2023 HOUSE HUMAN SERVICES

HB 1254

2023 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1254
1/24/2023

Relating to the prohibition of certain practices against a minor; to provide a penalty; and to declare an emergency.

Chairman Weisz called the meeting to order at 4:04 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:

- Protection of children
- Role of parental authority in certain medical practices
- Rational capacity of children
- Effects of gender-affirming care
- Long-term effects
- Mental health of children
- Perspectives on transgenderism
- Evidence-based medical care

Rep. Tveit introduced HB 1254 with supportive testimony (#16477).

Amber Vibeto, North Dakota citizen, supportive testimony (#16325).

Gregory Demme, Pastor from Minot, North Dakota, supportive testimony (#15767).

Patty Armstrong, social worker and North Dakota citizen, spoke in support.

Jacob Thomson, Policy Analyst for North Dakota Family Alliance Legislative Action, supportive testimony (#16358)

Jodi Plesity, business owner from Fargo, spoke in support.

Christopher Dodson, Executive Director for the North Dakota Catholic Conference, supportive testimony (#16354).

Andrew Alexis Varvel, citizen from Bismarck, North Dakota, supportive testimony (#16310).

Elia Jay Scott, North Dakota citizen from Fargo, opposition testimony (#14950).

Parker Lee, North Dakota citizen from Grand Forks, spoke in opposition.

Courtney Koebele, Executive Director for the North Dakota Medical Association, opposition testimony (#16343).

Zeke Langemo, student from Fargo, North Dakota, opposition testimony (#15757).

Bree Langemo, North Dakota citizen and parent, opposition testimony (#15759).

Luis Casis, pediatrician, opposition testimony (#14813).

Amanda Dahl, pediatric endocrinologist, opposition testimony (#15413).

Heather Nelson, physician from Bismarck, North Dakota, spoke in opposition.

Dr. Rachel Peterson, certified OBGYN, opposition testimony (#15796).

Rachel Sinness, Legal Director of Protection and Advocacy of North Dakota, spoke in opposition.

Dan Sturgill, Clinical psychologist, offered testimony in opposition to bill (#16229).

Gabriela Balf, psychiatrist and citizen from Bismarck, North Dakota, offered testimony in opposition to bill (#16447).

Danielle Walls, North Dakota citizen, spoke in opposition.

Additional written testimony:

(#14861), (#14893), (#14904), (#14919), (#14938), (#14998), (#15006), (#15032), (#15045), (#15056), (#15057), (#15113), (#15117), (#15142), (#15143), (#15261), (#15349), (#15355), (#15357), (#15413), (#15476), (#15566), (#15620), (#15672), (#15681), (#15780), (#15783), (#15799), (#15804), (#15807), (#15814), (#15825), (#15854), (#15856), (#15861), (#15894), (#15898), (#15908), (#15911), (#15945), (#15955), (#15957), (#15966), (#15971), (#15978), (#15983), (#15989), (#15991), (#16028), (#16044), (#16057), (#16062), (#16063), (#16070), (#16083), (#16084), (#16103), (#16114), (#16160), (#16177), (#16195), (#16221), (#16227), (#16297), (#16313), (#16314), (#16315), (#16316), (#16317), (#16318), (#16328), (#16336), (#16341), (#16345), (#16348), (#16349), (#16364), (#16376)

Chairman Weisz adjourned the meeting at 6:16 PM.

Phillip Jacobs, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1254
2/15/2023

Relating to the prohibition of certain practices against a minor; to provide a penalty; and to declare an emergency.

Chairman Weisz called the meeting to order at 10:45 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
- Gender-affirming healthcare
- Gender dysphoria
- Amendments (23.0869.01001)

Representative Prichard moved to adopt amendment HB 1254 (Separate section C into a separate section, Subsection C is a Class A Misdemeanor)

Seconded by Representative Anderson.

Roll Call Vote:

Representatives	Vote
Representative Robin Weisz	Y
Representative Matthew Ruby	Y
Representative Karen A. Anderson	Y
Representative Mike Beltz	Y
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	Y
Representative Brandon Prichard	Y
Representative Karen M. Rohr	Y

Motion carries: 11-3-0

Representative Porter moved to further amend to HB 1254 with limit Section 2 to under 14.

Seconded by Vice Chairman Ruby

Roll Call Vote:

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

Motion fails 7-7-0.

