November 18, 2022

Sexual & Gender Minority Research Office (SGMRO)
Division of Program Coordination, Planning, and Strategic Initiatives (DPCPSI)
Office of the Director (OD)
National Institutes of Health (NIH)

Feedback on research opportunities related to the upcoming NIH Scientific Workshop on Gender-Affirming Care for Transgender and Gender-Diverse Populations

Submitted via email to SGMRO@nih.gov:
"RFI: Gender-Affirming Care Scientific Workshop" (FR Doc. 2022-22553)

Introductory Note

The Women's Liberation Front (WoLF) is a nonpartisan, nonprofit organization that works to restore, protect, and advance the rights of women and girls.[1]

WoLF thanks the Sexual & Gender Minority Research Office (SGMRO) at the National Institutes of Health (NIH) for the opportunity to provide feedback on research opportunities related to the upcoming NIH "Scientific Workshop on Gender-Affirming Care for Transgender and Gender-Diverse Populations."

The information provided in this document is intended to inform SGMRO about a wide variety of research opportunities and possible ethical issues related to the concept of "gender-affirming" care for people who identify as transgender, gender non-conforming, gender diverse, or other terms used to describe people who do not conform to sex stereotypes. This document is a compendium of comments written by a group of professionals with expertise and decades of professional experience in the fields of women's reproductive health and mental health counseling. Several of the authors of this document are licensed, practicing professionals in the fields of medicine and counseling. Each section of this document contains information that may be of interest to researchers who want to explore various aspects of "gender affirming" care and the impact this type of care has on patients, especially female patients.

WoLF would be pleased to answer questions and engage in further discussion with researchers and NIH administrators about any of the issues addressed in this document. Please contact us at contact@womensliberationfront.org if we may be of assistance.

[1] https://womensliberationfront.org/

Pediatric and Adolescent Care

This section addresses a variety of research opportunities related to the impact of “gender affirming” care on children and adolescents, especially girls.

Impact of Puberty Blockers on Children

From 2007 to 2022, there was a 500% increase in the number of gender clinics in North America; these estimates are conservative, and the increase may be even greater than 500%.[2] It is possible that GRNH puberty blockers will result in long-term effects on males and females, including, but not limited to, loss of fertility, bone density issues, sexual dysfunction, and stunted growth.

The now closed Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Trust have published their data showing that 98% of youth who were prescribed pubertal suppressants go on to receive exogenous hormones.[3] In the UK, data show that in clinical practice, pubertal suppressants are used not as a “pause,” but as a gateway to full medical “transition.” There is limited data for the United States to track the number of children who receive exogenous hormones after being prescribed pubertal suppressants. It is urgent for researchers to examine the long-term impact of people undergoing a wide variety of interventions, including puberty blockers; a recent study found that patients who underwent “sex reassignment” procedures experienced higher risk for suicide attempts and higher levels of psychiatric inpatient care.[4]

Risk of Children’s Death by Suicide

Many policies and processes regarding care for “gender-questioning” children arises from the fear that these children will die by suicide unless they are “affirmed” by family, friends, educators, and medical professionals. The 2015 National Transgender Survey stated that 41% of transgender youth have attempted suicide.[5] However, the study’s methodology and conclusions have faced significant criticism.[6]

A 2020 study claimed that puberty blockers decrease suicidal ideation.[7] However, the design of this study also has faced criticism, since “adolescents with severe psychological problems

[2] www.gendermapper.org
[3] https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(22)00254-1/fulltext#%20
[4] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885
[5] https://www.ustranssurvey.org/reports
[6] https://link.springer.com/article/10.1007/s10508-020-01844-2
[7] https://doi.org/10.1542/peds.2019-1725

would have been less eligible for drug treatment, which confounds the association between treatment and suicidal ideation."[8]

An additional article validates the phenomenon of Rapid Onset Gender Dysphoria (ROGD) and also points out flaws in studies regarding suicidality in transgender youth. The suggestion that transgender-identified youth are at greater risk for suicide has often been cited as a reason to "affirm" them via social and medical "transition." According to Zucker, "one could consider recommending exploratory psychosocial treatment without social transition and hormonal suppression, particularly if the case formulation is that the gender dysphoria has emerged in the context of other psychosocial factors or as a result of other mental health issues."[9]

The need for research into the suicide rates of other cohorts is often overlooked. Robust and comprehensive research is needed to look comparatively at suicide rates among, at a minimum, the following populations: 1) those who have "transitioned" both socially and medically, 2) those who questioned their gender identities but did not pursue such interventions, and 3) the suicide rates of those who socially and medically "transitioned," regretted it, and then "detransitioned." The last population appears particularly vulnerable.

