), (#15000), (#15008), (#15054), (#15058), (#15084), (#15118), (#15238), (#15240), (#15263), (#15351), (#15361), (#15362), (#15414), (#15477), (#15567), (#15621), (#15682), (#15762), (#15763), (#15771), (#15781), (#15784), (#15797), (#15803), (#15805), (#15808), (#15815), (#15862), (#15863), (#15865), (#15888), (#15913), (#15914), (#15921), (#15946), (#15956), (#15962), (#15967), (#15968), (#15979), (#15990), (#15994), (#16048), (#16058), (#16064), (#16071), (#16079), (#16085), (#16086), (#16106), (#16116), (#16167), (#16179), (#16196), (#16218), (#16222), (#16225), (#16281), (#16287), (#16288), (#16295), (#16298), (#16307), (#16319), (#16320), (#16321), (#16322), (#16323), (#16326), (#16329), (#16331), (#16337), (#16340), (#16346), (#16350), (#16352), (#16353), (#16359), (#16362), (#16365), (#16368), (#16377), (#16382), (#16446)

Chairman Weisz adjourned the meeting at 6:24 PM.

*Phillip Jacobs, Committee Clerk*

# 2023 HOUSE STANDING COMMITTEE MINUTES

**Human Services Committee**
Pioneer Room, State Capitol

HB 1301
2/15/2023

Relating to prohibiting medical gender transitioning procedures on a minor; to provide a penalty; and to declare an emergency.

Chairman Weisz called the meeting to order at 11:19 AM.

Chairman Robin Weisz, Vice Chairman Matthew Ruby, Reps. Karen A. Anderson, Mike Beltz, Clayton Fegley, Kathy Frelich, Dawson Holle, Dwight Kiefert, Carrie McLeod, Todd Porter, Brandon Prichard, Karen M. Rohr, Jayme Davis, and Gretchen Dobervich. All present.

**Discussion Topics:**

- Committee work
- Civil torts

Representative Prichard moved a DO PASS on HB 1301.

Seconded by Representative Holle.

Roll Call Vote:

| Representatives | Vote |
|---|---|
| Representative Robin Weisz | N |
| Representative Matthew Ruby | Y |
| Representative Karen A. Anderson | Y |
| Representative Mike Beltz | N |
| Representative Jayme Davis | N |
| Representative Gretchen Dobervich | N |
| Representative Clayton Fegley | N |
| Representative Kathy Frelich | Y |
| Representative Dawson Holle | Y |
| Representative Dwight Kiefert | Y |
| Representative Carrie McLeod | Y |
| Representative Todd Porter | N |
| Representative Brandon Prichard | Y |
| Representative Karen M. Rohr | Y |

Motion carries: 8-6-0.

Bill carrier: Representative Prichard.

Chairman Weisz adjourned the meeting at 11:35 AM.

*Phillip Jacobs, Committee Clerk By: Leah Kuball*

**REPORT OF STANDING COMMITTEE**

**HB 1301: Human Services Committee (Rep. Weisz, Chairman)** recommends **DO PASS** (8 YEAS, 6 NAYS, 0 ABSENT AND NOT VOTING). HB 1301 was placed on the Eleventh order on the calendar.

**TESTIMONY**

**HB 1301**

January 20, 2023

Regarding House Bill 1301

Dear House Members,

My testimony is in opposition to HB 1301. I ask that you give this bill a **DO NOT PASS.**

The reason for my opposition to this bill includes:

1) As a pediatric endocrinologist, this bill will impact the care of my patients. Prohibiting the appropriate medical care for my patients with gender dysphoria would go against my most important oath. The Hippocratic Oath I swore to includes **DO NO HARM**. Not providing the necessary medical treatment to my patients will put them at risk for self-harm and suicide.

2) There are many medical treatments that patients and parents seek that like hormone treatment for gender dysphoria, have irreversible effects.

    a. Patients born with dwarfism will often undergo permanent limb lengthening surgical treatments that will permanently alter their appearance. This is cosmetic, not medical. It is to alleviate the distress they feel about being short and for a condition that they genetically inherited and is part of their DNA

    b. Patients who are short and are treated with growth hormone therapy to become permanently taller. This treatment also goes against their genetic predisposition based on part of their DNA.

    c. Patients who are born with ambiguous genitalia due to genetic conditions will often undergo genital surgery to repair a genetic condition that they were born with.

All of these conditions are done to alleviate a distress about personal appearance and not for a medical reason other than the psychological effects of their inherited or genetic traits. Yet, somehow patients who are born with the wrong genetic code that does not match their gender identity may be denied the same rights simply because lawmakers and other feels they should not have the right to decide for themselves what is right for them.

Treatment for gender dysphoria that includes pubertal hormone blockers, hormone affirmation treatments and surgery is only done in conjunction with their behavioral health team, based on standards of care and with the consent of the patient and parents.

In North Dakota, a child or teen can get a permanent and disfiguring tattoo as long as they have the parent's consent. Yet with parental consent, the same adolescent is not given the same rights to alter their physical appearance to conform to their gender identity.

3) Patients with gender dysphoria will seek treatment whether it is in North Dakota or in another state. Banning these treatments will only assure that many families will be displaced and leave North Dakota knowing that the place they called home, rejected them and did not support them. I can tell you that there are many adolescents and young adults with gender dysphoria that are children of physicians, lawyers, business owners, working in our government, in our churches and in many industry in the state of North Dakota. Are you willing to lose this talent and distract other potential talent from coming to the State of North Dakota because of these bigoted laws?

4) As one of only two pediatric endocrinologist in the state, gender affirmation treatment is part of my practice and something that nearly every pediatric endocrinologist in the country treats because it is the right thing to do for these patients. There is a national shortage of pediatric endocrinologist in the country who care for children with diabetes, thyroid disorders, endocrine tumors, growth concerns and other endocrine things. The state of North Dakota cannot afford to lose medical providers who seek to work in states that provide them with the ability to care for their patients in the manner we were trained to do and not how lawmakers feel we should practice.

Thank you for your time, consideration and service to our state.

HB 1301

Medical procedures should be between the patient, their doctor and their parents if the patient is a minor. The state should not be involved in medical decisions. This legislation is discriminatory against individuals that are trying to be who their spirit calls them to be.

*Members of the House Human Services Committee,*

*My name is Seth Flamm and I reside in District 27. I am asking that you please render a DO PASS on House Bill 1301*

*The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance. This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones. Pediatric medicine has been hijacked by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.*

*Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.*

Seth Flamm

*Members of the House Human Services Committee,*

*"My name is Patricia Burckhard and I reside in District 15. I am asking that you please render a DO PASS on House Bill 1254."*
*The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance. This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones. Pediatric medicine has been hijacked by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.*
*Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.*

Patricia Burckhard

**WRITTEN TESTIMONY IN OPPOSITION TO HB 1301**

House Human Services Committee on House Bill 1301

Date of Hearing: January 24, 2023 2:45 p.m.

Debra L. Hoffarth, 1320 11th Street SW, Minot, ND 58701

This written testimony is presented in opposition to HB 1301, which is an overreach into the private medical decisions of North Dakota residents.

Doctors and their patients should be allowed to make medical decisions without the interference of the government. The care and treatment of transgender children should be left to the informed decisions between the parents and their doctor, who know the child best. There is no room for the North Dakota Legislature's involvement in those decisions.

Doctors are in the best position to determine if treatment is medically necessary, not the North Dakota Legislature.

Creation of a private remedy, with the extensive statute of limitations and excessive fines are unprecedented. The proposed legislation also creates litigation within the family system and potentially sowing discord, including between parents of the minor child. It allows litigation for a parent's damages caused by gender-affirming care of a minor child. The only harm involved in this proposed legislation is the prohibition of providing gender-affirming care to the child in need.

The public right of action to have a doctor investigated and fined is an egregious abuse of power by the Legislature. There is no public interest in the medical care of a transgender individual and their private medical information should never be compromised or shared in the public sphere.

Provision of gender-affirming care is central to improving the health and well-being of transgender individuals.[1] It saves lives. Transgender children need access to appropriate medical care. All people within the State of North Dakota deserve dignity and respect when seeking needed medical treatment.

Please oppose HB1301.

Debra L. Hoffarth
1320 11th Street SW
Minot, ND 58701

[1] Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth, Journal of Adolescent Health, Volume 70, Issue 4 (April 1, 2022).

**WRITTEN TESTIMONY IN OPPOSITION TO HB 1301**

Date of Hearing: January 24, 2023

Denise Ann Dykeman 1840 12th Street SW, Minot, ND 58701

My name is Denise Ann Dykeman. I am a parent, a lawyer, and a Lutheran. I am happy to have family members and friends who are transgender adults and kids – some of the most wonderful and brave people I could ever be blessed to encounter. This written testimony is presented in opposition to HB 1249, which appears to be part of a concerted, nationwide effort to target transgender youth for unequal treatment.

The transgender youth I've met are already experiencing exclusion and feeling "different" than their peers. They need love and acceptance. All parents want the best for their kids- to have a childhood full of fun, love, laughter, supportive friends, and all of the experiences and opportunities that any other kid can have.

Transgender youth have the same needs as every North Dakotan: security, a sense of belonging, economic well-being, respect, autonomy, love, and access to appropriate health care.

Health care decisions are private and best made by transgender youth and parents together with their medical providers. The North Dakota Legislature is not a medical body and should not intervene in very personal and important health care decisions. This bill appears to be solving a problem that doesn't exist as youth, medical professionals, and parents are already in the best place to make the nuanced case-by-case personal health care decisions in the best interest of each individual considering options to help align a young person's biological sex with their gender. I'd even go so far to say that no parent or health care provider in North Dakota is going to take surgery or hormone therapy for a minor child lightly. In fact, most health insurance companies already have gender affirming care policies and safeguards in place as well. What useful purpose does this bill serve for our citizens? It's insulting to parents and health care providers alike.

In North Dakota, people believe strongly in personal freedom and many don't even want to be advised that they need to wear a mask to prevent a deadly disease from spreading. It's absurd to think that the government should involve itself in matters of personal bodily autonomy. I ask that the legislature leave these very personal decisions to individuals, families, and their doctors. Gender affirming care can be life-saving. If you don't know anyone personally who has transitioned or questioned their gender as a young person, I strongly encourage you to seek out someone who has had the experience to speak with about it. It's not something that the transgender that people I know have done on a whim.

This bill, like several others in this session, unfairly targets and discriminates against the LGBTQIA+ community. This is bad for North Dakota. Businesses, families, and individuals will not want to move to North Dakota. Good, smart, thoughtful people that are here will leave. Universities won't be able to recruit young people. Doctors, nurses, and other health care professionals, already in short supply, won't want to work here. Even proposing these discriminatory bills is painful for the LGBTQIA+ people and their families in our state. Just earlier this week, I met a young man who lost his transgender sister to suicide right here in North Dakota. I would be much more impressed with a legislature that heard and responded to the voices of mental health care providers and the LGBTQIA community cautioning that exclusionary and hateful rhetoric leads to suicide, depression, and anguish and responded with kindness, wisdom, and compassion rather than ill-founded fear and undeserving disgust.

I believe all Americans should treat one another as they would want to be treated. As part of my Lutheran faith, I learned about loving our neighbors, not discriminating against them. I understand that not everyone holds the same religious beliefs that I do, however, I do know North Dakota is about building strong communities. Discrimination has no place in North Dakota. Transgender and non-binary individuals are beloved members of our community and need compassion and inclusion, not hatred and exclusion.

All young people, and especially transgender youth, need compassion and inclusion, not hatred and exclusion. All people within the State of North Dakota deserve dignity and respect and to be valued as part of the community.

Please oppose HB 1301.

Denise Ann Dykeman
Minot, ND

HB 1301

Thought it easy to believe everything on the internet regarding the LGBT community, as its possibly new and un-ventured territory for most involved in the writing of this legislation. However, it shouldnt be penalized or treated as an emergency for a minor to discuss affirming care if they feel they were born in the wrong body. It should be treated as a discussion with the parent, child, and medical professional/therapist.

I understand that as a parent one might not want to have this conversation, but as time marches on and humans evolve were going to venture into more complex ideas. Mental health has been something that should be better considered for all individuals and pushing legislation like this shows the lack of empathy towards an individual that may not conform to ones world view. But drawing that line puts those seeking that type of support at risk of seeking alternatives without being able to talk with an empathetic parent and medical professional.

Elia Jay Scott,
Fargo, ND 58103 (district 46).

# Please stop the war on trans lives.

Chair and members of the committee, I'm Elia Jay Scott; I've lived in Fargo, North Dakota, since birth; I'm a physics and computer science bachelor from NDSU, 2016; I'm a DSP for Fraser LLC, serving recently unhoused youth; and I am testifying against HB 1301, and more broadly – if I may – against all the anti-transgender bills that have been introduced this session by our state legislature, of which HB 1301 is only one.

Imagine (if you are not) that you are Catholic. And imagine that your state legislature proposes ***21 bills*** targeting, demonizing, and persecuting the Catholic community. One bans you from wearing a crucifix in public. One bans you from privately praying anywhere near a school. And one bans sale of alcohol for religious purposes, making it illegal for your church to obtain the spiritual medicine that keeps your soul alive, the Eucharist.

Now, instead, imagine that you are ***transgender***. Instead of banning crucifixes, the state wants to ban you from going outside your house in clothes consistent with your identity. Instead of banning prayer in schools, they want to ban any school accommodation for your condition, gender dysphoria. And instead of banning the Eucharist, they want to ban the evidence-based, lifesaving healthcare that has saved your ***actual, physical life***, and the lives of so many of your beloved friends.

***That is what the North Dakota state legislature is doing right now.*** Republicans have introduced 21 – yes, 21 – bills, targeting, demonizing, and persecuting the transgender community, doing all I have described and more.

HB 1301 is perhaps the evilest. Gender-affirming care, or transition, is evidence-based, lifesaving healthcare. Transition relieves gender dysphoria, reduces suicidality and depression, and saves transgender lives; that is a ***FACT***. To deny this is to deny reality. I know this fact three ways—

I know it thirdhand, because I have read the scientific literature. The vast body of the evidence and overwhelming consensus of the scientific community agree.

But I also know it secondhand, because it has saved the lives of my most beloved friends, who are alive today, whom I can hold in my arms living and breathing today, because of it.

And I know it firsthand, because transition saved ***my*** life. I will tell you, chair and members of the committee, that I had the barrel of a loaded rifle between my teeth multiple times in the days before I got on estrogen, on March 5, 2018; and I will tell you I have not had one deliberate suicidal thought since I woke up on the morning of March 6, 2018. So if you tell me to my face that transition is not lifesaving care, I will laugh in your face; and I will tell you, to your face, that you are either a liar or deceived by liars.

This bill targets trans kids. The supporters of bills like this will have the gall to say, "*There is no such thing as a trans child.*" Chair and members of the committee, trans people do not pop up out of the ground, fully formed, like golems. I was a kid; I'm trans; I was trans when I was a kid. I had recognizable gender dysphoria from the age of 6, if not earlier, a decade before I even knew the *word*

“trans”.

If you are a woman, I’d like you to imagine what it would be like to watch your body transformed in front of your eyes into a hairy beast, your voice broken like a foghorn, your face twisted and distorted, and your genitals turned inside out and hanging outside your body like prolapsed tumors, touching your legs every single second of every single day. If you are a man, I’d like you to imagine what it would be like to wake up one morning and look down and find that your own genitals were gone, replaced by a bleeding vagina; you open your mouth to scream, and a woman’s scream comes out. That is gender dysphoria. And that is what the supporters of bills like this want to subject trans children to, untreated. Whether they say it out loud or not, what they want, in practical effect, is for trans kids to kill themselves.

The pushers of bills like this are not respectable company. They include such figures as Matt Walsh, a self-identified “theocratic fascist”, who has openly said teenaged girls should be impregnated young. Tucker Carlson, who has been proven to lift his language directly from Stormfront, an openly neo-Nazi website, and is therefore himself a literal “*ghostskin*”, that is a neo-Nazi who doesn’t shave their head or get White Power tattoos, but instead tries to appear respectable and charismatic to appeal to the masses. And I will disclose to the chair and members of the committee that I am the niece of Peter Tefft, a notorious local Nazi in Fargo, who has called me a “race traitor” for not procreating with a White woman, a “spiteful little cuck” because I said I would marry a Jew, has openly joked to my face about throwing trans people and other undesirables into ovens, and believes trans people are a plot by the Jews to weaken the White male. I am simply telling you the facts when I say: This is the company the chair and members of the committee will be in, if you vote “do pass” on this bill.

I do not hyperbolize or exaggerate in the slightest, when I say this: A vote for this bill is a vote for ***attempted genocide*** – *United Nations definition genocide* – against a minority group in North Dakota, by stripping them of proven lifesaving medicine.

Chair and members of the committee, if you are Catholic, Christian, or a human being of conscience, I ask you ***please to vote NO on HB 1301 and on all these other anti-transgender bills,*** and to stop this merciless, hateful war on our trans neighbors – whom, if we are Catholic, Christian, or people of conscience, we are commanded by God and human decency ***to love as ourselves.***

†

As a licensed Marriage and Family Therapist in North Dakota, I urge you to oppose HB 1301.

LGBTQ Youth are more than 4 times as likely to attempt suicide than their peers (Johns et al., 2019; Johns et al., 2020). This isn't a result of the label, it's a direct outcome of being marginalized and discriminated against. This bill, and others that seek to further limit the LGBTQ+ community directly contribute to the increased risk of suicide.

I've seen this firsthand in my office from youth and young adults who share things like, "I don't belong here," "It's clear I'm not wanted," and "it's stuff like this that makes me want to die." As a mental health provider, I cannot support a bill that contributes to a community where members do not feel entitled to live the lives they are born into. More than half of transgender and nonbinary youth seriously considered suicide in the last year (Trevor Project 2022 National Survey on Youth Mental Health). North Dakota cannot afford to pass legislation that contributes to this.

I urge the committee to listen to the testimony from the experts in the field, who are well versed in the standards of care for transgender individuals.

Youth who aren't able to receive puberty blockers have to undergo more surgeries than peers who were able to. This is costly, time consuming, and brings on increased risk.

North Dakota banning these services will not prevent people from seeking the care they need, it just makes it harder, more expensive, and difficult for those with less privilege.

North Dakota will lose citizens to other states if this bill passes. Families will move out of state to get the care they need. North Dakota may also lose providers who contribute to the health and well-being of many citizens, not just the transgender community.

This is not a bill that recognizes or appreciates a diverse population of North Dakotans and will result in loss of community members. It does not make North Dakota a desirable place to live and is not reflective of the values that most North Dakotan's hold toward their friends, neighbors and family members.

I strongly urge you to oppose HB 1301

Dear Chair Weisz and members of the House Human Services Committee,

My testimony is in opposition to House Bill 1301. I ask that you give this bill a Do Not Pass.

As someone who lives on the border of North Dakota, whose medical care happens mostly within the state of North Dakota, there is nothing that makes me want to move away from North Dakota more than the state thinking it should be involved in the medical decisions doctors make. The medical care that I receive and that any minors who are dependent upon me receive should be decided upon only by qualified medical professionals with expertise in treating the particular medical issue at hand. The North Dakota legislature is not a medical body and is not staffed with people who understand medical treatments.

I have known minors whose ability to successfully navigate adolescence has been dependent upon the kind of care this bill seeks to ban. They made the decision to proceed with one or more of the kinds of medical treatment listed in this bill after careful research and under the care of qualified medical professionals. Denying them access to qualified medical treatment would have been exponentially more life threatening than protecting that access. A vote for this bill means risking the lives of North Dakota children.

Thank you for your time, consideration, and service to our state

Best regards,

Rev. Michelle Webber

DO PASS - HB 1301

Dear Members of the House Human Services Committee,

Please render a DO PASS on House Bill 1301.

The interventions used in “gender affirming care” have permanent and often devastating consequences, and these consequences are often least recognized by those who will be most affected. Minors must be protected from “treatments” which are known to cause mutilation, sterilization, and other permanent health problems.

Thank you for considering this critical bill, and for your service to North Dakota.

Sincerely,

Rebekah Oliver

District 11

House Human Services Committee Members:

I am a long-time resident of Minot who raised my children in North Dakota after leaving the state to obtain my undergraduate and graduate education. I am writing to express my opposition to HB 1301 which prohibits medical gender transitioning procedures on a minor, provide a penalty and declare this to be an emergency measure. This bill relates to medical procedures that are performed by medical professionals who have been educated and trained to "do no harm". I am not a medical expert but I know enough to see that this bill would cause major harm if it passes. It concerns me that the sponsors of this bill, who do not appear to have any medical expertise, feel that they know medicine better than the experts. This is one more bill that is an answer to a problem that does not exist and is a waste of legislators' time and taxpayers' money.

Laws like this one that ban gender affirming care are ignoring the wealth of research and data available that shows the benefits of this care to transgender individuals. Gender dysphoria is "the acute and chronic distress of living in a body that does not reflect one's gender and the desire to have the bodily characteristics of that gender." There is documented research, including one study on 30,000 people, that shows that access to gender-affirming hormone treatment reduced depression in transgender people. We know that suicidal attempts occur in 35-50% of transgender people in the world but a recent study showed they are 73% less likely to be suicidal if they received puberty blocking medications.

This bill also seems to encourage people to engage in medical malpractice suits if they or their family members feel that they were harmed by gender affirming care. 4 under 23-52-03 states that the parent or next of kin of a minor may bring a wrongful death action against a health care provider if the death was a result of the physical or emotional harm inflicted on them by this treatment. Since evidence-based research shows that gender affirming treatment actually reduces suicidal thoughts, it is clear that banning this type of therapy would be more likely to cause increased depression and suicidal thoughts. Following this line of logic, if this passes this legislature, families could bring wrongful death actions against the legislators that voted for this bill.

I believe the sponsors of this and other bills that attack transgender youth are under the misguided impression that they are somehow protecting young people, but unfortunately, they are doing the opposite. Bills that were banning the use of pronouns that were different from the pronoun on the birth certificate is banning social gender transitioning, which gives young people an opportunity to express their desire to live publicly as their desired gender. This and HB 1254 make it illegal for medical professionals to assist young people to make that transition safely.

Junk science is being used to push this bill and others like it across the nation. It goes against the recommendations of 29 medical organizations, including the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the Endocrine Society, the American Medical Association, the American Psychological Association and the American Psychiatric Association. These organizations have researched gender affirming care and have published policy statements and guidelines on how to provide age-appropriate care. These guidelines take into account both physical and mental factors in determining the right course of action and the timing of it.

My son has friends who are transgender, some of whom transitioned earlier in life and others who transitioned long after puberty. Those who were able to use puberty blockers when they were young had a much easier time in their transition, both physically and mentally. When treatment starts after the body has gone through puberty, testosterone blocking drugs need to be given, which can have numerous negative side effects. This bill would force young people who are transgender to wait until they are through puberty to start any medical transition which could increase the risk of medical complications. As such, this bill is not following the medical practice of "Do No Harm".

Medical treatment for gender dysphoria is not done by doctors on a whim. There are therapists, medical doctors and psychiatrists that specialize in gender affirming care. They follow the protocols that take into consideration both the physical health, the level of development and their mental and emotional health before any puberty blocking treatment is started. Hormones are normally not given before the age of 16 and I don't believe any surgical procedures are done on minors in our state. Bottom surgeries are very expensive, medically complicated and only performed by a handful of surgeons in our country. Puberty blocking treatment is somewhat reversible, but puberty itself is not. By denying young people in our state with gender dysphoria an opportunity to transition gradually to the gender they identify with, this bill causes much harm.

Please vote a Do Not Pass on this bill.

Thank you for your time and consideration,

Jane Hirst
Minot, ND

# HB #1301

68th Legislative Session

Senators: Boehm, Dwyer, Paulson, Vedaa
Representatives: Prichard, Dyk, Ruby, Tveit, and VanWinkle

I am writing in opposition to HB #1301. I was born and raised in North Dakota. I am just like you but with two big dramatic differences: I believe in equality for all citizens of North Dakota no matter what their gender, race, ethnic or orientation; and I am a parent of a transgender person.

How many of you know a transgender person? Have many have you talked with a parent of a transgender person? I know Mike Dwyer has in the past sat down with me, another parent of a transgender person and Dr. Balf after the defeat of HB #1298.

For the benefit of the rest of you, I will tell what you should know but don't about transgender people.

1. Transgender people are born transgender. The false narrative being spewed by FOX News, on Facebook pages and from religious clergy that this is just a fad or a phase. My child never gravitated to what others would deem "typical" boy play. My youngest preferred to play with dolls, dress up and watch movies that my oldest was watching and playing with. Yes, we did expose both kids to gender neutral toys but you see, you CAN NOT MAKE a person transgender no more than anyone can make you the opposite sex that you identify as now. I was a farm kid, playing in a sand box with my brothers Tonka Truck and other toys. What others like to say is that a person can be forced to be something they are not is bizarre and frankly a poor attempt to negative the person.
2. My child has never deviated once since she came out to be as transgender, not once even though I have asked her. She just chuckles and says no mom, I'm still a girl. My daughter came out to me when she was able to put to words what she saw in the mirror. My daughter was in fifth grade when she came out to me. I admit, I took the news poorly. My reaction was to get my kid into counseling, and so I did just that.
3. My daughter spent years in counseling. We went to counseling as a family. It was during the counseling sessions when we learned that our concepts of sexuality and society norms are wrong and antiquated. There is in fact a spectrum concerning sexuality and to deny the spectrum is to bury your heads in the sand and refuse to look at life as black and white. Life is not absolute as our former beliefs and what we were taught as children at home, school and church is not only outdated but just simply wrong.
4. My child and I went to Mayo Clinic, there we saw a team of doctors, psychiatrists and other medical staff. Tests were done on my child and afterwards she and I sat down and were told the findings; my child is transgender with NO mental confusion of who she is. I asked how my daughter became transgender and it was explained to us that in utero, the baby's body forms first and then the brain forms. During gestation, when the brain is forming, a surge of hormones is released from the mother and this surge interferes with the formation process; causing the brain to form as the opposite gender from the body. This of course, can't be detected by the

naked eye such as a cleft pallet, club foot or other issues that children are born with but nonetheless, that is what happens. Transgender people ARE BORN transgender. Transgender is not a fad, choice or a way to get an edge in sports. That is all lies and rumors started by people and organizations who have an agenda but refuse to speak the truth. What I say is backed by 21st Century Science. An MRI image of my daughters brain shows her brain is that of a female. Males and female brains are physically formed differently. The MRI images show this and backs up what I have been saying all along, these people are BORN transgender.

5. Refusing medical care, medication, counseling by doctors, counselors is barbaric. If this passes then all people born with issues should be refused treatment of the same kind as what is proposed here. No cochlear implants for kids, no correct eye surgery, no back braces, no heart surgeries, nothing. Following the ideology of HB #1301, these people are born this way and there fore that is how God intended it to be. If you deny treatment for one group, you must deny treatment for all. It is not the transgender person's fault they were born transgender nor is it the mother's fault. This just happens, just like the instances I spoke of earlier and many, many more. This bill is a hate bill, plain and simple. The authors and supporters of this bill lack any firsthand knowledge or experience with transgender people.
6. The legislative body that is pushing for this bill is not medically trained. How can this group tell a physician that their treatment is wrong and they will impose a fine and other drastic, uncalled for measures when the legislative body is not physicians? You lack the knowledge or understanding of what the process is for transgender care. For instance, NO SURGERIES are even done until the individual reaches the age of 18. Blockers are reversable so there isn't any harm there AND the person goes through a set period of counseling before any medication is talked about.
7. As a parent, how can the state think they know what is best for my child? I am with my child 24/7, none of you were with us at home, in the doctor's office or in counseling. How can you say you know what is best for MY CHILD? You don't know her or me. The state is overreaching their authority with regards to parents and their caring for transgender minors. Would any of you like the state to come in and take your child because of what bible you are reading out loud to them? What gives you the right to think your idea of what is right is a one size fits all for the citizens of North Dakota? You don't even know what it's like to be transgender because you haven't spoken to a transgender person. You know none of their struggles, their fears, their hopes and dreams. All you think about is that these people are a threat based on myths, rumors and insecure people who believe that a transgender person is out to take something from them.
8. This bill also gives the citizens of North Dakota the impression that if you are different from what is perceived as acceptable, then those people who need medical care and treatment can be ignored, mistreated and in fact are defective. Is that your vision for North Dakota? To marginalize people so they become so distraught that they self-harm or move out of this state? This bill is also reminiscent of what Hitler did to the Jews. Hitler took away rights and privileges of the Jews because Hitler thought the Jews were the downfall to society. Is that the direction North Dakota is headed, to be an Aryan State where everyone looks the same, the same religion, the same everything? Haven't we as a society learned from history that in doing this, isolating and segregating people, only harm and mistreatment at the expense of the selected is the result. Hitler wasn't successful, thank God. Hitler didn't have the strength or moral conscious to know that his hysterical thinking was wrong, unjust let alone unfounded.

# HB #1301

As a parent of a transgender person and that of a CIS daughter, I can see no harm in being transgender. The harm I do see is what society is putting on others due to their moral compass. Let's be honest, no legislative body should pose themselves as the moral compass for the people they work for. It is NOT in the government's place to supersede a parent and doctors care for a minor child when that government body knows nothing about the situation. As a parent we have the right to take our child and seek medical treatment and care. The state should not interfere with this at all. No harm is done to the child. No parent is forcing their child to become transgender. Again, that is stories spun to make the false narrative work. Stop listening to those who are ignorant of what transgender care is. Religion does not have a part in state policy and nor should it. Implementing this bill on the grounds of religion is not separation of church and state. What and how you worship is your own individual liking but DO NOT try to impose your religious beliefs onto the state. I grew up catholic. I went to church, taught Sunday school even and I still say that religion is a person thing between that person and their God. Imposing my beliefs on others is wrong and it is wrong here as well.

I challenge you to vote DO NOT PASS on HB #1301 and then take the next step and meet someone in the transgender community. Get to know the facts, the people and listen to how this bill would impact their lives. You owe it to the citizens of North Dakota to do this and anything less than this is not due diligence for the State of North Dakota and its citizens.

Kristie Miller
Parent of Transgender

January 22, 2023

To Whom It May Concern,

My name is Tim Baumann and I live at 1308 35th Ave. SW in Minot. I am writing today to express my opposition to HB 1301. As I stated in my opposition to HB 1254, I believe medical decisions for a minor should be made between them, their parents/guardians, and their medical care provider. It is government overreach for politicians to insert themselves into that conversation.

Respectfully Submitted,

Tim Baumann

1308 35th Ave. SW

Minot, ND 58701

*Members of the House Human Services Committee,*

*“My name is Lisa Pulkrabek and I reside in District 31. I am asking that you please render a DO PASS on House Bill 1301.”*

*The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance. This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones. Pediatric medicine has been hijacked by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.*

*Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.*

*Lisa Pulkrabek*

*Members of the House Human Services Committee,*

*“My name is Wade Pulkrabek and I reside in District 31. I am asking that you please render a DO PASS on House Bill 1301.”*

*The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance. This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones. Pediatric medicine has been hijacked by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.*

*Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.*

*Wade Pulkrabek*

Members of the House Human Services Committee,

My name is Andrea Leingang and I reside in District 34.I am asking that you please render a DO PASS on House Bill 1301.

The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance. Children and teens are being actively groomed into the cult-like ideology of transgenderism. They are being purposefully confused about their identity which inevitably leads them down a destructive and irreversible path of sterilization and bodily mutilation.

This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones. Pediatric medicine has been hijacked by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.

Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.

Andrea Leingang

Mariah Bates
Williston, North Dakota
House Bill 1301

Members of the House Human Services Committee,

My name is Mariah Bates and I reside in District 1. I am asking that you please render a DO PASS on House Bill 1301.

The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance. This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones. Pediatric medicine has been hijacked by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.

Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.

Mariah Bates

*Members of the House Human Services Committee,*

*My name is Cionda (C.C.) Holter and I reside in District3. I am asking that you please render a DO PASS on House Bill 1301.*
*The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance. This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones. Pediatric medicine has been hijacked by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.*
*Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.*

Cionda N Holter

701-580-4746

*Members of the House Human Services Committee,*

*My name is Jacob R. Holter and I reside in District3. I am asking that you please render a DO PASS on House Bill 1301.*
*The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance. This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones. Pediatric medicine has been hijacked by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.*
*Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.*

Jacob R. Holter

701-580-7800

Regarding House Bill 1301

Dear House Member,

**My testimony is in strong opposition to HB1301. I ask that you DO NOT PASS this bill.**

My reasons for opposing this bill include:
1. I swore to always do good and do no harm when I became a physician
2. I am following standards of care guidelines for transgender care in adolescents
3. Medical treatment of transgender health DECREASES their mental health burden and lessens suicidal risk.

I was born and raised in North Dakota. Now I am a board-certified Pediatric Endocrinologist who chose to come back to practice in the state of North Dakota. I have the distinct privilege and pleasure of caring for a multitude of pediatric patients throughout the state with hormone problems. My scope includes caring for children with diabetes, thyroid disorders, adrenal problems, endocrine tumors, bone metabolism problems, growth concerns, early/late puberty, and gender affirming care for transgender individuals. As a board-certified physician, I follow expert committee guidelines and strictly follow best practices established by these governing bodies. On my first day of medical school over 10 years ago we had to recite the Hippocratic Oath where in summary I swore to ALWAYS DO GOOD (beneficence), DO NO HARM (nonmaleficence), the RIGHTS OF THE PATIENT COME FIRST (autonomy), and BE FAIR AND EQUITABLE (justice).

As one of two Pediatric Endocrinologist's in the state, we work with a team including clinical psychologists to provide care for transgender individuals. Our evaluation and management include the use of puberty blockers, discussion of fertility preservation, medications for menstrual management, gender affirming medications and possibly gender affirming surgeries. With each of these, there is a thorough discussion with all stakeholders including the patient and family members through multiple visits to discuss the best treatment options for that patient.

Some people might think gender and sex are the same thing, but sex is usually categorized as female or male based on chromosomes (XX and XY). However, there are more combinations to the sex chromosomes. This includes X (classic Turner syndrome), X/XY (mosaic Turner syndrome), XXY (Klinefelter syndrome), XYY (Jacob syndrome) or patient's born with ambiguous genitalia where their genitalia does not match their chromosomes because of an adrenal genetic condition. So, since those people do not have the classic XX or XY chromosomes should they not receive individualized care?

Gender is different than sex and refers to socially constructed roles, behaviors, expressions and identities of girls, women, boys, men, and gender diverse people. Gender dysphoria is a clinically diagnosed term used to describe a PERSISTENT and intense sense of uneasiness that patients have where their gender (male or female) they were born into doesn't match their gender identity. Why should people with gender dysphoria be treated any different? We know that if these patients are not given adequate care (psychological and medical) their risks of anxiety, depression, and suicidal risk are VERY high because they feel like they don't fit in their own skin.

In the transgender population that I care for across the state, some of the patients that I care for not only have gender dysphoria but also have short stature or thyroid disease or type 1 diabetes. So why should I be told I can only prescribe medications for 1 of these conditions (like insulin once the patient has clearly met the diagnostic criteria for type 1 diabetes) and not be able to prescribe gender affirming treatment when they've met the WPATH established guidelines for gender dysphoria? Also, if you believe giving gender affirming medications is "cosmetic" then does that means I shouldn't give growth hormone to a patient that is significantly short and meets the criteria for growth hormone deficiency?

If this bill passes, we know the patients and families will still seek gender affirming care which could result in a large exodus of families to other states. You also have the potential to lose specialists that are providing specialized care to hundreds of children across the entire state.

Treatment with gender affirming care DOES NOT cause any more harm to these patients than the medications we'd be prescribing for other hormone imbalances. BUT there are proven studies that have found not treating gender dysphoria increases their mental health burden and suicidal risk. To not allow care of these patients in the state which includes GENDER AFFIRMING CARE, you are telling these people they do not matter. If this bill passes, the North Dakota legislature governing body should be at fault for the increase in adolescent suicide rates.

Thank you for allowing me to speak and for your time in this important matter. I trust that the legislature will do what is best for the state and that includes opposing HB1301.

I knew that I was different from a very young age. Growing up in Texas with immigrant parents & in a poor immigrant community, my perspective of the world was limited. The first time I kissed a girl, we were hidden in her closet at midnight, scared of being found by her parents. It was a beautiful & deeply sad moment. A memory that should be cute and awkward and funny is tainted forever because of it was clouded by our terror of being found out to be "wrong". We weren't wrong.

I'm a fantastic actor. My greatest performance, to date, was convincing those around me that I was heterosexual & cisgender. I hid my feelings, my personhood, & my joy for over a decade. When I learned the word transgender, after I had spent my whole life convinced that I was completely alone, I was beside myself with grief over my life so far & utter joy at the life I now had the chance to start living. My family didn't accept that I wasn't their daughter. I attempted suicide multiple times. One attempt landed me in a medically induced coma. When I woke up, to the surprise of even my doctors, my family told me how happy they were that their "little girl" came back to them. I kept trying to kill myself, I ran away from home, my parents threw me out & my guardians in North Dakota took me in. They didn't accept me either, so I went back to acting.

Three years later, at 18, I was homeless, traumatized from years of abuse, & **still transgender**. No beating took it out of me, no vitriolic words could stem who I was, lack of support couldn't make me a different person. Now that I have transitioned socially, medically, & legally, I am three years free from a suicide attempt, two years sober, & finally at home within myself. I have friends. I have a place to live. I have pets. I am alive & happy to be so.