Representative Prichard moved a DO PASS as amended on HB 1254 with 23.0869.01001

Seconded by Representative McLeod.

Roll Call Vote:

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

Motion carries 12-2-0. Bill Carrier: Representative Prichard.

Chairman Weisz adjourned the meeting at 11:18 AM.

Phillip Jacobs, Committee Clerk By: Leah Kuball

Adopted by the House Human Services Committee

February 15, 2023

2-15-23

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1254

Page 2, line 9, replace "this section" with ":

a. Subdivisions a, b, or d of subsection 1"

Page 2, after line 9, insert:

"b. Subdivision c of subsection 1 is guilty of a class A misdemeanor."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1254: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). HB 1254 was placed on the Sixth order on the calendar.

Page 2, line 9, replace "this section" with ":

a. Subdivisions a, b, or d of subsection 1"

Page 2, after line 9, insert:

"b. Subdivision c of subsection 1 is guilty of a class A misdemeanor."

Renumber accordingly

2023 SENATE HUMAN SERVICES

HB 1254

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1254
3/15/2023

Relating to the prohibition of certain practices against a minor; to provide a penalty; and to declare an emergency.

10:27 AM **Senator Cleary** called the hearing to order. **Senators Cleary, Clemens, K. Roers, Weston, and Hogan** were present**. Senator Lee** was absent.

Discussion Topics:

- Health care restrictions
- Rights of individuals
- Formative years
- Irreversible surgeries
- Protecting youth

10:28 AM **Representative Tveit** introduced HB 1254, and testified in favor. #25238, #25239, #25264.

10:48 AM **Representative Prichard** testified in favor. #25122.

10:58 AM **Mark Jorritsma, Executive Director North Dakota Family Alliance Legislative Action,** testified in favor. #25301.

11:11 AM **Bryan Herbel**, **Psychiatrist,** testified in favor. #24868, #24869, #24870, #24871.

11:29 AM **Juwle Nagbe** testified in favor verbally.

11:31 AM **Patti Armstrong, Journalist, TV Talk Show Host, Former Social Workers,** in favor. #25266

11:39 AM **Andrew Alexis Varvel** testified in favor. #25165.

11:42 AM **Christopher Dobson, Executive Director, North Dakota Catholic Conference,** testified in favor. #25150.

11:46 AM **Don Eaton** testified in favor verbally.

11:47 AM **Melissa Hauer, General Counsel North Dakota Hospital Association,** provided information testified in opposition. #25053.

11:54 AM **Courtney Keobele** provided additional information verbally.

Additional Written Testimony:
Lilly Funk, Assistant Teacher, Head Start in favor #23815.

Mary Saxer in favor #23835
Shawna Grubb in favor #23945
Sheila Glaser in favor #24410
Lisa Pulkrabek in favor #25076
Naomi Franek in favor #25096
Lavita and Daniel Scrimshaw, Emergency Medicine Physician, North Dakota American Academy of Medical Ethics State Director in favor #25106, 25107
Doug Sharbono in favor #25155
Ashley Limesand in opposition #23597
Andi Wheeler, Licensed Professional Clinical Counselor in opposition #23625
Bree Langemo in opposition #23846
Zeke Langemo in opposition #23882
Jay Gaare in opposition #23917
Alannah Valenta, President, North Dakota Association of School Psychologists in opposition #23998
Christopher Brown in opposition #24064
Kristie Miller in opposition #24082
Jan Snortland in opposition #24333
Sarah Piersol in opposition #24478
Doug Griffin in opposition #24634
Jessica Babin in opposition #24671
Oliver Jensen in opposition #24688
Jared Solomon, Child and Adolescent Psychiatrist in opposition #24804, #24805
Brenda Weiler in opposition #24817
Mary Weiler in opposition #24879
Derek Harnish in opposition #24883
Brenda King, Clinical Psychologist in opposition #24897
Whitney Oxendahl in opposition #24979
Hilde van Gijssel in opposition #25021
Kristin Nelson, Founder, Project RAI in opposition #25024
Liam Blanford in opposition #25034
Rose Nichols in opposition #25041
Kara Gloe, Mental Health Therapist, Canopy Medical Clinic in opposition #25060
Elizabeth Loos, Lobbyist for North Dakota Chapter, National Association of Social Workers in opposition #25075
Tara Jenses in opposition #25089
Cody Severson, Chair, Fargo Human Rights Commission in opposition #25090
Mariah Ralston Deragon in opposition #25094
Faye Seidler in opposition #25103
Michael Southman in opposition #25104
Amber Lefers in opposition #25130
Stephen McDonough, Pediatrician in opposition #25146
Christina Sambor, Lobbyist and Legislative Coordinator for Youthworks, North Dakota Human Rights Coalition, Human Rights Campaign in opposition #25175
Shannon Krueger in opposition #25177

11:54 **AM Madam Chair Lee** adjourned the hearing.
Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1254
3/15/2023

Relating to the prohibition of certain practices against a minor; to provide a penalty; and to declare an emergency.