Furthermore, two research studies indicate that patients' mental health is not improved and their suicide risks may even worsen in the long-term if "gender confirmation" surgery is performed. One study found that most of the evidence claiming positive outcomes for "gender reassignment" procedures is of poor quality, and the few studies that used high-quality methods found that some patients experienced poor outcomes and might be at risk of suicide.[10] Another study found that death by suicide was higher for patients who had "sex reassignment" procedures, and concluded that patients who underwent these procedures were at "considerably higher risks" of suicidal behavior, psychiatric morbidity, and death.[11]

Comorbidities and Gender Dysphoria

Comorbidities in patients presenting with gender dysphoria have seemed to present a "chicken or the egg" dilemma for clinicians and researchers. Some believe treating gender dysphoria first will relieve other mental health symptoms, while others find it dangerous to provide "affirmative" care without first attending to other mental health disorders. Common comorbidities include ADHD, autism, mood disorders, PTSD, eating disorders, borderline personality disorder, and body dysmorphia. In a 2018 article by authors in Finland and Sweden, Kaltiala-Heino, et. al., concluded, "Gender-referred adolescents actually display psychopathology to the same extent as mental health–referred youth. In a nationwide

[8] https://doi.org/10.1007/s10508-020-01743-6
[9] https://www.researchgate.net/publication/334552874_Adolescents_with_Gender_Dysphoria_Reflections_on_Some_Contemporary_Clinical_and_Research_Issues
[10] https://journals.sagepub.com/doi/10.1177/1039856218775216
[11] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885

long-term follow-up study of adult cases, psychiatric morbidity, suicide attempts and suicide mortality persisted as elevated after juridical and medical SR."[12]

In an additional study out of Finland, the authors concluded, "In the presence of severe psychopathology and developmental difficulties, medical SR treatments may not be currently advisable. Treatment guidelines need to be reviewed extended [sic.] to appreciate the complex situations."[13]

Some diagnoses are more prone to symptoms of obsessions and ruminations. Patients with OCD, anxiety, autism, eating disorders, borderline personality disorder, and body dysmorphia are vulnerable to becoming fixated on topics, including "gender identity." In that context, medical interventions can seem appealing; these types of interventions can appear to be simple, concrete solutions to relieve obsessional discomfort. However, such interventions are unlikely to provide the desired relief from symptoms which have arisen from mental health diagnoses outside of "gender dysphoria."

Several studies support the claim that 80% of transgender-identified adults and adolescents have, on average, three personality disorders, with the most frequently diagnosed personality disorder being narcissistic personality disorder.[14] Further exploration into this topic is urgently required to prevent further mass misdiagnosis of people who may be experiencing personality disorders.

WoLF also recommends further investigation into the possible misdiagnosis of "gender dysphoria" in patients who may actually have Borderline Personality Disorder (BPD). The possibility of a higher presence of Borderline Personality Disorder (BPD) in patients with "gender dysphoria" has been a subject of research in several studies. BPD manifests as a global disorder in the individual's identity. Both BPD and "gender dysphoria" are associated with a high risk of self-mutilation and suicide.[15] Research into the misdiagnosis of BPD as "gender dysphoria" might indicate that a personality disorder is being treated with physical interventions that are actually contraindicated for BPD.

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[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5841333/#b39-ahmt-9-031
[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4396787/pdf/13034_2015_Article_42.pdf
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4301205/
[15] https://www.sciencedirect.com/science/article/abs/pii/S092493381377175X#:~:text=The%20possibility%20of%20a%20higher,of%20self%2Dmutilation%20and%20suicide

Impact of Social Stereotypes and Peer Pressure on Children's Mental Health

In the United States, many schools promote "social transition" as a baseline policy when requested by a student who believes that he or she is "transgender." Numerous studies suggest that social "transitioning" is a very potent psychological force that can propel a child toward medical interventions.[16] Additionally, once a child has been socially affirmed by his or her peers, educators, families, and medical professionals, it can take a great deal of psychological fortitude to rescind or take back a "coming out" announcement of being "transgender" if the child thinks that he or she might no longer be "transgender."[17]

The effects of social media and peer influence on children and adolescents cannot be underestimated. Mental health clinicians increasingly see adolescent patients presenting with self-diagnosed mental health conditions, including "gender dysphoria," which they have learned about from various social media platforms, peers, schools, and celebrities.[18] [19] [20] Many of these patients use advanced diagnostic vocabularies to describe themselves without having a full understanding of these terms. In addition, many adolescents have learned scripts from online sources with the intent to obtain a "gender dysphoria" diagnosis. Among peers and educators, particularly in some geographic regions, there is potentially higher social status for children and adolescents who present themselves as "transgender." Therefore, it is essential that all mental healthcare and medical healthcare providers use careful and deliberate clinical judgment in assessing these patients. More research is needed to assess the variety of motivations children and adolescents may have when seeking to "transition."

"Breast hatred" by teenage girls as they navigate puberty has been anecdotally reported among clinicians in the mental health community, as well as by parents. Girls experience dramatic changes in their bodies when puberty occurs, and many of them report embarrassment that others notice the changes in their bodies. Sometimes, this unwanted and embarrassing attention comes in the form of sexual harrassment.[21]

While breast binding might temporarily alleviate this embarrassment, it carries risks.[22] As internet searches quickly reveal, "top surgery" is celebrated among transgender TikTok and YouTube stars. The impact of social media on adolescent decision-making cannot be underestimated. As Lisa Marchiano, LICSW, notes:

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[16] https://www.tandfonline.com/doi/full/10.1080/00332925.2017.1350804?scroll=top&needAcces
[17] https://acamh.onlinelibrary.wiley.com/doi/10.1111/camh.12330
[18] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330
[19] https://www.tandfonline.com/doi/full/10.1080/00332925.2017.1350804?scroll=top&needAcces
[20] https://www.annualreviews.org/doi/10.1146/annurev.psych.093008.100412
[21] https://www.tandfonline.com/doi/full/10.1080/00332925.2017.1350804?scroll=top&needAccess=true
[22] https://pubmed.ncbi.nlm.nih.gov/33542145/

> There is an incredibly positive climate around being trans in many places on the Internet. On just one of the hundreds of thousands of YouTube videos that document the poster's 'top surgery,' there are 48 comments such as:
>
> 'Can't believe how far you've come! You are amazing in every way!'
>
> 'So proud and happy for you.'
>
> 'You are totally rad.'
>
> 'By the way, you are totally attractive.'
>
> Young people are also finding validation online for their self-diagnosis as transgender.[23]

The impact of peer pressure and social contagion on children and adolescents needs much more research and analysis. Additionally, WoLF recommends research that focuses on the impact of school authorities, including teachers, counselors, and administrators, promoting or normalizing the idea that children can "change sexes" or "transition" into the opposite sex.