The attack on transgender rights all across the country will not stop people from being transgender. Centuries of history have shown, time and time again, from book burnings to murders to genocides, that transgender people cannot be subdued into nonexistence. Even if every single transgender person were to die tomorrow, more would be born the next day. The outcome of bills like these is that transgender people are made to suffer more for existing, suicide rates of transgender people increase dramatically, & the murders of transgender people are normalized.

The Lemkin Institute for Genocide Prevention has classified the actions of lawmakers within the GOP against the LGBTQ+ community as a movement driven by fascistic, genocidal ideology. Transgender people, whether adults or children, deserve the freedom to identify as themselves & to seek treatments that are deemed appropriate by World Health Organization, the World Professional Association for Transgender Health, & other unbiased medical organizations that rely on science to determine the proven safest treatments that lead to the proven best outcomes for people. Transgender people do not pose **any** risk to non-transgender people. Transgender people, very simply, wish to live our lives, as ourselves, in peace.

Dear Chair Weisz and members of the House Human Services Committee,

My testimony is in opposition to House Bill 1249. I ask that you give this bill a Do Not Pass.

The reason for this is that I am against bills that endorse discrimination as policy. This bill hurts our state as it intrudes on individual liberties and causes actual harm to LGBTQ+ people in North Dakota, contributing to higher suicide rates among LGBTQ+ youth and mass exodus of youth from our state whether they are LGBTQ or not.

Among queer youth in North Dakota:

- 74.7% Have ever seriously considered suicide (Middle School Data)
- 46.3% Have ever attempted suicide (Middle School Data)
- 94.4% Do not talk to parents when feeling sad, empty, hopeless, or angry (High School Data)
- 72.7% Didn't feel safe at school most of time or always (High School Data)
- 61.0% Bullied on School Property (Middle School Data)
- 27.0% Didn't Sleep in Parents Home + 20.0% Have Run away or homeless (High School)

Thank you for your time, consideration, and service to our state

Best regards,

Kaitlyn Kelly

Dear Members of the Senate Judiciary Committee,

My testimony is in opposition

to Senate Bill 1301. I ask that you give this bill a **Do Not Pass.**

Gender affirming healthcare can save lives. Gender affirming healthcare is vital to transgender people and will help them gain a better quality of life. Sometimes living in the body that you were born into just does not feel right. This feeling can drive people to extremes and end in suicide. Please do not take away this life saving healthcare from the transgender children in North Dakota.

Please,

consider not passing this dangerous piece of legislation, vote **DO NOT PASS**

Thank you for your time,

consideration, and service to our state

Best regards,

Becky Craigo

President of Beach Pride Family; House of Safe Spaces

Beach North Dakota

January 23, 2023

Chairperson Lee and Committee Members,

I strongly urge a Do NOT Pass on HB 1301. The determination of the best practices of caring for trans and non-binary youth should rest with that youth's parents or guardians and their medical team, who are guided and bound by codes of ethics, professional standards, and the best current science and research. The government has no place in regulating this care.

I urge a Do NOT Pass on HB 1301.

Sincerely,
Sylvia Bull
522 N 16th St
Bismarck, ND 58501

**Testimony Against Bill 1301**

My name is Zeke Langemo, I am sixteen years old, and I am a senior at Sheyenne High School in Fargo, North Dakota. I am an honors student and throughout my high school career I've maintained a 4.0 GPA and in addition, I've participated and excelled in choir and musical theatre. Next year, I plan to attend Concordia College where I will double major in Data Analytics and Mathematics. Overall, I am a normal teenage boy trying to enjoy my last year of high school.

However, I find myself feeling extremely threatened by the amount of anti-trans and anti-LGBT+ legislation that is being pushed this legislative session. I am assigned female at birth and I have identified as a transgender man for many years now. Because I have received support and care throughout my transition process, I am now able to live a happy, healthy, and fruitful life. Although I do not want to discredit the work I've put in to bettering myself, I know it is majorly because of gender affirming care that I am as happy as I am today. The thought of losing this happiness, and my right to living out my teenage years as my cisgender peers would, I am concerned about how Bill 1301 will affect not only me, but my transgender peers.

To begin, I would like to share my personal story and experience with gender affirming care. I began to question my gender in eighth grade, though I have always vaguely felt a disconnect between my body and mind. Before I transitioned, I can confidently say I was in the worst mindset of my life. I severely struggled with anxiety, depression, self esteem and body image issues, gender dysphoria, and self harm. By my ninth grade year, I was aware of my identity but terrified to transition and be my authentic self due to a fear of how my peers and family would react, and how I would be treated in a state that has not been kind to my people. I would eventually attempt suicide because I no longer wanted to live as a female. I was entirely trapped in the wrong body; and could think of no other solutions.

Nevertheless, I learned from this experience and began socially transitioning before my sophomore year of high school. Going on HRT (Hormone Replacement Therapy) has improved my mental health and social life significantly. Being able to live as a man has permitted me the opportunity to grow in various areas of my life where I previously struggled due to my unstable mental state.

Transitioning has allowed me to become a thriving member of our community. Even so, I'm not where I need to be yet. Binding my breasts on a daily basis has begun to cause me chest pain, and not binding makes me

uncomfortable and restricts my clothing options. I am frequently in changing rooms for both gym and musical theatre and am forced to be in a state of discomfort, and possibly out myself to my classmates. I want to get top surgery so I can reach my greatest potential in school, work, and life. I desire to enter locker rooms and swimming pools without facing, at the very least, an uncomfortable situation, or at the worst- a dangerous encounter. I planned to get top surgery before I began college in the fall to avoid situations that will cause me fear due to my gender identity. I want my years living in the dorms to be both exciting and memorable, and I feel that is not possible without this surgery. If I could not receive it, I would likely live at home, which is not the college experience I wish to receive.

From the first time I was alerted of Bill 1301, one question stuck with me. Why should legislators, many of whom are likely uninformed about the transgender population, be able to override the decisions that myself, my family and medical providers have decided are best for me? Why should you have a place in my home and my family when you are oblivious to my personal situation?

My parents, doctors, and therapists have have helped me immensely throughout my transition. It has not been an easy process to get where I am today. Additionally, gaining access to gender affirming surgery is extraordinarily difficult. It has taken a considerable amount of time and resources for me to even receive a consultation. The American Medical Association and the American Psychiatric Association both support care for trans youth- If the professionals in my life, and throughout the United States, say this is the best move for my wellbeing, why is the government allowed to intervene?

Many of you are religious, and I would like to mention that I am as well. Furthermore, Concordia, my school of choice, is a Lutheran establishment. Concordia has expressed their displeasement with the anti-trans legislation present in the North Dakota House of Representatives. This demonstrates how religion is not an excuse to erase the rights of the transgender population.

For those who I may reach by discussing the impacts this bill will have on our economy; passing bill 1301, and others like it, demonstrates how North Dakota is not an LGBT+ friendly state. This will discourage many citizens from moving here who may have been taking it into consideration. Even heterosexual, cisgender allies will be deterred from taking up residence in ND. You will lose business due to this decision. Businesses will move to Moorhead where they are allowed to be LGBT+ friendly. You will also lose young people potentially looking to enter the workforce in North Dakota. I believe I would be a valuable asset to a

team in the future. I will be pursuing work as a data analyst and would have loved to work in North Dakota- only now, I feel unsafe, and I know many of my peers, regardless of their identity, feel the same.

Finally, I would like to note how gender affirming care saves lives. Going on testosterone saved me from another suicide attempt. I would like to say my situation is unique, but unfortunately, it is not. I am one of many transgender teens who've contemplated or attempted suicide. Transgender suicide rates are alarmingly high and they will continue to rise if we prohibit life saving care. In comparison, the detransition rate is 1%. It is rare to detransition, but it is not rare for transgender youth to commit suicide. The question begs: why are we so concerned with the mistakes of detransitioners when trans youth are dying or being put into severe distress due to this legislation?

In conclusion, gender affirming care has made the lives of trans teens, including myself, significantly better. Passing this bill is not only affecting the trans population, it is ensuring harm to our economy and a rise in the suicide rate. As representatives of our state, you cannot in good conscience use your voice to pass this bill. Preventing gender affirming care only serves to cause harm to a population that is already suffering.

As a mother of a transgender teen in North Dakota, I strongly oppose HB 1301. Several years ago, my son was suicidal and self harming on his arms and legs to significant degree. We sought help from Sanford in a three week behavioral program for teens and that was the start of a turning point. My son was diagnosed with anxiety, depression and gender dysphoria, which is medical diagnosis defined by the American Medical Association, the American Academy of Pediatrics, and the American Psychological Association. Gender Dysphoria indicates distress or discomfort with gender identity and is a diagnosis that has specific requirements that need to be met over a period of time. My son met the criteria.

My son came out as transgender in 2021 which was very difficult for him to share with us, his surrounding family, friends and school. It was especially difficult at the beginning but over time, he has become more himself. In the past few years, we have had access to therapists at Solace Counseling, doctors and nurses at Sanford and Canopy Clinic, a therapist at Together Counseling, and an occupational therapist at mOTivate Minds. With their full support, my son has made significant progress in his transition with hormone replacement therapy. This year, he is the happiest I have seen him in a long time due to medical interventions that have aided in his progress.

With their support and all of the time and work that my son has committed in the process, he is thriving in school, a 4.0 student in Honors and dual credit college courses, graduating a year early, and receiving the highest Academic Excellence scholarship he could receive at Concordia College to start as a freshman in the fall. He is fully engaged in musical theater and choir and has a strong community of friends at school. His social anxiety dissolved to the extent that he was able to excel in a job as a server. I could not have imagined this level of confidence several years ago.

My son is so hopeful to start college in August with a fresh start being fully transitioned with gender affirming surgery (top surgery). His therapists, doctors, nurses, his parents and surrounding family all fully support him in this transition. This surgery would remove his breasts and would allow him to stop wearing binders. Binders are painful and cause cysts in his breasts. The surgery will help his comfort level physically and emotionally and will greatly impact the start of his college experience, especially with living in college dorms.

If this legislation is passed, it will not only bring his gender affirming surgery to a sharp halt, it will also remove his access to the hormone replacement therapy that has gotten him this far. I worry deeply about the damage this legislation will cause to his mental and physical health and all of the progress that has been made over the past few years to get him to a happier place where he can thrive and focus on things that teens should be focused on like academics, co-curriculars, work, and college. This legislation, if passed, will cause a significant setback and harm to his well-being.

I also believe that if this legislation moves forward, it will be in great disrespect to me as a parent fully capable of making decisions for my child, to the medical community as experts with the medical research to make diagnoses and plan treatment, but mostly, to my son, a minor

who has done everything right to get to this point and deserves access to hormone replacement therapy and gender affirming surgery to be his most authentic self as well as a thriving, contributing human in this state.

I will end with this final thought. I am born and raised in the State of North Dakota. My great grandparents on both my grandmother and grandfather's size immigrated to the state from Norway and my family had decades of being farmers in Hannaford, North Dakota. I had many summers as a child riding the combine and seeing the fruits of hard, physical work that goes into farming. I started work at a young age and had the opportunity to be a teller at Bell Bank in high school and college, and then received a job straight out of college as a financial accountant at Gate City Bank in Fargo.

I left the state to go to law school in Ohio in 2001 and that led to eighteen years of practicing as an attorney, being a faculty, chair, and dean in higher education, and a president of an education company outside of the state. During that time, I was always so incredibly proud of my North Dakota roots and the advantage they often gave me with values rooted in integrity, hard work, and intellect as well as kindness and compassion. When my husband was recruited back to this state to lead economic development in the Fargo Moorhead area, I thought it would be a wonderful opportunity to raise my child in such a culture to ensure the same value system. I have begun to question that decision as I see how harmful legislation like this bill is to his mental and physical health.

Please don't support HB 1301 or any anti-LGBTQ+ legislation. Please allow me to parent my child and to work with medical professionals to make the best decisions for and with him. Please allow my son to thrive as the wonderful human he is and someone who can contribute greatly to this state. Please maintain our North Dakota virtues of kindness and compassion.

Members of the House Human Services Committee,

My name is Greg Demme. I am a Pastor who resides in District 3, at 5220 14th St SE, Minot, ND. I urge you to please render a DO PASS on House Bill 1301.

In recent years, the perception has taken over that progressive social policies have cornered the market on compassion and that the most conservative policies are far more involved with amassing money and things than about caring for people, or worse, that conservatives just hate people who are different. This perception is especially strong whenever we hear discussions about such topics as transgenderism. We're told, "If we really care about people, we'll affirm whatever a person wants to think about their gender because to do otherwise is to harm them, and would subject them to even more difficulty than they're already facing."

There are even pediatricians who are trying to say that this bill would force them to violate their Hippocratic Oath, because not allowing them to use hormonal or surgical treatments on such patients would cause them harm.

The reality, however, is that gender dysphoria is **not** a medical condition. I repeat: "gender dysphoria" is not a medical condition. While there are true cases of Disorders of Sex Development, or DSD, requiring medical intervention, they are extremely rare. According to Dr. Michelle Cretella, a pediatric researcher and immediate past executive director of the American College of Pediatricians, "When we talk about transgenderism, we're not dealing with any biological or medical condition. We are speaking about belief."

And if we're speaking about belief, then we must ask the question: Is it compassionate to encourage minors—not even adults, but minors—to permanently, irretrievably alter, even mutilate their bodies through chemical or surgical means, especially knowing that neither their brains nor their bodies are yet fully formed? Is it compassionate to encourage them to succumb to societal pressures that heavily influence children and youth in such a way that if they were ever to change their mind, change their belief about themselves, it's already too late? They've already done permanent damage to their bodies. Is that compassionate? Is it compassionate to encourage children and youth to brutally reject their bodies the way their creator made them? No, I contend that is **not** compassionate. Rather, it is highly short-sighted, destructive, and harmful.

Instead, it would be compassionate to equip youth and teens undergoing social and psychological pain with the metal and emotional tools it takes to live in a society that, no matter how hard we try, will never be a utopian paradise of good feelings for everyone at all times. It is far more compassionate to help them learn how to deal with their own feelings of rejection and hatred of the bodies they were born with, feelings that may stem either from within or from feeling rejected by society or friends or even family, for not living up to some current fad of what it means to be a boy or a girl.

How many boys who like music or dance or art simply need to be told it's OK to be a boy and like music and dance and art? How many girls who like sports simply need to be told it's OK to be a girl and like sports? Here in ND, how many girls grew up surrounded by horses and cattle and the rodeo circuit, and maybe were considered tomboys at the time, and as they grew, they were perfectly content knowing that it's OK for girls to like cattle, horses, and rodeo? Should we have encouraged them all to get physically and chemically mutilated? Would that have been compassionate?

No. It is not compassionate for us to allow such irretrievably permanent alterations to children and youth, alterations that go against their very created nature, when what we need to be doing is teaching and training them how to accept themselves, their likes and dislikes, and the bodies they have without bowing to the most recent societal fad. Some societal fads are mostly harmless. Strange haircuts are a mostly harmless societal fad. Chopping off breasts and penises and chemically altering boys and girls is not compassionate, and it is not harmless. It is destructive, and it has already led to intense regret on the part of many people who are now trying to "de-transition." Only they can't ever truly get back to the way they were or could have been, despite them often being told that anything they do is completely changeable if they ever change their mind. It's not.

House Bill 1301 is crucial for the protection of our children and youth in ND. I strongly urge you to render a DO PASS on this bill.

Gregroy Demme, Pastor
Grace Baptist Church of Minot
5220 14th St SE
Minot, ND 58701

Dear Chair Weisz and members of the House Human Services Committee,

My testimony is in opposition to House Bill 1301. I ask that you give this bill a Do Not Pass.

I am a public school educator and a 29 year resident of North Dakota. HB 1301 actively harms the students I serve and the people I love – family, friends, and community members.

All individuals deserve fair access to health care. Individual medical decisions deserve to be made those affected and informed by the best practices of licensed professionals. North Dakota has no need to deny care to those in need.

Thank you for your time and consideration.

Sincerely,

Christopher Brown

I write to you in opposition to HB 1301. It not only shows great ignorance of the current science regarding gender and identity, but also disregards the clear mental health benefits for trans youth in receiving gender-affirming care. Please put more trust into the governing bodies of pediatricians, physicians, counselors, and psychiatrists. No one is providing this care without careful assessment of their patient, without consultation with parents and guardians, and without discussion of all possible outcomes. At the end of the day, many parents prefer to have their children receive gender-affirming care than to continue to see their children suffer depression, anxiety, and suicidal thoughts. I urge you to vote Do Not Pass, and resist the efforts to turn North Dakota into a state of ignorance and cruelty.

Sincerely,

Merie Kirby

Health and Human Services Committee
1/24/23
HB 1301

Chair Weisz, members of the committee,

My name is Rachel Peterson. I am a board-certified OB/Gyn who has been practicing in Bismarck since 2017. I grew up in Mandan and completed my college and medical school at the University of North Dakota. I then moved to Nebraska for 4 years to complete my residency in Ob/Gyn.

I am here today to testify against House Bill 1254. I strongly encourage a do not pass vote.

As part of my practice, I provide gender affirming care for patients. This usually is in the form of medication although on occasion I do provide gender affirming surgery in the form of hysterectomy or removal of the uterus, as well as removal of the ovaries. I do not perform these surgeries on anyone under the age of 18. I have been performing this care for the 5 years I have been in Bismarck as well as in my residency training. As part of my practice, I do treat patients under the age of 18 who have gender dysphoria.

I follow guidelines set out by National organizations including WPATH (World Professional Association of Transgender Heath) and ACOG (Association of Obstetrics and Gynecology). These guidelines are evidence based and go through rigorous review before they are released. The WPATH guidelines alone are 260 pages that go through all treatment aspects for gender affirming care.

ACOG's position is that all transgender and gender diverse individuals have access to respectful, equitable, and evidence based care free from discrimination and political interference.

I want to outline what this treatment and counseling looks like, in particular for those under 18 because I feel that there are some misconceptions on what these visits look like and what the treatment involves.

When I first meet a patient, we spend time getting to know each other. I usually sit down with them and their support person, who is usually a parent. I ask their pronouns and their name. I discuss with them how long have they felt their gender did not align with their assigned sex at birth. We discuss what their support system is including friends, parents, teachers, and other family members. I discuss with them any medical problems, surgical history, their mental health history and what resources they have in regards to their mental health and if they have a counselor or psychiatrist. We review their family history, discuss any substance use. We discuss their sexual history and plans for future biological children. I discuss their understanding of the treatment as well as their goals.

I then review with them what treatment looks like including any risks of the medication, when to expect the changes and how significant those changes will be. We talk about long term use of these medications, what additional health screening they may need. We talk about what changes are considered permanent and how this may affect their ability for fertility in the future. We talk about financial cost of the medications. We also review what would happen if they want to stop these medications. I answer any questions they have. Typically, these visits take 30-60 minutes. At this point I will have the patient go home with the information and think everything over. I encourage them to discuss more with their support system and decide if they want to start these medications. They then return and we go over all the information again. After obtaining consent from them and their parents, we start the medications. I closely monitor my patients every 3 months for the first 1-2 years and then slowly space out to 6 months then yearly. I encourage these patients to reach out with any side effects, medication changes they wish to make, or other concerns.

There are many transgender and gender diverse individuals who never start medications. We may manage dysphoria in a patient by working to safely stop their period, set them up with counseling or support groups, or simply be a safe place to get care where they know they are respected and heard. Not every person who is transgender or non-binary will use hormones or get surgery. It is very much an individual decision.

If these house bills pass this state becomes a very dangerous place for transgender and gender diverse people. Multiple studies have shown that gender affirming care is lifesaving. People who receive this care report lifelong improvements in their mental health and a significantly reduced risk of suicide. This is especially noted in patient under the age of 18. Supportive family, friends, and community makes a difference in their mental health and prevents suicide. This is Lifesaving care.

We know from multiple studies that individuals who cannot access this care report higher rates of poverty, unemployment, homelessness, substance abuse and more. Discriminatory policies in health care not only create inequalities in health care but criminalize physicians and undermines their ethical obligations to patients.

From my personal experience working with transgender and gender diverse youth, I can tell you it makes such a difference for them to have access to this care. Many come in and are shy and worried they will be denied this care. Once they start care they truly open up. Their personalities shine and its truly humbling to witness. They are so happy to be living as their true selves. Most report significant improvement in their mental health. They do better in school and at home. It is lifesaving care.

I would strongly encourage you to reach out to transgender and gender diverse youth to see their side prior to creating these bills. These bills are incredibly harmful to them and I fear will result in loss of life of young people.

In summary, I cannot recommend strongly enough a DO NOT pass on HB 1301  Please tell the transgender and gender diverse people in our state that they matter and they are valued and important in our communities.

Rachel Peterson MD (she/her)
Obstetrician/Gynecologist

January 23rd, 2023
**Regarding House Bill 1301**

Dear ND House Human Services Committee,

My testimony is in opposition to House Bill 1301. I ask that you give this bill a **DO NOT PASS**.

This legislation along with others like it are billed as protecting children when in fact, they will do the opposite. It is well accepted practice in the medical community to provide gender affirming care to treat Gender Dysmorphia. Please listen to the expert testimony of medical practitioners and oppose this harmful bill. Please let parents make the right choices for their children's health and well being.

To continue pushing this kind of legislation tells both Trans youth and adults that they are not entitled to the same rights as everyone else. It disallows and criminalizes parents for doing what is best for their childrens and it will increase stress and lead to increased cases of harm and even death.

Why waste ND resources on increasing harm? Why not spend our resources lifting others up?

Please search your hearts and minds, and make the compassionate, rational decision.

Respectfully,

Will Lovelace
ND District 18 Resident

January 23, 2023

Re: HB 1301

Dear ND House Human Services Committee,

I am writing in opposition to HB 1301. This bill is disruptive to the right to private decisions about healthcare that should be left to parents, their children, and doctors. We need legislation that is **evidence-based** that aims to strengthen our communities. Passing legislation that denies the diversity that exists within our communities is not only willfully ignorant, it's harmful and detrimental to the well-being of our state. Please--**DO NOT PASS**.

Brittney Christy
Grand Forks
District 18

*Members of the House Human Services Committee,*

*"My name is Kayla Johnson and I reside in District 26. I am asking that you please render a DO PASS on House Bill 1301."*
*The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance.*
*This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones.*
*Pediatric medicine has been hijacked by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.*
*Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.*

*Kayla Johnson*

Dear Chair Weisz and members of the House Human Services Committee,

My testimony is in opposition to House Bill 1301. I ask that you give this bill a Do Not Pass.

This bill impacts people that I care about. As a pastor and as an active member of my community I know and care about numerous transgender and nonbinary people. Some of them are minors. It has been shown that gender-affirming treatment reduces the risk of suicide among transgender adults and youth. I will never forget the look of joy upon the face of one young person who was able to have gender-affirming surgery after their eighteenth birthday. I had known them as someone prone to anxiety and with their ability to begin to transition there was a new vibrancy in their life.

You will probably note this individual was no longer a minor when they had this surgery after they reached the age of majority. The concerns that minors will receive gender-affirming surgery is inaccurate. Gender-affirming treatment for minors usually is in the form of using the youth's chosen name, the pronouns that match their gender identity, and in some cases, puberty blockers, which are reversible.

Without the ability to receive treatment for gender dysphoria the possibility of suicide is great. Any treatment comes in tandem with psychotherapy to help the person navigate their own emotions and help them to understand the incongruence of their external sex traits and the gender that they experience internally.

This also takes medical autonomy from children and their families in consultation with their health care providers. This is a governmental overreach into individual privacy.

I fear as a pastor I will preside over the needless deaths of young people who have been told that their authentic identity is a terrible secret to be hidden. When one thinks of the ability of families to seek civil damages related to gender affirming practices, I wonder if the state legislature is prepared to defend lawsuits based on the psychological toll of this bill.

Federal policy affirms the importance of allowing families to pursue gender-affirming treatment for their children who have a diagnosis of gender dysphoria. There is no good reason for the state of North Dakota to go against this policy and the science that affirms a spectrum of gender identities.

Finally,, North Dakota will lose the promise of having hard-working, professional North Dakota families exiting the state in fear of a hostile environment. Please, let us show the extraordinary welcome that North Dakota is known for to all its citizens. Recommend a Do Not Pass on HB 1301.

Thank you for your time, consideration, and service to our state

Best regards,

Rev, Grace Morton

Dear Chair Weisz and members of the House Human Services Committee,

My testimony is in opposition to House Bill 1301. I ask that you give this bill a Do Not Pass.

The American Association of Pediatrics has provided an evidence-based gender-affirming approach to caring for transgender and gender diverse young people. You can read about the release of this policy statement **here**, which is further linked to the policy statement, itself. The proposed legislation of Bill 1301 runs counter to what we can read there: **a clear, consistent and compelling piece of guidance from our nation's largest association of medical professionals trained and experienced in caring for our nation's young people.**

Why am I, a Minnesota resident, writing this testimony? The vast majority of my 30-year career has focused on working with young people in school and ministry settings. I am committed to their well-being.

Best Regards,
Jon M. Leiseth

100 4th St S, Ste 608
Fargo, ND, 58103
701-264-5200 (p)
701-999-2779 (f)
info@canopymedicalclinic.com

Dear House Members,

I am the Medical Director at Canopy Medical Clinic, located in Fargo. Our clinic specializes in the medical care of LGBTQ+ individuals. I am writing in opposition to HB 1301, and I ask that you give this bill a **Do Not Pass** recommendation. HB 1301 seems to target one of our most vulnerable populations, which are our neighbors and community members who identify as transgender and gender diverse.

Our clinic treats individuals 16+ for gender dysphoria, using evidence-based medical guidelines. These guidelines have been put forth by numerous national healthcare associations and medical organizations, using decades of research on treating transgender individuals. As a medical provider, it is unethical to disregard medical guidelines that are effective and based on evidence. We know that treating individuals, both adults and youth, with gender affirming hormones and gender affirming surgeries is often the only way to treat their gender dysphoria. Research also shows us that these treatments reduce depression, anxiety, and suicide rates in all individuals.

I can not think of any other life-saving medical procedures or treatments that are criminalized by the State. I often hear arguments from non-medical providers that a youth's brain isn't fully developed yet, so we shouldn't be providing gender-affirming treatments. This hardly makes sense, as the medical community does not deny any other life-saving procedure or intervention in fear of a youth's brain not being fully developed. The decision for a youth to start hormones does not come rapidly or without input from parents, therapists and medical providers. When a youth starts hormones or receives other gender-affirming medical treatments, it is a carefully thought out decision from all parties involved, often with months of decision making and therapy before an individual receives a prescription.

To criminalize a medical intervention that has been researched for decades, ND would clearly be targeting a specific population of people for no other reason than misunderstanding, fear and prejudice. I have personally treated youth with hormones who have gone from severely depressed and suicidal, to budding teens who are able to live their life to the fullest once their body is being exposed to the correct hormone. In recent weeks, a parent of a transgender youth told me she has never regretted the decision to have her son start gender-affirming hormone therapy, but instead regrets living in ND where these hurtful bills are being introduced. Again, it is completely unethical for the State to criminalize a medical provider for providing care that is life-saving, life changing, and based on decades of research.

For the reasons listed above, I again urge a **Do No Pass** recommendation for this bill.

Heidi Selzler-Echola, MSN, APRN, WHNP-BC
Medical Director
Canopy Medical Clinic

hechola@canopymedicalclinic.com
701-264-5200

January 23, 2023

Dear members of the House Human Services Committee,

My testimony is in opposition to House Bill 1301. I ask that you give this bill a Do Not Pass.

This proposed bill is certainly not an example of “small government.” This is BIG government, getting into the personal health care decisions of families and parents of transgender teens. It also will further erode the desire for families with transgender children to move to or remain in the state. Please give House Bill 1301 a Do Not Pass!

Thank you for your consideration.

Sincerely,

Christopher Gable

Grand Forks

Dear Senators, I am writing in opposition to HB 1301. This bill is a dangerous and harmful affront to the human rights of every North Dakotan this bill targets and every North Dakotan's ability to treat everyone with the kindness, dignity, and respect we all deserve. HB 1301 is discriminatory and aims to undermine the current standards of care for transgender individuals and is an effort to undermine all North Dakotan healthcare professionals the ability to do their jobs responsibly.

Additionally, HB 1301 section 23-52-03 proposes the ability for parents or next of kin the ability to bring wrongful death action against the health care provider or medical facility employing the provider if alleged to have violated section 23-52-02, but what about the children of North Dakota that would die due to the lack of the lifesaving healthcare services that HB 1301 intends to disallow? In 2022, 93% of transgender and nonbinary youth said that they have worried about transgender people being denied access to gender-affirming medical care due to state or local laws and nearly 1 in 5 transgender and nonbinary youth attempted suicide (Trevor Project 2022 National Survey on Youth Mental Health).

I firmly believe that HB 1301 would not protect North Dakotan youths, but rather further disenfranchise them from successful and prosperous futures. We all want the future generations of North Dakota to grow up happy, healthy, and hopeful to give back to their communities, but HB 1301 severely limits an entire population's ability to do so.

As a lifelong resident of North Dakota, I urge the committee to listen to the experts in the field and vote NO on HB 1301.

## Chairman Weisz and members of the House Human Services Committee,

My name is Maura Ferguson and I am writing this testimony as a resident of ND and independently from my employer. My views do not represent my employer. I write to you today as a community organizer, a mother, and as someone who cares very much about the LGBTQIA+ community.

I strongly oppose HB 1301 and I urge you to do the same. The North Dakota legislature has no business making medical decisions for
ND residents. These decisions should be left to medical professionals and parents with input from the children themselves. This bill is government overreach that is rooted in fear of gender nonconforming people, and that is wrong.

This bill is one of many that are meant to make transgender people feel unwelcome in our state and that is so shameful.

I urge you to vote Do Not Pass on HB 1301.

Sincerely,

Maura Ferguson, LMSW
Grand Forks

Dear Chair Weisz and members of the House Human Services Committee, My testimony is in opposition to House Bill 1301. I ask that you give this bill a Do Not Pass. The reason for this is that it is harmful to our children and you are attacking the constituents that you are relying on to keep you in office. You are wasting the tax payers money attacking them and their children. a. Personal Impact: This bill impacts the people I care about, because I have children who are non-conforming and they have friends who are non-conforming. b. Unintended Consequence: This bill creates inconsistency with interstate competition and could invite lawsuits, other consequences may include children harming themselves or even attempting suicide. Both things I will not hesitate to make known the role you played in causing this. Thank you for your time, consideration, and service to our state.

Best regards,

Rody Hoover Schultz

Dear Committee Members,

I am a former “trans” kid. I started identifying as a boy in 1st grade after a brutal sexual assault.

I have no doubt that if I had. the option to take puberty-blockers and cross-sex hormones, I would have done everything I could to obtain them, including threatening suicide.

In the short term, it would have been so much easier to kill myself as a girl and attempt to become a boy with puberty blockers, cross-sex hormones and surgery, rather than work though the difficult feelings related to my trauma.

Initially, I probably would have felt better.

Testosterone is a controlled substance and almost anyone who takes it initially feels a sense of euphoria. It would have boosted my confidence and increased my energy.

It would have allowed me to completely dissociate from myself as a girl and create a new persona who could pretend that the horrible trauma that triggered my gender dysphoria didn’t happen to me.

But in the long term, it would have reinforced the mistaken belief that caused me to develop gender dysphoria:

That it was too dangerous to be a girl.

If I had been medically transitioned, I wouldn’t have gotten the help I needed to work through my fear, self-hatred, and shame.

I never would have realized that my transgender identity was a coping mechanism. I have talked to dozens of detransitioners who were not so lucky, like those sharing their stories with you today.

I am grateful to the therapists who helped me understand that my gender dysphoria was a result of the sexual assault not because I was inherently flawed or born in the wrong body.

Puberty blockers and cross-sex hormones allow children to avoid facing their problems, whether that be grappling with homophobia, struggling with autism, or trying to recover from a significant trauma.

It is our job as adults to give children the message that no matter how intense and difficult their feelings are, they can work through them without dissociating from themselves to become a different person, irreversibly damaging themselves in the process.

We know that encouraging children to run away from their pain and struggles is not a good solution, even if it makes them feel better in the short term.

It is natural for children to do what they can to shut down difficult feelings, which is why we have policies to stop them from self-medicating with drugs and alcohol. We need similar policies to protect children from the dangerous effects of puberty blockers and cross-sex hormones.

Because of loving, caring, and supportive adults, I got the therapy I so desperately needed as a child.

Therapy gave me the gift of healing and I am so incredibly grateful.

I urge this committee to provide the children of North Dakota who are struggling with gender dysphoria the same gift.

January 23, 2023

Chairperson Lee and Committee Members,

I urge a Do Not Pass on HB 1301. Medical decisions should be made in consultation with the patient and doctor, and parent/guardian when appropriate. This bill removes the right for individuals and parents to make the best health care decisions for themselves.

Sincerely,
Gretchen Deeg
Bismarck, ND

Testimony in Support of House Bill 1301

My name is Catherina Girton, and I identified as a transgender male beginning at age 13. I medically transitioned later as an adult. After years of struggling with gender dysphoria, along with diagnosed anorexia, bulimia, anxiety, and depression, I thought that pursuing medical transition and living as the opposite sex would bring me happiness. I believed what trans activists told me: transitioning was my best option and the only way to prevent suicide.

I received a prescription for testosterone from Planned Parenthood after only a 30-minute phone call with a doctor. No blood work nor therapy was required. My other serious psychological issues, as well as my hesitation due to being unsure of the effects testosterone would have on my singing voice, were of no concern to the doctor. I was a semi-professional singer at that time.

Hormones, but not therapy, were covered by my health insurance. After just a few months, a second Planned Parenthood doctor wrote me an approval letter for a double mastectomy, also without any in-person meeting or recommendation that I address my other mental health issues first.

After four months of injecting testosterone, I suffered health side effects, including heart palpitations, stabbing pain in my right side, nausea, vomiting, and edema. I acquired a vocal disability that made it painful to speak or sing. I was forced to make the difficult decision to stop transitioning. Although most of my health symptoms resolved, I still struggle with daily vocal discomfort and pain.

I am one of a quickly growing number of detransitioners: individuals for whom transition not only failed to improve, but worsened, their situation. Sadly, the lack of proper evaluation and medical negligence I experienced are common themes expressed among this group.

Gender dysphoria is a symptom and often temporary. In contrast, transgender body modification is permanent, known to cause negative health effects, and has not been shown to improve mental health long-term.

While puberty blockers are often called “fully reversible” or a simple “pause button” by trans activists, this couldn’t be further from the truth. These drugs halt the development of the reproductive organs, interfere with bone maturation, and may permanently stunt brain development (1-4). Marci Bowers, president-elect of WPATH, has admitted that every male child they have treated with puberty blockers suffers from permanent sexual dysfunction (5). Over 95% of children who start puberty blockers proceed to cross-sex hormones, completely bypassing natural puberty, which has catastrophic, life-altering health effects (6-7).

Today, gender identity ideology is even more pervasive than it was when I was a teenager. Children are learning from the internet, TV shows, friends, and even school personnel that they might be in the wrong body and require drugs and surgeries to correct this. I was forced to wait until adulthood to transition, which I'm grateful for now. Had I had access to puberty blockers, testosterone, and surgeries at such a young age, I'd likely be sterile, suffering from osteoporosis, stunted brain development, and any number of unknown health issues, since gender transition procedures have not been tested through clinical trials or controlled studies.

After spending two years healing from my transition experience, I have come to accept my biological sex. Believing transition was the only option led me down a path that resulted in irreversible damage I will live with for the rest of my life. Others went much further in their transition and now regret having body parts removed or feel devastated they will never be able to have children. It is insane to even consider that minors can consent to permanent body modification resulting in the loss of their future fertility and a lifetime of serious health problems.

I wholeheartedly support House Bill 1301, which safeguards children from making irreversible damaging decisions and becoming victims of medical experimentation. Extreme body modification is not a treatment for mental illness, and it is barbaric to practice it on children.

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Dear Chair Weisz and members of the House Human Services Committee,

My testimony is in opposition to House Bill 1301. I ask that you give this bill a Do Not Pass. The fact that we have a bill going through the North Dakota legislation that is aimed at telling parents and youth how to use their healthcare is again the state trying to regulate their citizen. This also hedges on the idea that we can pick and chose how gender expression and sexuality can be governed. This goes against every scientific study and scientific fact that is common knowledge to those that actually do real research. You can't change DNA. To be LGBTQIA2S+ cannot be groomed or changed by anyone. The science has already proven it. Youth is constantly told by the state of ND that they are less than. We have some high suicide rates among our LGBTQIA2S+ youth because of these very actions of our state.

You can't say that you want to protect the children of North Dakota and then pick and choose. Truly it is that simple.

It is for these reasons that I ask you to vote Do Not Pass. Thank you for your time, consideration, and service to our state.

Best regards,

Sarah Galbraith

I support bills:
HB 1254 & 1301

Jeff Miller
707 Aster Loop
Minot, ND  58701

Dear Members of the Human Services Committee,

I am writing to oppose HB 1301 which prohibits gender-affirming medical care.

Our esteemed doctors in the North Dakota take the care of their patients seriously, and act in the best interest of their patients. This bill is asking them to put aside what is best for their patients. Passing this bill will further our crisis of medical professionals because it will make it more difficult to recruit doctors who know they can not provide the best care for their patients. In addition, it will send LGBTQ youth who can afford it to neighboring states to get their medical care.