2:56 PM **Madam Chair Lee** called the hearing back to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, and Hogan** were present**.**

Discussion Topics:

- Medical decision
- Medical standard of care
- Conflict
- Constitution

2:56 PM **Cody Shuller, Advocacy Manager,** testified in opposition. #25088.

3:01 PM **Courtney Koebele, Executive Director, North Dakota Medical Association,** testified in opposition. #25032.

3:02 PM **Courtney Koebele** proposed amendment #25031

3:07 PM **Dr. Gabriela Balf, Psychiatrist**, **North Dakota Psychiatric Society,** testified in opposition. #25312, #25313, #25314.

3:27 PM **Dan Sturgill, Clinical Psychologist in Gender Care, Sanford North Dakota Medical Association,** testified in opposition. #25047, #25306.

3:38 PM **Dr. Amanda Dahl, Pediatric Endocrinology**, testified in opposition. #24983.

3:58 PM **Luis Casas, Pediatric Endocrinology Sanford Health,** testified in opposition. #24744.

4:21 PM **Dan Sturgill** provided additional information in opposition verbally.

4:23 PM **Rachel Peterson Nelson Obstetrics and Gynecology Physician,** testified on-line in opposition. #25027.

4:34 PM **Dr. Mayson Bedient, Family Medicine Physician,** testified online in opposition. #25025.

4:38 PM **Shelly Ferrellz,** testified in opposition verbally.

4:51 PM **Mia Halvorson,** testified in opposition. #25129.

4:58 PM **Madam Chair Lee** adjourned the hearing.
Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1254
3/28/2023

Relating to the prohibition of certain practices against a minor; to provide a penalty; and to declare an emergency.

11:16 AM **Madam Chair Lee** called the meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, and Hogan** were present**.**

Discussion Topics:

- Medical decision
- Medical standard of care
- Conflict
- Constitution

Senator K. Roers proposed an amendment #26891.

Senator K. Roers moved to adopt amendment LC 23.0869.02001.

Senator Hogan seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	N

Motion passed 4-2-0.

Senator Cleary moved **DO PASS** as **AMENDED**.

Senator Hogan seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	N
Senator Kathy Hogan	N
Senator Kristin Roers	Y
Senator Kent Weston	Y

The motion passed 4-2-0.

Additional WrittenTestimony:
Representative Tveit in favor #26899, 26900, 26901, 26902
Daniel Weiss neutral #26892
David Thompson neutral #26894
Ari DeWolf neutral #26893, 26895
Chloe Cole neutral #26896
January Littlejohn neutral #26897
Mariam Grossman neutral #26898

Note: Bill was reconsidered on 3/29/2023.

11:41 PM **Madam Chair Lee** adjourned the meeting.

Patricia Lahr, Committee Clerk

23.0869.02001
Title.03000

Adopted by the Senate Human Services Committee

March 28, 2023

BK
1 of 2
3-28-23

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1254

Page 1, line 11, after "2." insert ""Mental health professional" is defined pursuant to subsection 11 of section 25-03.1-02.

3."

Page 1, after line 12, insert:

"4. "Pre-pubertal" means an individual who has not yet entered puberty.

5. "Puberty" means the period of a minor's development during which secondary sex characteristics start to developing."

Page 1, line 13, replace "3." with "6."

Page 2, line 1, remove "Prescribe, dispense, administer, or otherwise supply any drug that has the"

Page 2, remove lines 2 through 6

Page 2, line 7, remove "d."

Page 2, after line 8, insert:

"d. Prescribe supraphysiologic doses of testosterone to females; or

e. Prescribe supraphysiologic doses of estrogen to males."