Furthermore, WoLF has received numerous anecdotal reports from young women, parents, and mental health professionals about sexual abuse being a motivating factor for girls who want to "transition" into boys. The United States has an extreme problem when it comes to men and boys sexually abusing girls. The Rape, Abuse and Incest National Network states that that 1 in 9 girls are survivors of sexual abuse committed by men,[24] while the Centers for Disease Control and Prevention states that approximately 1 in 4 girls are survivors of sexual violence.[25] It is reasonable to consider the possibility that many of these young female survivors of abuse are seeking a form of escape by "transitioning" into boys. WoLF strongly recommends qualitative and quantitative research to help our society better understand why so many girls are seeking "transition," and how escape from further sexual abuse might be a motivating factor for them.

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[23] https://www.tandfonline.com/doi/full/10.1080/00332925.2017.1350804?scroll=top&needAccess=true

[24] https://www.rainn.org/statistics/children-and-teens

[25] https://www.cdc.gov/violenceprevention/childsexualabuse/fastfact.html

Adult and Older Adult Care

This section addresses a variety of research opportunities related to the impact of “gender affirming” care on adults, especially women.

Long-Term Impact of Testosterone on Female Patients

Testosterone in females is normally produced by the ovary, as well as in the adrenal glands. The major androgen products of the ovary are dehydroepiandrosterone (DHA) and androstenedione, as well as small amounts of testosterone. Dehydroepiandrosterone (DHA) is converted to androstenedione by 3B hydroxysteroid dehydrogenase to Androstenedione. Androstenedione, in turn, is converted to Estrone by P450 aromatase, which is further converted to Estradiol by 17B hydroxysteroid dehydrogenase. This enzyme also converts the androstenedione to testosterone, which is further aromatized to Estradiol. In the adrenal glands, the cortex produces glucocorticoids, mineralocorticoids, and sex steroids. The adrenal sex steroids reprosent intermediate byproducts in the synthesis of glucocorticoids and mineralocorticoids and any excessive secretion of sex steroids occurs only with neoplastic (cancer) cells or in association with certain enzymatic deficiencies. Without any untoward pathology such as a sex steroid producing tumor, or a deficiency in normally present enzymatic production or function, the adrenal gland production of sex steroids is less significant than gonadal production of androgens and estrogens. Half of the daily production of DHA and androstenedione is from the adrenal gland and the other half of androstenedione is secreted by the ovary; the other half of DHA is split between the ovary and peripheral tissues (a series of enzymes are used peripherally to convert cholesterol to androstenedione.[26]

Most testosterone is measured in this ‘bound’ form to sex hormone binding globulin, or SHBG. Free testosterone is metabolically active and circulates in much lower levels than ‘bound’ testosterone. One study estimated the 5th and 95th percentiles for a 30-year-old woman were: testosterone, 15-46 ng/dL (520-1595 pmol/L); free testosterone, 1.2-6.4 pg/mL (4.16-22.2 pmol/L); calculated free testosterone, 1.3-5.6 pg/mL (4.5-19.4 pmol/L); bioavailable testosterone, 1.12-7.62 ng/dL (38.8-264.21 pmol/L); and SHBG 18-86 nmol/L.[27] Testosterone that is normally produced in the female is converted to estradiol via the aromatase enzyme as described above.

Research indicates that women can experience “significant cosmetic and reproductive changes” when they use anabolic steroids, and that such steroid use can be addictive.[28] The doses of testosterone used in supraphysiologic “gender affirming” care are not dissimilar from

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[26] https://books.google.com/books/about/Clinical_Gynecologic_Endocrinology_and_I.html?id=8sIkqPT2gh4C

[27] https://pubmed.ncbi.nlm.nih.gov/21771278/

[28] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/04/performance-enhancing-anabolic-steroid-abuse-in-women

anabolic steroid abuse. The physiologic and psychological risks posed to patients do not change even though the clinical reasons for using the testosterone have been changed.