Do we really want more of our talented doctors and our patients' dollars going out of state?

Please keep our doctors in North Dakota and our LGBTQ youth safe and vote Do Not Pass on this bill.

Sincerely,

Kathy Hintz
Minot, ND

January 23, 2023

Opposition to House Bill 1301

Dear House Members,

My testimony is in opposition to HB 1301. I urge you to give this bill a **DO NOT PASS**.

*Gender dysphoria (previously gender identity disorder), according to Diagnostic and Statistical Manual of Mental disorders are defined as a "marked incongruence between their experienced or expressed gender and the one they were assigned at birth." People who experience this turmoil cannot correlate to their gender expression when identifying themselves within the traditional, rigid societal binary male or female roles, which may cause cultural stigmatization. This can further result in relationship difficulties with family, peers, friends and lead to interpersonal conflicts, rejection from society, symptoms of depression and anxiety, substance use disorders, a negative sense of well-being and poor self-esteem, and an increased risk of self-harm and suicidality. Patients with this condition should be provided with psychiatric support. Hormonal therapy and surgical therapy are also available depending on the individual case and patient needs. (*Garg G, Elshimy G, Marwaha R. Gender Dysphoria. [Updated 2022 Oct 16]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan.)

Transgender people (including non-binary and third gender individuals) have existed in cultures worldwide since ancient times. The modern terms and meanings of “transgender”, “gender”, “gender identity”, and “gender role” only emerged in the 1950s and 1960s. Many people in western societies, particularly the United States, have been unaware or ignorant of the existence of people we call transgender today. **Western societies have had an unfortunate history of dismissing or persecuting groups of people who were outside what the majority of the population considered “normal”.**

I cannot understand how so many people in this state fail to take the time to understand transgender people or the LGBT community as a whole. The disturbing rhetoric, largely rooted both in bigotry and ignorance, that I hear on an almost daily basis make me sick to my stomach. Homosexuality was considered a mental disorder for decades by the western medical community. Homosexuals are still are executed in many parts of the world today. Homosexuality is no longer considered a mental disorder because it is not a mental disorder. It is a natural variation of human sexuality. The fight for the rights of transgender people today is no different than the gay liberation movement of the late 1960s through the mid 1980s. Transgender people are not going away and deserve to be fully embraced by our society. The confused, hurtful, vile and dehumanizing language that a concerning amount of people use, particularly when discussing transgender members of our community, is absolutely disgusting and needs to stop. Trans people should not be referred to with language such as: anomalies, exceptions, deformities, mentally ill, etc. Similar language has been used throughout history to ostracize groups of people who are different from the majority of the population in an attempt to dismiss them as freaks and perverts for simply trying to exist in the world. **Trans people are not a threat to society.**

People need to understand that being transgender, albeit rare, is also a natural variation among humans. Transgender people deserve respect and access to healthcare just like everyone else. I frequently hear unkind language used by my fellow North Dakotan's regarding trans people, gay people, lesbians, etc. The recent rise in, what I call, *anti-trans-panic* is largely driven by political right-wing media outlets such as *FOX News;* far-right outlets such as *Newsmax* and *One America News Network*; and other outright hateful organizations such as *The Daily Wire* (founded in 2015 by religious fundamentalists Ben Shapiro and Jeremy Boreing). The latter organization recently produced a disgusting, misinformed, hateful, and dishonest film titled "*What is a Woman*". Anyone who has had any exposure to this film should have been able to easily recognize the intentionally dishonest jump-cut editing tactics and the film's overtly cartoonish condescending tone. It was one of the worst pieces of "journalism" ever produced in the modern era. Anyone with a basic level of critical thinking and media literacy would have been able to identify this film for what it was. Unfortunately, too many people are unwilling to think critically and question any of their preconceived notions of what people are, how people interact in society or how the world actually works. **The existence of transgender people is not a political issue. It is a medical and human rights issue.**

I have heard many people express concerns about irreversible side effects about medical treatments for transgender youth. What people are ignoring is the extensive diagnostic testing and specialized counseling that occurs when determining whether or not a child is transgender in the first place. Children who are suspected of being transgender begin by transitioning socially. This can include letting the child wear clothes typical of the opposite gender, referring to the child by their preferred pronouns, referring to them a different name, etc. Children during this stage of "social transition" are monitored closely by their family, community and their health care specialist. These children are not coerced in any way to maintain their behavior. Evaluation continues until the child reaches a particular stage of puberty and at that time medical intervention can become necessary. The effect of puberty blockers, within the first few years of taking the medication, is indeed reversible and would be stopped if there was evidence that is in the best interest of the child to continue through the puberty that aligned with their assigned gender (sex) at birth. If this is not the case then the child could proceed with further medical intervention which would allow their body to develop in a manner consistent with their gender identity. By contrast, allowing a transgender child to physically develop in a manner consistent with their assigned gender (sex) would indeed cause many irreversible physical characteristics. In adulthood, a transgender person, whose body was developed by their natural puberty, could have a very difficult time transitioning into a body consistent their preferred gender identity. Certain characteristics such as their voice, bone structure, etc., can make it difficult, if not impossible, for them to blend into society and live as the gender they identify as. **The diagnostic and treatment processes need to be left to medical professionals.**

Suicide is the second leading cause of death among people from the ages of ten to twenty-four. Lots of young people think about it. LGBT people, in that age group, are almost five times as likely to have attempted suicide than their heterosexual peers. What is worse is that LGBT youth who report coming from non-accepting and non-supporting families are eight times more likely than the other LGBT youth to have attempted suicide. So, we're talking about people who are eight times more likely than the people who are already five times more likely than the rest of the population in that age range who may attempt to kill themselves. This is exacerbated even further by people on TV who attribute the suicidal ideation of LGBT people to a mental disorder that these children, and young adults, don't even have.

Everyone in this country deserves access to healthcare. Transgender youth and adults are no exception. HB 1301 seeks to further reduce the limited Healthcare that American's have access to in the first place. Decisions concerning the health of all American's need to be kept between the patients, their loved ones and their doctors. **The government has no business intervening in the medical care that people receive from their doctors and any attempt to do so is a massive authoritarian overreach of the government**. Medical care needs to be handled by medical experts who are trained to follow the scientific evidence wherever it leads.

Please be kind, open minded and understand that the children being targeted by this bill do not need your help. They are already loved and in good hands. There is no need to intervene in their medical care. **This bill will cause far more pain and suffering in the lives of people who don't deserve it.**

I strongly urge you to oppose HB 1301.

Shawn Nixon

In support of 1301

District 18

This bill is necessary as children all over the country are being mutilated and scarred emotionally and physically by “affirming” care. The only ones who benefit from this lifetime dependency on surgeries and medications are the hospitals and pharmaceutical companies that can rake in $450,000 for each child that they destroy.

Children cannot understand the consequences of these decisions and parents should not be bullied into thinking that this is the only way to help their child who is having a hard time growing up. Statistics and studies show that getting help to accept the weirdness of your changing body is what actually helps to prevent suicide. Destroying a child’s body, fertility, ability to ever experience sexual pleasure, and turning them against their parents is a recipe for disaster and lifelong turmoil.

We know that if someone is struggling with anorexia, we wouldn’t affirm them and sign them up for liposuction. If someone is not feeling comfortable in their body, we shouldn’t be offering untested, unsafe, and irreversible medications and surgeries as the fix.

Anyone who is in support of these barbaric practices is either financially benefiting or trying to affirm their own twisted view on reality. Parents should be able to bring a cause of action against anyone causing this harm to their child.

Erin J McSparron

January 23, 2023

Re: HB 1301

Dear Chair Weisz and members of the Human Services committee,

My name is Kara Gloe. I am a mental health therapist licensed in both North Dakota and Minnesota. I work at Canopy Medical Clinic in Fargo, ND. Among the primary populations of people I serve are lesbian, gay, bisexual, transgender, queer, intersex, asexual, aromantic, and Two Spirit (LGBTQIA2S+) folks in North Dakota – including students in North Dakota's public schools. I urge you to vote ***Do Not Pass*** **on HB 1301.** If passed, this bill would do irreparable harm to transgender youth throughout North Dakota; attempts to superseded well-established clinical guidelines; infringes upon the rights of parents, children, and doctors; and will drive businesses and professionals out of the state. This bill and every other like it is already doing damage and would be devastating if passed. Gender affirming care is not only necessary but literally lifesaving.

First, the data on the lethality of being a young trans person in the State of North Dakota is concrete. For trans high schoolers in North Dakota we know:

- More than half seriously considered suicide in the last year
- That rate is 3.3 times higher than their straight cisgender counterparts
- 30.4% attempted suicide in the past 12 months
- That is five times higher than their straight cisgender counterparts

This data, which focuses solely on youth in North Dakota, is easily accessible as part of the 2021 Youth Risk Behavior Survey. These are the stats before the 2023 North Dakota legislature introduced 16 bills, to date, which will either directly target or will severely disrupt the lives of our transgender friends, family, and neighbors. We also know being transgender is not a mental health disorder. The American Association of Psychologists removed it as such in 2012. It is now recognized by every major healthcare organization – mental and physical, as a health disorder, specifically a sex disorder. Meaning, the 50% of trans youth in North Dakota who have seriously considered suicide in the last year have not done so *because* they are trans. Rather, the increase in suicidality is due to minority stress, discrimination, and ostracization.

Further, there seems to be misunderstanding regarding how a minor child, their parents, and their doctors arrive at the decision to start gender affirming medical care. It is not because the child woke up one morning, decided to try on another gender, and immediately walked into their doctor's office. Rather, it is a process people, of all ages, go through and a recognition they come to over time. Beyond one's personal process, the clinical guidelines used by physicians and mental health professionals require "The experience of gender diversity/incongruence is marked and sustained over time." For a person to receive a gender identity disorder diagnosis, people must experience incongruence with their body for at *least six months*. Before a minor can be recommended for hormone replacement therapy it is recommended both they and their family receive "age-appropriate information about gender development," and "about potential gender affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation." Further, it is often required by doctors and/or insurance that patients have a letter of recommendation from a mental health therapist before they begin hormone replacement therapy. Before an adolescent can be recommended for gender affirming surgery, they must have *at least 12 months* of continuous hormone replacement

therapy and likely a letter or letters from a mental health professional. The decision by the child, parents, and doctor to receive/provide gender affirming care is thoughtful and thoroughly considered. Furthermore, medical care best practices are established through well-researched and widely accepted guidelines that require sustained gender incongruity over time.

Lastly, bills criminalizing medical care will force professionals out of the state. We cannot afford to lose more healthcare providers.

Please allow children, families, and professionals with the knowledge and the expertise to provide lifesaving gender affirming care to North Dakota's youth. Please help protect North Dakota's children by voting **Do Not Pass** on HB 1301.

Sincerely,
Kara Gloe, LMSW
Canopy Medical Clinic

**Do Pass Testimony**
**of Doug Sharbono, citizen of North Dakota**
**on HB1301**
**in the Sixty-eighth Legislative Assembly of North Dakota**

Dear Chairman Weisz and members of the House Human services Committee,

I am writing as a citizen and believe HB1301 is beneficial legislation. This seems common sense to wait on what are called “gender affirming cares” when they are a minor. Consider this absolute tragedy and what appears to be a lack of medical care and likely malpractice in “gender affirming cares”. Detransition: The Wounds That Won't Heal | Chloe Cole | EP 319 - YouTube

Please give HB1301 a Do Pass.

Thank you,

Doug Sharbono
1708 9th St S
Fargo, ND 58103

**Testimony in Support of HB 1301**

Dr. Daniel Scrimshaw, DO, Emergency Medicine Physician
Dr. Lovita Scrimshaw, DO, Emergency Medicine Physicians
American Academy of Medical Ethics, North Dakota State Directors
January 23, 2023

Good morning Chairman Weisz and honorable members of the House Human Services Committee. We are physicians in Minot, ND and also serve as the North Dakota State Directors of the American Academy of Medical Ethics. We are testifying in regard to House Bill 1301 and respectfully request that you render a "DO PASS" on this bill.

We would like to quote from the Christian Medical and Dental Associations Ethics Statement related to the medical impact of these procedures which will explain in detail medical reasons for our support of this bill.

> "1. Transient gender questioning can occur during childhood. Most children and adolescents who express transgender tendencies eventually come to identify with their biological sex during adolescence or early childhood. [48,49,50,51,52,53] There is evidence that gender dysphoria is influenced by psychosocial experiences and can be exacerbated by promoters of transgender ideology. [27,33] Early counseling for children expressing gender dysphoria is critical to treat any underlying psychological disorders, including depression, anxiety, or suicidal tendencies, and should be done without promoting attempts for gender transitioning.
> "2. Hormones prescribed to a previously biologically healthy child for the purpose of blocking puberty inhibit normal growth and fertility, cause sexual dysfunction, and may aggravate mental health issues. Continuation of cross-sex hormones, such as estrogen and testosterone, during adolescence and into adulthood, is associated with increased health risks including, but not limited to, high blood pressure, blood clots, stroke, heart attack, infertility, and some types of cancer. [51,54,55,56,57,58,59,60]
> "3. Although some individuals report a sense of relief as they initiate the transitioning process, this is not always sustained or consistent over time. Some patients regret having undergone the transitioning attempt process and choose to detransition, which involves additional medical risk and cost.[56,61,62,63,64]
> "4. Among individuals who identify as transgender, use cross-sex hormones, and undergo attempted gender reassignment surgery, there are well-documented increased incidences of depression, anxiety, suicidal ideation, substance abuse, and risky sexual behaviors in comparison to the general population. [21,22,23,61,65,66,67] These health disparities are not prima facie evidence of healthcare system prejudice. These mental health co-morbidities have been shown to predate transgender identification. [24,25,26,27,28,34,68] Patients' own gender-altering attempts and sexual encounter choices (or, in the case of children, their parents' choices on their behalf) are among the factors relevant to adverse outcomes in transgender-identified patients.
> "5. Although current medical evidence is incomplete and open to various interpretations, some studies suggest that surgical alteration of sex characteristics has

> uncertain and potentially harmful psychological effects and can mask or exacerbate deeper psychological problems. [7,8,9,69] Evidence increasingly demonstrates that there is no reduction in depression, anxiety, suicidal ideation, or actual suicide attempts in patients who do undergo surgical transitioning compared to those who do not. [7,70] The claim that sex-reassignment surgery leads to a reduction in suicide and severe psychological problems is not scientifically supported.[64,71,72,73] „

In our practice of emergency medicine, we have seen many transgender patients who experience depression and suicidal ideation, including patients who have undergone such surgeries and/or hormonal therapies. Unfortunately, such surgeries and/or hormone therapies did not help their psychiatric illness; often these procedures and hormone therapies worsen their depression. In our practice, this often necessitates admission to inpatient psychiatric care in order to help prevent death by suicide. We support this bill, because sex-reassignment surgeries and hormonal therapies are dangerous and harmful to children (as enumerated above). As the professional Osteopathic Physician Oath says "I will be mindful always of my great responsibility to preserve the health and the life of my patients." The government of North Dakota also shares in this responsibility to protect its children from such harmful therapies.

We appreciate the opportunity to provide testimony on HB 1301 and again recommend a "Do Pass."

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21. Some professional organizations appear to acknowledge the same, even if they generally claim gender-sex discordance is normal. The World Professional Association for Transgender Health says in its Standards of Care that "gender dysphoria" may be "secondary to, or better accounted for by, other diagnoses." (Wpath.org. 2012. Standard Of Care For The Health Of Transsexual, Transgender, And Gender Nonconforming People. [online] Available at:<https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf?_t=1604581968> [Accessed 11 November 2020]. p24) The British Psychological Society says, "In some cases the reported desire to change sex may be symptomatic of a psychiatric condition for example psychosis, schizophrenia or a transient obsession such as may occur with Asperger's syndrome...." (Shaw L, Butler C, Langdridge D, et al. Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients. British Psychological Society Professional Practice Board. Leicester, UK, 2012, p. 26 [Accessed online 16 January 2021 at: https://beta.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20%282012%29.pdf]) The American Psychological Association's APA Handbook of Sexuality and Psychology allows for the possibility that pathological family of origin dynamics may be causal. (Tolman, D., Diamond, L., Bauermeister, J., George, W.,Pfaus, J. and Ward, L., 2014. APA Handbook Of Sexuality And Psychology. American Psychological Association, p.743.)

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**Testimony in Support of HB 1301**

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Dr. Lovita Scrimshaw, DO, Emergency Medicine Physicians
American Academy of Medical Ethics, North Dakota State Directors
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House Human Services Committee
HB 1301
January 24, 2023

Good afternoon Chairman Weisz and members of the Committee. My name is Dr. Heather Sandness Nelson. I am an physician here in Bismarck. Thank you for giving me the opportunity to speak with you today. I am asking for a Do Not Pass of HB1301.

I am a North Dakota native. I was born here in Bismarck and completed my Medical School education at University of North Dakota. I completed my residency training and specifically returned to North Dakota not only to raise my family but to practice Medicine and bring quality healthcare to our residents.

As part of my practice I provide care for transgender patients. This can include medical or surgical affirming therapies. HB 1301 raises several concerns regarding the care I provide my patients.

The bill defines several areas of transgender care that is prohibited because Gender Dysphoria is not a recognized disorder of sex development. I would argue that Gender Dysphoria is a disorder of sex development that is already recognized in the medical community and these individuals should be afforded the same access to healthcare as their peers.

We recognize the International Classification of Diseases (ICD) is a database of medically verifiable disorders. It allows us to collect, classify and report medical conditions. Conditions such as high blood pressure, Diabetes, Breast Cancer and thyroid disorder all have identifying codes. Mental health conditions such as Depression, Anxiety, Post Traumatic Stress Disorder and Postpartum Depression are also medically verifiable disorders with ICD codes. We recognize these as distinct medical conditions with diagnostic criteria that require care from qualified providers to keep a person healthy. We also recognize that failure to properly treat these conditions can result in permanent, irreversible changes.

Gender Incongruence and Gender Dysphoria are the two diagnostic terms used in the World Health Organization's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), respectively. These are medically verifiable disorders within the medical community.

Gender Dysphoria is not a new diagnosis. "Gender Identity Disorder," the "disparity between anatomical sex and gender identity," was recognized in 1980 with DSM III. Gender dysphoria replaced Gender Identity Disorder in the DSM V (2013).

Gender Dysphoria is no different from the conditions I mentioned above. It carries an ICD code. It is a medically verifiable disorder with diagnostic criteria requiring quality healthcare. We also know that failure to properly treat individuals with this condition can result in permanent, irreversible changes.

It should not matter if the individual diagnosed with Gender Dysphoria is a minor. We would not withhold insulin from the child with Diabetes, or thyroid medication from the child with thyroid disfunction just because of their age. We would not ask a child to "think better thoughts" or "calm themselves down" if they had Depression or Anxiety. We would offer those individuals medical intervention and our patients with Gender Dysphoria should be afforded the same.

The decision to treat an individual with Gender Dysphoria is based on standard of care guidelines. Guidelines established by WPATH (Word Professional Association of Transgender

Health) and ACOG (American College of Obstetrics and Gynecologists). These guidelines are evidence based and intended to promote quality, consistent care for transgender individuals.

These guidelines advocate for thorough assessment of adolescents including a multidisciplinary approach to their care. We actively involve the patient's guardian in the consent process and discuss minimum requirements to initiate care as well as long term expectations and outcomes. We do not advocate for irreversible therapies for adolescents.

These decisions are made with careful consideration and most importantly, with guardian consent. Transgender care of a minor, just like any other care of a minor, can not be initiated without guardian consent.

We trust in parents and guardians to direct the care of their child in all aspects of their healthcare. From day one of life they are the medical decision makers and have the legal capacity to accept and even decline medical intervention for what they believe is in the best interest of the child. If a parent or guardian wants to pursue lifesaving medical intervention for their child, they have that right. We as the medical community have the responsibility to present the options for care and the associated risks and benefits. We have the responsibility to answer their questions, however it is in the capacity for the parent or guardian to make the final decision whether to pursue care. The final decision does and should always rest with patient and their family. If the good faith decision of a parent of guardian is sufficient for general medical healthcare, transgender care should be no different.

We do not advocate for irreversible procedures in adolescents. I do not perform Gender affirming surgery in anyone under the age of 18. Gender affirming surgeries such as hysterectomies, oophorectomies, mastectomies, vasectomies, phalloplasty and vaginoplasty would not be recommended for prepubertal individuals. Adolescence is a time of significant physical change, which can lead to failure of some of these procedures if done too soon.

Parents or guardians have the capacity to make medical decisions for their children. They should be allowed to do so in all aspects of their child's care. This includes initiation of gender affirming therapies.

Transgender children and adolescents are a marginalized group of individuals and if we further restrict their access to evidence based care we have failed them. Transgender care is healthcare. To withhold healthcare from a medically recognized patient population is irresponsible and not what we as physicians took a oath to do. I strongly urge for a Do Not Pass Recommendation on HB 1301.

Thank you for time,

Heather Sandness Nelson, MD (She/Her)

Dear Chair Larsen and members of the Senate Industry and Business Committee,

My testimony is in opposition to Senate Bill 1301. I ask that you give this bill a Do Not Pass. Please, I have written this over and over so much so, that I could have sworn like 2 bills ago I already asked for a don't pass this on something eerily similar. However this time as I went and read some of the other testimonies I noticed something in the 'in favors', this phrase *"The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance…"* It goes on a little longer but… that phrase and what follows it popping up in all but one (At the time of submitting) of the Testimonies. Like some sort of anti-trans propaganda copy pasted facebook post by some low effort hate mongering effort. But to their point let me again mention How Once it became more socially acceptable and was no longer punished, Left handed people Came to realize their left handedness and not because of some left handed agenda.

But the 'in favor' submissions I have seen all claim that some sort of Hijacking of medicine by activists (And using a facebook link that talks about the coronavirus as part of the hyperlink as if that is some sort of proof. I don't know, I didn't click it. That's how you get viruses and phishing attempts to your account). It's nothing more than Conspiracies and hate. But these bills, if fueled by the misguided hate of mass hysteria, will do REAL significant harm to the marginalized and vulnerable trans community. This bill seeks to oppress trans,non-binary, and intersex while it helps fuel the bigots that help make us one of the highest 'hate crime per capita' states in the US. The people sending in to support this bill conspired on face book and copy pasted a hateful and factually false narrative to try and guide these laws in their own misguided way and if that is not indicative of the kind of people pushing for this sort of thing I don't know what is. I will say though that my side has credible medical professionals. Theirs has a facebook link with a coronavirus conspiracy thread. Please recommend a do not pass on 1301 and all the other discriminatory bills.
-Nate Brown

Testimony of Mia Halvorson

In Opposition to HB 1301: " Relating to prohibiting medical gender transitioning procedures on a minor; to provide a penalty."

January 24th, 2023

Dear Committee Members,

My name is Mia Halvorson, and I am currently a North Dakota resident and undergraduate student taking classes at both North Dakota State University and Minot State University. I am double majoring in Human Development Family Science and Social Work, with an emphasis on women and gender studies, our youth, and marginalized communities – groups of people that certainly include transgender kids.

First and foremost, I would like to say that transgender kids are not getting gender-affirming surgeries within North Dakota. No insurance providers would cover that, nor would surgeons complete these surgeries without coverage.

Regarding gender-affirming healthcare, such as puberty blockers and hormone replacement therapy, I want to emphasize that these are life-saving treatments for some trans individuals. Trans individuals can start and stop these medications early in their transition with minimal to no side effects.

We should not be putting healthcare decisions into the hands of local politicians. We should leave these decisions to medical providers, parents, and their kids. Please create bills and laws that benefit the state of North Dakota, not bills that target and discriminate against transgender individuals.

I ask that you vote NO on HB 1301 for the reasons listed above, the reasons other individuals testifying provide, and the hundreds of additional reasons I could provide.

Thank you for your time and the opportunity to share this testimony.

-Mia Halvorson

Dear Chair Weisz and members of the House Human Services Committee,

My testimony is in opposition to House Bill 1301. I ask that you give this bill a Do Not Pass.

I've noticed at time of writing, every piece of testimony for HB 1256 appears to exist verbatim for HB 1301. I can't say for sure, but it appears everyone who found fit to testify against one, submitted against the other. I think drawing no difference of attention between these bills, at least so far, so a pretty clear indicator the differences don't specifically matter. The point of these bills is to stop medically necessary trans care.

Language of extending legal rights of cisgender youth to sue doctors, while denying trans youth any bodily autonomy is certainly challenging to our sensibilities and clearly indicates a 2x standard. I'm writing this section, after finishing my HB1256 testimony. The bold choice I appear to be given is if I'd rather my doctors go to jail or give extraordinary healthcare privileges and disadvantages I'm not sure I've ever seen in healthcare legislation or implementation in my life. Is the language in HB 1301 created out of thin air? Is there precedent for any of this? Honestly curious.

Below I explain in what some may call excruciating detail trans healthcare in a nutshell, except it's a very large nutshell. Maybe like a Coconut? Definitely not a peanut. If you're able to think of some larger shell, I recommend utilizing it within this metaphor.

If we can call this what it is, it is a moral panic designed to disenfranchise and harm a minority community. I've heard similar legislation called worse things, by organizations that track hate groups, but I don't want to use that language here. Whatever clever spin is put on it, it goes against all major medical organization guidelines, by the research will cause significant harm to transgender populations, and overrides so many things I know so many republicans care deeply about in terms of keeping the government out of your life and personal medical autonomy. Our government doesn't get to tell us what to do about COVID or vaccines, but it does about hormones? I guess?

It even seems to go against these bold parental rights bills we're seeing this legislative session. If we're giving parents absolute authority to decide their kids' healthcare, why not let parents decide their trans kids healthcare? It really feels like certain legislators were given a paint by number picture and were told the number 4 was trans and they just refuse to paint that in. And then showed everyone their "finished" picture and told us it was "perfect". They kept nudging us with their elbows and winking at us, like they had done something quite clever, but we all really understood what was going on.

So, please vote Do Not Pass for all of the reasons above and below. Vote Do Not Pass because this isn't sensible legislation, it's politicians playing doctor and real people will get hurt.

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I'm a suicide prevention advocate who specializes in LGBTQ+ populations. I'm also an LGBTQ+ Care Coordinator at Canopy Medical Clinic. I was a founder for Harbor Health Clinic, which was a clinic that exclusively treated transgender populations. I am the data outcome expert for LGBTQ+ individuals in North Dakota.

In the last five years I have spent thousands of hours with transgender oriented medicine, patient experience, research, and attending medical conferences. I would like to use my experience to help our public become knowledgeable on the topic.

I'm sad to say that the entire committee hearing and subsequent floor vote on this legislation will take less time than me writing this testimony. I'm writing it at 4:30 AM on what I guess is now Tuesday morning. This will be my eighth piece of testimony I've had to submit because of bills targeting LGBTQ+ individuals within our state that have the capacity to increase suicidality for this population by the data.

On Tuesday, January 24th, the House Human Services Committee will hear two bills banning trans athletes, a bill banning any support of trans students in school, a bill allowing conversion therapy, and two bills prohibiting and criminalizing trans healthcare. How many days will our committees consider the decades of research, expert testimony, or impact these bills will have on communities? Oh wait, they have approximately fifteen minutes per bill I mentioned. I can hardly expect any good governance would be possible in these conditions.

Yet, in the time it takes to order and receive a burger from Doordash, we will hear testimony for HB 1254. A bill that seeks to prohibit and criminalize gender affirming care to youth, presumably on the principle that it is harmful. That is a conversation worth having, but not one that is possible in the fifteen minutes allowed by this committee.

I would like to provide individuals with a detailed history of trans medicine, the disinformation we see impacting it, and what care actually looks like for trans youth. If we are to have reasonable discussions, we must understand the actual problem we hope to discuss. Not the speculation or fear, not the politics, but the reality of medicine for the people who receive it.

**The History of Transgender Medicine**

While reports of trans medicine date back 100 years, with the sex institute in Germany, within America it largely started with Harry Benjamin and Christine Jorgensen in the 1950s. Prior to this time when someone went in to get help for gender dysphoria, they were treated as crazy or having a mental health illness. We tried every intervention we could think of to help a person with a mental health disorder for decades and that never worked for this demographic. Doctor Benjamin, seeing treatment options for transgender individuals across the world, decided to try allowing affirmation for Christine. This was the first time we had positive results and someone with this condition thrived. It was considered this enormous breakthrough and Christine was celebrated in her time.

Harry Benjamin took this treatment and started researching a guideline to help people like this. This eventually became The Transsexual Phenomenon published in 1966.

At the time there became an antagonistic relationship between patients and doctors, because patients had to present in very hyper feminine ways for the endocrinologist to treat them. They had to all follow a specific script just to get medication and outside of the office would revert to whatever normal and often diverse presentation would entail. With these doctors largely being male, many of their views on women or what a woman was were often overly sexual or stereotypical. These doctors would force their trans female patients to fit these roles before prescription medication.

Part of the treatment guidelines around this also encouraged individuals who transitioned to hide the fact they did. Often it would encourage them to move to different cities to better integrate into their new role. This treatment model ended up having major detriments on trans individuals and social acceptance.

The first being that feminists within the seventies were seeing transgender women as appropriating femininity and womanhood, because they were being forced into hyper feminine stereotypical expressions just to get treatment. This reaction to treatment eventually led to the Transsexual Empire by Janice Raymond, which is the prototype to a political movement that now calls itself the gender critical feminists. This all was created in a reaction to how male endocrinologists forced hyper femininity onto trans patients or didn't give them treatment.

Another consequence of this is that often trans patients would lie and tell doctors what they wanted to hear, because they were afraid if they didn't follow the script, they wouldn't get access to medication. Doctors saw every trans person saying the same thing and mistakenly believed being trans always presented in very specific ways. This distorted our understanding of trans individuals and medicine for a pretty long time, because of the harsh gatekeeping models to care. And what we understand is the stricter we make care or the more hurdles trans people have to jump through, the more likely they will lie to get the services they think they need.

This means more restrictive models tend to be more harmful, because it becomes more difficult to honestly talk with and screen individuals. If trans individuals see care as extremely limited and their chances of getting care strict, they won't take any chances on talking about doubt or insecurity when talking with doctors. A lot of modern detransition stories seem to follow similar pathways of the patient paving forward and saying whatever they had to, misleading doctors into thinking care was appropriate.

The other detriment is that we never had the cultural conversations in the sixties or seventies, because of medicine encouraging trans individuals to hide. We didn't really start having these conversations in any meaningful way until the last ten years. And this creates this discordance we see today. Where the medical field has seventy years of research, knowledge, guidelines and practice and the cultural field has barely ten.

Because of this people who are new to trans medicine think trans medicine is new. They think we just start throwing hormones at kids and adults and have no idea what we're doing. I have given training to over a thousand people and I ask every person I train how long they think we've been providing hormone therapy to people in America and the most common answer I get is ten years.

The Transsexual phenomenon published 1966 became the groundwork for what we call the Standards of Care that the World Professional Association of Transgender Health puts out. The first edition was released in 1979 and since then we've published 8 editions, with the last one coming out in 2022. The last edition is 260 pages long and features 100 pages of citation to research. It took two years, with dozens of experts in their field, to come to the best guidelines possible in treating transgender youth and adults.

I just wish people could see it, could read through the research, guidelines, and considerations to understand why care is like it is. Oh wait, here it is: https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.

That guideline represents 70 years of work. Yet, we'll have approximately 30 minutes to talk about this, with mostly individuals who have never done clinical research, gone to medical school, have talked to trans individuals at all, or know literally anything about any of this. People who have been fed misinformation and misrepresentation of research or over exposure of purported harm.

**Disinformation Around Trans Medicine**

Before we talk about transgender medicine or the disinformation around it, we need to consider why every major medical organization supports trans affirming care. We hear that trans affirming care is this leftist ideology or wokeness gone too far or some other asinine conspiracy theory with no substances and we cannot move past this point until an answer is firmly settled.

Honestly, most people have no real interaction with medical care, research, or major medical organizations. They have no idea what goes into it at all. What they do have access to is things like "What is a Woman?" by Matt Walsh. They have access to infotainment and they think what they're seeing is this exposé on the real horrors of trans medicine and not a carefully constructed disinformation campaign to radicalize individuals into a moral panic.

We are loaded with highly charged language like mutilation, groomer, or irreversible to offend the sensibilities of average people. We frame trans experts with a critical and skeptical lens, we ignore any positive outcomes, overblow the negative, give platforms to the most skeptical, and create narratives that position themselves as "just asking questions" to appear neutral to an audience. But the conclusion you will come to from that movie is abundantly clear. You will walk away saying that gender shenanigans have gone too far, it's hurting everyone, and it needs to be stopped. That is the only goal and real message of that movie. Every bit of it is designed to take you to the journey to agree with how it ends - politically attacking people who support trans youth.

So, how did doctors fumble so much? How how major medical health association miss what Mr. Walsh presented so clearly and obviously within his documentary? That is the real question here. How did this political pundit who has a long history of being anti-LGBTQ+ stumble into this truth that nobody else was brave or smart enough to find?

Because he didn't. He gained interviews under false pretense and heavily manufactured a narrative through which he went on to lead a campaign against a children's hospital that resulted in bomb threats. In December, I noticed almost every day Fox News ran another piece on a person who detransitioned. These are heartbreaking, sobbing stories of people harmed by gender affirming care. And the intent of the stories is to show this harm and frame it as the norm, rather than the rare exception.

If this is the only information people have to go on, then banning medical care is the only logical and sane thing to do. If this is the only information people have to go on it is easy to believe medical care has been taken over by wokeness or ideology, because how else could we explain this nonsense?

Well, a few things come to mind. Detransition harm is extremely over exposed. Modern demographic research suggests it accounts for approximately 1-2% of individuals treated. When you think about trans care, do you get the impression it is helpful for 98% of people who pursue it? Because that is what the data suggests. If you think that transition care hurts 10% of the people treated, you are thinking of the problem as five times worse than it is. And that isn't even looking at the nuanced complexity involved in detransition and why someone chooses to detransition.

Doctors who treat patients see this overwhelming amount of success, improved outcomes, reduce suicidality for the vast majority of their patients. Research, time and time again, proves affirming individuals in how they identify helps community health. Every effort is made to help ensure transition treatment is correct for an individual and I'll get into that later, but the reason people believe transition treatment is harmful is political disinformation. Literature suggesting otherwise simply does not exist in modern medicine. (I refer you to the 260 page standard of care).

Other questions come up. Puberty blockers, doesn't that destroy bones? I read that in the New York Times, so it has to be true! No, puberty blockers can impact bone density in a number of ways that should be monitored and managed. Things doctors are aware of and if there are underlying conditions blockers shouldn't be used. If this was ignored and not mentioned as part of care, that is a doctor failing, not the medical guidelines. Further, bone density tends to be lower in trans populations due to malnourishment often attributed to depression and anxiety because of minoritized stress. So there is limited research showing improvement on mood and nutrition could offset any diminish within bone density. That would disappear if society was very kind and nice to trans people as a default though.

Yes, but aren't hormones causing irreversible damage to kids, how dare doctors!? Irreversible…hmm. I believe, natal puberty is also irreversible and requires medical intervention and surgery to correct for trans adults. Why do we not frame the harm natal puberty has on transgender individuals as irreversible? If kids are too young to know they're transgender, how come they're old enough to know they're cisgender? How come we can assure all kids are cisgender, but no kids are transgender? Do you see where I'm coming from here? It's one of those standards and there are two of them. I think we have a word for that. Bystanderd?

But, it's mutilation! Horribly disfiguring these kids, how could we allow this? Probably the same way we allow cisgender boys to remove breast tissue and cisgender girls to get breast augmentation done. Because it improves mental health. Vastly more cisgender youth are getting these surgeries than transgender youth. It is that twin standard again. Where things are fine, unless it is transgender youth, then it's irreversible, awful, mutilation, and damaging. I'm starting to hone in on it, it's one third less of a triple standard.

And here is the big problem. Doctors are largely not investing their time having a culture war on reddit. Doctors don't have time to follow this nonsense at all. They are completely baffled by these inane and manufactured accusations. They don't study the culture, political backlash, or disinformation that is happening. They innocently try to talk about their research, experience, and patient outcomes like that has value to a crowd that has been primed to treat any trans acceptance as an agent of woke ideology.

Damn the research, the medicine, the bathwater and the baby, it all has to go. All major medical organizations are simply wrong and we the people by virtue of being mad need to fix this. Only we are qualified to say how the world should work and if someone disagrees, it's them who is political. Incredibly convenient when the people you disagree with all happen to be biased, wrong, and political or pitching an agenda. I wonder what it's like to be that blindingly sure of something.

And we all have bias obviously. I have bias. Nothing in what I'm writing should be taken as the hard truth. This is often what the data suggests, it's what the guideline suggests, it's the best information we have to operate on until better information comes along.

I try very hard to examine my own bias. I constantly think of how much I care about the life of LGBTQ+ individuals and how that is impacting my rationale when thinking about bills like this. And when scrolling through dozens of new pieces of legislation it's difficult to tell the difference between an honest policy to help individuals based on sex placement and a political attack on a marginalized community. But honestly, when I saw the research that only 1% of individuals detransitioned, the first thing I did was share it with doctors I knew and ask them to disprove it, because it seemed too low. Also if our research isn't airtight, it is completely picked apart by anti-trans individuals. Airtight research on the other hand is completely dismissed by anti-trans individuals, but it does add an exciting second layer to the discourse where researchers meet in the bar and cry over science.