Page 2, line 9, after "2." insert "Except as provided in section 12.1-36.1-03, a health care provider may not prescribe puberty-blocking medication to any minor unless:

a. The minor has received mental health care for at least twelve consecutive months prior, as documented by a mental health professional; and

b. The minor has begun to experience puberty, as documented by a medical provider.

3. Except as provided in section 12.1-36.1-03, a health care provider may not, for the purpose of changing the sex of a pre-pubertal, engage in prescribing, dispensing, administering, or otherwise supplying any drug for the purpose of aligning the pre-pubertal's sex with the pre-pubertal's perception of the pre-pubertal's sex when the perception is inconsistent with the pre-pubertal's sex, including puberty-blocking medication to stop normal puberty.

4."

Page 2, line 10, replace "d" with "c"

Page 2, line 11, replace "Subdivision c" with "Subdivisions d or e"

Page 2, line 11, after "1" insert ", subsection 2, or subsection 3"

Page 2, line 11, replace "a class A misdemeanor" with "an infraction"

Renumber accordingly

DR
2-2
3-28-23

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1254
3/29/2023

Relating to the prohibition of certain practices against a minor; to provide a penalty; and to declare an emergency.

9:23 AM **Madam Chair Lee** called the meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, and Hogan** are present**.**

Discussion Topics:

- Medical decision
- Medical standard of care
- Conflict
- Constitution

9:24 AM **Senator Lee** calls for discussion.

9:24 AM **Courtney Koebele,** provided information verbally.

9:26 AM **Marnie Walth, Sanford Health,** provided information verbally.

9:28 AM **Courtney Koebele**, **Executive Director ND Medical Association**, provided additional information verbally.

Senator K. Roers moved to reconsider prior actions.

Senator Hogan seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	N

Motion passed 4-2-0.

Senator K. Roers moved to **adopt amendment,** remove reference to 12-month limitation.

9:34 PM **Courtney Koebele** provided additional information verbally.

Senator Hogan seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	N
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	N

Motion failed 3-3-0.

Senator Cleary moved **DO PASS** as **AMENDED**.

Senator K. Roers seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	N
Senator Sean Cleary	Y
Senator David A. Clemens	N
Senator Kathy Hogan	N
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion failed 3-3-0.

Senator K. Roers moved **Without Committee Recommendation as amended.**
Senator Hogan seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion passed 6-0-0.

Senator K. Roers will carry HB 1254.

Additional Testimony:
Dr. Luis Casas, Pediatric Endocrinologist in opposition #26978

9:44 AM **Madam Chair Lee** adjourned the meeting.

Patricia Lahr, Committee Clerk

REPORT OF STANDING COMMITTEE

HB 1254, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **BE PLACED ON THE CALENDAR WITHOUT RECOMMENDATION** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1254 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

Page 1, line 11, after "2." insert ""Mental health professional" is defined pursuant to subsection 11 of section 25-03.1-02.

3."

Page 1, after line 12, insert:

"4. "Pre-pubertal" means an individual who has not yet entered puberty.

5. "Puberty" means the period of a minor's development during which secondary sex characteristics start to developing."

Page 1, line 13, replace "3." with "6."

Page 2, line 1, remove "Prescribe, dispense, administer, or otherwise supply any drug that has the"

Page 2, remove lines 2 through 6

Page 2, line 7, remove "d."

Page 2, after line 8, insert:

"d. Prescribe supraphysiologic doses of testosterone to females; or

e. Prescribe supraphysiologic doses of estrogen to males."

Page 2, line 9, after "2." insert "Except as provided in section 12.1-36.1-03, a health care provider may not prescribe puberty-blocking medication to any minor unless:

a. The minor has received mental health care for at least twelve consecutive months prior, as documented by a mental health professional; and

b. The minor has begun to experience puberty, as documented by a medical provider.

3. Except as provided in section 12.1-36.1-03, a health care provider may not, for the purpose of changing the sex of a pre-pubertal, engage in prescribing, dispensing, administering, or otherwise supplying any drug for the purpose of aligning the pre-pubertal's sex with the pre-pubertal's perception of the pre-pubertal's sex when the perception is inconsistent with the pre-pubertal's sex, including puberty-blocking medication to stop normal puberty.

4."