Female Reproductive Tract Cancer Risks

Unfortunately, there are many unknowns to the risks posed to female patients who are undergoing masculinizing supraphysiologic androgen hormone administration for “gender affirming” care.[29]

It is important to note that many androgen receptors are located within the cells of many organs within the female body, including the female reproductive tract. In recent years, androgen receptors are found to be related to the occurrence and progression of ovarian, cervical, and endometrial cancers. Novel chemotherapeutic agents are being developed against the androgen receptors as treatments for female gynecologic cancers.[30]

There are increasing concerns that supraphysiologic doses of androgens to the female sexed body within the parameters of ‘gender affirming’ medicalization has to increase female patient’s risks for developing ovarian, cervical, and endometrial cancer. The knowledge from many years of research indicates that testosterone is converted to estrogen via the aromatase enzymatic action, and thus excess testosterone can be an independent risk factor, potentially, for higher estradiol levels which thus lead to increased risks of ‘unopposed’ estrogen leading to reproductive cancer formation.[31] For example, unopposed estrogen is a known risk factor for endometrial cancer.[32]

Fertility Risks for Female Patients

Currently, we do not know the long-term effects of testosterone treatments on the future fertility or health of children. We do know that during “female to male” medical treatments, androgen therapy affects the functions of the gonads; ovulation is typically blocked.[33]

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[29] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7807311/
[30] https://www.mdpi.com/1422-0067/23/14/7556/htm
[31] https://journals.lww.com/greenjournal/Fulltext/2021/11000/Testosterone_Therapy_in_Women__A_Clinical.18.aspx
[32] https://www.cancer.gov/types/uterine/hp/endometrial-prevention-pdq
[33] https://pubmed.ncbi.nlm.nih.gov/36183988/

Surgical Risks for Female Patients

A meta-analysis of the outcomes for "gender-affirming phalloplasty" surgeries revealed that the complication rate was 76.5%, and the expected post-operative outcomes of these surgical procedures was "weak."[34] Out of the 1,731 patients studied in this meta-analysis, 76.5% experienced complications; 34.1% experienced urethral fistula, and 25.4% experience urethral stricture.[35]

A separate research study indicated that after metoidioplasty surgery, urethral complications were "frequent," and approximately 50% of the patients needed corrective surgery to address the complications. 56.8% of patients experienced urethral complications.[36]

Cardiovascular Risks for Female Patients

Risk factors for venous thromboembolism increase for female patients who undergo testosterone treatments as part of their "gender affirming" care.[37] One research study indicated that female patients who received testosterone treatments experienced a two-fold and four-fold increase in the rate of myocardial infarction compared to male patients and female patients who did not receive testosterone.[38] Put another way, female patients who use testosterone experience an increased overall risk of myocardial infarction (heart attack) *above* the rates of males.

A recent study indicated that "gender affirming" care results in significant cardiovascular risks for adolescents.[39] In the editorial about this new study, the editors acknowledged that it would "not be surprising" if these patients experienced long-term health risks.[40] This study also indicated that transgender-identified youth experience significantly higher rates of mental health comorbidities.

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[34] https://pubmed.ncbi.nlm.nih.gov/36031521/
[35] https://pubmed.ncbi.nlm.nih.gov/36031521/
[36] https://pubmed.ncbi.nlm.nih.gov/34274043/
[37] https://academic.oup.com/jcem/article/106/6/1710/6138195
[38] https://pubmed.ncbi.nlm.nih.gov/30950651/
[39] https://academic.oup.com/jcem/article/107/10/e4004/6659182#374570584
[40] https://academic.oup.com/jcem/advance-article/doi/10.1210/clinem/dgac592/6758530

Regret and Detransition

People who “detransition” following medical “transition” should be considered absolutely essential research participants, because they have experienced a wide range of healthcare related to their “gender dysphoria.” This important population deserves more research. In one of the largest studies of detransitioners, many individuals endorsed difficulties accepting themselves as same-sex attracted; they stated that rather than viewing themselves as lesbian, gay, or bisexual, “transitioning” to a different gender identity seemed to be a more acceptable option for them:

> Despite the absence of any questions about this topic in the survey, nearly a quarter (23%) of the participants expressed the internalized homophobia and difficulty accepting oneself as lesbian, gay, or bisexual narrative by spontaneously describing that these experiences were instrumental to their gender dysphoria, their desire to transition, and their detransition. All of the participants in this category indicated that they were either same-sex attracted exclusively or were same-sex attracted in combination with opposite-sex attraction.[41]

Within the same study, 20% reported that they chose medical “transition” due to social pressure. Another 7.2% reported that internalized misogyny was a factor that led to “transitioning.” In addition, 36% endorsed the statement, “What I thought were feelings of being transgender actually were the result of trauma” and 36% endorsed the statement, “What I thought were feelings of being transgender actually were the result of a mental health condition”. Therefore, it is extremely important for mental health professionals to explore patient concerns thoroughly before recommending a treatment plan that favors one outcome over another.

The possibility that some presentations of “gender dysphoria” could be the result of internalized homophobia has been an area of debate for some time and needs more research. In a 2008 article, authors concluded, “Most children with gender dysphoria will not remain gender dysphoric after puberty. Children with persistent GID are characterized by more extreme gender dysphoria in childhood than children with desisting gender dysphoria. With regard to sexual orientation, the most likely outcome of childhood GID is homosexuality or bisexuality.”[42]

Certainly, medical and mental healthcare providers do not want to unintentionally encourage gay, lesbian, or bisexual patients to “transition” as a way to avoid the social stigmas related to homosexuality or bisexuality. Therefore, much more research is needed on detransitioners and why they regret their decisions, in order to ensure that “gender affirming” care is not an inadvertent type of conversion therapy.