I know I can get things wrong. I know medicine isn't always perfect, I know there are doctors that screw up or caution that should be taken when it isn't. But if you care about the thousands of hours I have spent on this, the experiences I've cultivated to improve outcomes and reduce suicidality, I can assure you no good answer comes from banning medically necessary healthcare and it absolutely is not an answer non-medical people will come to good conclusions in within a few hours. So, let me explain what that healthcare looks like.

**Trans Healthcare for Youth**

The very first recommendation is to bring a kid to see a mental health specialist. If a kid talks about being trans or wanting to transition, the first recommendation is getting them to talk to a therapist. That is step one.

A therapist will then talk to the kid. They will assess if this kid is able to adequately express their concerns and then what those concerns may be. They will explore if the issues the youth is having may be better explained by things like traditional body dysmorphia, anxiety over puberty, anxiety in general, or other factors related to what is going on in their life.

It is much simpler to treat all of that than to treat transition related care. Typically the first recommendation to make around care is socially transitioning. For youth this typically means growing out hair for trans girls or cutting it short for trans boys. It can mean using a new name or pronouns. We then assess how the youth is doing in this role, if they feel support, and if it feels right for them. These sessions can be weekly or monthly depending on availability and affordability.

If at any point the youth says this isn't working, we stop. If it appears to improve their mood and involvement, we continue. Transition care is a constant negotiation between a healthcare team, parents, and youth, often for years. Some kids explore gender identity and determine they're comfortable as the sex that was assigned to them at birth. Some don't.

You sometimes hear that kids who socially transition are more likely to go on to start puberty blockers as some scare tactic that allowing social transition starts kids on an inescapable ride to being trans. This would also be true if most kids just knew who they were and largely weren't confused about their identity. And that's probably what's happening here.

Kids can come out as trans at a young age, around five years. This is in line with developmental psychology's understanding of identity development. Some kids will try to come out and be told they're wrong or be hit, so they stop mentioning until later in life. Some kids will know something is wrong with their body, but not have the language to communicate it. Some kids won't really have any alarm until puberty happens and their body starts developing in a way their neuroanatomy doesn't expect. Every kid is different in what their needs are, but we as parents or healthcare providers listen and respond to kids.

We hear arguments that kids are too young to decide things like this, but being trans isn't a choice. We're not electing them into a decision about their 401k retirement plan that requires some serious thought and experience. We are listening to them express distress with their body,

because there is an anatomical conflict as seen in literature review of research and twin studies. Suggesting kids are too young to know this is similar to suggesting kids are too young to know if their leg is broken or they feel pain. It is simply not the right way to look at being trans. Outside of questions of identity, what gender is, what biology is, or what human rights are - we're talking about fundamentally how an individual's physiology is functioning. A trans person's physiology does not care how we define sex, what XY or XX is supposed to be or do, it just knows something went wrong.

Social transition is obviously non-invasive and a safe way for kids to explore gender to see what is right for them. This is healthy and encouraged for any kid who wants to explore it. This doesn't mean we encourage kids to be transgender or cisgender, but rather we show kids they will be loved no matter who they are. We let them play and if they find something that works for them, we explore that.

Once puberty happens there are considerations to be made. Puberty blockers are the first option, to put a pause on puberty. They have risks and side effects that are both known and managed. But this allows the kid, parent, and doctors more time to see if transitioning is right for them. We don't want any kid to go through an irreversible puberty - natal or otherwise, they don't want to. That is a horrifying and traumatizing experience, that is preventable.

So we do puberty blockers typically depending on when puberty starts and what is going on with the people in their life and what will be appropriate for them. This continues with visits to the therapist and check-ins with an endocrinologist. If something isn't working or if the kid says they actually would rather be the sex assigned at birth, we stop and puberty resumes.

So, if they've been doing really well socially transitioning as the sex they identify as, we look at including the correcting puberty through hormone treatment. We again look at if this is working for the kid. We closely monitor their mood and involvement with life. We continue to have conversations as a care team throughout this process. If they've been on puberty blockers and went into hormone therapy, they may not even need top surgery.

If they came out later in life during or after puberty, they may have developed secondary sexual characteristics in line with their sex assigned at birth that are irreversible outside of surgery. As stated earlier in this testimony, this is common surgery for cisgender youth. As they get older, gender confirmation surgery may be considered. Not all trans people will want to pursue hormones or surgery. Often care teams like to see stable trans identity for years before recommending more permanent healthcare options.

While a lot of surgery around trans individuals is framed around mutilation, that is inaccurate for a number of reasons. Often surgeries create empowerment for individuals, increase functionality, increase mood, and improve quality of life. That is again why we do this.

Care for trans individuals is highly personalized and individualized. There is not one treatment that will work for each person as they come to understand gender identity and experience

puberty at vastly different ages and with different access to resources. The vast majority of transgender individuals, when accounted for by minoritized stress and discrimination, report improvement on quality of life, mental health, and physical health associated with transitioning. I will refer you to the 260 page guideline for this, put together by dozens of medical experts, over two years.

It can be hard for individuals who have only ever seen trans stories in the news to understand this care pathway or the benefit it has to patients, because they often just see the people who have the worst experiences. The fact is that healthcare can fail everyone, trans or otherwise. Doctors are overworked and hospitals are understaffed. Not all patients get the focus or care they deserve and that is a challenge in all of healthcare. People who pursue transition may be failed by the medical system in the same way people may pursue help with chronic pain, disability, or a number of other issues and be underserved and misdiagnosed.

The solution to these problems is not eliminating healthcare. It is creating better opportunities and more funding for our doctors and nurses. This is what I've learned attending healthcare conferences representing the current best treatment options for trans youth. I think what may surprise some readers is those who work in trans healthcare are just as offended seeing stories of pain from people who went through gender affirming care. It is just that when we see it, we can understand how the person was failed going through care and what should've been done differently so they could've gotten the care they needed. A layperson just watches it and assumes it's all bad.

**Conclusion**

I wanted to demystify the history of trans healthcare, breakdown disinformation, and explore what it is actually like to treat trans youth and why. There is a reason every major medical association shows affirming and accepting trans youth to be the gold standard of care and that's because it is based on sound practice, research, outcomes, and experience.

This care is evolving, new research is happening, and better models of treatment are devised to make sure patients are healthy and happy. There are hundreds of new studies coming out each year that get added to the literature and consideration of care. If one has concerns they would be well suited to study it or talk to the experts on it.

It took us seventy years of research to get to today. It took millions of hours of conversations, deliberation, conferences, debates, and analyzing literature to determine the treatment protocols for transgender youth from the lens of medical doctors, researchers, and experts. Legislators are not well suited, nor do they have the time to accurately decide the best medical protocols. They are not by virtue of being legislators qualified to practice medicine.

This bill suggests banning the medically necessary, safe, and appropriate treatment by the research for transgender care. If this passes it sets a dangerous precedent that all care can be determined by the whims of legislators and political agents, rather than medical doctors. I think

we can all think of legislators we don't want in our doctors office directly or indirectly, even if they're a person we could watch a football game with. Go Bison!

Please consider voting Do No Pass for this Legislation. I am happy to talk to anyone who wants to learn more about the process.

Thank you for your time, consideration, and service to our state.

Best regards,

Faye Seidler
(fseidler@canopymedicalclinic.com)
LGBTQ+ Care Coordinator
Canopy Medical Clinic

Please give a DO PASS to HB1301. Our children are our greatest commodity. If you don't agree, I wonder why? They're our future. We are tasked with the very high purpose of protecting them and guiding them to become what they were meant to become. That protection presently is being attacked by some very strange ideology that isn't rooted in truth. This ideology is toxic and dangerous. Our children MUST be protected from those who believe they are in a position to "affirm" a child's delusion that they are born into a body that is different than the XX OR XY that their DNA is forming them to become. It's illegal to give chemical castration medications to inmates in America, yet people are telling you it's safe for children. That's just crazy. Our children deserve to be protected, not be some crazy lab experiment for the perverse. Because that's what this is. There is no long term study that shows what chemical castration does to a body of a child. And the sexual mutilation of a child is unspeakable! What child knows at age 15 that they want to no longer be the sex they were created at birth? Have you informed yourself of the tens of thousands of detransitioning stories that are out there? Because I have. I watch them weekly on YouTube. They're everywhere, along with the hundreds of thousands of TikTok's that are now doing the opposite and promoting "Days of Girlhood" or "Days of Boyhood" as they put every kid in America Front and Center to their promotion of how to become rich and famous if you become a TikTok influencer. But that's another battle for another day. Our children need protection from the world around them telling them lies. They are doing irreparable damage to themselves. We need to be the adults in the room and stop this madness. I heard something the other day that stuck. So simple, yet so true: "What we allow, will continue." That is so true of this toxic ideology that's destroying our society. North Dakota needs to say NO MORE.

Thank you for your time,

Vicki Grafing

Thank you for your time,

Vicki Grafing

Dear Chair Weisz and members of the House Human Services Committee,

My testimony is in opposition to HB 1301 and I ask that you give it a Do Not Pass.

For a party whose stated purpose is to “promote sound, honest, and limited constitutional government” this is quite the intrusion. Should parents bring their children to their district representatives before seeing a doctor since legislators feel they’re more informed about what is and is not worthy of medical treatment. This bill, along with other bills heard this week, make it difficult to believe the intent is to protect anyone, especially kids. It’s more likely this bill is to give credibility to rumor and outright lies. If the intent were to protect kids, legislators would educate themselves, listen to medical professionals and the transgender lived experience, and write evidence based bills that had integrity.

Thank you for your time and consideration
Christina

North Dakota Women's Network

**Kayla Schmidt – Interim Executive Director, North Dakota Women's Network**
**Opposition – HB 1301**
**North Dakota House Human Services Committee**

January 24, 2023

Dear Chair Weisz and members of the House Human Services Committee,

My name is Kayla Schmidt and I am the Interim Executive Director of the North Dakota Women's Network. I am providing testimony in opposition to House Bill 1301.

Our mission includes empowering individuals to take an informed role in their health care decisions. We rely on experts to guide us in making these personal choices. We trust that the care we receive is informed and will not do harm.

The expertise of a doctor should not be overshadowed by limited definitions that restrict their ability to treat patients. North Dakotans deserve to receive medical care that is not hindered by interference from the government.

North Dakotans deserve healthcare that preserves their personal liberty, dignity, and privacy. House Bill 1301 endangers these ideals. Whereas we often hear about the need to invest in North Dakota's economic growth, legislation like this is a deterrent for modern families and workers to want to live or work in our state.

Similar attempts to pass discriminatory legislation in North Dakota has strongly been opposed by community leaders, athletic organizations, medical experts, social workers, parents, educators, students, faith leaders, representatives of local Chambers of Commerce and tourism organizations, and the LGBTQ+ community.

The North Dakota Women's Network stands with these groups and asks that HB 1301 receives a Do Not Pass Recommendation.

Thank you.

Kayla Schmidt
director@ndwomen.org

Olivia Data
Testimony on HB 1301
January 24, 2023

RE: Testimony in Opposition to HB 1301

Good morning, Chairman Weisz and members of the committee. My name is Olivia Data, I am the Youth Action Council Coordinator for the North Dakota Women's Network, and I urge you to vote "Do Not Pass" on HB 1301.

The Youth Action Council is an organization that believes in building a future in which youth are empowered to grow, learn, and give back to their communities. But how can we ever reach this future if the youth of North Dakota are not even allowed to be true to themselves? HB 1301 is incredibly dangerous towards the children of our state, and for this reason, I encourage you to oppose it.

Recent years have seen a wave of prejudice and fear mongering towards transgender people. Yet, in truth, the idea that there is a difference between sex – something based on biology and DNA – and gender – a social construct based on the characteristics a culture associates with men or women – is a scientific and social reality, not an edgy trend[1]. People who do not identify with the sex they are assigned at birth have a right to express themselves and feel safe in society just like the rest of us.

Even beyond disagreements about transgender people, it is common sense that medical decisions about minors should stay between parents and their medical providers. Denying a parent the right to make an informed decision with a doctor about what is best for their child would be gross governmental overreach. This is especially true when so many scientific studies have shown that gender affirming care can save lives. According to the National Library of Medicine, 82% of transgender people have contemplated killing themselves, and 40% of transgender people have actually attempted suicide[2]. Among LGBTQ+ youth, those whose identities are not respected by the adults in their life are almost twice as likely to attempt suicide as those whose identities are respected[3]. Affirming a transgender or nonbinary child's identity can save their life. According to Scientific American, data consistently shows that transgender youth who are denied access to gender affirming care tend to have higher rates of suicidal behavior, while those with access to medical treatments are around 70% less likely to contemplate suicide[4]. Furthermore, many forms

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[1] "Gender and health." *World Health Organization (WHO)*, https://www.who.int/health-topics/gender#tab=tab_1. Accessed 18 January 2023.
[2] "Suicidality Among Transgender Youth: Elucidating the Role of Interpersonal Risk Factors." *PubMed*, https://pubmed.ncbi.nlm.nih.gov/32345113/. Accessed 23 January 2023.
[3] "Pronouns Usage Among LGBTQ Youth." *The Trevor Project*, 29 July 2020, https://www.thetrevorproject.org/research-briefs/pronouns-usage-among-lgbtq-youth/. Accessed 23 January 2023.
[4] Boerner, Heather. "What the Science on Gender-Affirming Care for Transgender Kids Really Shows." *Scientific American*, 12 May 2022, https://www.scientificamerican.com/article/what-the-science-on-gender-affirming-care-for-transgender-kids-really-shows/. Accessed 23 January 2023.

of gender affirming care, such as puberty blockers, are reversible and have limited negative side effects[5].

Denying children access to gender affirming care can be a death sentence. Thus, between the limited risks of providing transgender youth with appropriate medical treatment and the severe dangers of denying access, HB 1301 is an extremely concerning bill. Many people who support it claim to want to protect children, but HB 1301 sends a message loud and clear that we would rather have the children of North Dakota be dead than transgender. I know this is not a message I would want to send to any child questioning their safety and value in our state, and I sincerely hope that the members of this committee find such an idea as abhorrent as I do.

HB 1301 will not protect children. In fact, it will endanger the mental and physical health of many children. If we continue in this path of denying transgender children access to appropriate resources, accommodations, and treatments, we will only be building a community full of intolerance and hatred. Rather than protecting and empowering the youth of North Dakota, we will be raising a generation of children who are not confident in their own worth as people and who will not have the tools to properly engage with their communities.

Please, if you value the youth of North Dakota, I urge you to vote “Do Not Pass” on HB 1301. Thank you for your time.

Olivia Data
Youth Action Council Coordinator
District 35
Bismarck, ND

[5] “Puberty Blockers for Youth.” *Provincial Health Services Authority*, http://www.phsa.ca/transcarebc/child-youth/affirmation-transition/medical-affirmation-transition/puberty-blockers-for-youth. Accessed 23 January 2023.

24 January 2023

To Whom It May Concern:

My name is Brenda Thurlow and I live in District 41. I am writing to express my **strong opposition to House Bill No. 1301**, which would prohibit medical care of transgender minors in ND.

I am a pediatrician, with over 20 years of experience practicing in ND. This bill would directly and negatively impact the mental health of patients seeking gender-affirming medical care.

My practice is a 50/50 mix of general pediatrics and specialty pediatric diabetes care. In my general pediatric practice I follow a number of transgender patients. In my specialty practice I work closely alongside ND's only two pediatric endocrinologists. This bill would threaten their ability to practice in our state, and would make it extremely difficult to recruit pediatric endocrinology specialists in the future. Our state has a shortage of pediatric medical specialists and we cannot afford this risk.

Lastly, I am the mother of a young adult who is transgender. I have witnessed firsthand the positive impact of gender-affirming care for our daughter.

Please vote against this harmful bill.

Sincerely,

Brenda K Thurlow, MD

Legislative Assembly

North Dakota
House of Representatives

STATE CAPITOL
600 EAST BOULEVARD
BISMARCK, ND 58505-0360

**Representative Brandon Prichard**
District 8
8600 Creekside Drive
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**COMMITTEES:**
Human Services
Agriculture

**House Bill 1301**
**House Health and Human Services Committee**
**Representative Weisz, Chairman**
**January 24, 2023**

Chairman Weisz and members of the House Health and Human Services Committee,

My name is Rep. Brandon Prichard and I represent District 8 which covers all of Emmons County, rural and suburban portions of Burleigh County, and Wilton which is in McLean County. I am here to testify in support of HB 1301 which would provide a course of legal action for a minor who received a transition surgery, hormone therapy, or puberty blockers with the intent to change the gender of the minor or stop development to consider gender transition. If passed, HB 1301 would give a minor 30 years to bring litigation against (1) their parents if they consented to the surgery or medications, (2) the doctor who performed the gender reassignment surgery or prescribed the gender-affirming medication, and (3) the medical institution that allowed the doctor to preform the surgery or prescribe the medication. Further action could be taken by the local State's Attorney Office or the Attorney General's Office for the purpose of penalizing the doctor and medical institution. The North Dakota Board of Medicine may also revoke a medical license for the infraction. HB 1301 is the sister bill to HB 1254 and would create a civil penalty for the aforementioned procedures and medications, while HB 1254 would only create a criminal penalty.

On page 2 under "Gender transitioning procedure on a minor prohibited – Exceptions," the language would preempt a health care professional from performing gender reassignment surgery or prescribing drugs that intend to change the gender or stop development of a minor. According to the language, "[a] health care provider may not perform or offer to perform a medical procedure on a minor, or administer or offer to administer medication to a minor, if the performance of the medical procedure or administration of the medication is for the purpose of: (a). [e]nabling a minor to identify with, or live as, a purported identity inconsistent with the minor's sex; or (b). [t]reating purported discomfort or distress from a discordance between the minor's sex and asserted identity." Page 2, lines 15-21 would clearly define exceptions for surgeries on minors and medications prescribed, including any surgery that (1) intends to treat a minor's congenital defect, disease, or physical injury, and (2) if the medical procedure or medications were prescribed before the effective date of this legislation. Page 3, lines 16-18 clarifies that "disease" does not include gender dysphoria, gender identity disorder, gender incongruence, or any mental condition, disorder, disability, or abnormality that can be used to justify gender transitioning.

On page 3 under "Private right of action," the extent of a minor to bring a civil lawsuit is defined. Under 23-52-03, a minor may bring a civil cause of action to recover compensatory damages, punitive damages, and reasonable attorney's fees, court costs, and expenses. Page 3, line 24-30 is where the potential liable parties are listed. Page 4, lines 8-15 allows the next of kin or parent if they did not consent to the surgery or medications to bring a cause of action in the case of a wrongful death. If a court in a civil action finds a health care provider or the

administration of a medical facility employing the health care provider knowingly violated the regulations in this bill, the court shall notify the appropriate regulatory authority, the appropriate state's attorney, and the attorney general by mailing a certified copy of the court's order.

On page 5, lines 5-25, a right of action is given to the State's Attorney Office and the Attorney General to penalize and claim a business's profits for performing transition surgeries or prescribing medications. Within twenty years of the violation, the attorney general or appropriate state's attorney may investigate any alleged violation. If there is probable cause to believe that a violation has occurred, the attorney general or appropriate state's attorney may bring an action against a health care provider to enjoin further violations, to disgorge any profits received due to the medical procedure or medication, and to recover a civil penalty of: (a). twenty - five thousand dollars per violation if the violation involved the surgical removal, modification, alteration, or entering of tissues, cavities, or organs of an individual; and (b). twenty thousand dollars per violation if the violation involved prescribing, administering, dispensing, or otherwise supplying any drug or device to an individual. Page 5, lines 26-31 gives the Board of Medicine the ability to strip a healthcare provider of their license if a violation occurs.

Transition surgeries and medications have a brutal and life-altering impact of the recipient. This is particularly true in the case of a patient under the age of 18. Medications like hormone therapy and puberty blockers are linked to lose in bone density and osteoporosis, partial or complete loss of fertility, long-lasting brain fog, increased risk of cardiovascular disease, increased risk of breast and uterus cancers, and harmful psychoactive effects. Meanwhile, the surgeries are permanent and cannot be reversed.

I encourage the Health and Human Services Committee to support the effort to protect the innocence of children by banning transition surgeries and medications on minors. I respectfully ask for the committee to support HB 1301 by giving the bill a "Do Pass" recommendation.

Dear Committee Members,

I am a former “trans” kid. I started identifying as a boy in 1st grade after a brutal sexual assault.

I have no doubt that if I had. the option to take puberty-blockers and cross-sex hormones, I would have done everything I could to obtain them, including threatening suicide.

In the short term, it would have been so much easier to kill myself as a girl and attempt to become a boy with puberty blockers, cross-sex hormones and surgery, rather than work though the difficult feelings related to my trauma.

Initially, I probably would have felt better.

Testosterone is a controlled substance and almost anyone who takes it initially feels a sense of euphoria. It would have boosted my confidence and increased my energy.

It would have allowed me to completely dissociate from myself as a girl and create a new persona who could pretend that the horrible trauma that triggered my gender dysphoria didn’t happen to me.

But in the long term, it would have reinforced the mistaken belief that caused me to develop gender dysphoria:

That it was too dangerous to be a girl.

If I had been medically transitioned, I wouldn’t have gotten the help I needed to work through my fear, self-hatred, and shame.

I never would have realized that my transgender identity was a coping mechanism. I have talked to dozens of detransitioners who were not so lucky, like those sharing their stories with you today.

I am grateful to the therapists who helped me understand that my gender dysphoria was a result of the sexual assault not because I was inherently flawed or born in the wrong body.

Puberty blockers and cross-sex hormones allow children to avoid facing their problems, whether that be grappling with homophobia, struggling with autism, or trying to recover from a significant trauma.

It is our job as adults to give children the message that no matter how intense and difficult their feelings are, they can work through them without dissociating from themselves to become a different person, irreversibly damaging themselves in the process.

We know that encouraging children to run away from their pain and struggles is not a good solution, even if it makes them feel better in the short term.

It is natural for children to do what they can to shut down difficult feelings, which is why we have policies to stop them from self-medicating with drugs and alcohol. We need similar policies to protect children from the dangerous effects of puberty blockers and cross-sex hormones.

Because of loving, caring, and supportive adults, I got the therapy I so desperately needed as a child.

Therapy gave me the gift of healing and I am so incredibly grateful.

I urge this committee to provide the children of North Dakota who are struggling with gender dysphoria the same gift.

January 24, 2023

Human Services Committee
HB 1301

Chairman Weisz and Committee members:

Let the record reflect my support for House Bill 1301 ("HB 1301"), as written and introduced by Representatives Prichard, Dyk, M. Ruby, Tveit and VanWinkle, and Senators Boehm, Dwyer, Paulson and Vedaa.

What is "child abuse" in an era where all terminology and language is under constant assault to obfuscate, demean, and degrade? To borrow from former Supreme Court Justice Potter Stewart: "I know it when I see it." Permanently disfiguring a minor child as a means to avoid addressing an underlying psychological malady IS child abuse, irrespective of what the credentialed lab coat types who stand to reap material monetary benefits from the administering of such "treatments" contend.

Lobotomies and electro-shock therapy were once the darlings of medical consensus.

HB 1301 addresses short-comings in existing statute by providing means of recompense, at least in a monetary sense, for individuals abused as minors under the demonic religion of "gender affirming care".

There is substantial financial incentives for medical providers to disregard their Hippocratic Oath placed into effect by politicians who seek to place themselves in power positions by the administration of large sums of money. HB 1301 provides a counterbalancing financial disincentive for such medical malpractice and barbarism.

Similarly, there is social credit in our current culture to be reaped from being the parent of a "transitioning" child. We, as a collective society, have punishments in place for the exploitation of minors, but seem to disregard if it may offend a newly-minted "protected class". Why? Our foremost duty is the defense of the defenseless if we purport to hold ourselves out as a moralistic people.

We have a moral obligation to defend children. Mutilation, disfigurement, chemical castration and every other "Island of Doctor Moreau" horror being perpetrated upon minors who are incapable of legally making these decisions for themselves is abhorrent and should be thoroughly rejected, renounced, and defeated. Full stop.

I respectfully request a "do pass" recommendation from the Human Services Committee.

Respectfully,

Matthew S. Simon

Hello. My name is Adam Miller, a resident of Bismarck. I am writing in opposition to HB1301.

It is clear in this bill, and the nearly dozen other bills targeting the LGBTQ+ community filed this session, the intent of these bills is not to protect anyone, only to harm that community. Supporters of this bill have suggested that there is a “meteoric rise” in the number of trans people. This is hyperbole and simply not true. Trans people have always existed and in similar percentages of the overall human population as they do now. The only difference now is that they feel society has progressed enough to not oppress them or deny their existence. But, even if the “meteoric rise” were true, where is the harm if they are causing no harm to you? Why are the writers of this bill attacking individual freedoms?

This bill and those like it are not solving problems in North Dakota. They are the result of a political party that has chosen to engage in senseless culture war rather than fixing actual problems at hand. It’s a sign that there is no intention of good governance or making people’s lives better. I expect better from North Dakota and its legistors.

I ask to vote no on HB1301 and every other bill attacking the LGBTQ+ community.

**2023 HOUSE BILL 1301**

**House Human Services Committee**

**Representative Robin Weisz, Chairman**

**January 24, 2023**

Chairman Weisz and members of the House Human Services Committee. I am Danial Sturgill, PhD, a clinical psychologist at Sanford Health Fargo. I am here to testify in opposition to House Bill 1301. I respectfully ask that you give this bill a **Do Not Pass** recommendation.

North Dakota needs to be a state where parents and families are free to pursue the best possible health care for our youth. As a clinical psychologist, I have seen firsthand the seriousness of Gender Dysphoria. It is a serious health condition where a person's internal sense of gender is inconsistent with their body experience. Patients frequently express a sensation of being born into the wrong body. It is a condition that can begin at an early age, but frequently intensifies at or around puberty. For those of us who have never had to endure this painful situation, it is hard to fathom the way that it can negatively impact every aspect of a person's life.

Over the last 30 years, significant research has been conducted on alleviating this condition. Initial efforts at changing the mind (conversation therapy) have been unsuccessful and dangerous (leading to increased depression, functional difficulties, and increased risk for suicide). We have come to understand that gender dysphoria can be best addressed by bringing a person's body experience into alignment with their internal identity. For many, this may involve a social transition. I am aware of many individuals whose symptoms have improved with just this intervention. For others, the body dysphoria is best relieved with positive changes to the body.

There are no known medical treatments for patients who have not yet entered puberty. Once someone enters puberty, a full assessment that looks at biological, psychological, and social functioning is completed. Puberty blocking agents can provide patients, families, and physicians time to evaluate the source of the dysphoria. Effects of puberty suppression are fully reversible and do not preclude later fertility. After thorough assessment, some

patients may go on to benefit from hormone treatment that will trigger secondary sex characteristics consistent with the person's gender experience. Although more rare, some patients require surgeries to further provide relief and a chance for a fulfilling life.

Breast construction should be available for a woman that loses her breasts through cancer. Breast removal should occur for those men who have a condition where breast growth occurs (gynecomastia). In transgender care, similar procedures are life-saving for some individuals. As for other surgeries with youth, these procedures are exceedingly rare and not being done in our state.

When it comes to youth care:

1) Health care providers have an obligation to follow best practice when they diagnose a medical condition. Every intervention meets the standard of medical necessity. To withhold such treatment would be malpractice.
2) I have personally witnessed numerous examples of youth improvements in dysphoria, academic functioning, social functioning, and overall well-being following proper administration of medical interventions. These improvements last into adulthood. Patients that are not afforded this treatment in youth experience a variety of challenges as adults (increased mental health problems, lower economic status, social problems, increased substance use, etc.)
3) Current standards are being followed to rule out conditions or situations that could be better treated by other means. These decisions are being made with multiple providers each of which brings specialized expertise in the decision-making process. There is a careful process of weighing the risks and benefits and sharing this with parents and youth.

To acknowledge that gender dysphoria is a serious medical condition (as members of the legislature have) and then provide no means of treatment would be very cruel indeed. Please allow physicians and families to be the driving force for the health of our youth by voting **DO NOT PASS** on HB 1301.

Thank you for your time. I would be happy to answer any questions you may have.

Respectfully submitted,

Danial Sturgill, PhD
Clinical psychologist

**House Human Services Committee**
**House Bill 1301 – January 24, 2023**
**Testimony of Rachel Sinness, P&A Legal Director**

P&A protects the human, civil and legal rights of people with disabilities. The agency's programs and services seek to make positive changes for people with disabilities where we live, learn, work and play.

Our advocates and attorneys assist not only individuals with developmental and intellectual disabilities, but also those with mental health disabilities. Mental health disabilities include depression, anxiety, and post-traumatic stress disorder, but this is certainly not an exhaustive list. Individuals may be born with mental health disabilities or may acquire them through trauma and other life stressors. P&A works with individuals across all age groups and, as our mission suggests, we support efforts that positively affect people with disabilities while opposing those which do not protect the human, civil, and legal rights of people with disabilities.

The intersectionality between gender identity and mental health is apparent. Transgender and gender non-conforming individuals often experience gender dysphoria, or "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth." Gender dysphoria - Symptoms and causes - Mayo Clinic. Transgender individuals are four times more likely to experience mental health challenges than individuals whose identity corresponds to the sex they were born with. The Intersection of Sexual Identity and Mental Health - Valley Oaks Health. P&A offers testimony today in opposition to HB 1301 because the behavioral health ramifications of this bill to North Dakotans are detrimental.

The Williams Institute on Sexual Orientation and Gender Identity Law and Public Policy estimates there are approximately 150,000 individuals between the ages of 13 and 17 who identify as transgender in the United States. The American Academy of Pediatrics indicates that trans and gender-nonconforming youth are at a substantially elevated risk of poor mental health outcomes, including anxiety, depression, and suicidal tendencies. Medical and psychosocial care is designed to balance beneficence (the obligation to provide a benefit to patients) and nonmaleficence (the avoidance of unnecessary harm). Ethical Issues in Gender-Affirming Care for Youth | Pediatrics | American Academy of Pediatrics (aap.org). Studies routinely show that a lack of access to appropriate gender-affirming care may lead to trans and gender-nonconforming youth being at greater risk of violence, depression, anxiety, and suicide.

Meanwhile, gender-affirming medical interventions are proven to have a positive effect on mental health. An observational study of 104 youths, with data gathered between August 2020 through November 2021 and published in February 2022 by the National Center for Biotechnology Information, concluded that gender-affirming medical interventions including puberty blockers and gender-affirming hormones resulted in 60% lower odds of depression, and 73% lower odds of suicidality. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care - PubMed (nih.gov). Another study of 55 transgender youths who underwent a thorough psychological screening prior to undergoing treatments revealed a complete resolution of gender dysphoria. Ethical Issues in Gender-Affirming Care for Youth | Pediatrics | American Academy of Pediatrics (aap.org).

A 2018 article titled “Ethical Issues in Gender-Affirming Care for Youth” published by the American Academy of Pediatrics, provides that gender-affirming medical interventions are “highly effective in addressing gender dysphoria and mitigating associated adverse outcomes.” The article further suggests that health care providers, patients, and families should carefully weigh the risks and benefits of these medical treatment options. Ethical Issues in Gender-Affirming Care for Youth | Pediatrics | American Academy of Pediatrics (aap.org)

However, HB 1301 would prohibit providers, patients, and families from considering these options and puts the decision solely in the hands of this legislature. As a result, providers, patients and families would have little say over the mental health outcomes of denying these potentially life-saving procedures.

P&A urges a DO NOT PASS on HB 1301, as it does not protect the human, civil, and legal rights of North Dakota youth.

01/24/2023

HB 1301
Testimony in Opposition

Chairperson and Members of the House Human Services Committee:
My name is Naomi Tabassum, and I am the owner, director, and a practicing clinician at New Story Counseling Services in Fargo. I am a Licensed Professional Clinical Counselor (LPCC) in the state of North Dakota, a certified clinical supervisor, and have over ten years' experience in clinical mental health counseling. I specialize in LGBTQ+ issues as they related to mental health, specifically focusing on client who identity as transgender and/or gender expansive.
I oppose HB 1301 for the following reasons:

1. The confusing language of "enabling a minor to identify with, or live as, a purported identity inconsistent with the minor's sex". What constitutes "enabling"? This seems to stretch beyond the act of medically treating into a very vague and undetermined space. "Identify with or live as" seems to expand way beyond the realm of the medical provider's office. Medical providers cannot control or effectively influence how patients live or identify, regardless of medical prescriptions or procedures provided.
2. It is not the position of the legislators in our state to define what does or does not constitute a medical "disease". It would be most advised to keep medical definitions to medical professionals and their licensing bodies and professional associations, nationally and internationally. Gender Dysphoria and Gender Incongruence are well-established medical illnesses with well-established treatable interventions.
3. There is notable focus in this bill on the "injury" of minors and minor's parents impacted by medically treating gender dysphoria. "Emotional, mental, or physical effects of the violation"; "The cost of counseling, hospitalization, and any other medical expenses associated with treating the harm caused"; "psychological and emotional anguish" and so on. In actuality, injury would come from refraining or refusing to treat gender dysphoria. As you

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will read in my testimony as well as the testimonies of other reputable medical and mental health professionals who are testifying on this bill and other transphobic bills, children who have gender dysphoria that goes untreated and unaddressed are more likely to experience depression, anxiety, homelessness, and suicidality. This bill also addresses "wrongful death action" for the treatment of gender dysphoria. Again, wrongful deaths will occur if a medical condition goes untreated and results in death by suicide or emboldened hate acts as a result of this bill passing. Whom do we bring wrongful death actions against in a state where proper medical care has been outlawed? Who pays for the counseling and hospitalizations of transgender youth who experience worsened mental health as a result of their gender dysphoria going untreated?

4. This bill will would seek to undermine the professional judgement of our physicians and autonomy of our parents to provide best care to their patients as children as they see fit. Outlawing gender-affirming care will not stop transgender youth from obtaining treatment. It will drive them out-of-state to seek care elsewhere. I'm sure Moorhead, MN and East Grand Forks, MN will happily benefit from the boost in spending by driving ND citizens across boarders to access healthcare.
5. Finally, threatening the reputable medical providers in ND and their employers with legal penalties for providing safe, effective, and evidence-based care is not a good look. Threatening caring, responsible parents who consent to medical care for their children with legal penalties will not be well-received. Is it the intent of this committee to create a divide between state law and healthcare professionals as well as parents of minor children?

I urge you to render a DO NOT PASS for HB 1301.

**Naomi Tabassum, LPCC**
*Owner, President, and Practicing Clinician*
New Story Counseling Services

Bills like HB1301 are a major reason why I left North Dakota. I have three children and the thought that I, as their parent, would not have the autonomy to make decisions with them and their doctor regarding the best course of action for their physical and mental well being is appalling. The attack on trans and non binary individuals further confirms that I made the right decision in leaving a state that does not view all people as equals.

I see this as a clear cut case of bigotry and genocide. Children who are not given access to gender affirming care are at much higher risk of suicide. Puberty blockers can literally save a child's life. It should not be within the state's authority to interfere in such matters, especially when that interference is costing children their lives.

I happen to have my sex match my gender identity, but it's not hard to imagine how devastating it would be to have been born the opposite sex. I would want my physical body to be female presenting. Could you imagine what it

would be like to have been born into a body that does not match your mind? Are you really wanting to put others through that distress?

I find it ironic that legislators who are elected to uphold the freedoms of their constituents would attempt to interfere in decisions that should be a private matter. Offering gender affirming care ultimately does not have any effect on you or how you choose to live your lives. In your private life, you can think whatever you want. But you were elected to uphold the rights of all North Dakotans, even the ones you may not agree with. Please vote no on HB1301.

Jan 24 2023

In regards to HB1301

House members,

My name is Raymond Rahrich, born and raised in North Dakota. I am opposed to this and the other regressive anti- transgender bills that are being introduced across mostly the Midwest by extremist groups trying to keep us divided. Most of these bills are very similar, as well as the 'form letter' testimony in support of them. The sponsors offer no evidence of there being a problem, so you have to wonder as to the motivation for this bill is.

On the front page of the Bismarck Tribune this morning there is a story about the state spending millions of dollars trying to bring young people to the state to work and raise their families. This bill would have the opposite effect and cause most young people to avoid moving to a state that would restrict their freedom to be who they are.

I have an interest in this bill as personally having transgender members in my family, but everyone should be concerned when local legislators go against science and the medical communities advice. Make no mistake. If this bill goes into effect, it will cost lives.

Please stick to being a REAL conservative and keep the government out of your Doctor's office.

Please do no pass this bill.

TED H HALLEY
(334) 315-7648

I experienced distress about my sex beginning in my pre-teens. I wanted God to make me a girl and at age 8 I fantasized about cross-dressing in my mother's clothes. I experienced feelings of wanting to be a woman and struggling with my gender identity between adolescence and age 50, as an un-married father of 5 and active-duty member of the Military.

At 51 I began attending a cross-dressing group, and that confirmed for me that I wanted to fully transition. I had facial feminization surgery in 2009, a second facial feminization surgery in 2010, over 200 hours of electrolysis to remove all facial hair, and began taking estrogen and spironolactone in 2009.

In 2011, I had genital surgery to remove my male genitalia and a "neo-vagina" was created. Dilation of the "neo-vagina" was very painful for about six months. In December 2011, I had my name legally changed to "Teresa" and the gender marker on my birth certificate and IDs changed. I transitioned to a female identity at work and had breast augmentation surgery in 2012. I was highly functioning and happy with my transition for several years.

After being on cross-sex hormones and living as a female for eleven years, I began to have an intense internal realization that what I was pretending to be was not real. The internal incongruity grew to the point that I became suicidal. I could no longer live what was essentially a lie. I became severely depressed. The only thing that kept me alive was that my granddaughter was living with me and faith in God.

In 2021, I made the decision to detransition. I re-connected with my male biology and re-established my male identity. I stopped taking hormones. I removed the breast augmentation and changed my gender marker and name back to male. I did what I could to change my appearance, cut my hair, stopped wearing make-up and women's clothes, but I could not undo the facial surgery, facial hair loss or the genital surgery. I could not get back the lost organs, **enjoyment**, or functionality. I am unable to ever again even think of the possibility of a "Normal" marriage and have a life-long sexual dysfunction. Still wake up numerous times a night due to hot-flashes from female hormone discontinuation.

I deeply regret having wasted years of my life, the damage and permanent loss to my body, the exorbitant cost of these treatments, and the damaged relationships. The depression was so severe, I think I would have taken my life if I had not detransitioned.

I had been convinced that I was a "female" born in a male body. I had felt that way since childhood. Based on that consistent and persistent conviction, I fully transitioned in every possible way to live and appear as a woman. Now I realize that it was all untrue, a mental state of mind that was subject to change, and that it didn't solve the deeper emotional problems. I urge the board to adopt a rule that will protect others from similar loss and distress.

# House Human Services Committee

## House Bill 1301 – DO PASS

Andrew Alexis Varvel

Written Testimony

North Dakota State Capitol Pioneer Room

January 24, 2023 2:45PM

## Chairman Weisz and Members of the Committee:

My name is Andrew Alexis Varvel. I live in Bismarck, District 47.

One feature of House Bill 1301 that is especially noteworthy is how it limits North Dakota's future reparations liability. The State of California is currently conducting a desperate search to find victims of its own eugenics policy which sterilized tens of thousands of people, in the hope of being able to pay reparations to them before they die. This was reported in an Associated Press article ("California seeks to help sterilization victims", A2) in the January 7th edition of the Bismarck Tribune, the very same newspaper which as attacked HB 1301 in its editorial space two weeks later.

Talk about cognitive dissonance!

There was a time when sterilization in the name of eugenics was called health care.

Under House Bill 1301, the State of North Dakota would establish a private right of action under 23-52-03 and a public right of action under 23-52-04. The State of North Dakota would not only establish avenues of redress for victims of these sterilization surgeries, but it would also absolve itself from the liability of permitting such a practice. I think these reforms could save our state money in the long run.

I am under no illusions that any law could prevent at least some parents from going out-of-state to sterilize their children. Probably nothing can deter the most fanatical adherents of a recent social trend which equates social status with having a transgender child. Not even ridicule from Bill Maher. Yet, if these bills can prevent even one child from getting sterilized, then they will have achieved their purpose.

Steroid hormones and intimate surgeries may affect outward appearances, but they cannot alter anyone's DNA. Just as there is no way – realistic or not – to turn me into a hallucinogenic mushroom, there is no way to turn me into a woman. And no amount of hormones, surgery, or Barney costumes will ever turn me into a purple dinosaur, no matter how much I may try. Let's not equate being a facsimile of a man with being a man, nor equate being a facsimile of a woman with being a woman.

North Dakota was one of the first states in the Union to decriminalize homosexuality in 1975. Sadly, it seems to have become fashionable for people to vent their spleens at this state, as if it were the worst place in the world, worse than Afghanistan or Russia. Not only are these characterizations unfair, but they are counterproductive.

Child sterilization should not be the kind of topic over which friendships are broken.

To those who are transgender, or think they are transgender – once you reach the age of eighteen, you can still get the hormones and surgery that you say you want, and it will no longer be illegal for a doctor to sterilize you in the name of changing your outward gender. Although I hope you can eventually accept the body you have, rather than the body you wish you had, this legislation respects your adult decisions.

I want North Dakota to be a welcoming place for you. In that spirit, I am pushing for the State of North Dakota to establish a separate prison for trans-gender, trans-species, non-binary, and gender non-specific inmates. If, for whatever reason, you do wind up in prison – as all too many transgender people tend to be in our society – you deserve to be protected from conditions in men's prison.

I recommend a **DO PASS** recommendation from this committee.

Thank you. I am now open for questions.

Andrew Alexis Varvel
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**SUPPORT OF BILLS 1254 and 1301**

I am an attorney, a life-long Democrat who voted for same-sex marriage and a mother of two. I am a co-lead of Our Duty, an international group of parents from various political backgrounds and religious or agnostic backgrounds

I am the parent of daughter who at age 13 was convinced that she was a trans boy. She did not come by this belief organically. She was indoctrinated by her public school, an older trans-identifying girl and people she met online. She was influenced by TikTok, Youtube, Instagram and Twitter. She came to her identity after spending hours online during the COVID lockdown. She was taught how to dissociate from her body and that all of her pain would disappear if she just transitioned to a boy. I watched as close to 50% of her girl scout troop - 7/16— came out as trans or non-binary.

As soon as she announced her trans identity, her mental health plummeted. She barely got out of bed. Brushing her teeth was a feat. She copied her older trans-identified friend and limited her calorie intake. She imitated this girl and others online – cutting her hair, dying it different colors, donning binders, piercing her nose, decorating her room in a goth motif. She started failing her classes at school. She was diagnosed with severe depression and anxiety.

All of the medical providers, teachers and therapists, save for the one we hired, told us that she would kill herself and that we needed to accept that she was a "he." We did our own research. We ignored the medical advice and my daughter is now happy in her female body, and thriving with her body intact. No child can consent to sterilization, and no parent has the right to take that from a child. Parents are pressured into believing that they have two options – transition or suicide. That is belied by my story and countless others, and most importantly the medical evidence. I have attached materials that demonstrate what Europe is doing. Sweden, the most progressive country, has stopped medicalizing minors. The US turns a blind eye because of comflation with "trans" and being gay, and the enormous profits that are exacted from creating a life-long medical patient.

Be on the right side of history, it is astounding to me that states are even considering whether children should be experiemented upon, locked into an identity as children, have undiseased body parts removed, in the name of true self. Authenticity does not require medical intervention.

Support AB 1254 and AB1301. But remove the phrase, "assigned sex at birth". Sex is observed, not assigned. Don't adopt nonsensical language.

Respectfully,

Erin Friday, Esq.
Our Duty - USA

*What are*

# PUBERTY BLOCKERS?

The pharmaceuticals now sold as "puberty blockers" are better known as GnRH agonists, a class of drugs developed for use in men with advanced prostate cancer. GnRH agonists are also FDA-approved for endometriosis, uterine fibroids, and central precocious puberty (CPP). They are prescribed off-label to chemically castrate sex offenders, and they were briefly used as a treatment for autism (now debunked) in the 2000s and early 2010s. They are NOT approved as a treatment for gender dysphoria or any other mental illness.

For more information on the effects of GnRH agonists, follow the QR code below.

# SIDE EFFECTS OF PUBERTY BLOCKERS

- loss of bone mineral density
- lowered peak BMD
- increased risk of osteoporosis and fractures
- periodontal disease
- increased risk of heart attack and heart disease
- increased risk of stroke
- increased risk of type 2 diabetes
- lowered resting heart rate
- weight gain
- increased percentage body fat
- insulin resistance
- higher glycemic markers
- arterial stiffness
- vasculitis
- atherosclerosis
- angina
- impaired thyroid function
- changes in TSH, FT3, and FT3/FT4 ratios
- hyperthyroidism
- hypothyroidism
- thyroiditis
- thyroid autoimmunity
- lowered intelligence and IQ
- memory loss
- impaired working memory and attention
- impaired executive function
- impaired visual spatial ability
- increased risk of dementia
- intracranial hypertension
- pseudotumor cerebri
- pituitary tumors
- depression
- anxiety
- insomnia and other sleep disorders
- increased emotional reactivity
- increased risk of suicide
- psychosis
- mania
- chemical castration
- lack of sexual development
- regression of sexual development
- penile shortening
- infertility
- vaginal dryness
- vaginal bleeding
- polycystic ovary syndrome (PCOS)
- frequent urination
- bloody urine
- constipation
- nausea and vomiting
- abdominal pain
- chronic intestinal pseudo-obstruction
- poor gut motility
- hot flashes
- headaches and migraines
- injection site pain
- injection site granulomas
- fibromyalgia and other chronic pain disorders
- cataracts
- increase in natural killer cells
- increased risk of autoimmune disease

# SIDE EFFECTS: TESTOSTERONE

- increased risk of heart attack, heart disease, and stroke
- irregular heartbeat
- type 2 diabetes
- high blood pressure
- metabolic syndrome (MetS)
- rapid weight gain
- shortness of breath
- sleep apnea
- depression and anxiety
- mood swings
- hostility
- insomnia
- worsening of existing mental illness
- addiction to and abuse of artificial testosterone
- intracranial hypertension
- seizures
- liver toxicity
- dyslipidemia
- polycythemia
- vaginal atrophy, which can lead to the need for a hysterectomy
- extreme vaginal bleeding
- vaginal, pelvic, and abdominal pain
- persistent menses
- vaginitis
- cervicitis
- pain during intercourse or orgasm
- painfully enlarged clitoris
- increased risk of uterine fibroids
- urinary urgency
- increased risk of UTIs and yeast infections
- joint pain
- acne

# SIDE EFFECTS: ESTROGEN

- stroke
- heart disease
- increased risk of heart attack, heart disease, and stroke
- blood clots, including deep vein thrombosis, venous thrombo-embolism, and pulmonary embolism
- increased risk of cancer
- type 2 diabetes
- high blood pressure
- weight gain
- depression
- anxiety and nervousness
- increased risk of suicide
- fainting and lightheadedness
- pituitary tumors
- breast and prostate tumors
- high triglycerides
- high potassium
- gallstones
- sexual dysfunction
- infertility
- nipple discharge
- abdominal cramps and muscle cramps
- bloating
- dry mouth and excessive thirst
- nausea and vomiting
- urinary urgency
- incontinence

*Be kind.*

Don't administer or prescribe artificial hormones to minors.

# SUICIDE — Reality vs. Misinformation

Every parent of a gender questioning child has been told that half of all trans youth attempt suicide. This statistic is used to convince parents (sometimes in front of their child), that medical transition is not only recommended but life-saving. Most parents of gender confused teens have been told by their child's clinician, "Better a trans daughter than a dead son (or better a trans son than a dead daughter)." Most clinicians citing those alarming figures have not read the actual studies on which this claim is based.

## REALITY

There is no **data to support the claim that puberty blockers, cross-sex hormones, or "gender-affirming" surgeries are life-saving**.

- There is no record of scores of teen suicides due to gender dysphoria prior to the 2016 exponential rise in medicalization of minors seeking gender transition.
- There is no record of scores of teen suicides due to minors seeking gender transition who were unable to get treatment.
- According to Dr. Laura Edwards-Leeper, PhD, who brought pediatric gender-affirming care (the "Dutch Protocol") from the Netherlands to the US, "As far as I know, **there are no studies that say that if we don't start these kids immediately on hormones when they say they want them that they are going to commit suicide.**"
  - Self harm risk among gender-nonconforming children is about the same as other children with mental health disorders.
    - At the world's largest clinic for transgender youth, the UK's Gender Identity Development Services, from 2010-2020, only 4 out of 15,000 (<1%) minors treated or on the waitlist and unable to access services committed suicide.
    - At the only Belgium Pediatric Clinic, 2.8% of trans-identifying minors completed suicide from 2007-2010.1
- There is no record of large numbers of adults over 30 seeking to medically transition now that medical treatments are vastly more available. The dramatic rise in treatment is exclusively in minors and young adults, and primarily in females.

> ***"…it is difficult to interpret suicide risk among people with gender dysphoria — other co-occurring psychiatric diagnoses may be more pronounced contributing factors to suicide than the fact that a person has gender dysphoria."***
>
> **National Board of Health and Welfare, Sweden, Feb 2020**

*"Sometimes I just feel so sad that I did this to myself. I dealt with a lot of grief and loss and regret. ... I feel full of dread knowing I forever altered myself and future and can never go back."*

— Post on www.reddit.com/r/detrans/, 9/18/22

*"i dont really wanna do this anymore. im staying alive for my mom, but i miss myself."*

— Post on www.reddit.com/r/detrans/, 9/19/22

- There is no evidence that medical transition reduces suicide risk of trans-identifying adults; if anything, **there is evidence that suicide rates increase post hormones or surgeries.**
  - In California from 2012-2018, **suicide attempt rates were twice as high after vaginoplasty or phalloplasty as before (3.3% post vs. 1.5% pre, p=0.017)**; rates of psychiatric emergencies were no lower during the 2 years post surgery than before surgery.
  - In Sweden, a country with a long history of tolerance, the longest (30-year) study of sex-reassigned adults found that compared to same birth sex controls, rates of all-cause mortality were 2.8 higher post hormones and surgeries, **completed suicides 19.1 times higher, suicide attempts 4.9 times higher**, and psychiatric inpatient care 2.8 times higher. Transgender mortality rate diverges sharply from that of all adults starting about 10 years post-medical intervention.

### MISINFORMATION: 48% of all trans youth attempt suicide

**2015 RaRE (Risk and Resilience Explored) Research Report, conducted by the UK LGBT charity, PACE (Project for Advocacy Counselling and Education)**

- Of the 27 respondents under 26 years old, 13 reported having attempted suicide, resulting in the oft-repeated 48% suicide statistic.
- The survey does not distinguish whether suicide attempts occurred **before or after** transition.
- The survey does not provide any information on what, if any, mental health issues the 27 respondents suffered.
- The survey does not provide any information about the sexuality of the respondents — LGB in and of itself is a risk factor for suicide.

## MISINFORMATION: 41% of all trans youth attempt suicide

**The 2015** National Transgender Discrimination Survey**.**

- Survey-based study of 6,456 transgender and gender non-conforming respondents, 18 and older.
- Participants were recruited through transgender advocacy organizations, yielding a large sample that was highly skewed toward political activism.
- The survey asked only one question about suicide: "Have you ever attempted suicide?" **Authors admit that such a broad question can inflate affirmative responses by two-fold.**
- Only 8% of female participants and 5% of male participants transitioned before the age of 18, so responses are largely not relevant to medicalizaiton of minors.
- The survey did not ask if the suicide attempts were pre-social transition, while waiting for interventions, or post-medical interventions.
- For biological females, passing as men did not decrease the prevalence of suicidal attempts.
- Those with companion mental health issues were at a 65% higher risk of suicidal attempts.
- Those who wanted to medically transition in the future and those that had medically transitioned had almost identical suicide attempt rates except for those seeking phalloplasty. **Those who did not want medical interventions had the lowest suicide attempt rates.**
- A very high number of survey participants (nearly 40%) had not transitioned medically or socially at the time of the survey, and a significant number reported no intention to transition in the future.

*"…when inaccurate data and alarmist opinion are conveyed very authoritatively to families we have to wonder what the impact would be on children's understanding of the kind of person they are… and their likely fate."*

**Dr. David Bell,**
**former lead psychologist,**
**Tavistock and Portman NHS Foundation Trust, UK**

**Neither report can be extrapolated to the new adolescent cohort with late onset of gender dysphoria.**

*"I regret it all. And I did it to myself. I'm genuinely contemplating suicide because I just don't think I'll ever get over this. … I'm ruined."*

— Post on www.reddit.com/r/detrans/, 9/6/22

**MISINFORMATION: Transgender and nonbinary youth who received gender affirming medical care experienced greatly reduced rates of suicidality and depression over the course of 12 months.**

***Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, University of Washington**

University of Washington researchers knowingly published a seriously flawed paper describing their study results in *JAMA Network Open* in which they initially claimed that for children on puberty blockers and cross-sex hormones, depression and/or suicidality "dropped" or "plummeted". One of the authors made the following public claims:

- "What our study found was just vast reductions in depression and suicidality, a reduction of depression of 60%, suicidality 73%. More to the point, we also saw worsening of these, as much as two- to three-fold and severity for the folks who did not receive similar care.
  …
  We don't see these sorts of improvements with any sort of other treatment."
- "Also, for the folks who did not receive this care, the severity of the depression itself was much worse."

**None of these claims were supported by the data in the researchers' own supplemental table:**

- The medicalized children **experienced no statistically significant mental health improvement during the study**.
- 80% of the children not medicalized left the study, rendering the results worthless.
- A member of the research team admitted: "We did not observe a decrease in rates of depression."

***"There's no reason for me to continue to live. I destroyed my life and I feel like all hope I have is stupid for me to have. … I can't stop thinking about the life I could have had. … I wanna kill myself but then [my mom] will feel even more miserable. How can I kill myself and let her know that I want her to be happy. Im 17 why do I have to think about ending my life. It's too much for me to handle. There's no joy in my life anymore. "***

— Post on www.reddit.com/r/detrans/, 8/30/22

***"I can't love myself like this"***

— Post on www.reddit.com/r/detrans/, 9/59/22

# HOW MANY PEOPLE REGRET TRANSITIONING AND WHY?

**No one knows how many experience transition regret because no one is tracking patients, but there are indications of growing numbers... and the reasons for regret are telling.**

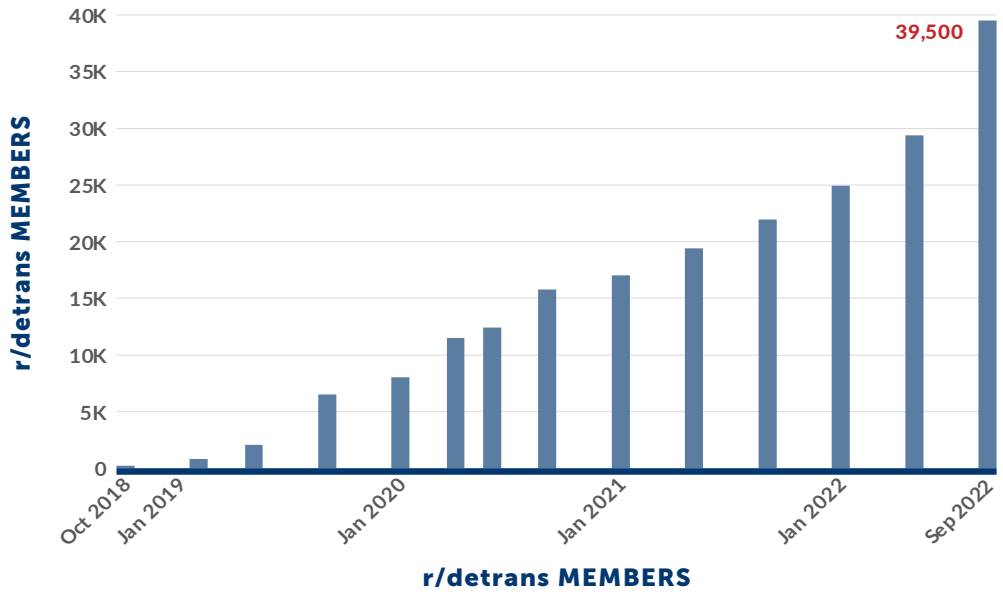
- A **detransitioner** is someone who identified as trans, non-binary, or another gender identity but then regrets the medical interventions and re-identifies with their natal sex.
- A **desister** is someone who identified as transgender but stopped identifying before medicalizing.
- There are also people who regret transitioning without detransitioning, sometimes because they feel it would be too hard to detransition.

> *"my chest is maimed with heavy scarring ... i miss being feminine ... from the second i woke up in the operating room i knew it was a mistake. ... i was so sure of my identity. I'm realizing I was just lost and in over my head."*
>
> — Female detransitioner, hormones and double mastectomy at 15

## WHAT WE KNOW ABOUT REGRET

- Studies show that 80% to 88% of pre-pubescent children who believe that they should be the opposite sex, but **do not socially transition** (change name, pronouns and outward appearance) would grow up to be comfortable with their unaltered, natal bodies. A large portion are same sex attracted.
- Recent studies show that most people detransition within 4-6 years of transitioning.
- Reddit/Detrans, a platform for those questioning transition was created in November 2017. In the last 6-months, an average of **60 new subscribers join every day**. While not every member is a detransitioner and not all detransitioners join, the significant growth indicates rapid increase and interest in detransitioners.

**Reddit/detrans members by year**



*"My parents were told the options were transition or suicide. They complied. My distraught parents wanted me alive."*

— Chloe Cole, 18-year-old female detransitioner
Puberty blockers, cross-sex hormones, and double mastectomy at age 15

Photo: John Fredricks, The Epoch Times

## MISINFORMATION ABOUT REGRET

Many physicians quote a 1% regret rate. This statistic is based on The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets. This study had significant limitations and cannot be used as a baseline for the current cohort:

- All study participants were adults and those who had significant pre-pubescent gender dysphoria.
- Definition of "regret" **excludes most detransitioners**. The study included:
  - **ONLY** those who had their testes or ovaries removed
  - **ONLY** those who resumed natal sex hormones
  - **ONLY** those who returned to original medical provider — most don't inform their original provider that they detransitioned
- The study **DID NOT INCLUDE:**
  - those who committed suicide or those who died as a result of gender treatment complications
  - those who regret puberty blockers, cross-sex hormones, mastectomy or breast augmentation
- 20% were lost to follow-up

## WHY PEOPLE DETRANSITION

Due to the lack of patient follow-up, the reasons for detransition are largely unknown, but three recent studies shed some light on the subject:

Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners (Littman), found:

- The majority (55%) felt that they did not receive an adequate evaluation from a doctor or mental health professional before starting transition.
- Nearly half (46%) said counselors over-promised the benefits and about one quarter (26%) said counselors minimized the risks. Counselors were much more likely to encourage than to urge caution about medical transition.
- 76% of respondents did not inform their clinicians that they had detransitioned, which has lead to a tremendous underestimate of the number of individuals with regret.

**For both males and females, the most common reason for detransitioning was that the person became more comfortable identifying as their natal sex.**

| Reasons for detransitioning* | Natal female N (%), N = 69 | Natal male N (%), N = 31 |
|---|---|---|
| My personal definition of female or male changed and I became more comfortable identifying as my natal sex | 45 (65.2%) | 15 (48.4%) |
| I was concerned about potential medical complications from transitioning | 40 (58.0%) | 9 (29.0%) |
| My mental health did not improve while transitioning | 31 (44.9%) | 11 (35.5%) |
| I was dissatisfied by the physical results of the transition/felt the change was too much | 35 (50.7%) | 5 (16.1%) |
| I discovered that my gender dysphoria was caused by something specific (ex, trauma, abuse, mental health condition) | 28 (40.6%) | 10 (32.3%) |
| My mental health was worse while transitioning | 27 (39.1%) | 9 (29.0%) |
| I was dissatisfied by the physical results of the transition/felt the change was not enough | 22 (31.9%) | 11 (35.5%) |
| I found more effective ways to help my gender dysphoria | 25 (36.2%) | 7 (22.6%) |
| My physical health was worse while transitioning | 21 (30.4%) | 11 (35.5%) |
| I felt discriminated against | 12 (17.4%) | 11 (35.5%) |
| I had medical complications from transitioning | 12 (17.4%) | 7 (22.6%) |
| Financial concerns about paying for transition care | 11 (15.9%) | 6 (19.4%) |
| My gender dysphoria resolved | 10 (14.5%) | 5 (16.1%) |
| My physical health did not improve while transitioning | 9 (13.0%) | 2 (6.5%) |
| I resolved the specific issue that was the cause of my gender dysphoria | 6 (8.7%) | 4 (12.9%) |
| I realized that my desire to transition was erotically motivated | 1 (1.4%) | 5 16.1%) |
| Other | 19 (27.5%) | 6 (19.4%) |

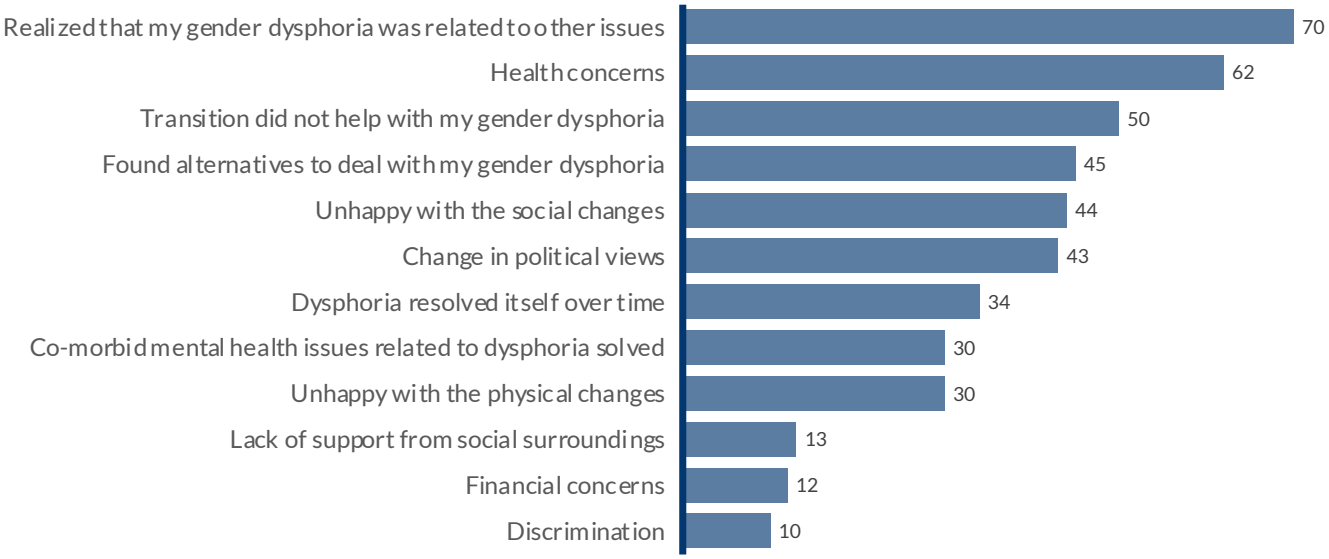
**May select more than one answer*

Detransition-Related Needs and Support: A Cross-Sectional Online Survey, Journal of Homosexuality (Vandenbussche), found:

- 45% reported they were insufficiently informed about health risks before starting medical transition or other interventions.
- Most detransitioners had comorbidities — over half (54%) had 3+ comorbidities, 69% reported depression, 63% anxiety, and 33% post-traumatic stress disorder.

The most common reported reason for detransitioning was realizing that gender dysphoria was related to other issues (70%); the second was health concerns (62%), followed by transition not helping with dysphoria (50%).

**Reasons for detransitioning** (Vandenbussche)

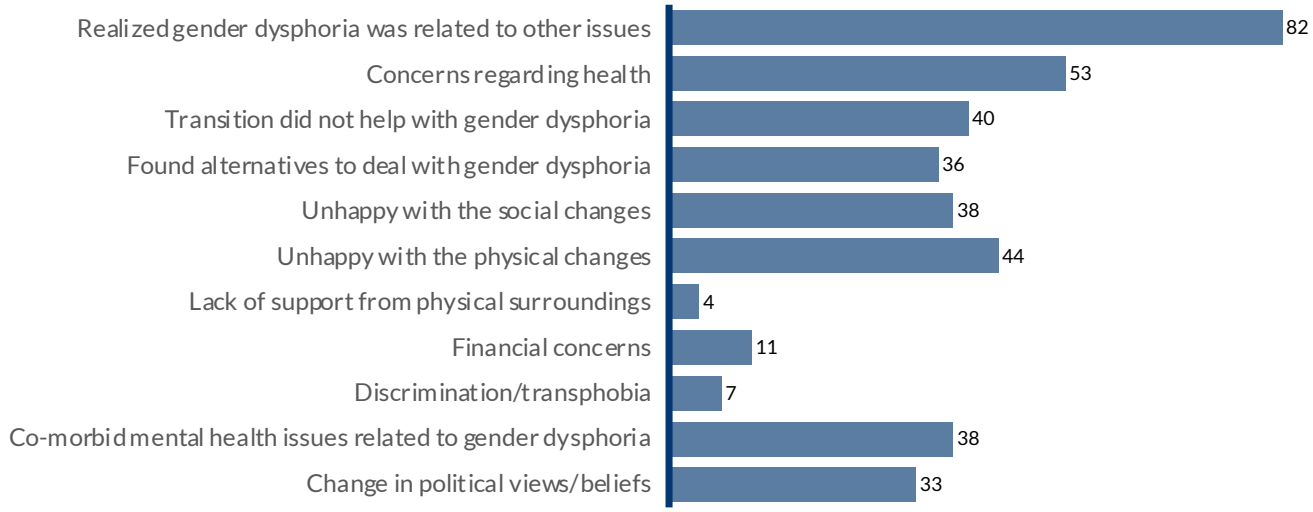


*"After years of struggling with gender dysphoria, along with diagnosed anorexia, bulimia, anxiety, and depression, I thought that pursuing medical transition and living as the opposite sex would bring me happiness. I believed what trans activists told me: that transitioning was my best option and the only way to prevent suicide."*

— Cat Cattinson, adult female detransitioner
Cross-sex hormones

The 2022 r/detrans Demographic Survey also asked about reasons for detransitioning.

**Reasons for detransition** (r/detrans)




While each of these studies has limitations, all three found similar primary reasons for regret. Though often claimed as the main reason for detransition, despite different samples and questions, **none found that discrimination or lack of support was a major reason for detransitioning.**

Members of the House Human Services Committee,

“My name is Thea Holter and I reside in District 1.  I am asking that you please render a DO PASS on House Bill 1301.”

The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance. This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones.  Pediatric medicine has been hijacked by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.
Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.

Thea Holter

Chairman Weisz and Members of the House Human Services Committee,

My name is Amber Vibeto and I reside in District 3. I would like to state my strong support for House Bills 1254 and 1301 in hopes that one strong bill will emerge from this session that would ban the medical gender transition of minors.

There has been a complete collapse of ethics within the medical establishment, particularly regarding the issue of gender. Gone are the days when we could trust doctors and hospitals to first *do no harm*. We now live in a time where the temptation to first *profit off of patients* has become too great. Does this describe every health professional? Of course not. But when leading professional associations like the American Association of Pediatrics and The American Medical Association advocate for financially and ideologically-driven pseudoscience, we should sit up and take notice. We should stand up and say, no. No, you will not sacrifice the health and safety of children and teens for financial gain while claiming to care about their health.

Medically transitioning children and teens is one of the cruelest and most barbaric things we have ever done as human beings. When a child is socially affirmed, it is incredibly hard for them to eventually change their mind because coming out as transgender is a hard thing to walk back. This inevitably leads to medical transition and becoming a life-long medical patient. If you support the transitioning of children, plan to also hold their hand through the major health struggles they will inevitably go through in their lifetime.

Hormonal intervention for gender dysphoria introduces disease into an otherwise healthy and growing human being. It steals from children and teens that which will never be given back.

- Blocks normal breast development
- Causes sexual dysfunction
- Prevents ovulation and stunts penile & testicular growth which leads to infertility
- Disrupts normal bone development which leads to osteoporosis as young adults
- Disrupts normal brain development
- Causes memory loss

- Causes decreased IQ
- Increased risk for serious health problems, including heart attack, stroke, and cancer

Gender-affirming surgical intervention is irreversible and has led many to a lifetime of suffering, devastation, and regret. It entails:

- Double mastectomies
- Hysterectomies
- Creation of a fake penis using the skin of the girl's forearm leaving a significant wound and scar
- Castration
- Removal of the penis
- Creation of a genital pouch that has to continually be stretched to avoid it closing and causing infection

There is a lot of talk about hate from the opposition of these bills. But I can't think of anything more hateful than sterilizing, mutilating, and introducing disease to young people who do not have the capacity to understand the lifelong ramifications of their decisions. This is not healthcare. This is abuse of the worst kind. Parental rights are sacred, but they do not encompass the right to destroy their children's minds and bodies.

Unfortunately, many parents have been manipulated into believing they have no choice but to medically transition their child due to a risk of suicide if left untreated by denying hormones and surgery. They are asked the impossible question, "Do you want a dead daughter or a live son"? It's an alarming question, and many parents choose to trust these seemingly kind and supportive doctors and therapists. They choose to put their child in the hands of these professionals out of a desperate attempt to fix their child's mental health struggles. They assume that professionals can't possibly be ideologically-driven. But we know that's not true. There is bias and obfuscation of truth in the facts and figures cited by gender-affirming providers. Please don't be too impressed by their credentials and cherry-picked data. There is currently no scientific support for gender-corrective treatment to reduce the risk of suicide. Please refer to the resource I have provided in my testimony regarding the myths of suicide and gender dysphoric children. I submit that if a teen who identifies as trans is suicidal, it is not because they are not affirmed by society. It is because

they are being lied to about who they are by the adults that they are supposed to be able to trust. It's because they are being led down a path that entails a frustrating and never-ending striving towards a goal that can never be attained. These young people need to know that they can find healing and happiness without cutting off body parts and being sterilized. They need to know that the concept of gender identity was created by two so-called scientists, John Money and Alfred Kinsey, two deeply disturbed, predatory men who sexually abused children for their fundamentally flawed research.

One final point. I don't know if doctors and hospitals in ND are medically transitioning kids yet. But I do know that Sanford Health has fully bought into gender ideology and I have no doubt that they have the same dollar signs in their eyes as Tennesee's Vanderbilt University Medical Center. Let's not give them the chance to profit off of the suffering of vulnerable children and teens. And let's not allow the threat of potential litigation prevent us from doing what is right and moral and decent.

Thank you so much for your time.

**Transgender Surgery: What Have I Done?**
**https://player.vimeo.com/video/500280130**

The Myth About Suicide and Gender Dysphoric Children

Society for Evidence Based Gender Medicine: Complications of Medical Intervention

'Huge Money Maker': Video Reveals Vanderbilt's Shocking Gender 'Care,' Threats Against Dissenting Doctors

Kinsey's Kids

American College of Pediatricians: Transgender Interventions Harm Children

American College of Pediatrics: Deconstructing Transgender Pediatrics

Leading Transgender Health Association Removes Age Minimum In New Guidelines

Sanford Health and the Transformation Project

New Declaration Launches Opposition To Leading Transgender Health Association

Leading Transgender Health Association Seeks to Include 'Eunuch' As 'Gender Identity'

House Judiciary Committee
**HB1254 and HB 1301**
January 24, 2023

Chair Weisz, Vice Chair Ruby, and Committee members:

The American Civil Liberties Union of North Dakota strongly opposes HB 1254 and HB 1301. Due to the similar nature of these bills we offer joint testimony in opposition to both bills.

By categorically banning all medical care for minors related to "gender transition", HB 1254 and HB 1301 discriminate based on transgender status and sex in violation of the United States Constitution and likewise violates the rights of parents under the Due Process Clause.

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This bill represents vast government overreach into the doctor-patient and parent-child relationship. When Arkansas passed similar legislation, Governor Hutchinson vetoed the bill. He explained that such a sweeping ban on care created "new standards of legislative interference with physicians and parents" and "puts the state as the definitive oracle of medical care, overriding parents, patients and healthcare experts," which "would be—and is—a vast government overreach."[1] Governor Hutchinson further noted that "denying best practice medical care to transgender youth can lead to significant harm to the young person—from suicidal tendencies and social isolation to increased drug use."[2] The Arkansas General Assembly ignored Governor Hutchinson's warnings and overrode his veto. However, the law was enjoined in federal court before it could take effect and remains enjoined.[3]

By singling out medical care related to gender transition for unique prohibition, HB 1254 and HB 1301violate the United States Constitution.

Where a law singles out people based on the fact that they have a gender identity that does not match the sex assigned to them at birth and therefore undergo "gender transition", it necessarily discriminates on the basis of sex and trans status, thus triggering heightened equal protection scrutiny under the Constitution. "[I]t is impossible to discriminate against a person for being ... transgender without discriminating against that individual based on sex."[4] As the U.S. Supreme Court has explained, "[a]ll gender-based classifications today warrant heightened scrutiny."[5] There is no exception to heightened scrutiny for gender discrimination based on physiological or biological sex-based characteristics.[6] This bill, if passed, would separately trigger heightened scrutiny for discriminating against individuals based on transgender status.

Parties who seek to defend gender-based and trans status-based government action must demonstrate an "'exceedingly persuasive justification' for that action." Under this standard, "the burden of justification is demanding and it rests entirely on the

[1] "Governor Asa Hutchinson Holds Pen and Pad Session with Local Media," April 5, 2021, at 9:16, 9:30 https://www.youtube.com/watch?v=9Jt7PxWkVbE.9:30.
[2] *Id.* at 8:58.
[3] See *Brandt v. Rutledge*, No. 4:21CV00450 JM, 2021 WL 3292057 (E.D. Ark. Aug. 2, 2021)(enjoining Arkansas ban on gender-affirming care for transgender minors and finding plaintiffs likely to succeed on merits of their equal protection, due process and First Amendment claims).
[4] *Bostock v. Clayton Cty., Ga.*, —— U.S. ——, 140 S. Ct. 1731, 1741, —— L.Ed.2d —— (2020).
[5] *United States v. Virginia*, 518 U.S. 515, 555 (1996).
[6] *See Tuan Anh Nguyen v. INS*, 533 U.S. 53, 70, 73 (2001).