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[41] https://doi.org/10.1007/s10508-021-02163-w
[42] https://pubmed.ncbi.nlm.nih.gov/18981931/

Systemic and Institutional Policies

In this section, WoLF addresses the stance that several prominent professional organizations have taken regarding “gender affirming” care. WoLF believes that it is imperative for research to be conducted regarding the impact that these types of professional organizations have on their members. Do professional and student members feel compelled to agree with their organizations' public promotions of “gender affirming" care, and do they have the academic and professional freedom to openly disagree if they have concerns about these types of treatments? Or, do they feel compelled to stay silent out of fear of losing their jobs or being expelled from graduate programs? For example, in 2022 the National Social Workers Association issued a public statement condemning the depiction of “gender affirming” care as child abuse.[43] Undoubtedly, not all social workers and social work graduate students agreed with this public statement, but the fact that their national organization issued it certainly put undue peer pressure on them to remain silent and not openly disagree with the sentiments expressed in the statement.

Before addressing issues related to various professional organizations, however, this section provides insights into the importance of revisions for research and clinical protocols related to “gender affirming” care.

International Revisions to Guidelines Regarding Affirmative Care in Mental Health

Internationally, mental health care guidelines for gender dysphoric patients are rapidly changing. In 2020, the Finnish Health Authority (FHA) adjusted their guidelines regarding gender-affirming treatments for patients 25 years and younger, citing that there was not enough research to justify the value or safety of these interventions. FHA noted the substantial changes in the demographics of those presenting for care, the general instability of identity for everyone in this adolescent developmental stage, the lack of neurological maturity, and the risk of regret after irreversible procedures. FHA also questioned whether puberty blockers could impair brain development, including whether they could possibly impair a patient’s ability to consent to the procedures.[44]

In early 2022, Sweden moved to prioritize therapy over hormone use after the Swedish National Board of Health and Welfare (NBHW) determined that current research on the use of puberty blockers and cross-sex hormones was of low-quality. NBHW also pointed out the difference in the demographics of the current population seeking gender care compared to

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[43] https://www.socialworkers.org/News/News-Releases/ID/2406/NASW-Condemns-Efforts-to-Redefine-Child-Abuse-to-Include-Gender-Affirming-Care

[44] https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors

earlier years. Hence, there is a need for more research before prescribing hormonal care. Therefore, the first line of treatment in Sweden for clients questioning their "gender identities" will be psychiatric care and gender-exploratory psychotherapy.[45]

Also in 2022, the French National Academy of Medicine pointed out the roles of peer influence and social media usage in the shifting demographics of patients reporting gender dysphoria, stating, "The addictive character of excessive consultation of social networks which is both harmful to the psychological development of young people and responsible, for a very important part, of the growing sense of gender incongruence." In addition, this organization pointed out "the risk of over-diagnosis is real," and emphasized the irreversible nature of medical interventions. A paucity of quality research was also noted.[46]

In the UK, the Cass Review resulted in substantial changes to healthcare policy for treating gender dysphoria.[47] The review consistently pointed to the lack of evidence surrounding current affirmative models of care. It also recommended improved assessment procedures beyond current DSM-5 criteria for gender dysphoria. The National Health Service then adjusted care guidelines based on the Cass Review.[48] Psychotherapy and psychoeducation are now considered to be first-line interventions for clients who are questioning their "gender identities." Changes include acknowledging that social transition is *not* a neutral act, including this important consideration:

> For adolescents the provision of approaches for social transition should only be considered where the approach is necessary for the alleviation of, or prevention of, clinically significant distress or significant impairment in social functioning and the young person is able to fully comprehend the implications of affirming a social transition.[49]

The number of countries that are adjusting their care recommendations suggests that the US should also pursue a thorough review of current policies, research, and outcomes, especially given the change in the demographics of the current cohort of gender dysphoric patients

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45 https://segm.org/segm-summary-sweden-prioritizes-therapy-curbs-hormones-for-gender-dysphoric-youth

46 https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en

47 https://cass.independent-review.uk/publications/interim-report/

48 https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/user_uploads/b1937-ii-interim-service-specification-for-specialist-gender-dysphoria-services-for-children-and-young-people-22.pdf

49 https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/user_uploads/b1937-ii-interim-service-specification-for-specialist-gender-dysphoria-services-for-children-and-young-people-22.pdf

compared to prior years.[50] Clearly, more research is needed regarding best practices and whether the current affirmative model of care is an appropriate intervention.
Prior to these recent shifts in guidelines internationally, “the Dutch Protocol” had been the standard used for treating gender dysphoria. It has become clear, however, that the protocol from the 1990’s was developed for a very different demographic population (mostly males) compared to the demographics of the population currently seeking care (mostly females). In 2022, a publication reviewing the Dutch protocol noted many criticisms of the protocol and the research associated with it:

> The results after surgery exclude eight patients who refused to participate in the follow-up or were ineligible for surgery, and one patient killed by necrotizing fasciitis during vaginoplasty. The authors did not mention the fact that this death was a consequence of puberty suppression: the patient’s penis, prevented from developing normally, was too small for the regular vaginoplasty and so surgery was attempted with a portion of the intestine, which became infected. A fatality rate exceeding 1% would surely halt any other experimental treatment on healthy teenagers.[51]

The publication also pointed out additional core issues regarding study design and reporting of data:

> The Dutch clinicians chose incommensurable scales to measure gender dysphoria, which calls into question their finding that dysphoria declined following cross-sex hormones and surgery. Worse still, American clinicians eschewed the measures of psychological functioning used by the Amsterdam and London clinics (YSR, CBCL, and CGAS), thus ensuring that their tiny samples could not contribute to cumulative knowledge. One final point to remember in evaluating published studies is that the field of transgender medicine is subject to the same publication bias as every other field: unsuccessful results will not be published. This bias is illustrated by the London clinic’s attempt to replicate the Amsterdam clinic’s findings: the lack of improvement on GnRHa appeared in print only after the clinic was taken to the High Court of Justice for England and Wales.[52]

Therefore, researchers should no longer consider the Dutch protocol to be the standard treatment method.