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State."[7] The North Dakota legislature's only purported justification for the bill is that the banned care could cause hypothetical future problems. But under heightened scrutiny, justifications "must be genuine, not hypothesized or invented post hoc in response to litigation."[8] This demanding standard leaves no room for a state to hypothesize harm and impose a categorical ban on medical treatment that is supported by every major medical association in the United States.

The only court to consider a challenge over a law like the one proposed here concluded, based on an extensive record, that "[g]ender-affirming treatment is supported by medical evidence that has been subject to rigorous study. Every major expert medical association recognizes that gender-affirming care for transgender minors may be medically appropriate and necessary to improve the physical and mental health of transgender people."[9] The Court went on to identify the many harms that would flow from allowing a law like the one proposed here to go into effect:

> The Act will cause irreparable physical and psychological harms to the Patient Plaintiffs by terminating their access to necessary medical treatment. Plaintiffs who have begun puberty blocking hormones will be forced to stop the treatments which will cause them to undergo endogenous puberty. Plaintiffs who will soon enter puberty will lose access to puberty blockers. In each case, Patient Plaintiffs will have to live with physical characteristics that do not conform to their gender identity, putting them at high risk of gender dysphoria and lifelong physical and emotional pain. Parent Plaintiffs face the irreparable harm of having to watch their children experience physical and emotional pain or of uprooting their families to move to another state where their children can receive medically necessary treatment. Physician Plaintiffs face the irreparable harm of choosing between breaking the law and providing appropriate guidance and interventions for their transgender patients.[10]

The Court ultimately held that the law failed heightened scrutiny and would fail any level of constitutional review.[11] The Arkansas court's well-supported and reasoned analysis applies here.

Likewise, if passed, HB 1254 and HB 1301would violate the fundamental rights of parents to direct the custody and care of their minor children. "The liberty interest…of parents in the care, custody, and control of their children is perhaps the oldest of the fundamental liberty interests" recognized by the Supreme Court. *Troxel v. Granville*, 530 U.S. 57, 65 (2000). [Bill] bars treatment in cases where the treatment is recommended by physicians and supported by parents and their minor children. Such an intrusion into the medical decision-making of parent infringes their Due Process rights. Particularly here with such clear science showing that withholding care to transgender young people can be deadly, the law would seriously infringe the rights of parents to not only guide the care of their children but also

[7] *Virginia*, 518 U.S. at 531.
[8] *Id.* at 533.
[9] *Brandt v. Rutledge*, No. 4:21CV00450 JM, 2021 WL 3292057, at *4 (E.D. Ark. Aug. 2, 2021)
[10] *Brandt v. Rutledge*, No. 4:21CV00450 JM, 2021 WL 3292057, at *5 (E.D. Ark. Aug. 2, 2021)
[11] *Id.*

keep their children alive and well. As the Arkansas court held in Brandt about Arkansas's comparable law, "Parent Plaintiffs have a fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary. So long as a parent adequately cares for his or her children, "there will normally be no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children."[12]

If passed, HB 1254 and HB 1301 could set off a public health crisis for transgender youth and their families and open the door to other governmental intrusion into the doctor-patient relationship. This bill violates the United States Constitution and harms transgender youth and their families, all to solve a problem that plainly does not exist. Transgender young people, their parents and their doctors are in the best position to decide the appropriate course of medical treatment for each minor patient. The state's unprecedented intrusion into these complex dynamics and decisions will cause grave harm. For these reasons, we urge this committee's "do not pass" recommendation.

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[12] *Brandt v. Rutledge*, No. 4:21CV00450 JM, 2021 WL 3292057, at *5 (E.D. Ark. Aug. 2, 2021)(*citing Troxel*, 530 U.S. at 68-69, 120 S.Ct. 2054).

Members of the Committee,

My name is Joni Rahrich and I am in opposition to bill HB1301 and would like to see a DO NOT PASS on this legislation.

When you wanted to be elected to represent the people of North Dakota, it was your job, if elected, to protect the citizens of the state. Making laws that target citizens of the state shows you don't live up to your duty. Making laws because you think something is icky, goes against what you consider normal, puts a hardship on lives, puts a penalty on those whose job it is to help people, is wrong. Almost every letter that supports your bill is a form letter. The other ones are from unqualified people who think they should have a say in other peoples lives, which they aren't qualified to have a say. What penalty is put on lawmakers who pass bills that most certainly will cause harm to transgender people who know there are laws specifically aimed at stopping their means of existence? Shame on you. Your bill leaves transgender people from having a personal relationship with their doctors. You do not belong in a doctor's office. You do not belong in the legislature creating laws that contradict certain people's existence. You were not elected to do that. This legislature is using the platform created by people who do not want transgender people receiving any medical help, any support to be administered to them, and is aimed at not caring if they commit suicide because there is nowhere to turn for help. Is that really your goal? If it is, you should have a penalty against you for making such cruel laws. As a parent of a transgender child, it has always been my job to listen to my child, to help my child, to accept my child, to help keep them from harm, to love my child, to do whatever I have to so I can protect my child. Isn't that what you do for your child? My child is no different than yours, except for the fact that you want to make a law against my child being born free in the United States, which treats all citizens with life, liberty, and the pursuit of happiness. If this bill makes it to the floor, which I hope it doesn't, when you say the pledge of Allegiance on the floor I hope the words, "With liberty and justice for all" echo's through your head and you admit to yourselves you will make a mistake voting to ostracize the lives of transgender people who need your acceptance as citizens, not as some evil you deemed necessary to

persecute to pacify a group of people who won't accept them for who they are.

Thank you,

Joni Rahrich

To whom it may concern,

My testimony is in opposition to House Bill 1254 and 1301. I ask that you give this bill a Do Not Pass.

I am bringing this forth as my own person, I am not representing any group or city. It is of my own opinion and research I was able to find. Due to what I was able to find is that I believe these bills are unfair and unprofessional. The reason for this is because this bill impacts people I care deeply about as well as people I don't know well enough. I understand that any transition is difficult for anyone. However, stopping adolescents from receiving necessary medical care has a more harmful impact. When compared to their cisgender counterparts, trans kids have a higher suicide rate. According to Harvard Health, not only are gender-nonconforming kids at a far greater risk of depression and anxiety than their gender-conforming classmates, but 56% of them have considered suicide and 31% have attempted it.

While gender-affirming treatment may include hormone therapy or surgery, the fundamental goal is to provide gender-nonconforming adolescents and their families with a team of physicians who understand their specific requirements. Denying such needs — or, even worse, adopting "reparative" or "conversion" treatments to prevent or discourage children and teenagers from expressing themselves in various genders — is not only unsuccessful, but may be harmful. This is why, in addition to the American Academy of Pediatrics, the Substance Abuse and Mental Health Services Administration and the American Psychiatric Association have also issued statements against it.

The main part I like to bring up is that if the medical professionals, parents, and the child(ren) are able have a conversation and what they all believe will be good for the child. This feels more like a parent’s right on how their child(ren) should be able to help better their child(ren)’s life. Medical professionals are trying to help their clients be healthy and live their full life.

I know some might say that puberty-blockers or other gender therapy causes health issues, and yes they do but have a long-term effect. Meaning if a child is on puberty-blockers for way longer than suggested, it does have an effect. Each issue is case-by-case on how each the child, parent/guardian, and the medical professional decide on how to move forward. Some might say gender dysphoria is not really, but there have been studies and MRI showing that gender dysphoria exists.

These bills say gender dysphoria would not be included the care of children. In Bill 1301, it states on lines 16-18, “ As used in this section, "disease" does not include gender dysphoria, gender identity disorder, gender incongruence, or any mental condition, disorder, disability, or abnormality”. Gender dysphoria can be found in The Diagnostic and Statistical Manual of Mental Disorders and World Health Organization.

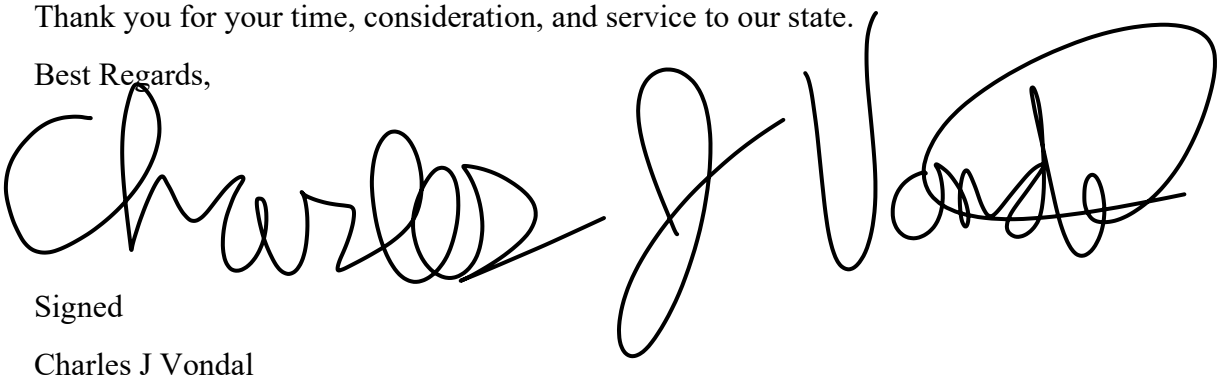
I however never got to experience medical care some children got to experience with gender-therapy till I was 18 years old due to my mother though it would be best to wait to transition when I came out around 14 or 15. Yet, I can still remember wishing I had the chance to experience puberty blockers due to I was miserable going through female puberty. I was depressed, and yet my anti-depression medication did nothing to help. I had trouble sleeping, and I was miserable.

Yet, the day I started to medical transition at the age of 18/19 changed my life. I was happier, and not as moody. All my friends could tell that something chance for the better. Just saying I'm not stating other people's kids will be happier if they start medical transition and having surgeries. Instead, I feel like parents need a bit more information about the effects and what truly going into medically transitioning. That why they can have conversations with their children instead of putting bills that will prevent medical professionals from doing their job.

Like I said before, a child's healthcare should be the parent's choice, bills like these have a negative effect on the children. That is why I ask you once again to give Bill 1254 and1301 a Do Not Pass.

Thank you for your time, consideration, and service to our state.

Best Regards,



Signed

Charles J Vondal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**House Human Services Committee**
**HB 1301**
**January 24, 2023**

Chairman Weisz and Committee Members, my name is Courtney Koebele. I am the executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

NDMA opposes this bill. North Dakota has existing laws governing medical negligence, comparative fault, and damages (including punitive). If this bill went to effect, it could have a strong effect on medical malpractice coverage. A thirty-year statute of limitations is highly unusual in any civil action. If this bill passes, it is unlikely anyone would be willing to offer this type of treatment, based on the extensive limitations in the bill.

Other states have addressed this type of legislation. In Alabama, the law that prohibits this type of therapy was found to violate parents' fundamental right to autonomy of obtaining medical treatment for their children subject to medically accepted standards. The court further found that the law is unconstitutional sex discrimination in violation of the 14th Amendment's equal protection clause because the law denies medically necessary services only to transgender minors, while allowing those services to other minors. The Alabama law is on appeal to the 11th Circuit. In Arkansas, its law is on appeal to the 8th Circuit. 20 states have filed an amicus opposing the law, with 19 states filing an amicus brief supporting Arkansas.

This bill makes evidence-based medical decision making and treatment of transgender individuals unavailable to North Dakotans. There are physicians here today to testify as to the details of that treatment, and why patients would be harmed if this bill was passed.

NDMA requests a DO NOT PASS recommendation on the bill. Thank you for the opportunity to testify today. I would be happy to answer any questions.

My name is Billy Burleigh and I used to be transgender.

As a child I had the reoccurring thought that, “God made a mistake, I’m a girl.” I prayed before going to bed and, every time I prayed, I asked, “God, please make me a girl before I wake up.” If I could have, I would have quickly chosen any path that would have transformed me into a girl.

When I was in my early 20s, I sought help for the disconnect between my mind telling me I was a woman, and my body telling me I was a man. In seeking help and doing my own medical research, the message I received was that I had to change my body to match my mind. After seeking any other path forward, I decided to take the therapists’ encouragement and medical researchers’ advice, i.e. the journal articles and the information in books, to change my body.

I started on a testosterone blocker and estrogen. My emotions were up and down, and my body was changing, but I was supposedly on this new road to happiness and that made me happy.

In my first surgery I had a penile inversion, an Adam’s apple shave, and a brow shave. After the surgery, the doctor and nurses had difficulty stopping the bleeding from my new “vagina.” My artificial vagina was packed with gauze and a sandbag was placed on my lower abdomen, but the bleeding did not stop. Later, my mom told me that going into my hospital room was awful. The pungent odor in the room was that of stale blood, my blood. I received a blood transfusion and plasma and, eventually, the bleeding stopped. My two weeks stay in the hospital turned into three weeks stay. But changing my penis to an artificial vagina required two surgeries, so about four months later I was back for part two. My money was low at that point, so I did not have any family or friends accompany me – I went through this second surgery on my own. I was desperate for the happiness I believed was ensured me.

After this, I had additional feminization surgeries, but no matter how many I had, every time I looked in the mirror, I saw a man staring back at me. I tried hard to resolve the conflict between my mind and my body, but after seven years of trying, I had more problems at that point than I had when I started on the road of transition.

The bottom line is that the therapists and medical researchers were wrong – changing my body did not resolve my internal conflict and it did not make me happy, but what it did do was drain my financial resources and left a scarred body.

I have fully transitioned back to male, I am happily married, I have two beautiful stepdaughters, and I have peace of mind and body.

Lastly, I was past the age of responsibility when I made a horrible mistake. In hindsight, I am male, and I was born into the right body. The therapists and medical researchers failed to help with my underlying metal problems. They identified me as transgender, and they were wrong. How often are they wrong?

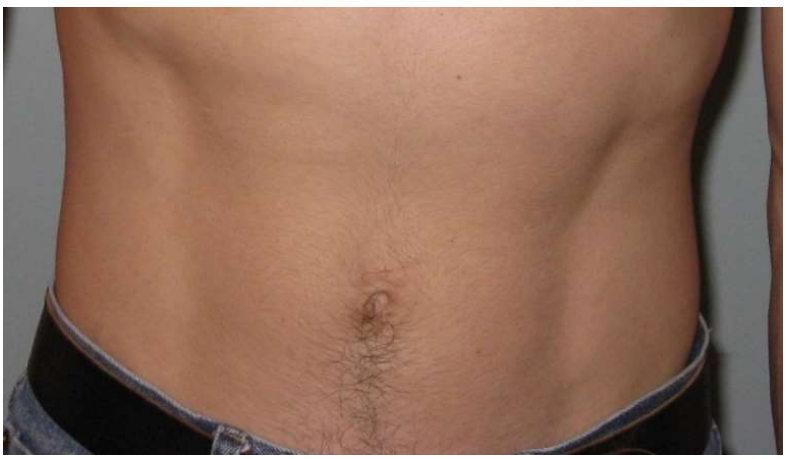
## How did the therapists and medical researchers fail me? What were my underlying mental health problems?

Later in life, after detransitioning, I heard it said that everyone has a need to be acceptance, secure, and significant. Though I hadn't heard this before, I agreed with this statement, and I started thinking about how I had tried to satisfy these needs in my younger years. I had some problems as a child – I was very skinny, had a speech impediment, had learning difficulties, was not athletic, and I didn't seem to fit in with the other boys. I did, however, seem to fit in well with the girls and I enjoyed playing with them more than I enjoyed playing with the boys. As a boy, I didn't feel accepted or secure, and I most certainly didn't feel significant. But if I were a girl, I believe I would have felt accepted and would have felt more secure. And, with my childhood thinking, I may have been more significant to my dad. In hindsight I see that I had several underlying problems that reinforced the false thought that I was a girl, including being sexually abused in the sixth grade. The therapists never did uncover, never did delve into these underlying issues, and my research on transgenderism failed to turn up anything on these needs for acceptance, security, and significance. The therapists and researchers, with respect to me, got it wrong.

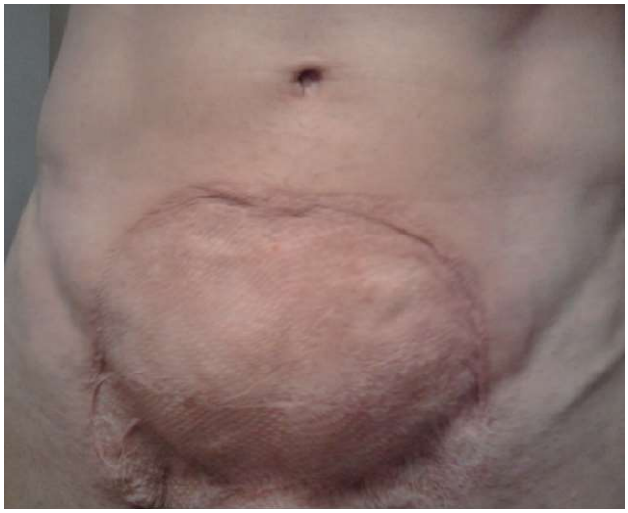
Addendum: When I was transitioning from identifying and presenting as a female back to male, male being my birth gender, I needed a means to change all my documentation from Female back to Male. Having a Phalloplasty would provide the needed document. Long story short – I asked the doctor many times if I was a good candidate for this surgery, my body-fat was very low, and he assured me that I was. He said that I would be very happy with the outcome. I trusted him. He's a doctor, he's a surgeon, and he has my best interest in mind - or so I thought. Below are two pictures; the first is of my abdomen prior to the surgery and the second is my abdomen about a year after the surgery. Needless to say, I Was Not happy with the results. I was Horrified with the results, and I had post-op complications that I had to seek medical help with. Here again, the gender-transition medical-provider Failed me!

The therapists and medical professionals say trust us, we care for you and we know how to help you. If they really cared for me, they would have helped me uncover and work-through my childhood issues, my mental health issues. Instead, I was encouraged and set me on a road to great financial expenditures and bodily harm. To watch a 17 minute video of my story, go to Family Watch International, Videos, Transgender Issues, { https://familywatch.org/transgenderissues/ } Video Library, Victims, and watch "**Transgender Victim: Billy's Story**".

Before Phalloplasty



After Phalloplasty



Jan 24, 2023

Re: Bill 1301 - Relating to prohibiting medical gender transitioning procedures on a minor; to provide a penalty; and to declare an emergency.

Dear North Dakota leadership,

I support ND on banning gender medicalization on minors. Minors under 18 are under huge pressure from school indoctrination, social media, and their peer groups to be obsessively focused on gender ideology.

Teachers, new science books and gender curriculum is all teaching kids that they may be “born in the wrong body” if their appearance, preferences, or behaviors don’t align with what is typically associated with their sex.

All of this is worsening kids’ mental health issues as they reject their natural bodies at unprecedented rates.

You can’t reverse gender surgeries as minors amputate healthy body parts and cross sex hormones cause irreversible damage.

No one under 25 or 30 years of age can possible consent to gender medical procedures and treatments.

Sincerely

Beth Bourne

Bill 1301

Members of the House Human Services Committee,

My name is Curtis Kadrmas, District 8. I support this bill and ask the committee for a Do Pass on bill 1301. It is with deep sadness that this is upon us to consider such matters but it would seem that there is an agenda to destroy what is good and natural for our children. It would seem that those we believe are trying to help educate our children outside of the home are trying to influence our children to do irreparable harm to themselves without the consent of their parents or guardians. Peer pressure, incorrect and obscene adult influence can indeed influence a child into thinking physical alterations are ok (after all they are only children, minors) and further they should not tell their parents, this is wrong. Adults have a huge influence on children and it needs to stop. What impact will there be to future relationships and families? Please support a do Pass on 1301.

Thank you for your consideration of this important matter and for your service to the state of North Dakota.

North Dakota Catholic Conference

*Representing the Diocese of Fargo and the Diocese of Bismarck*

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**To:** House Human Services Committee
**From:** Christopher Dodson, Executive Director
**Subject:** House Bill 1301 - Protection of Minors from Gender Transitioning Interventions
**Date:** January 24, 2023

The North Dakota Catholic Conference supports the intent of House Bill 1301 to prohibit medical providers from using puberty-blocking drugs, cross-sex hormones, or surgeries on a child who has emotional distress surrounding his or her sex.

We are still analyzing the details of House Bill 1301, but wish to encourage the committee to work on this and related bills to enact legislation to protect children from these procedures.

Much has already been said regarding the lack of information about the long-term consequences of these interventions, the inability of children to fully comprehend the nature of the interventions and their consequences, and the overriding fact that no medical intervention can truly realign a person's sex.

We wish to offer some other facts for consideration.

To begin with, we need to recognize that these medical interventions may be called "gender-affirming," but in reality, they are acts of gender transitioning. Each intervention included in the bill — puberty blockers, cross-sex hormones, and surgeries — act on the physical body so that it takes on the characteristics of the person's self-identified gender.

Several principles exist when examining whether a medical intervention is ethical.

The first is whether the object, that is, the direct and intended purpose of the act is good. In the case of puberty blockers, cross-sex hormones, and sex reassignment surgery the purpose — indeed, the only purpose — is gender transitioning or providing a step toward gender transitioning. Certainly, some practitioners will talk about alleviating stress or reducing anxiety, but the chosen method to address those conditions is gender transitioning.

Gender transitioning is ultimately a fiction or a battle against nature. The body cannot change its sex. This raises serious doubts as to whether the intended act is itself good.

Another criterion for determining whether a medical intervention is ethical is whether the intended effect is achieved by a harmful action. In this

regard, all three interventions addressed in this bill — puberty blockers, cross-sex hormones, and sex reassignment surgery - clearly fail.

Puberty blockers do only one thing. They suppress normal and healthy bodily development.

The administration of cross-sex hormones does not treat any disease. It only interferes with the normal and healthy functioning of the human body.

Sex reassignment surgery does not treat any pathology. It is the alteration or removal of healthy organs and tissue, an act also known as mutilation. The consequences are permanent.

None of these actions treat any disease. No illness is averted and no pathology is treated. That is why they cannot properly be called “treatments.”

Some argue that as a result of these interventions, the individual might have less stress, anxiety, or depression. These are what are called “consequentialist” appeals. They attempt to justify a harmful act by appealing to an indirect, though possible, good consequence. These arguments ignore, however, that the act itself harms the body and that the act itself — that is, harming a healthy body does not directly treat (not medically indicated for) the gender incongruence.

Unfortunately, violations of these principles of medical ethics have become tolerated. They should not be tolerated when it comes to children. Children should not be subject to medical interventions that harm, sometimes irreparably, healthy bodily functions, organs, and tissues for the sake of forcing the body to look or feel like something it is not.

We urge this committee to work on this and related bills to enact legislation prohibiting these interventions on children.

NORTH DAKOTA Family Alliance LEGISLATIVE ACTION

Faith · Family · Freedom

**Testimony Supporting House Bill 1301**

Jacob Thomsen, Policy Analyst
North Dakota Family Alliance Legislative Action
January 24, 2023

Good afternoon Chairman Weisz and honorable members of the House Human Services Committee. My name is Jacob Thomsen and I am a Policy Analyst for North Dakota Family Alliance Legislative Action. I am testifying on behalf of our organization in favor of House Bill 1301 and respectfully request that you render a "DO PASS" on this bill.

A small but growing number of children struggle to embrace their God-given sex, instead feeling that they were born in the wrong body and "are" the opposite sex. The majority of these children will come to reconcile with their biological sex. In fact, 80 to 95 percent of children will outgrow gender dysphoria if untreated, so in many cases, watchful parenting and waiting is all that's required in many cases.[1]

For those who are especially struggling or who suffer from related psychological stress, talk therapy and other standard mental health interventions may be appropriate. However, in recent years, politicized medical organizations have pushed referring children for invasive, harmful forms of "treatment" that can include off-label use of puberty blockers, administration of cross-sex hormones above naturally occurring levels, and even – sometimes – surgery. The pressure is so great that in many states, medical professionals are legally barred from offering helpful talk therapy to children for this issue.

Giving kids puberty blockers, cross-sex hormones, and even transgender surgery violates the first duty of medicine: do no harm." For example, Female Genital Mutilation (FGM) is something that can be a part of some girls' transition process. It is unethical, and opposed by both the World Health Organization and the United Nations.

There is also long-term, irreversible harm of cross-sex hormones. Side effects are related to changes in the body's secondary sex characteristics. Once these effects begin, there is no reversing them. For example, a girl taking testosterone will notice a deepening voice and increased hair growth after a few months. These changes are permanent.

[1] https://www.getprinciples.com/understanding-and-responding-to-our-transgender-moment/

According to the American College of Pediatricians[2], for biological females, risks of cross-sex hormone treatment include:

- Irreversible infertility;
- Severe liver dysfunction;
- Coronary artery disease, including heart attacks;
- Cerebrovascular disease, including strokes;
- Hypertension;
- Erythrocytosis, which is an increase in red blood cells;
- Sleep apnea;
- Type 2 diabetes;
- Destabilization of psychiatric disorders.

For biological males, risks of cross-sex hormone treatment include:

- Irreversible infertility
- Thromboembolic disease, including blood clots;
- Cholelithiasis, including gallstones;
- Coronary artery disease, including heart attacks;
- Type 2 diabetes;
- Macroprolactinoma, which is a tumor of the pituitary gland;
- Cerebrovascular disease, including strokes;
- Hypertriglyceridemia, which is an elevated level of triglycerides in the blood;

However, these other issues notwithstanding, the most significant problem is that minors cannot consent to these harmful interventions. If a child is not old enough to vote, drink alcohol, buy cough syrup over the counter, or purchase cigarettes, why would we permit them to decide on dangerous hormones and drastic surgeries? We know that the prefrontal cortex – the part of the brain responsible for rational decision-making – may not be fully developed until age 25[3]. People who are vulnerable to making poor decisions should not be making drastic life-altering decisions about their medical and physical future.

Because these minors may not be entirely capable of making a massive decision about their medical and physical future, it is entirely the responsibility of the parents, physicians, and medical facilities to ensure the safest route of care. That care is clearly not surgeries and hormone treatments, as previously stated.

This bill holds parents, physicians, and medical facilities accountable for these harmful consequences to decisions about surgeries and hormone treatments. It protects minors from making rash, emotional decisions that end up harming them in the long run. For these reasons, North Dakota Family Alliance Legislative Action requests that you render a “DO PASS” on House Bill 1301.

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[2] https://acpeds.org/position-statements/gender-dysphoria-in-children

[3] https://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=1&ContentID=3051

Thank you for the opportunity to testify and I am happy to stand for any questions.

**2023 House Bill 1301**

**House Human Services Committee**

**Representative Robin Weisz, Chairman**

**January 24, 2023**

Chairman Weisz and members of the House Human Services Committee, I am Melissa Hauer, General Counsel/VP of the North Dakota Hospital Association (NDHA). I testify in opposition to House Bill 1301 and ask that you give the bill a **Do Not Pass** recommendation.

NDHA opposes this bill for various reasons, some of which are specific to how it will interfere with health care decision making by parents for their children and some of which are related to provisions regarding legal actions. There are several providers that will address the health care issues so I will limit my comments to the concerns we have regarding the creation of a new legal action that may be brought against health care providers, their employers, and even parents.

North Dakota already has existing laws governing medical negligence, comparative fault, and damages. There is a specific statute of limitations for such actions (generally two years) that the legislature has decided is appropriate. Current law also requires certain steps that a plaintiff must complete in order to maintain such a lawsuit against a health care provider, such as the filing of an affidavit in which a qualified medical expert attests to his or her opinion that negligence was committed by the named health care provider. This bill will throw that process out for health care provided for gender dysphoria treatment. A thirty-year statute of limitations is highly unusual in any civil action. If this bill became law, it could also have a strong effect on the cost of medical malpractice insurance coverage. This bill is also at odds with other parental consent laws already on the books. North Dakota law allows a parent to consent to a 16 or 17 year old's marriage but that same parent would not be allowed to consent to any health care treatment or procedure if it is gender identity-related care.

Other states have addressed this type of legislation. In Alabama, the law that prohibits this type of therapy was found to violate parents' fundamental right to autonomy of obtaining medical treatment for their children subject to medically accepted standards. The court further found that the law is unconstitutional sex discrimination in violation of the 14th Amendment's equal protection clause because the law denies medically necessary services only to transgender minors, while allowing those services to cisgender minors. The Alabama law is on appeal to the 11th Circuit. In Arkansas, its law is on appeal to the 8th Circuit. That court upheld an injunction prohibiting enforcement of the law stating that statutes such as this one that discriminate based on sex must be supported by an "exceedingly persuasive justification". The court found there was substantial evidence to support the conclusion that because the biological sex of the minor patient is the basis on which the Arkansas law distinguishes between those who may receive certain types of medical care and those who may not, it is discrimination on the basis of sex. Twenty states have filed an amicus opposing the law, with nineteen states filing an amicus brief supporting Arkansas.

This bill makes evidence-based medical decision making and treatment of transgender individuals unavailable to North Dakotans. There are physicians here today to testify as to the details of that treatment, and why patients would be harmed if this bill was passed.

NDHA requests a **DO NOT PASS** recommendation on the bill. Thank you.

Respectfully Submitted,

Melissa Hauer, General Counsel/VP
North Dakota Hospital Association

Mr. or Madam Chairman, and members of the House Human Services Committee, My name is Rozell Unruh from Dickinson. Please render a DO PASS on HB1301.

Due to adults who their main objective is to promote the sexualitzation and grooming of our children and teens is why we are in the position today to need this type of legislation. It is our responsibility to protect our children and teens from the medical & educational institutions and sadly, even their parents from this heinous ideology of sterilization, castration, medical and chemical mutilation. There are more and more transgender individuals that are coming out and saying how they have been abused by a system that never gave them the full and honest truth about the side effects of these procedures. Many transgender individuals have stated if they would have actually received the proper mental health care they would not have chosen to go down the mutilation path to change their bodies. One such person is Chole Cole. I implore you to please look up her story.

Thank you,
Rozell Unruh

*“My name is Fred Braun and I reside in District 13. I am asking that you please render a DO PASS on House Bill 1301.”*
*The meteoric rise in young people identifying as transgender is not an organic development due to an increase in cultural acceptance, but due to a social contagion spurred on by predatory, ideologically and financially-motivated adults who seek to undermine the parent-child relationship and promote the sexualization of children and teens under the guise of tolerance.*
*This is turning young people into permanent medical patients and leading them down a path of sterilization, mutilation, and a myriad of serious health problems from taking cross-sex hormones.*
*Pediatric medicine has been corrupted by activists, and the recommendations of the American Academy of Pediatrics and WPATH should be dismissed as ideologically-driven pseudoscience.*
*Thank you for your consideration of this highly important matter and for your service to the state of North Dakota.*

Fred J Braun

House Bill 1301 is a bill that intentionally targets a very small group of people, trans youth, who already face a much higher rate of suicide and homicide in this country. 1301 joins a wave of anti trans legislation in the State of North Dakota, attempting to criminalize a minority for their very existence. The sponsors of this bill have no authority to control the lives of their transgender constituents so they try in vain to legislate them out of existence.Not only is this impossible but it is antithetical to the small government approach supposedly favored by the conservative caucus.

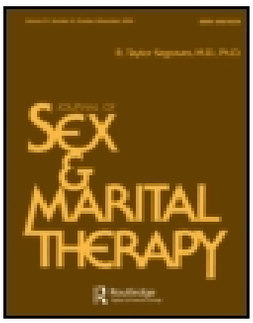
I can't speak to the legality of a bill like this, although I'm sure many attorneys today will. I can't speak to its medical implications, but I know there are doctors and mental healthcare providers pleading with you to vote against this bill. If all of their expertise is meaningless to you, I can only offer my testimony as someone whose lived experience as a transgender person raised in North Dakota is relevant here.

What you seek to do in passing HB 1301 will kill children. I know because I barely survived growing up trans in North Dakota. I barely survived adulthood as a trans person here. While living in North Dakota and being subjected to multiple assaults and hate crimes, I attempted to take my own life just shy of a dozen times. Since I moved to Minneapolis in 2016 and gotten hormone replacement therapy and gender affirming surgeries, I have not attempted to take my own life a single time. I feel safe here in a way I never did in Bismarck or Fargo for the 25 years I spent there.

Hormone blockers are already prescribed to plenty of children for precocious puberty. Hormone supplements like estrogen are prescribed in the form of birth control, and I knew young men in high school who, as puberty hadn't reached them yet, were prescribed testosterone or human growth hormone to start their puberty. As a young person, I knew I was trans without having the language for it. I told every person who would listen to me from the age of 3 on that I wasn't a girl. I could have avoided my mastectomy if I had been able to get on puberty blockers instead. I could have avoided all the violence I did to myself.

If you vote for this bill, there are children who will choose to end their lives instead of suffering this violence and bigotry. If I were you, there is not one more word of testimony I would need to hear.

I doubt many of you will read what I'm saying to you. I know it isn't as powerful when I can't be there in person to stare you in the eyes and ask you to recognize my humanity. But I am a human being, and so are the children who will die as a result of your hate. Reconsider what you're doing, or live to regret the children you've sent to their graves.



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Journal of Sex & Marital Therapy

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/usmt20

# The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed

E. Abbruzzese, Stephen B. Levine & Julia W. Mason

**To cite this article:** E. Abbruzzese, Stephen B. Levine & Julia W. Mason (2023): The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed, Journal of Sex & Marital Therapy, DOI: 10.1080/0092623X.2022.2150346

**To link to this article:** https://doi.org/10.1080/0092623X.2022.2150346



Published online: 02 Jan 2023.

JOURNAL OF SEX & MARITAL THERAPY
https://doi.org/10.1080/0092623X.2022.2150346

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ARTICLE COMMENTARY

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# The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed

E. Abbruzzese[a], Stephen B. Levine[b] and Julia W. Mason[c]

[a]Society for Evidence-Based Gender Medicine, Twin Falls, ID, United States; [b]Department of Psychiatry, Case Western Reserve University, Cleveland, OH, United States; [c]Calcagno Pediatrics, Gresham, OH, United States

**ABSTRACT**

Two Dutch studies formed the foundation and the best available evidence for the practice of youth medical gender transition. We demonstrate that this work is methodologically flawed and should have never been used in medical settings as justification to scale this "innovative clinical practice." Three methodological biases undermine the research: (1) subject selection assured that only the most successful cases were included in the results; (2) the finding that "resolution of gender dysphoria" was due to the reversal of the questionnaire employed; (3) concomitant psychotherapy made it impossible to separate the effects of this intervention from those of hormones and surgery. We discuss the significant risk of harm that the Dutch research exposed, as well as the lack of applicability of the Dutch protocol to the currently escalating incidence of adolescent-onset, non-binary, psychiatrically challenged youth, who are preponderantly natal females. "Spin" problems—the tendency to present weak or negative results as certain and positive—continue to plague reports that originate from clinics that are actively administering hormonal and surgical interventions to youth. It is time for gender medicine to pay attention to the published objective systematic reviews and to the outcome uncertainties and definable potential harms to these vulnerable youth.

## Introduction

In our recent paper on informed consent for youth gender transition, we recognized a serious problem: the field has a penchant for exaggerating what is known about the benefits of the practice, while downplaying the serious health risks and uncertainties (Levine et al., 2022a). As a result, a false narrative has taken root. It is that "gender-affirming" medical and surgical interventions for youth are as benign as aspirin, as well-studied as penicillin and statins, and as essential to survival as insulin for childhood diabetes—and that the vigorous scientific debate currently underway is merely "science denialism" motivated by ignorance, religious zeal, and transphobia (Drescher et al., 2022; McNamara et al., 2022; Turban, 2022). This highly politicized and fallacious narrative, crafted and promoted by clinician-advocates, has failed to withstand scientific scrutiny internationally, with public health authorities in Sweden, Finland, and most recently England doing a U-turn on pediatric gender transitions in the last 24 months (COHERE

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This article has been corrected with minor changes. These changes do not impact the academic content of the article.

(Council for Choices in Health Care), 2020; Socialstyrelsen [National Board of Health and Welfare], 2022; National Health Service (NHS), 2022a). In the U.S., however, medical organizations so far have chosen to use their eminence to shield the practice of pediatric "gender affirmation" from scrutiny. In response to mounting legal challenges, these organizations have been exerting their considerable influence to insist the science is settled (American Medical Association (AMA), 2022). We argued that this stance stifles scientific debate, threatens the integrity and validity of the informed consent process—and ultimately, hurts the very patients it aims to protect.

To demonstrate problems in existing research, we discussed two seminal studies that gave rise to the now-common practice of performing gender transitions on young people by giving them puberty blockers, cross-sex hormones, and "gender-affirming" surgery (de Vries et al., 2011; de Vries et al., 2014). We argued that these Dutch studies suffer from such profound limitations that they should never have been used as justification for propelling these interventions into general medical practice. We called for rigorous clinical research into the interventions known as "gender-affirming" care before these interventions are further scaled. Until such research is available, we urged clinicians to disclose the profound uncertainties regarding the outcomes of this treatment pathway to enable patients and families to make better-informed decisions about their care.

Our assertions drew a response from the first author of these Dutch studies (de Vries, 2022).[1] de Vries dismissed much of our criticism as a mere "misunderstanding" of their gender clinic's process. While de Vries acknowledged some of the limitations in the Dutch research, she asserted that these gaps have since been sufficiently remedied by subsequent research from others in the field, rendering the practice of pediatric gender transition as proven beneficial, and ready to be widely scaled in general medical practice.

Having carefully examined de Vries' counterarguments, we failed to find a single instance where our "misunderstanding" could explain away the significant problems that we pointed out. In this article, we justify our position that neither the Dutch research, nor the research that followed, is fit for shaping policy or treatment decisions regarding gender dysphoric youth at the population level. We present our response to de Vries in three sections. *First,* we provide a more complete justification for our assertions of the significant flaws in the foundational Dutch research. *Second,* we demonstrate that the claims that subsequent research remedied the deficiencies in the prior research are untrue. *Third*, we provide recommendations for research structure to yield reliable, trustworthy information. We conclude with a sense of urgency to avoid future harms by reminding readers of the intrinsic value of high-quality science.

Before we embark on outlining the critical methodological limitations of the Dutch research, we would like to make it clear that it is not our intention to discredit the Dutch clinicians' past work. The quality of the Dutch studies, while unacceptably low by today's standards, is commensurate with clinical and research practices in the 1990s. The key problem in pediatric gender medicine is not the lack of research rigor in the *past*—it is the field's *present-day* denial of the profound problems in the existing research, and an unwillingness to engage in high quality research requisite in evidence-based medicine.

## *Evidence-based medicine vs empirical-based medicine*

When the Dutch clinicians launched the practice of pediatric gender transition, it was not uncommon for medical professionals to practice medicine based on "empirical evidence," relying on expert opinion and often backed by only minimal research (Drisko & Friedman, 2019). The term "evidence-based medicine" and its focus on quality comparative clinical research to determine optimal treatment only emerged in the 1990s (Guyatt, 1993). The Dutch researchers began to medically transition gender dysphoric adolescents in the late 1980s–early 1990s—just as medicine was starting to undergo this major paradigm shift.

Examining the Dutch research from today's vantage point, their gender-transitioning of youth is most consistent with the "innovative practice" framework. This framework allows clinicians

to implement untested but promising interventions for a condition which, if left untreated, might have dire outcomes; when existing treatment options seem ineffective; and when the number of affected patients is small (Brierley & Larcher, 2009; Earl, 2019). The number of adolescents suffering from gender dysphoria in the 1990s was exceedingly small. Evidence was starting to demonstrate that gender reassignment undertaken in adulthood failed to resolve trans people's mental health problems (Cohen-Kettenis & Van Goozen, 1997). The Dutch clinicians hoped that the "less positive results among adults" (p. 266) would be remedied with early adolescent gender transition. In this context, the methodological deficiencies in the foundational Dutch research ought not to be viewed as a *failure*. It was never their goal to generate *reliable reproducible research*. In fact, the many irregularities, which we elucidate below, reflect the Dutch *success* at rapidly evolving their approaches to reach a point of *technical excellence*: convincing physical transformations of adolescent bodies that satisfied the young patients (Biggs, 2022). These clinicians were "flying the plane while building the plane," and their published research merely reflects this messy clinical reality.

The "innovative practice" model of care is a double-edged sword. On the one hand, it rapidly advances the medical field. On the other hand, it is capable of hurting individuals and societies by promoting a nonbeneficial or harmful intervention. For these reasons, it is an ethical requirement that as soon as viability of a new intervention is demonstrated under the "innovative practice" framework, the research must move into high-quality clinical research settings capable of demonstrating that the benefits outweigh the risks. This step is imperative because it prevents "runaway diffusion"—the phenomenon whereby the medical community mistakes a small innovative experiment as a proven practice, and a potentially nonbeneficial or harmful practice "escapes the lab," rapidly spreading into general clinical settings (Earl, 2019).

"Runaway diffusion" is exactly what has happened in pediatric gender medicine. "Affirmative treatment" with hormones and surgery rapidly entered general clinical practice worldwide, without the necessary rigorous clinical research to confirm the hypothesized robust and lasting psychological benefits of the practice. Nor was it ever demonstrated that the benefits were substantial enough to outweigh the burden of lifelong dependence on medical interventions, infertility and sterility, and various physical health risks. The studies also failed to quantify the risk to "false positives"—that is, those gender dysphoric youth whose distress would have remitted with time without resorting to irreversible medical and surgical interventions.

The speed of the "runaway diffusion" accelerated exponentially when pediatric gender dysphoria/transgender identity went from a relatively rare phenomenon before 2015, to one that impacts as many as 1 in 10–20 young people in the Western world (American College Health Association [ACHA], 2022; Johns et al., 2019; Kidd et al. 2021). The current politicization of transgender healthcare has provided further fuel to the rapid proliferation of youth gender reassignment. A proposal by the U.S. government to mandate healthcare entities to provide "gender-affirming" interventions to minors, or risk claims of "discrimination" and loss of federal healthcare funding is yet another example of "runaway diffusion" (Health and Human Services [HHS], 2022; Keith, 2022).

The difficult task of reversing runaway diffusion begins with a systematic review of evidence, follows with updating treatment guidelines, and culminates with de-implementation of unproven or harmful practices, known as "practice reversals" (Herrera-Perez et al., 2019; Prasad, 2011; Prasad & Ioannidis, 2014). *Systematic reviews of evidence* play a uniquely important role in this process. Rather than arbitrarily selecting studies and simply restating their results and conclusions, systematic reviews of evidence analyze *all of the available evidence* meeting pre-specified criteria and *scrutinize the studies* for methodological bias and errors, issuing an overarching conclusion about what's known about the effects of an intervention based on the totality of the evidence (Higgins et al., 2022). A "practice reversal" of pediatric gender transitions has already begun. Several recent international systematic reviews of evidence have concluded that the practice of pediatric gender transition rests on *low to very low quality evidence*—meaning that the benefits reported by the existing studies are unlikely to be true due to profound problems in the study designs (National

Institute for Health and Care Excellence (NICE), 2020a, 2020b; Pasternack et al., 2019; SBU (Swedish Agency for Health Technology Assessment and Assessment of Social Services), 2022). Following these systematic reviews of evidence, three European countries—Sweden, Finland and England—have begun to articulate new and much more cautious treatment guidelines for gender dysphoric youth, which prioritize noninvasive psychosocial interventions while sharply restricting the provision of hormones and surgery (COHERE (Council for Choices in Health Care), 2020; Socialstyrelsen [National Board of Health and Welfare], 2022; NHS, 2022a).

Paradoxically, this international reckoning has had almost no influence on the U.S. gender medicine establishment. When Florida's Medical Board, following an overview of existing systematic reviews (Brignardello-Peterson & Wiercioch, 2022), took on the question of regulating pediatric gender medicine and invited the proponents of pediatric gender transitions to reconcile their stance with the recent European developments, these clinician advocates were either unaware of the European changes, or minimized their extent and significance (Janssen, 2022 00:46:43; McNamara, 2022 01:45:27). More generally, when faced with questions about the rapidly growing numbers of youth subjected to highly invasive and often irreversible interventions based on *low to very low quality evidence*, the field of U.S. pediatric gender medicine has chosen to throw its weight behind two indefensible and contradictory claims: (1) that "low quality evidence" is a misleading technical term which actually describes high quality reliable research; and (2) that true high quality research can only come from randomized placebo-controlled trials, which are unattainable and unethical (Drescher, 2022; McNamara et al., 2022). We refuted these misleading claims in our recent publication (Levine et al., 2022b).

As we begin our discussion of the profound limitations in the two foundational Dutch studies that have propelled the practice of pediatric gender transition into mainstream clinical practice worldwide, we are aware that we are mounting a serious challenge to the research that has been viewed by many as the "gold standard" in the field. Questioning this assumption, we welcome further debate. A quote from philosopher Karl Popper, perceptively invoked by Balon (2022), is particularly apt: "the growth of knowledge depends entirely on disagreement."

## I. The "Dutch studies" are deeply flawed

There is no argument that the Dutch experience, and in particular two Dutch studies—de Vries et al. (2011), and de Vries et al. (2014)—forms the foundation of the practice of youth gender transition. It is evident when examining prevailing treatment guidelines. The Endocrine Society's statements regarding the potential benefits of puberty blockers and cross-sex hormones in gender dysphoric adolescents are supported only by references to these two studies (Hembree et al., 2017, p. 12, p. 16). Similarly, the World Professional Association for Transgender Health (WPATH) "Standards of Care" guidelines version 7 (SOC 7)—the version under which the practice of medicalization of gender dysphoric youth became widespread—only references the Dutch experience (Coleman et al., 2012). Despite several newer studies available, the proponents of gender affirmation still correctly emphasize that "the best longitudinal data we have on transgender youth comes primarily out of the Dutch clinic…the Dutch studies in the Dutch model of care. That's the prevailing model that most of the American clinics have based their care upon" (Janssen, 2022, 00:47:42). de Vries in her response to us, also agrees with this: "…indeed, as of today, the Dutch papers, and especially the de Vries et al., 2014 study, are still used as main evidence for provision of early medical intervention including puberty blockers in transgender youth (de Vries et al., 2014)" (de Vries, 2022, p. 2).

The two main Dutch studies in question, de Vries et al., 2011, and de Vries et al., 2014 (from here on, "the Dutch studies") convincingly demonstrated that hormonal and surgical interventions can successfully change the phenotypical appearance of secondary sex characteristics of adolescents and young adults. What the studies *failed* to show, however, is that these physical changes resulted in meaningful psychological improvements significant enough to justify the adverse effects of the treatment—including the *certainty* of sterility.

Besides the lack of a control group and a small final sample of 55 cases, with key outcomes available for as few as 32 individuals, there are *three major areas of concern* that render these studies unfit for clinical or policy decision-making.

A. **High risk of bias**: The Dutch studies suffer from multiple sources of bias which undermine confidence into the reported "benefits." The subject selection assured that only the most successful cases at each treatment stage were included in reported results. The linchpin finding of "resolution of gender dysphoria" is entirely invalid, since the home-grown gender dysphoria scale and its scoring mechanism were reversed after treatment, essentially guaranteeing a significant post-surgical drop in "gender dysphoria" scores. The finding of modest psychological benefits was compromised by the conflation of medical interventions with psychotherapy, making it impossible to determine whether gender reassignment, therapy, or the psychological maturation that occurs with the passage of time led to these few modest "improvements."
B. **Incompleteness of evidence regarding physical health risks**: The Dutch studies did not evaluate *physical health* outcomes of "gender-affirmative" treatments, even though adverse effects of hormonal interventions on bone and brain had been hypothesized from the start (and were confirmed by subsequent research). Even without setting out to assess the risks, the Dutch research inadvertently revealed that the rate of short-term morbidity and mortality associated with "gender-affirming" interventions may be as high as 6%-7%.
C. **Poor generalizability/applicability to current cases**: Today, most youth suffer from post-pubertal onset of gender dysphoria and significant mental illness—two clinical presentations the Dutch *explicitly disqualified* from their studies. As such, none of the Dutch findings are applicable to most of the youth seeking treatment today.

de Vries (2022) disputed only our assertion that the studies suffer from *high risk of bias* and therefore their findings of benefits are unreliable. She did not comment on our arguments that the research *failed to assess physical health risks* and *were not generalizable* to the majority of currently presenting cases. It is unclear if this silence indicates agreement or disagreement. Below, we address each of our points in greater detail, concluding with an additional observation about the overall lack of equipoise—genuine uncertainty about which treatment options are superior (London, 2017), which limits the utility of the Dutch research beyond describing a small-scale "innovative practice."

## A. High risk of bias in the Dutch research

de Vries rejected our assertion that the Dutch findings suffer from a high risk of bias and insisted that we mistook the study protocol's careful process of establishing study eligibility for "bias." To clarify, we use the term "risk of bias" in a strict methodological sense. It refers to a systematic error, or deviation from the "truth" in study results (Boutron et al., 2022; Socialstyrelsen [National Board of Health and Welfare], 2022). Observational research conducted in the context of ongoing clinical care is often subject to risk of bias (Nguyen et al., 2021), which is one of the main reasons why rigorous clinical research using robust research designs must follow. In the case of the Dutch studies, we identified three major sources of bias, or systematic error, involving: (1) case selection; (2) measurement of outcomes; and (3) confounding.

### 1. Bias in case selection: Only the "best-case scenario" cases made it into the Dutch studies' "completers"

Because of an unusual case selection and reporting methodology, the Dutch studies inadvertently reported on only their best-case outcomes at each of the three phases of treatment (puberty blockers, cross-sex hormones, and surgery)—while failing to report the outcomes of the less positively affected, or even harmed, cases. de Vries disagreed with this assertion, continuing to insist that "participation was based on consecutive referral" (de Vries, 2022, p. 4).

Below, we present evidence that the claim of consecutive referral-based *prospective case selection* is not technically accurate. The actual case selection for the original sample of 70 puberty-blocked cases (de Vries et al., 2011) was *retrospective* and inadvertently biased toward including cases with favorable outcomes. The outcome reporting methodology in the second and final Dutch study (de Vries et al., 2014), which evaluated the final outcomes post-surgery, further biased the results toward reporting on the most favorable cases.

***de Vries et al., 2011 ("puberty blocker" study).*** The 70 cases comprising the entire sample for the "puberty blocker" study (de Vries et al., 2011) were *retrospectively, non-randomly selected* from a larger group of consecutively referred 111 cases. According to both the original study, and de Vries' response to us, to participate in the "puberty blocker" study, a study subject already had to be starting the *next phase* of treatment with cross-sex hormones:

> Of the 196 consecutively referred adolescents…111 (those below age 16) had started puberty suppression… In the 2011 study we evaluated the first 70 of those 111 who were about to start with the next step of their treatment, affirming hormones, around the age of 16 years. (de Vries, 2022, p. 4)[2]

Using the start date of the *next phase* of treatment (cross-sex hormones) as the defining inclusion criterion for the study of the *prior phase* of the treatment (puberty blockers) introduced serious bias.

*First*, had any of the original 111 study subjects been harmed by puberty blockers or chosen to stop the treatment, they would never have advanced to the next phase, and thus, they had no chance of being included in the puberty blocker study, skewing the sample. *Second*, since the Dutch considered the puberty suppression phase both a treatment and a *diagnostic phase* (Cohen-Kettenis & van Goozen, 1998), the more complex cases may have remained in the puberty blocked phase longer. As de Vries' predecessors explained, subjects for whom the psychotherapist or parents had doubts, or where "the personal situation of the youngster" was more complicated, were delayed from starting cross-sex hormone treatment, which was the first stage the Dutch researchers considered to have an "irreversible" effect (Gooren & Delemarre-van de Waal, 1996, p. 11). This would further skew "the first 70 of those 111 who were about to start with the next step of their treatment, affirming hormones" (de Vries, 2022, p. 4)—the entire puberty blocker study sample—toward the most clinically straightforward and stable cases.

*Third*, such an unusual case selection methodology may have skewed the sample toward an older age than was stipulated by the protocol. Since to be eligible for the "puberty blocker" study, a subject had to have been deemed ready to start the next phase of cross-sex hormones, which *required a minimum age of 16* (accroding to the Dutch protocol version published in 2012, de Vries, 2012), all else being equal, older subjects had a greater chance of being included than younger ones. This may explain why the sample of 70 selected subjects was on average, age 15 when started on puberty blockers rather than age 12 as outlined by the protocol, which introduced another source of systematic error, by biasing the sample toward subjects with greater physical and cognitive maturity.

Given that the 2011 Dutch study's main goal was to evaluate the novel use of *puberty blockers* for gender dysphoria in a prospective cohort study (de Vries et al., 2011), the study should have enrolled, and reported the outcomes of, *all of the intent to treat* cases based on the date of eligibility to start *puberty suppression*—not cross-sex hormones.

It is notable that the only attempt to replicate the 2011 Dutch study results with more than a handful of cases took place in the UK but failed (Carmichael et al., 2021), with the conclusion of "no changes in psychological function" (p. 1). We suspect the key reason for this failure was the fact that the UK researchers truly *prospectively* selected "sequentially eligible" cases for treatment (Carmichael et al., 2021, p. 4) and as a result, ended with a diverse range of outcomes, including worsening of problems among female subjects during puberty blockade (Biggs, 2020). In contrast, the Dutch *retrospective* case selection methodology (misunderstood as prospective) inadvertently resulted in skewing the sample toward the best-case-scenario puberty-blocked cases. In our view, such case selection methodology invalidates the 2011 study conclusions of

psychological benefits of puberty suppression—or, as research methodologists would say, puts this finding at a "critical risk of bias."

***de Vries et al, 2014 (post-surgery study).*** Skewing the sample toward the best-case scenario cases is even more apparent in the 2014 study, which reported on post-surgical outcomes and assessed the entire "gender-affirmative" treatment pathway (de Vries et al., 2014). The 70 participants who began the 2014 study, already biased toward more positive outcomes, shrank to 55. Fifteen subjects were dropped from the study and relabeled "nonparticipants." This subset, however, was not random, but instead heavily skewed toward subjects who experienced serious problems, including 3 who developed severe diabetes and obesity and 1 death following surgical complications. There is also considerable uncertainty about the outcomes of the 5 of 70 subjects (refusal, failure to return questionnaire, and dropping out of care) who, after several years of close contact with the research team, were unwilling to engage further:

> Nonparticipation (n = 15, 11 transwomen and 4 transmen) was attributable to not being 1 year postsurgical yet (n = 6), refusal (n = 2), failure to return questionnaires (n = 2), being medically not eligible *(e.g., uncontrolled diabetes, morbid obesity) for surgery (n = 3)*, dropping out of care (n =1), and *1 transfemale died after her vaginoplasty owing to a postsurgical necrotizing fasciitis* [emphasis added]. (de Vries et al., 2014, p. 697)

In her response, de Vries repeated the assertion that because a statistical comparison of the 15 "nonparticipants" to the 55 "participants" revealed no significant difference in their *pretreatment* baseline characteristics, "the results of the 2014 study can be generalized with substantial trust to the complete group of 70" (de Vries, 2022, pp. 4–5). We strongly disagree. The "participant" and "nonparticipant" cohorts are demonstrably different: while 100% of the 55 "participants" had successful gender reassignment according to the study reporting, at least 27% of the "nonparticipant" group (4/15: 1 death and 3 cases of diabetes) did not. Not only is a statistical analysis of such small subgroups massively underpowered to detect differences, ***no*** statistical analysis of *pretreatment* data suggesting "similarity" can negate the reality of the markedly different *post-treatment* outcomes in two groups. Nor is it clear why the research team made the unusual decision to stop the study early, before the remaining 6 participants had a chance to complete the 1-year post-surgical follow-up.

***The "missing" Dutch study on the effect of cross-sex hormones.*** The second and final Dutch study (de Vries et al., 2014) combined the cross-sex hormone and post-surgical treatment results into a single set of outcomes. This conflation may have made some sense at the time, as all the hormonally-treated patients were *required* to undergo surgery (removal of breasts, ovaries, uterus, penis, testes, and construction of a neovagina) by the protocol. When surgery is not required, only 25–35% of transgender-identified adults appear to seek "gender-affirming" surgical procedures (Nolan et al., 2019). According to recently published data, this number is even smaller for youth: for every teen treated surgically, there are 15 treated *only* with cross-sex hormones (Respaut & Terhune, 2022). The inability of the Dutch research to elucidate the outcomes of cross-sex hormone treatments (separate from surgery) has been noted by NICE, which appropriately excluded the 2014 Dutch study from its systematic review of evidence (NICE, 2020b).

It is unknown whether the 4.3% of the sample (n = 3) that experienced obesity and diabetes sometime before the surgery was a result of the hormonal treatment; this rate appears to be double the expected rate for pediatric populations in the Netherlands at the time (Rotteveel et al., 2007; Schönbeck et al., 2011). Nor is it known if the cross-sex hormones contributed to the one subject who discontinued treatment due to other medical or psychological problems. Other research suggest that testosterone may actually *increase* dysphoria in female gender-dysphoric individuals (Olson-Kennedy, Warus, et al., 2018).

### 2. Bias in measurement of outcomes: The finding of "resolution of gender dysphoria" is invalid

The linchpin result of the Dutch studies is the reported *resolution of gender dysphoria*, as measured by the Utrecht Gender Dysphoria Scale (UGDS) (Steensma, Kreukels, et al., 2013). de

Vries agreed with us on this point: "the main finding remains the resolution of gender dysphoria" (de Vries, 2022, p. 3). According to the final Dutch study, the UGDS *gender dysphoria* scores plummeted, from a near-maximum score of 54 (maximum of 60) at baseline, to the near-minimum score of 16 (minimum of 12) after the final surgery (de Vries et al., 2014).

Rather than a true "resolution" of *gender dysphoria*, however, this spectacular drop was an artifact of switching the scale from "female" to "male" versions (and vice versa) before and after treatment, prompting a problematic *reversal* in the scoring. We argued that this fact alone invalidates the study's main conclusion of the resolution of gender dysphoria (Levine et al., 2022a). While de Vries conceded the use of the UGDS scale post-treatment was "not ideal" because "the UGDS was not…designed to be used after treatment," she asserted that it "does not imply that UGDS 'falsely' measured the improvement in GD [gender dysphoria]" (de Vries, 2022, p. 4). We think it is vitally important for the scientific community to recognize that the UGDS scale use was not merely "not ideal"—but that it *entirely invalidated* the Dutch study's main finding.

The following hypothetical scenario clearly demonstrates the problem. A severely gender dysphoric, cross-sex identified female patient is asked to answer two of the UGDS questions: "Every time someone treats me like a girl I feel hurt" and "Every time someone treats me like a boy I feel hurt" (Items 2 on the "female" and the "male" versions of the UGDS scale, respectively). It is likely that the patient would *strongly agree* with the first statement, and *strongly disagree* with the second. The first answer would lead to the score of "5" on the UGDS gender dysphoria scale, indicating the highest possible level of gender dysphoria. The second answer—which is effectively the same answer—would result in the score of "1" indicating the lowest possible gender dysphoria. This is because unlike the first question, which belongs to the "female" battery of questions, the second question belongs to the "male" battery of questions and effectively assumes the subject to be male—hence, the lack of distress of being associated with "maleness" receives the minimum "gender dysphoria" score.

If we now consider that only the "female" scale was used for gender dysphoric females at baseline but was then switched to the "male" scale after the final surgery (and vice-versa for male subjects), it becomes clear that the remarkable drop in "gender dysphoria" the UGDS scale registered after surgery entirely results from switching the scale. The *same* gender dysphoric individual, effectively answering the *same* question (albeit linguistically inverted), in the *same* way results in either the maximum or the minimum "gender dysphoria" score—depending on which sexed version of the scale was used. We reproduced both the "male" and the "female" versions of the UGDS scale in Table 1 so that others can easily observe how switching the scale "sex" version consistently leads to a "drop" of the gender dysphoria score, regardless of any treatment effect.

When defending the choice to reverse the UGDS scale (de Vries, 2022), de Vries pointed out—and we agree—that it would make no sense to ask postoperative natal males to rate a statement such as "I dislike having erections" (Table 1, UGDS-M, item 11), since they no longer have penises. We empathize with the Dutch researchers' plight, as they found themselves without a valid tool to measure the construct of "gender dysphoria" after treatment. It is equally nonsensical, however, to ask natal males to rate statements such as, "I hate menstruating because it makes me feel like a girl" (Table 1, UGDS-F, item 10)—and it makes even less sense to report "resolution of gender dysphoria" because they don't "hate menstruating."

In her response, de Vries pointed to the validation research of the UGDS dysphoria scale (de Vries, 2022; Steensma, Kreukels, et al., 2013). To the best of our knowledge, this work has never appeared in a peer-reviewed publication. In our opinion, this UGDS validation research missed a key opportunity to identify the threat to validity of using the UGDS scale in post-gender reassignment context, which should have become apparent to the Dutch research team by 2013 when the validation paper was published. The greater community of international gender clinicians relying on the Dutch pioneering experience was not alerted to the need to find another instrument that can provide a valid pre-post "gender dysphoria" measure. Instead, the validation

**Table 1.** Utrecht Gender Dysphoria Scale, Adolescent Version (de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006). Response categories are *agree completely, agree somewhat, neutral, disagree somewhat, disagree completely*.

| UGDS-F (female)<br>Response categories are: agree completely, agree somewhat, neutral, disagree somewhat, disagree completely. Items 1, 2, 4–6 and 10–12 are scored from 5 to 1; items 3 and 7–9 are scored from 1 to 5. | UGDS-M (male)<br>Response categories are: agree completely, agree somewhat, neutral, disagree somewhat, disagree completely. Items are all scored from 5 to 1. |
|---|---|
| 1. I prefer to behave like a boy. | 1. My life would be meaningless if I would have to live as a boy. |
| 2. Every time someone treats me like a girl I feel hurt. | 2. Every time someone treats me like a boy I feel hurt. |
| 3. I love to live as a girl. | 3. I feel unhappy if someone calls me a boy. |
| 4. I continuously want to be treated like a boy. | 4. I feel unhappy because I have a male body. |
| 5. A boy's life is more attractive for me than a girl's life. | 5. The idea that I will always be a boy gives me a sinking feeling. |
| 6. I feel unhappy because I have to behave like a girl. | 6. I hate myself because I'm a boy. |
| 7. Living as a girl is something positive for me. | 7. I feel uncomfortable behaving like a boy, always and everywhere. |
| 8. I enjoy seeing my naked body in the mirror. | 8. Only as a girl my life would be worth living. |
| 9. I like to behave sexually as a girl. | 9. I dislike urinating in a standing position. |
| 10. I hate menstruating because it makes me feel like a girl. | 10. I am dissatisfied with my beard growth because it makes me look like a boy. |
| 11. I hate having breasts. | 11. I dislike having erections. |
| 12. I wish I had been born as a boy. | 12. It would be better not to live than to live as a boy. |

research buttressed the problematic practice of using UGDS to measure the level of gender dysphoria after gender reassignment by stating: "From follow-up studies it was already known that gender dysphoria, as measured by the UGDS, disappeared post gender reassignment. These qualities make the instrument useful for clinical and research purposes" (Steensma, Kreukels, et al., 2013, p. 56). This statement is misleading, as the finding of the "disappearance" of gender dysphoria post-gender reassignment in the past "follow-up" research came from studies that also switched the sexed scale versions post-treatment, as Dr. de Vries pointed out in her response to us (de Vries, 2022).

Thus, in a spectacular display of circular reasoning, the scale validation research claimed that the follow-up research endorsed the use of the inverted UGDS scale version post gender reassignment, while the follow-up research defended this unusual practice by pointing to the validation research. de Vries doubled down on this circular reasoning in her response to our critique (de Vries, 2022):

> Levine et al. (2022) questions whether the improvement in gender dysphoria does then not stem from this switching, and not from the treatment? However, this seems turning the matter around. What the measure shows, the disappearance or resolution of gender dysphoria, is what the gender affirming treatment is aimed to resolve. (pp. 3–4)

At least three research groups noted the critical threat to the validity of the finding of "resolution of gender dysphoria" due to the switching of the scale (Biggs, 2022; McGuire et al., 2020; van de Grift et al., 2017). McGuire et al. (2020) explicitly stated, "Because the original UGDS is composed of two scales, it is impossible to determine if this is a real difference in gender dysphoria between groups or if this is an artifact of measurement error (p. 195).

***The likely meaning of the "plummeting" gender dysphoria scores.*** What, if anything, did the "plummeting" gender dysphoria scores post scale-flipping signal, if not the "disappearance of gender dysphoria" claimed by the Dutch researchers? We posit that the UGDS scale can only measure the construct which it was originally designed and validated to measure—the level of incongruence between natal sex and gender identity leading to the provision of the DSM diagnosis (Cohen-Kettenis & van Goozen, 1997; Iliadis et al., 2020; Steensma, Kreukels, et al., 2013). This is true whether the scale is used before or after treatment, and whether the "treatment" in question is "gender-affirmation" with hormones and surgeries, psychotherapy, or mere "watchful waiting," with the scale administered at various time points.

The fact that after gender reassignment, the UGDS scores were low on the opposite-sex scale indicates that the subjects would have scored high on the natal sex scale, which corresponds to a *persistence in transgender identity.* This is the only plausible interpretation of the "plummeting" UGDS scores that survives in the context of the scale questions and the linguistic and numerical gymnastics the scale underwent in the post-gender-reassignment context. The finding of persistence of transgender identity is not unexpected, especially since the Dutch researchers selected subjects with lifelong extreme cross-sex identification and follow-up was only 1.5 years post-surgery. What it does *not* mean is that the feeling of "incongruence" resolved. This point is underscored by the long-term follow-up data on male-to-female Dutch transitioners, presented at the WPATH 2022 Symposium by Dr. van der Meulen (Steensma et al., 2022). Nearly a quarter of the participants have felt that their bodies were still too masculine, and over half have experienced shame for the "operated vagina" and fearful their partner will find out their post-surgical status—despite registering low "gender dysphoria" UGDS scores (Steensma et al., 2022).

### *3. Bias from confounding: Psychotherapy was comingled with medical interventions*

Although the Dutch research is frequently commended for having demonstrated "psychological improvements," an examination of the outcomes reveals that standard measures of psychological functioning such as anxiety, depression, anger, and global function showed very little clinically significant change after treatment (Levine et al., 2022a). de Vries acknowledged that a number of psychological measures showed no meaningful change, but insisted that the "more robust" measures, such as Child Behavior Check List (CBCL) and Youth Self Report (YSR), *did* show clinically relevant changes (de Vries, 2022, p. 3). She also noted that post-intervention, the sample of gender dysphoric youth in the Dutch research functioned at a similarly high level as their non-dysphoric peers, which was also an indicator of success. We have three observations about this response.

*First*, the impressive drop in the percentage of cases in the "clinical" range for CBCL and YSR (de Vries et al., 2014) was only apparent after *dichotomizing* these scales into the "clinical" (problematic) versus "non-clinical" ranges. In comparison, the sample's *average* post-intervention score changes on these scales were much more modest. For example, while the 2014 Dutch study points out that the "percent in the clinical range dropped from 30% to 7% on the YSR/ASR," which looks like an impressive reduction, the *average* t-scores had a modest drop of from 54.72 before treatment, to 48.53 after surgery (de Vries et al., 2014, p. 702). Further, both before and after t-scores were less than 60—typically interpreted as having no clinically significant symptoms (Achenbach & Rescorla, 2001). This suggests the reported improvements in CBCL and YSR came from relatively small score changes, which are of limited clinical significance, even if in the process the clinical threshold is crossed for some cases.

*Second*, while de Vries points to the *post-treatment* similarity in function of the gender-dysphoric group to the general population as evidence of treatment success, it is not known how different the groups were from the general population *pretreatment*. According to earlier research by Cohen-Kettenis and van Goozen (1997), which presumably utilized similar selection criteria, "when both pre- and posttest group means were compared with Dutch normative data, *all scores turned out to be within the average range* [emphasis added]" (p. 269). Smith et al. (2001) confirm this and explicitly state that both pretreatment and post-treatment, the group of gender dysphoric youth selected for the interventions were "normal functioning" as compared to their age peers in the Netherlands (Smith et al., 2001, p. 477). If the sample used in the two Dutch studies, which was recruited several years later but used the same careful case selection criteria, bears resemblance to the sample described by this earlier Dutch research, then the reported post-treatment similarities in psychological function between the "treated" group and the general population of peers should not be attributed to gender reassignment.

*Third*, and perhaps most relevant to this discussion, is the question of whether *any* of the reported changes in post-treatment psychological function scores, clinically significant or not, can be reasonably attributed to gender reassignment—or if these changes were influenced by confounding factors not accounted for in the research design. As noted by the authors of the

CBCL and YSR scales that de Vries says she favors, "improvement in scores from before to after services does not prove that the services were responsible for improvement. Other explanations are possible, such as (a) children's problems tend to decrease as they get older; (b) the people providing the data may report improvements because they believe that the services helped, and (c) the test-retest attenuation effect (a general tendency for people to report fewer problems at a second assessment)" (Achenbach & Rescorla, 2001, p. 183).

In addition to the general sources of confounding in uncontrolled studies relying on "before and after" measures, a vital source of confounding in the Dutch studies has been hiding in plain sight: All the subjects received psychotherapy at the same time they were undergoing gender reassignment. This comingling of interventions makes it impossible to determine which of the interventions "worked."

***Psychotherapy was a key element in the Dutch protocol.*** Contrary to the now-common but erroneous assertion by the U.S. gender medicine establishment that psychotherapy for gender dysphoria is akin to "conversion" and should be avoided or even banned (Cantor, 2020), the Dutch studies reveal that psychotherapy was a key element of the protocol. According to the Dutch protocol, "[i]n cases involving confusion about gender feelings, psychotherapy and peer support can be helpful in *resolving the confusion and coming to self-acceptance* [emphasis added]" (de Vries, Cohen-Kettenis & Delemarre-van de Waal, 2006, p. 87). Not only was psychotherapy thought to be beneficial, but apparently it was a core part of the intervention: "…the adolescents were all regularly seen by one of the clinic's psychologists or psychiatrists. Psychological or social problems could thus be timely addressed" (de Vries et al., 2011, p. 2281). The researchers acknowledge that psychotherapy "…may have contributed to the psychological well-being of these gender dysphoric adolescents" (de Vries et al., 2011, p. 2281).

A discussion of the utility of psychotherapy to ameliorate gender dysphoria and related psychological distress is outside the scope of this article, other than to point out that the results of at least two studies suggest that psychological interventions are associated with improvements in two of the outcome domains—*gender dysphoria* (van de Grift et al., 2017) and *global function* (Costa et al., 2015)—absent any medical interventions.

### B. Incompleteness of evidence regarding risks

Failure to consider the physical health risks of "gender-affirming" endocrine and surgical interventions is another methodological weakness of the Dutch studies. This omission is surprising since the Dutch team hypothesized that hormonal interventions might adversely impact bone and brain development several years before their seminal studies commenced (Delemarre-van de Waal & Cohen-Kettenis, 2006, p. 134). As discussed earlier, the Dutch studies did, however, report on the cases that were reclassified from "participants" to "non-participants," and listed the reasons for the nonparticipation, which revealed a possible 6–7% rate of associated adverse events.

Several studies since have confirmed likely adverse health effects of hormonal interventions, although their long-term impact on future health is not yet known. Research suggests that youth treated with puberty blockers develop problems with bone density accrual (Biggs, 2021; Nokoff et al., 2022) and that bone density may be impaired even after treatment with cross-sex hormones is initiated (Klink et al., 2015). Other research suggests heightened insulin resistance (Nokoff et al., 2021), elevated blood pressure, elevated triglycerides, and impaired liver function (Olson-Kennedy, Okonta, et al., 2018). Cross-sex hormone administration places adolescents in the medical category of early life indicators of future cardiovascular disease (Jacobs et al., 2022).

These adverse changes, already evident after a relatively short period of hormonal interventions, do not bode well for long-term health, since "gender-affirming" hormones are prescribed with the presumption of ongoing, lifelong treatment essential for maintaining a masculinized or feminized appearance. It is likely that other medical risks will emerge in the future. Patients and their families cannot make informed decisions about a treatment when the physical health

risks are assumed to be minimal and not reported, and only the potential psychological benefits are considered.

### C. Poor generalizability/applicability to currently presenting cases

Given the dramatic change in the epidemiology of youth gender dysphoria which occurred after the studies were published (Levine et al., 2022a), the question of the applicability of the Dutch research to the current clinical dilemmas is one of the most important questions to interrogate in the field of pediatric gender medicine today.

Generalizability/applicability questions whether "available research evidence can be directly used to answer the health and healthcare question at hand" (Schünemann et al., 2022). We asserted and continue to assert that the Dutch studies are not applicable/generalizable to most gender dysphoric youth presenting today. This is evidenced by two facts: (1) the most common profile of youth seeking gender transition today is an adolescent with postpubertal emergence of a transgender identity and significant uncontrolled mental health comorbidities; (2) the Dutch researchers explicitly disqualified such patients from their studies because of their concern that the risks of early gender transition might outweigh the benefits.

#### 1. Most of today's adolescents have postpubertal onset of trans identity and comorbid mental illness

Until about a decade ago, most patients seen by gender clinics were very young boys who wished to be girls and most of these children subsequently lost their cross-sex identification before reaching adulthood (Hembree et al., 2017; Ristori & Steensma, 2016; Singh et al., 2021). Today, the majority are female adolescents (de Graaf et al., 2018; Kaltiala-Heino et al., 2018; Zhang et al., 2021) with previously gender-normative childhoods whose trans identity emerged around or after puberty (Hutchinson et al., 2020; Zucker, 2019). Many suffer from significant preexisting mental illness such as depression and anxiety or neurocognitive challenges such as autism spectrum disorder (ASD) or attention deficit hyperactivity disorder (ADHD) (Becerra-Culqui et al., 2018; de Graaf et al., 2021; Kaltiala-Heino et al., 2015; Kozlowska et al., 2021; Strang et al., 2018; Thrower et al., 2020).

The presentation of adolescent-onset gender dysphoria is not entirely new—what's new is its scale. As with many trends, the change occurred "gradually, then suddenly." While there was evidence of it in the mid-2000s, around 2014–2015 the presentation of pediatric gender dysphoria in the Western world sharply shifted, from childhood-onset that skewed toward males, to adolescent-onset with a preponderance of females with mental health problems (Aitken et al., 2015; de Graaf et al., 2018). The Dutch researchers began their experiments with pediatric gender transition well before this demographic shift began to dominate clinical presentations of youth gender dysphoria.