[50] https://pubmed.ncbi.nlm.nih.gov/28838353/
[51] https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2121238
[52] https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2121238

Medicalization of “Gender Non-Conformity” as a Form of Conversion Therapy

As mentioned previously in this document, increasing numbers of children and young adults are choosing to undergo medical treatments because they do not conform to sex stereotypes. All current evidence suggests the majority of these individuals are same-sex attracted; they are lesbian, gay, or bisexual. “Gender affirming” care frequently takes the form of puberty blockers, cross-sex hormones, and surgical procedures on a person’s genitalia or breasts. These drugs and procedures serve no physical medical purpose, but rather are undertaken to try to help the patients resemble the opposite sex, ostensibly to treat clinically significant distress that the patients experience as a result of not appearing “masculine” or “feminine” enough. These drugs and procedures can lead to sterilization and adult sexual dysfunction, including loss of fertility and loss of sexual pleasure. Children who “consent” to these types of medical interventions are too young to meaningfully consent to permanent impairment of fertility or sexual experiences.

Since many young people who express a “transgender” identity often grow up to be gay, lesbian, or bisexual, there is an urgent concern to recognize the possibility that young people may undergo medicalization of their healthy bodies with “gender affirming” care as a type of conversion therapy.

In countries that criminalize homosexuality, medical and surgical manipulation of young people through “gender affirming” care is often performed against the wishes of these young people. They face a horrendous choice: surgically “transition” or risk death for expressing their homosexuality.[53] For example, the “born in the wrong body” narrative has been notably embraced by countries such as Pakistan and Iran, where homosexuality is punished by death, but “sex changes” are government subsidized.[54]

This attitude may be more common in other countries than many people realize – whistleblowers from a children’s “gender clinic” in the UK stated that “gender-affirming” care is sometimes sought by families who prefer a “transgender” child over a gay child.[55] This has been reported in the U.S. as well. One conservative religious family believed its young son was gay; in response, the parents sought conversion therapy and physically abused their son to the point where he was suicidal.[56] Unsurprisingly, once they allowed their son to play with “girls’ toys” and wear what he wanted, and when they stopped beating him for not adhering to stereotypical “male” behavior, he appeared to thrive. Unfortunately, there are many families in the US who would rather believe that their sons were “born in the wrong body” rather than accept the fact that their sons simply want to play with dolls and wear princess dresses.

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[53] https://www.economist.com/middle-east-and-africa/2019/04/04/why-iran-is-a-hub-for-sex-reassignment-surgery

[54] The gay people pushed to change their gender - BBC News

[55] BBC Newsnight report on the Tavistock GIDS (transgendertrend.com)

[56] Time Magazine Promotes 'Trans-the-Gay-Away' Child (breitbart.com)

Therefore, given the high rate of desistance from childhood "gender dysphoria," as well as the very high number of "dysphoric" youth who are same-sex attracted, serious caution about "gender affirming" care should be urged.[57] [58]

Several jurisdictions throughout the United States have banned "conversion therapy," yet this type of therapy is never defined. Reparative therapy has a long and unethical history; this type of "therapy" was used as an attempt to "convert" homosexual people to heterosexuality, and therapists often used abusive methods to "convert" their clients. However, helping clients accept the realities of their healthy bodies just as they are, without imposing medical modifications to conform to sex stereotypes, is *not* conversion therapy. In fact, Dr. David Bell, consultant psychiatrist at the Tavistock and Portman NHS Trust, voiced concerns that the medicalization of young people with "gender affirming" care is actually conversion therapy of young people who would otherwise grow up to be homosexual.[59]

Impact of "Gender Affirming" Ideology on Professional Associations and Practitioners

Currently in the US, the "gender affirming" psychotherapy approach is taught in graduate counseling, psychology, and social work programs and continuing education courses. However, exploratory therapy has been a standard model of care within the mental health professions that is routinely applied across a wide range of presenting concerns. Within an exploratory model, clinicians use curiosity, collaboration, and positive regard. There is no evidence to suggest that it is contraindicated with gender dysphoria, and yet currently, clinicians are discouraged from using anything outside of an "affirmative" model. Some clinicians fear censure by licensing boards if they use the same exploratory model of therapy that they would use without question when working with a wide range of other concerns. Within an exploratory model, clinicians also consider information about how identity and developmental stages intersect, as well as the impact of biopsychosocial factors in a patient's life. There is no assumed correct outcome, as the therapist works with the patient to find the best course to meet that individual's short-term and long-term needs.[60] Robles suggests that clinicians use an ethical-decision making framework to analyze proposed treatments and interventions.[61]

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[57] Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study (transgendertrend.com)

[58] Psychosexual outcome of gender-dysphoric children - PubMed (nih.gov)

[59] https://www.theguardian.com/society/2021/may/02/tavistock-trust-whistleblower-david-bell-transgender-children-gids

[60] https://www.researchgate.net/publication/334559847_Towards_a_Gender_Exploratory_Model_slowing_things_down_opening_things_up_and_exploring_identity_development

[61] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8375366/

Robust and comprehensive research is needed to determine the comparative effectiveness of different therapy models when applied to patients with “gender dysphoria,” rather than only endorsing the affirmative model as valid. It is also notable that many experienced mental health clinicians abstain from seeing patients with gender-related concerns in their practices due to the rigid expectations of the “gender affirming” model of mental health care. Many clinicians are afraid of being accused of performing “conversion therapy” if they take a neutral, exploratory approach with their patients. Even if they successfully defend their licenses against such claims, such inquiries will always show up on searches related to their licenses, malpractice insurance premiums will likely increase, and sleep will be lost. As a result, they opt out of seeing these patients in a time when there is a particularly high demand for mental health care.

Patients are desperate to find care, and parents of adolescents are swimming in deep waters trying to find help that doesn’t shame them for asking for more evidence that affirmative social and medical interventions actually work. Discussion among professionals on this issue is also understood to be taboo; clinicians are chastised on listservs for asking questions about data and the lack of research regarding the affirmative model. In effect, the previously productive debate that leads to good science and peer review has been silenced in areas specific to “gender dysphoria” and “gender affirming” care. As a result, many clinicians who want to be assured of being able to keep an income in order to feed their families refrain from providing any care related to gender identity. This deepens the already problematic shortage of mental healthcare providers facing our country.

American Academy of Pediatrics

The American Academy of Pediatrics (AAP) has disparaged the use of ethical psychotherapy for treating gender dysphoria in children and adolescents; the AAP has frequently conflated ethical psychotherapy with reparative therapy, oftentimes referred to as “conversion therapy.”[62]

The AAP has ignored the vast literature from decades of caring for gender diverse children and adolescents when crafting its policy statement regarding “gender affirming care” and its promulgation of medicalization with GnRH agonists and supraphysiologic opposite sex hormone administration as well as surgical manipulation of the genitals.[63] The DSM V changed the diagnosis of ‘Gender Identity Disorder’ (GID) to ‘Gender Dysphoria’ in 2013. However, diagnostic criteria are not dissimilar[64] and therefore omitting the literature indicating that the approach of ‘watchful waiting’ is a serious error when prescribing a treatment

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62 https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000

63 https://www.tandfonline.com/doi/abs/10.1080/0092623X.2019.1698481?journalCode=usmt20

64 https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis

paradigm for a poorly understood condition and very vulnerable group of children and adolescents.
Recently, a concerned group of pediatricians submitted a resolution to the AAP challenging its 2018 position statement about Gender Affirming Care.[65] These pediatricians expressed concern that the cohort of young people who are currently treated at gender clinics today are not the same population as the original Dutch cohort. Furthermore, these professionals state that they have been silenced by the AAP, and that a new AAP rule prevents them from participating in discussions about their concerns.

Based on concerns raised from the dissemination of videos from prominent gender clinics in the United States, the AAP recently released a statement acknowledging that "gender affirming" care "does not necessarily lead to hormones or surgery."[66] This is a massive departure from what has been, up to now, a full throttle of social transition, pubertal suppression, cross-sex hormone administration in supraphysiologic doses, and surgical manipulation of genitalia. As mentioned earlier in this document, the UK, Sweden, and Finland have recently greatly curtailed the medicalized pathway of "gender affirming" care and instead have moved to ethical and comprehensive proper mental health care.

American Psychiatric Association

The American Psychiatric Association (APA) has continued to endorse the concept that "gender affirming" care necessitates medicalized interventions, including puberty blockers and administration of cross-sex hormones, as well as possible surgeries.[67]

American Medical Association

The American Medical Association (AMA) is the second largest lobbying organization in the United States. The AMA has not released an official position statement about the nature of "gender affirming" care, but still expresses support for access to this type of care. It appears that the AMA assumes that other specialty medical bodies should decide on what this type of care actually entails.[68] It is important to acknowledge that the AMA is one of the largest lobbying organizations in the United States and therefore has a vested interest in securing the

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65 https://thepostmillennial.com/pediatricians-who-questioned-gender-affirmation-silenced-by-medical-academy

66 https://www.aap.org/en/news-room/aap-voices/why-we-stand-up-for-transgender-children-and-teens/

67 https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf

68 https://www.endocrine.org/news-and-advocacy/news-room/2021/endocrine-society-applauds-ama-resolution-supporting-access-to-gender-affirming-care

needs of its members.[69] One of these interests is financial in nature. “Gender affirming” care has been described as a boon to the medical profession, generating profits in the tens of thousands of dollars per patient.[70] Unfortunately, it is not beyond the realm of possibility that the AMA has vested interests in securing financial gains for its physician members, hindering its ability to promote only care that is ethical or based on high quality evidence. It is also important to note that the AMA only represents about 15% of practicing physicians in the US.[71]

An important note: Medical providers are able to refuse to administer puberty blockers to patients based not only on conscientious objections, but also based on their rational objections.[72] More research is needed into the perceptions of medical providers about their understanding related to their abilities to refuse treatments to patients based on grounds related to both their conscientious objections as well as their rational objections.

American Psychological Association

While “gender affirming” interventions may appear to have been fully embraced by many mental health professionals, the reality is that both the American Psychological Association (APA) and the American Counseling Association (ACA) provide guidelines acknowledging the complex needs of working with transgender-identified clients.