Finland's national pediatric gender program was among the first to sound the alarm regarding the changing epidemiology of gender dysphoria presentation in youth. In 2015, they began observing that the youth presenting for treatment were primarily females who "do not fit the commonly accepted image of a gender dysphoric minor" (Kaltiala-Heino et al., 2015). The Finnish researchers saw a new pattern of "severe psychopathology preceding onset of gender dysphoria," with 75% already in treatment for other psychiatric issues when their gender dysphoria emerged. By 2019, the Finnish gender program was in full-alarm mode: "Research on adolescent onset gender dysphoria is scarce, and optimal treatment options have not been established… The reasons for the sudden increase in treatment-seeking due to adolescent onset gender dysphoria/transgender identification are not known" (Kaltiala-Heino & Lindberg, 2019, p. 62). This changing epidemiology was noted by other Nordic countries as well (Kaltiala, Bergman, et al., 2020).

The novel presentation of youth gender dysphoria was also reported by the largest pediatric gender clinic in the world at the time, the UK's GIDS/Tavistock (de Graaf et al., 2018). The now-famous graph of the GIDS data shows a trickle of gender dysphoric youth in years past

turning into a tidal wave by 2015, with a significant overrepresentation of teen girls. Between 2009 and 2016, the number of gender dysphoric females increased more than 70 times (de Graaf et al., 2018). The UK researchers concluded:

> The steep increase in birth-assigned females seeking help from gender services across the age range highlights an emerging phenomenon. It is important to follow birth-assigned females' trajectories, to better understand the changing clinical presentations in gender-diverse children and adolescents and to monitor the influence of social and cultural factors that impact on their psychological well-being. (de Graaf et al., 2018, p. 4)

The number of gender dysphoric youth referrals in the UK doubled again between 2020–2021 and 2021–2022 (NHS, 2022b).

While U.S. population-level data are hard to come by due to the country's decentralized and highly fragmented health care system, recent research shows that the number of gender dysphoric teens has also sharply risen in recent years, with a nearly 70% increase just between 2020 and 2021 (Respaut & Terhune, 2022). Combined with U.S. medical chart data samples, which show that the composition of the population changed "from predominantly transfeminine to…predominantly transmasculine in children and adolescents" (Zhang et al., 2021, p. 390) and that over 70% of gender dysphoric youth had been diagnosed with ASD, ADHD and other mental health problems *before* their diagnosis of gender dysphoria (Becerra-Culqui et al., 2018), it is apparent that the U.S. has not been immune to this remarkable epidemiologic trend that has engulfed youth in the Western world.

This now-ubiquitous presentation of gender dysphoria in troubled adolescents with previously gender-normative childhoods lacks a DSM-5-TR descriptor (American Psychiatric Association [APA], 2022), leaving clinicians to refer to it by many names, including *adolescent-onset gender dysphoria*; *postpuberty adolescent-onset transgender history*; and *rapid-onset gender dysphoria (ROGD).* The latter term was introduced by a U.S. researcher (Littman, 2018). Despite the controversy that Littman's hypotheses generated in the gender medicine establishment (Marchiano, 2018*),* her research withstood a second round of rigorous peer review (Littman, 2020). Subsequent detransitioner research lent further support to the ROGD hypothesis, with patients themselves reporting "that their gender dysphoria began during or after puberty and that mental health issues, trauma, peers, social media, online communities, and difficulty accepting themselves as lesbian, gay, or bisexual were related to their gender dysphoria and desire to transition" (Littman, 2021, p. 15). Even WPATH, which in 2018 strongly objected to Littman's research (WPATH, 2018), conceded in its 2022 "Standards of Care 8" that while no one has attempted to replicate Littman's research, it is apparent that "[f]or a select subgroup of young people, susceptibility to social influence impacting gender may be an important differential to consider" (Coleman et al., 2022, p. S45).

The novel phenomenon of high numbers of young people declaring a transgender identity for the first time in adolescence, often in the context of preexisting mental illness and/or trauma and social difficulties, has been described by several other mental health clinicians (Hutchinson et al., 2020; Schwartz, 2021; Zucker 2019). The only exception to the trend of mentally struggling adolescents presenting with gender dysphoria is the Amsterdam gender clinic itself, which has also seen an influx of teens and the preponderance of girls, but apparently without the mental health problems (Arnoldussen et al., 2020). Nonetheless, writing for the American journal *Pediatrics*, de Vries recognized the emergence of this new clinical phenomenon, noting that "gender identity development is diverse, and a new developmental pathway is proposed involving youth with postpuberty adolescent-onset transgender histories" (de Vries, 2020, p. 1) and noting that "some case histories illustrate the complexities that may be associated with later-presenting transgender adolescents and describe that some eventually detransition (de Vries, 2020, p. 2).

### *2. The Dutch studies disqualified cases most commonly presenting today: Adolescents with recent-onset gender dysphoria, nonbinary identities, or mental illness*

From the outset in the late 1990s when the Dutch researchers first began to report on the results of youth gender transitions, they made it clear that their focus was exclusively on youth with

complete cross-sex identification "from toddlerhood onwards" (Cohen-Kettenis & van Goozen, 1998, p. 1). Furthermore, there was a strict requirement of psychological stability:

> First, they must have shown a *lifelong extreme and complete crossgender identity/role* [emphasis added]. Around puberty these feelings and behaviors must have become more rather than less pronounced. Second, they must be *psychologically stable* [emphasis added] (with the exception of depressed feelings, which often are a consequence of their living in the unwanted gender role) and function socially without problems (e.g., have a supportive family, do well at school). (Cohen-Kettenis & van Goozen, 1997, p. 265)

Of note, youth with non-binary identities, common today (Green et al., 2022), were *ineligible* for medical interventions according to the Dutch protocol, and instead needed psychotherapy: "adolescents… whose wish for sex reassignment seems to originate from factors other than a genuine and complete cross-gender identity are *served best by psychological interventions* [emphasis added] (de Vries et al., 2006, pp. 87–88).

Thus, the Dutch protocol explicitly *excluded* the characteristics of adolescents presenting to clinics in recent years—those whose trans-identities emerged around puberty; non-binary presentations without the wish for a complete cross-sex reassignment; or cases of gender dysphoria accompanied by significant uncontrolled mental illness. The high level of psychological functioning of the Dutch cohort *at baseline* serves as evidence that these selection criteria were indeed followed at the time (de Vries et al., 2011). The fact that "gender-affirming" interventions are now provided to the very segment that was explicitly excluded from the eligibility in the foundational studies is alarming.

## D. Failure to consider alternatives (lack of research equipoise)

The Dutch researchers began their research into treatments of gender-dysphoric adolescents with the *foregone conclusion* that children who had life-long gender dysphoria and who continue to be cross-sex identified as adolescents would inevitably grow up to be transgender-identified adults. This assumption, based on "expert observations" from a handful of cases (O'Malley & Ayad, 2022; Cohen-Kettenis & van Goozen, 1997), has never been tested in rigorous comparative research. Further, the research team assumed that the only feasible treatment for these adolescents is early gender transition, and that psychotherapy alone is ineffective—also without testing this assumption through research. This violates the key requirement of equipoise in research—the principle that clinical investigators must approach research with genuine uncertainty regarding diagnostic, prevention, and treatment options—and allocate individuals to interventions in a manner that allows for generation of new knowledge (Freedman, 1987; London, 2017).

In fact, as de Vries' response to us emphasizes, the Dutch researchers continue to hold such firm belief into the beneficial nature of gender reassignment for youth, that they are far more concerned with the risk of "nontreatment" with hormones and surgery than they are with the possibility that the youth undergoing transition may not have needed such drastic interventions (de Vries, 2022, p. 3). However, some of the earlier research on the "non-treated" gender-variant and gender dysphoric adolescents challenges the assumptions of the permanence of trans identity in teens.

### 1. Non-treatment of "referred" adolescents with significant mental illness

Because of the careful case selection, the Dutch protocol rejected some youth from eligibility for gender reassignment due to serious "psychological or environmental problems" (Smith et al., 2001, p. 473). According to the study that followed the trajectories of these youth, the majority no longer wished to undergo gender transition once they reached *adulthood.*

Smith et al. (2001) reported that individuals rejected from gender reassignment in adolescence found noninvasive ways to deal with their gender dysphoria, and gender dysphoria significantly diminished. Upon follow-up 1–7 years later, only 22% of the rejected subjects (6/27) underwent gender reassignment as adults, while 78% refrained from it. Among those who remained medically untreated and participated in follow-up research, a remarkable 79% (11/14) "*did not feel*

*any regrets about having refrained from SR [sex reassignment] or being rejected*….” Only 7% (1 of 14) expressed strong regret (Smith et al., 2001, p. 477).

Data from the study by Smith et al. (2001) raise the possibility that the majority of those rejected from hormonal interventions not only were unharmed by waiting but benefited from “nontreatment” with gender reassignment in adolescence. Unlike the medically and surgically treated subjects, the “rejects” completed uninterrupted physical and psychological development, avoided sterility, maintained their sexual function, eliminated their risk of iatrogenic harm from surgery, and avoided the need for decades of dependence on cross-sex hormones. These cases also demonstrate that the assumption that “adolescents do not desist” was not true even at the time the Dutch team first introduced gender transitions of youth. It is even less true now, with research showing 10-30% rates of medical detransition among those who were trans-identified in adolescence and young adulthood (Boyd et al., 2022; Hall et al., 2021; Roberts et al., 2022). The long-term follow-up data on the Dutch adolescent transitioner cohort recently presented at the WPATH 2022 Symposim (Steensma et al., 2022) also suggest that the rate of cross-sex identification was not as stable as originally expected, with a sizable percentage reporting one or more instances of identity changes after treatment completion, especially among the individuals on the autistic spectrum (Steensma et al., 2022).

### *2. Non-treatment of “gender variant” youth in a community sample*

Another study, also from the Netherlands, that took place before the practice of pediatric gender transition became widespread (Steensma, van der Ende, et al., 2013), also sheds light on what happens when childhood and adolescent gender-variance remains medically untreated. This large prospective longitudinal study based on a community sample (n = 879) found that about 6% of children (n = 51) ages 7–8 in a community sample were identified as “gender variant.” At follow-up 24 years later, when the subjects were on average in their early 30s, *not a single individual* from the previously “gender-variant” subgroup of 51 children sought to undergo gender reassignment, despite the availability of these services.

There are three noteworthy observations in this study. *First*, the rate of “gender variance” of 6% reported in the community sample is remarkably similar to the current rate of transgender identification in U.S. youth of 2–9% (Johns et al., 2019; Kidd et al. 2021). *Second*, the gender-variant children were roughly 8–15 times more likely to grow up to be gay, lesbian, or bisexual adults compared to gender-normative youth. Gender variance is a common precursor to future homosexuality (Korte et al., 2008) and in fact in the Dutch studies, 97% of youth were gay, lesbian, or bisexual relative to their natal sex (de Vries et al., 2011). *Third*, only *one* of the 879 individuals in the sample underwent a male-to-female gender reassignment as an adult—and the individual had *not* been deemed “gender-variant” as a child (Steensma, van der Ende, et al., 2013, p. 2729). This challenges the current focus on medical interventions at increasingly younger ages.

The fact that none of the “gender variant” children in the sample sought gender reassignment as adults, when the study was published in 2013, merits scrutiny. These children would have been coming “of age” just a few years before the Dutch researchers conceived of the notion of *juvenile transsexual* and began to offer gender reassignment to adolescents. Thus, these children just missed the clinical shift in the Dutch practice—and perhaps not coincidentally, apparently all avoided the lifelong medical burden of living as a gender-reassigned individual.

The title of de Vries’ commentary, *Ensuring Care for Transgender Adolescents Who Need It* (de Vries, 2022) prompts us to pose two questions. First, has the availability of the Dutch protocol itself created the “need?” Second, absent clear criteria to separate a young person’s “wish” from a “need,” will research rigor be required to demonstrate that the benefits outweigh the risks?

## II. Newer research claiming benefits of youth gender transition is even more flawed

de Vries acknowledged that the Dutch research suffers from some limitations but insisted that newer research has sufficiently addressed these problems. She criticized us for not including a

review of newer studies that "consistently demonstrate improved or stable psychological functioning, body image, or treatment satisfaction varying from three months to up to two years from the initiation of treatment" (de Vries, 2022, p. 5). We are familiar with the seven studies de Vries mentions—as well as a number of other recent studies. What these studies "consistently demonstrate" is the art of *spin*—a well-documented problem in biomedical research where researchers "distort the interpretation of results and mislead readers so that results are viewed in a more favorable light" (Chiu et al., 2017). Due to length concerns, we discuss only three examples— Carmichael et al. (2021), Costa et al. (2015), and Tordoff et al. (2022). Most of the current research on the purported benefits of "gender-affirming care" suffers from similar limitations.

The UK study of puberty blockers by Carmichael et al. (2021), which attempted to replicate the Dutch puberty blocker study's findings of psychological improvements (de Vries et al., 2011), *failed to demonstrate psychological improvements*, conceding that its results are "in contrast to the Dutch study" (Carmichael et al., 2021, p. 19). The study found problems in bone mass density accrual among puberty-blocked youth. These problematic findings take on a decisively positive spin in the study conclusions, which refocus the reader on the positive "overall patient experience of changes on GnRHa treatment"; dismiss bone density problems as merely "consistent with suppression of growth"; and camouflage the failure to replicate the psychological benefits of puberty suppression by simply stating, "we identified no changes in psychological function" (Carmichael et al., 2021, p. 2). de Vries aided in the positive interpretation of the results by recasting the lack of improvement in psychological function following puberty suppression, as a *positive* finding of "stable psychological function" (de Vries 2022, p. 5)—yet it has never been demonstrated that psychological function of gender dysphoric adolescents with high baseline mental health function, as was required by the study criteria, would be expected to deteriorate absent intervention.

Spin also characterizes Costa et al. (2015), which compared psychosocial functioning of gender dysphoric youth who were puberty-suppressed to those who were delayed for medical treatment and received only psychotherapy. By the end of the 18-month study period, both groups ended up in the same psychosocial functional range using the Children's Global Assessment Scale (CGAS): 61–70 (out of 100 points), corresponding to "[s]ome difficulty in a single area, but generally functioning pretty well" (Shaffer, 1983). This study can hardly be cited as evidence of the superiority of the medical approach and in fact points to the viability of providing noninvasive therapy as an alternative to puberty suppression. Yet, the authors focus their abstract on the fact that the puberty-blocked group had higher function after puberty suppression than before, ignoring the fact that both the puberty-suppressed and the psychologically-treated only groups improved and there was no statistically-significant difference betwen the two by the end of the study period (Biggs, 2019). Questions regarding the extent to which improvements in self-reported psychological measures could be due to the placebo effect of puberty blockers have been recently raised (Clayton, 2022).

The spin of Tordoff et al. (2022) is dramatic. This study claimed that puberty blockers and "gender-affirming" hormones produced a 60% reduction in depression after only one year. However, this conclusion is in stark contrast to the raw data: at baseline, 59% of the yet-to-be treated patients had *moderate to severe depression*; by the end of the study at 12 months, 56% were still moderately to severely depressed, despite receiving hormone treatment (Supplementary material of eTable 3 Tordoff et al., 2022). This unchanged rate of depression became an "observed 60% lower odds of depression" via a methodology that *inferred* the "improvement" in the *treated cases* from the reported "worsening" in the *untreated cases*. Indeed, the untreated cases in the study had depression rates of 86% by the end of the study period (n = 7), compared to 56% of the treated cases (n = 57), seemingly supporting the conclusion that treatment with hormones alleviates depression.

However, by basing their conclusion about the relative success of the "treated" on the finding of lack of success among the "untreated" cases, the researchers failed to consider that

they lost an astounding 80% of their "untreated" cohort by the end of the study (28 of 35); in contrast, over 80% of the "treated" cohort (57 of 69) remained enrolled. The high dropout rate in "untreated" subjects makes intuitive sense: the study took place in a gender clinic setting, the primary purpose of which is provision of gender transition services. Youth whose distress was ameliorated without the use of hormones would have little reason to stay enrolled in the clinic and participate in the ongoing research. However, what this also suggests is that the highest functioning "untreated" youth dropped out of the study. Thus, the entire conclusion that because "untreated" cases faired so poorly on measures of depression, anxiety, or suicidality, it must be that hormones given to the "treated" cases "worked," is invalid. There are other problems in the study, including the fact that the use of psychiatric medications was not accounted for in the analysis. The university was aware of the problems with this research but chose to remain silent because the study's optimistic conclusions were so well received by national news media outlets (Rantz, 2022).

These examples demonstrate why we do not share de Vries' optimism that the newer studies conducted since the publication of the two seminal Dutch studies provide any additional confidence in, or support for, the practice of youth gender transitions. Most of the current research into the practice of pediatric transition continues in the context of gender clinic settings, which are actively providing gender transition to willing youth. Such low-quality observational research not only lacks the ability to control for the multiple sources of bias due to limitations in research design, but also is often led by clinicians with vested intellectual, professional, and financial conflicts of interest (Prasad, 2013).

## III. Suggestions for future research

We were pleased to learn that de Vries has been awarded a substantial research grant to continue to study the effects of the Dutch protocol (Amsterdam UMC, 2022a). We welcome her decision to study the effects of the Dutch protocol on the novel cohort of youth whose trans identity only emerged in adolescence, as we agree that it is important to know "whether medical treatment is …useful for this group or whether there are too many risks… such as regret afterwards" (Amsterdam UMC, 2022b).

However, we think the time has come to reexamine the entire 25 years of Dutch experience using rigorous methodologies, to answer the critical questions about the full range of risks and benefits of the Dutch protocol. We offer five suggestions relating to both past and future research:

### *1. Conduct comprehensive retrospective research*

There have been over 6600 referrals to the Amsterdam gender clinic alone between 2000 and 2019 (Steensma et al., 2022), with likely additional referrals to the other Dutch gender clinics over the same time period, as well as new referrals since 2019. A retrospective chart review of these referred patients, supplemented by the data from the Dutch health and civil records registries (Registers in The Netherlands 2022) could allow researchers to reexamine its quarter-century of experience of gender transition of youth and their outcomes in a way that is methodologically sound. The analysis should include outcomes of *all* patients diagnosed with gender dysphoria as children, adolescents, or young adults, rather than focusing only on those who chose to pursue medical interventions and explicitly agreed to participate in research. This retrospective review should seek to examine the outcomes of medical transition, psychotherapy, and no intervention. The effects of each step of the Dutch protocol should be disaggregated to gain a better understanding of the benefits and risks at each stage, and the results should be analyzed by natal sex and the age of gender dysphoria onset as validated by medical records.

### 2. Focus on comparative outcomes

The importance of *comparative* research to determine optimal treatments has been known since the 1990s (Guyatt, 1993). Comparing "before" and "after" psychological outcomes tends to overstate benefits due to number of factors, including "regression to the mean" (Knapp, 2016). Gender dysphoric youth often seek help at the peak of their distress. That many such "extreme" situations tend to naturally revert to a milder state even without an intervention is a well-recognized clinical and statistical phenomenon. While randomization is still the gold standard to reliably estimate treatment effects, when it is not possible (as is the case with retrospective research), researchers should consider utilizing quasi-experimental research designs (Harris et al., 2006). Recent post-hoc analysis of the effects of "gender-affirming" surgery, which utilized propensity-score matching to construct comparator groups, is an example of such analysis (Bränström & Pachankis, 2020c).

### 3. Track a full range of health outcomes utilizing objective measures whenever possible

The current exclusive focus on psychological and sexual functioning and self-reports is insufficient. Research should include a more objective evaluation of the effects of gender reassignment interventions on bone, brain, cardiovascular health, malignancies, and overall morbidity and all-cause mortality. As mentioned earlier, retrospective chart reviews of the referred patient cohorts, supplemented with relevant data from the Dutch health and civil records registries, should provide sufficient information to estimate the longer-term impact of hormonal and surgical interventions on morbidity and mortality, while also documenting the incidence of osteoporosis, cardiovascular disease, and cancer, as well as rates of mental illness and suicidality/suicide.

### 4. Pre-specify primary and secondary outcome measures and consistently track them

The primary outcomes of pediatric gender reassignment have been a moving target. In 1997, the Dutch researchers stated that the decision to start gender transition had as its goal to improve the "psychological problems of untreated adolescents" (Delemarre-van de Waal & Cohen-Kettenis, 2006, p. 132), since transitions undertaken in adulthood were already adequately relieving the feeling of gender incongruence itself. In her commentary, however, de Vries stated that psychological function may not the "best indicator for the benefits of such treatment" and that "measures that assess what makes life most worth living…" are most appropriate (de Vries, 2022, p. 3). Yet in a recent interview, she stated that the best indicator of treatment benefits is "satisfaction with care" (O'Malley & Ayad, 2022, 54:36). Primary outcome measures that serve as the rationale for the intervention must be clearly stated, justified, and consistently tracked.

If relief of "gender dysphoria" is still considered a primary outcome by the Dutch research team, a new measure of gender dysphoria that can be validated in both the pre- and the post-treatment settings is urgently needed, as the UGDS scale's use post-treatment is invalid. The updated UGDS-GS scale (McGuire et al., 2020) currently favored by de Vries (de Vries, 2022), appears to be a derivative of the earlier UGDS scale, and therefore may suffer from similar limitations when used in post-gender-reassignment settings.

### 5. Focus on long-term outcomes

Until recently, the long-term outcomes on the cohort of 70/55 cases have been an unanswered question. It was partially answered in a recent WPATH Symposium presentation by the Dutch team, comprised of presentations by Drs. de Rooy, Asseler, van der Meulen, van der Miesen, and Steensma (Steensma et al., 2022). As we look forward to seeing these preliminary findings elucidated in the upcoming peer-reviewed publications, we note several concerns.

*First*, it appears that the follow-up research combined the earlier-treated cohorts with the later-treated ones. We hope to see the outcomes of the 70/55 cases reported separately from other cases, so that the original cohort's outcomes can be quantified. *Second*, only half of the treated cases engaged in follow-up research (Bazelon, 2022; Steensma et al., 2022). This can bias the results, as individuals who experience more difficulties with their gender transition are less likely to engage with the physicians who treated them (Vandenbussche, 2022). Much follow-up research that reports positive outcomes relies on self-reported data compromised by high dropout rates (D'Angelo, 2018). In contrast, research that utilizes medical records and objective outcome measures shows much less optimistic outcomes (Dhejne et al., 2011; Bränström & Pachankis, 2020a, 2020b, 2020c). To mitigate the non-response bias, the Dutch research team should leverage chart data for all the referred patients, and report objective health outcomes for the *entire cohort* that was treated.

*Third*, we are concerned by the apparent dismissal of reproductive regret, which affected more than a quarter of the patients (according to the data presented by Asseler), as merely a problem of the past when sterilizing surgery was a requirement (Steensma et al., 2022). The current treatment protocol of blocking puberty at Tanner stage 2 followed by cross-sexhormones, endorsed by the Endocrine Society (Hembree et al., 2017) and WPATH (Coleman et al., 2022), will most likely lead to chemical sterility, just as the prior surgical protocol led to permanent surgically-induced sterility. There are currently no effective, established methods to preserve fertility of individuals whose gametes have not matured (Rosenthal, 2021).

*Fourth*, the reported relationship difficulties reported by Asseler, with over 60% of individuals in their early to mid-30's still single, also deserve serious consideration. The apparent sexual difficulties reported by male-to-female transitioners by van der Meulen (around 70% have problems with libido, have pain during sex, or have problems with achieving orgasm), combined with reproductive challenges, may be contributing to this outcome. *Fifth*, the team's preliminary optimistic conclusions that early puberty blockade did not worsen sexual function appears to be based on a problematic combining Tanner stages 2 and 3. The development of sexual organs and fertility is significantly more advanced in Tanner stage 3, compared to stage 2. Whether or not the high rate of sexual problems found in the transitioned population may be related to blocking puberty at Tanner stage 2 needs to be investigated.

These newly reported data underscore an urgent need to determine whether the benefits of medical interventions outweigh the now much better understood risks.

## Concluding thoughts

The question, "Just because we can, should we?" is not unique to pediatric gender medicine. What makes this arena exceptional is the radical, irreversible nature of "gender-affirming" medical and surgical interventions desired by the exponentially growing numbers of youth in the Western world. The recent changes announced by WPATH SOC 8—specifically the removal of minimum age limits for medical and surgical treatments, and the elimination of the "distress" requirement by switching from DSM-5-TR to ICD-11 diagnostic criteria (Coleman et al., 2022; Robles García & Ayuso-Mateos, 2019; World Health Organization, 2019)—takes the field further in a truly extraordinary direction whereby *any desired body modification* desired by a child or a young person becomes automatically "medically necessary."

Another unique aspect of the gender medicine field is that a number of clinicians tasked with caring for gender-distressed have taken on the role of political campaigners—and in doing so, have traded wisdom and nuance for blunt activism (Kuper et al., 2022; McNamara et al., 2022). Their insistence that today's gender-dysphoric teens are tomorrow's transgender adults, and that their future happiness and mere survival hinges on early access to gender reassignment, is demonstrably false. While still reported as "rare" by the gender medicine establishment (Coleman et al., 2022; McNamara et al., 2022), the rate of medical detransition is already 10%-30% just a few years following transition (Boyd et al., 2022; Hall et al., 2021; Roberts et al., 2022). These

numbers are likely to rise in the future as regret historically has taken over a decade to materialize (Dhejne et al., 2014). Not all of those who detransitioned will consider themselves harmed, but many will—and a number already have (Vandenbussche, 2022; Littman, 2021).

When clinician-activists misuse the eminence of their institutions and medical societies to deny or obfuscate important facts about pediatric gender transition—that puberty blockers are prescribed to peri-pubertal children as young as 8–9; that mastectomies are commonly provided to teens; that the wave of detransition is rising and already far exceeds what's been historically recorded; and that no other pediatric intervention of similarly drastic nature has ever been delivered at scale based such low quality of evidence (McNamara et al., 2022)—they may succeed in scoring a political or legal "victory" in the short-term, but they also contribute to the longer-term erosion of public trust in the medical profession. They also inadvertently contribute to medical harm.

The scale of the potential harm can be fully appreciated if one considers that an astounding 1 in 10–20 middle school, high school, and college students in the West currently claim a transgender identity (ACHA, 2022; Johns et al., 2019; Kidd et al. 2021). Adolescent mental health in general is at an all-time low (Centers for Disease Control and Prevention [CDC], 2022). Lesbian, gay and bisexual youth and those on the autism spectrum (Bradley, 2022) are at particularly high risk of refracting their gender-non-conformity through the prism of transgender identity. Youth referrals for gender reassignment have risen already several thousand percent in the last decade, and nearly doubled between 2020/2021 and 2021/2022 (NHS, 2022b; Respaut & Terhune, 2022). If these young patients' sense of urgency is confused with certainty about their future happiness, while a flawed evidence base is mistaken for proven safety and effectiveness of youth gender reassignment, harm at scale will ensue.

As physicians are increasingly instructed to widely adopt "gender identity screening" of adolescents to "facilitate and increase…the delivery of gender-affirming" interventions (Lau et al., 2021, p. 1) and are misled about the (very low) quality of research, an analogy of the opioid epidemic powerfully emerges. The gender medicine field must reflect on the parallels between the pain as the "fifth vital sign," the misuse of research (Porter & Jick, 1980; Zhang, 2017), the pressure to meet patient demands, and the role of powerful special interests during the height of the opioid epidemic—and the trends in pediatric gender medicine today.

The field of gender medicine has a short time to self-correct before a growing number of authorities step in and impose guardrails to safeguard youth. Public health authorities in Finland, Sweden, and most recently England have already done just that, sharply deviating from the WPATH's poorly evidenced recommendations in "SOC 7" (Dahlen et al., 2021), with no apparent intention to follow the updated "SOC 8" either (COHERE (Council for Choices in Health Care), 2020; Socialstyrelsen [National Board of Health and Welfare], 2022; NHS, 2022a). NHS England's decision to close GIDS/Tavistock—the world's biggest pediatric gender clinic—and to place the care of gender-distressed youth in established clinical settings that "maintain a broad clinical perspective," provide "strong links to mental health services," and do not "exceptionalise gender identity issues," (Cass, 2022; NHS, 2022b) is a vote of no-confidence in the WPATH-endorsed "gender-affirming" approach that dominates the "gender clinic" model of care.

The American medical establishment appears to be taking a different approach. Rather than acknowledging the problems with the gender-affirmation model of care, there is an apparent effort underway to retrospectively redefine what "gender-affirmation" is. Originally defined as comprised of the provision of hormones and surgery to youth (Table 2, Rafferty, 2018), more recently gender affirmation has been positioned as merely "holistic care." The American Academy of Pediatrics recently made a surprising and welcome statement that hormones and surgery are not the preferred treatment for gender dysphoric youth, and that in fact "for the vast majority of children, it recommends the opposite" (Szilagyi, 2022). Whether this statement will be followed by earnest efforts to restrict the provision of highly invasive interventions to exceptional situations and to endorse non-invasive psychosocial interventions as first line of treatment—instead of inappropriately conflating psychotherapy for gender dysphoria with "conversion"—remains to be seen.

The former era of eminence-based, expert-opinion-led medicine, under which the innovative clinical practice of pediatric gender transition proliferated, has been replaced by a new standard, *evidence-based medicine*, which demands rigor in the research that underpins population-level treatment recommendations (Sackett et al., 1996; Zimerman, 2013). Our analysis of the Dutch protocol has been written with three goals in mind. *First*, we wanted to definitively refute the claims that the foundational Dutch research represents "solid prospective research" that provides reliable evidence of net benefits of youth gender transition. In fact, it is much better described as case series—one of the lowest levels of evidence available (Dekkers et al., 2012, Mathes & Pieper, 2017). *Second*, we aimed to demonstrate that the type of non-comparative, short-term research that the gender medicine establishment continues to pursue is incapable of generating reliable information. And *third and most importantly*, we wanted to remind the medical community that medicine is a double-edged sword capable of both much good and much harm. The burden of proof—demonstrating that a treatment does more good than harm—is *on those promoting the intervention*, not on those concerned about the harms. Until gender medicine commits to conducting high quality research capable of reliably demonstrating the preponderance of benefits over harms of these invasive interventions, we must be skeptical of the enthusiasm generated by headlines claiming that yet another "gender study" proved benefits of transitioning youth. This time-honored concern about risk/benefit ratio is a sobering reminder that the history of medicine is replete with examples of "cures" which turned out to far more harmful than the "disease."

## Notes

1. de Vries also served as a peer-reviewer of our original paper, Levine et al. (2022a).
2. While not central to our argument, de Vries' claim that the selection of the 111 participants from the original 196 was based only on the researchers' interest in those age 16 and under is contradicted by the data. According to Table 1 in de Vries et al. (2011), there was at least one natal female participant who was 18.6 years old when the puberty blockers were initiated. Although selection criteria of the 111 from 196 may have introduced additional bias, we are most concerned with bias in the subsequent selection of 70 from the 111.

## Acknowledgements

The Society for Evidence-Based Gender Medicine (SEGM) paid for this publication to have Open Access.

## Funding

The author(s) reported there is no funding associated with the work featured in this article.

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January 24th, 2023
From: ND Psychiatric Society
**Re: In Opposition to HB 1301**

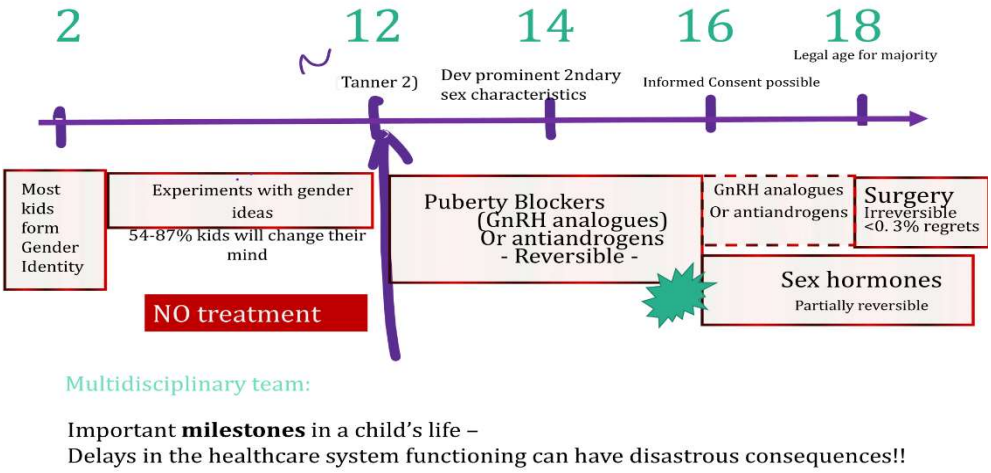
NORTH DAKOTA PSYCHIATRIC SOCIETY
A District Branch of the American Psychiatric Association

Esteemed Chairman Weisz and Committee Members,

My name is Gabriela Balf, I am a psychiatrist in Bismarck and a Clinical Associate Professor at UND, and I speak on behalf of my psychiatric society, as well as on my behalf.

As presented in testimonies for the previous bills this morning,

1. Transgender condition is a **real medical condition** – in many aspects akin to a congenital malformation– the medical term is Gender Incongruence*. I have presented earlier the science, including imaging studies that clearly reflect the reality of this condition: the brains of transgender people present as the brains of their gender identity, and not as the brains of their assigned gender at birth[1].
2. The mental distress that some transgender people experience as a result of Gender Incongruence condition + non-affirming conditions = Gender Dysphoria in the Diagnostic and Statistical Manual of Mental Disorders DSM5 (available on APA website at https://dsm.psychiatryonline.org/)
3. The treatment for Gender Dysphoria according to the standards of care of the American Medical Association (AMA), American Psychiatry Association (APA), American Association of Child and Adolescent Psychiatrists (AACAP), American Academy of Pediatrics, Pediatric Endocrinology Society, Endocrinology Society, American College of Obstetricians and Gynecologists (ACOG), follow the Standards of Care 8 of WPATH – an international multidisciplinary team of clinicians, researchers and stakeholders who have most expertise and have conducted most and longest studies in the domain of transgender care. Not following these Standards of Care simply means to be unethical, not follow the medical standards of evidence-based care, lose the medical license, not be able to practice anywhere else, etc. Bans of evidence-based medical care like the current bill have been strongly condemned by professional associations: AACAP, AMA, APA, etc.
4. There are several **misunderstandings** that I would like to clarify, because many provisions in this bill address non-existent situations. The figure below may help visualize the **real timeline of transgender care.**




*The Manual of International Statistical Classification of Diseases and Related Health Problems (ICD-11) eliminates the term "transsexualism" and replaces it with the term "Gender Incongruence " (GI)[9]. This new terminology will no longer be part of the chapter on mental disorders (chapter 6) but a new chapter is created (chapter 17) called "conditions related to sexual health".

a. Minors have **NEVER** received gender-affirming surgeries in our state. Until September 2022, when WPATH insisted on bringing decentralized, personalized treatment to the extremely rare individuals who may need a faster path, minors were not to have surgery.
b. Pre-puberty children are **NOT** prescribed puberty blockers or sex hormones.
c. Puberty blockers' actions block the development of the secondary sexual characteristics, allowing the youth to undergo thorough diagnostic evaluation, mental health evaluation and follow ups. **NO** sex hormones (gender affirming hormones) are prescribed without mental health supervision. Allowing natural sexual development causes severe distress and irreversible physical changes, very difficult to correct later.
d. **NO** gender affirming surgery is done without thorough **mental health evaluation** and/or **treatment** and **follow up**.
e. The whole transition **process takes many years**, and the youth is under close supervision from a multidisciplinary team.
f. All transgender care is documented so the whole transgender health domain gains from the collective experience at state, national and international levels. There are extremely few conditions where such close and transparent collaborations are possible.
g. There have been **misleading articles** that advanced ideas like rapid onset gender dysphoria (L Littman 2018) that the journals and the professional associations have since proven to be based on biased data and faulty methodology.

Therefore: Why persist in increasing minority stress [2] for a small number of our children? When we face so many urgent issues related to the mental health of children in our state, why don't we spend your valuable time thinking about productive ways to address those, instead of wasting your days of selfless volunteering on **bills that are proven to harm and/or kill**[3] **some of our people**, bills that will stain your legacy?

Also: Physicians who are part of their professional associations or simply want to practice medical care according to the best evidence available, up the standards of care, will be in the situation of **not being able to practice ethically in North Dakota**. Those who will want to avoid criminalization of their correct medical care will break their professional ethics code, Hippocrates's oath, and will see firsthand the well documented consequences of their malpractice: increased depression, substance use and will have lost lives on their conscience[4].

I urge you to be thoughtful when you vote for all the transgender bills that are coming your way, and listen to science. 21st century science.

On behalf of our patients, we thank the House Human Services Committee for listening to our presentation of scientific evidence.

Gabriela Balf-Soran, MD, MPH
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ND Psychiatric Society Past-President
World Professional Association Transgender Health member

**Selected References**:


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- Comprehensive statistics and scientific literature present in SOC 8 at WPATH.org – the World Professional Association for Transgender Health
- National Center for Health Statistics: https://www.cdc.gov/nchs/data/series/sr_02/sr02_175.pdf


Citations linked in the text:


- AACAP Statement Responding to Efforts to ban Evidence-Based Care for Transgender and Gender Diverse Youth- (November 2019)
- APA - Physicians Oppose Texas Efforts to Interfere in the Patient-Physician Relationship and Criminalize Gender-Affirming Care (March 01, 2022)
- AMA – Letter to the National Associations of Governors - Opposing state legislation that would prohibit the provision of medically necessary gender transition-related care to minor patients (April 16, 2021)