The 2015 (APA) guidelines state that psychologists who work with “transgender and gender nonconforming” (TGNC) youth should understand the different developmental needs experienced by these clients. The guidelines also state that not all TGNC youth will continue to identify as TGNC as they grow into adulthood. Additionally, the APA guidelines note that TGNC clients may experience mental health problems that are not related to their gender identity, and that their mental health problems may complicate accurate assessment and interventions.[73]

American Counseling Association

The American Counseling Association (ACA) guidelines for counseling transgender-identified clients states that these clients might be affected by the different lifespan development phases they are in. The ACA guidelines also acknowledge that there is a lack of research regarding best practices for providing interventions for transgender-identified clients. The guidelines

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[69] https://largest.org/people/lobbying-groups/

[70] https://www.dailywire.com/news/huge-money-maker-video-reveals-vanderbilts-shocking-gender-care-threats-against-dissenting-doctors

[71] https://www.physiciansweekly.com/is-the-ama-really-the-voice-of-physicians-in-the-us

[72] https://www.tandfonline.com/doi/full/10.1080/20502877.2022.2137906

[73] https://www.apa.org/practice/guidelines/transgender.pdf

indicate that counselors should routinely monitor and evaluate their methods for treating these clients.[74]

Concluding Thoughts: Pathologization and Elimination of Gender-Nonconformity

This call for comment from the NIH is part of a larger social movement toward reducing the incidence of non-conformity with sex-based stereotypes within the population, including the incidence of same-sex attraction (homosexuality and bisexuality).

As our document has noted, “gender affirming” care consists of elective medical interventions with high risks of significantly impairing sexual function, sexual pleasure, and fertility (up to the point of sterilization). These elective medical interventions are cosmetic; their intent and outcome is to make changes to the body to emulate the secondary sex characteristics of the opposite sex.

Young children cannot meaningfully consent to these procedures: they have no conception of what it means to give up the right to produce children if they are interested in becoming parents, nor can they possibly understand what it means to potentially be consigned to a lifetime of sexual dysfunction. Such weighty decisions should only be made by adults who are fully capable of understanding how their choices will affect them for the rest of their lives.

It appears that the NIH is unaware of the implications of promoting unnecessary medical interventions that can and do lead to gay, lesbian, and bisexual people being sterilized. This is despite the well-known fact that same-sex attracted people, including adolescents, compose an overwhelming proportion of those seeking these medical interventions, and despite the NIH’s stated interest in protecting the interests of “sexual and gender minorities.” Because the “origin” of same-sex attraction is uncertain, and therefore the unknown role that genetics may play is also uncertain, some critics might argue that the NIH is essentially playing around with eugenics. (As a side note, WoLF contends that homosexuality, bisexuality, and heterosexuality are all normal variations of human sexuality, regardless of origin.)

On a related yet distinct note, the NIH has inappropriately conflated people who identify as transgender with people who are same-sex attracted. These two groups do not inherently share any health needs, research needs, or any other objective characteristic. This conflation provides no benefit to same-sex attracted people whose needs are often subsumed by the needs of people who identify as transgender. This conflation also distracts the NIH’s attention and resources away from the unique needs of both groups of people, with harmful and sometimes deadly effects.

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74 https://www.counseling.org/docs/default-source/competencies/algbtic_competencies.pdf?sfvrsn=12

This is particularly true considering that the so-called "LGB community" is not a monolith: gay, lesbian, and bisexual individuals should not be "force-teamed" in order to receive academic or political attention. For example, lesbians and gay men as a group certainly have different needs regarding HIV prevention services, and a transgender-identifying person's need for HIV prevention services is based, statistically speaking, solely on his or her sex and the sex of the individuals with whom he or she is sexually intimate – not on the fact that he or she identifies as transgender.

The NIH has not identified reasons for combining these disparate populations of "sexual and gender minorities." Furthermore, it has offered no support for conflating the concept of "gender identity" and the characteristics of sexual orientation, which share no relevant features besides the fact that both do not align with sex-role stereotypes, and that people who are same-sex attracted compose a disproportionate number of those who identify as transgender.

The NIH is required by the 2021-2025 strategic plan to make "inquiry into SGM health outcomes also should take into special consideration subpopulations for whom research is lacking."[75] The strategic plan seeks to further expand this category by noting that "an individual's gender identity can develop in a variety of ways…" including a statement that it can "develop, stabilize, and/or change over time."

In formally searching for "key research opportunities in gender-affirming care" for so-called "gender-diverse" individuals, a category aligned with NIH's "sexual and gender minority" umbrella described above, the NIH appears to be expanding the category of gender-nonconforming individuals placed on this pathway. This expanded category now seems to include any person "whose sexual orientation, gender identity or expression, or reproductive development is characterized by non-binary constructs of sexual orientation, gender, and/or sex."

Included in these categories is gender "expression," which is synonymous with sex stereotypes. Sex stereotypes are the behaviors, appearances, and interests assigned to a certain sex by society. In other words, the NIH appears to be embracing the notion that if a person does not "grow out of" his or her non-conformity with sex stereotypes, that person can be medicalized out of it. We believe this to be inconsistent with the stated values of the NIH.

[75] https://dpcpsi.nih.gov/sites/default/files/SGMStrategicPlan_2021_2025.pdf