Page 2, line 10, replace "d" with "c"

Page 2, line 11, replace "Subdivision c" with "Subdivisions d or e"

Page 2, line 11, after "1" insert ", subsection 2, or subsection 3"

Page 2, line 11, replace "a class A misdemeanor" with "an infraction"

Renumber accordingly

TESTIMONY

HB 1254

January 20, 2023

Regarding House Bill 1301

Dear House Members,

My testimony is in opposition to HB 1254. 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 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. **I should not be criminalized for practicing under the scope of my training and when following standards of care.**

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.

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 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.

Seth Flamm

1-22-2023

Dear Legislators,

As a mother of a young man who has transitioned, I can testify to the fact that if he had not done so, I am not sure he would still be with us. This sounds jarring and perhaps harsh; however, this legislation is cause for concern.

Our son underwent several years of therapy, visited several medical professionals, and researched his options before deciding to move forward with his transition. It was not a moment decision, but it was a life-changing one. Happiness follows him now.

Please end this legislation and allow young people and their families to make their own private decisions with the help of medical professionals, not the state government.

Thank you,

Angie Moser

WRITTEN TESTIMONY IN OPPOSITION TO HB 1254

House Human Services Committee on House Bill 1254

Date of Hearing: January 24, 2023 2:30 p.m.

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

This written testimony is presented in opposition to HB 1254, 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 for making these informed decisions.

Doctors are in the best position to determine if treatment is medically necessary, not the North Dakota Legislature. To criminalize a physician for providing care to patients, within the appropriate standard of medical care, is a gross overreach of the legislature's authority.

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 HB1254.

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 1254

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?

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 1249.

Denise Ann Dykeman
Minot, ND

HB 1254

Certain practices should be better defined as regarding a minor most of the time the parent has a say in a childs medical care, not counting extraordinary circumstances.

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 1254, 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 1254 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 1254 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 1254 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 1254.

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 1254.

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

My testimony is in opposition to House Bill 1254. 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

I strongly oppose this bill. Trans children should have access to gender affirming medical care. The fact that this bill is being considered shows ignorance on the part of the bill's sponsors. Children are not receiving irreversible surgeries. Children are receiving appropriate medical care under the guidance of doctors.

Our state needs to work to be more inclusive of all of our citizens, not target an entire demographic because of personal prejudices. The fact that this bill is being considered is embarrassing for our state. It shows such ignorance of factual information and the discriminatory behavior of our lawmakers.

Megan Degenstein, Ph.D.
Licensed Professional Clinical Counselor

HB #1254

68th Legislative Session

Senators: Boehm, Clemens, Estenson, Luick, Myrdal and Vedaa.
Representatives: Tveit, D. Anderson, Bellew, Prichard, Rohr and Van Winkle

I am writing this in opposition to HB #1254. I, like some of you, was born and raised in North Dakota. I also am a parent of a transgender person who is also a citizen of North Dakota. I am like you but with one huge difference, this bill, HB #1254, affects people I know personally. How any of you know a transgender person or have talked to a person or parent of a transgender person? While none of you know a transgender person so you have no experience to draw from, I do. I gave birth to a child who is transgender as well as know others in the State of North Dakota who are transgender. I do believe, after reading this bill, that none of you are acting in the best interests of children who are transgender, quite contrary, your on a mission to seek out and annihilate any chance of these individuals of ever becoming whole. I want to give you my personal experience since your bill clearly shows none of you have had any interactions or conversations with a transgender person or a parent who is raising a transgender child in the State of North Dakota.

I noticed very early on that my child was not a rough and tumble boy. My youngest was very feminine and at a very early age gravitated to girl items such as dolls, clothing, books and movies that my oldest child liked. This didn't alarm me, being a farm kid, I spent plenty of time playing in the sandbox with my brothers Tonka Trucks and other boy toys. My youngest continued to show interest in girl items and even though we exposed both of our kids to gender neutral things like T-ball, Taekwondo, swimming lessons and gender neutral activities, our youngest still gravitated towards items that you would consider girlie.

Later in Fifth Grade, my child later understood herself and what she was seeing in the mirror and was then able to tell me that she was a girl trapped in a boy's body. I admit that I was very upset. I am ashamed to say that my child saw the worst in her mother that day. However, I am a person who has to find answers and so I got an appointment with a counselor that very week. It's with this family counseling did we learn that my daughter was transgender. That she was finally able to articulate who she was and we had learned to do because what we were all taught by others in school, at home then was that there were only heterosexuals and homosexuals. That concept is antiquated and what we learned is that there is a spectrum to human sexuality as well as the idea that we know everything about the human body. To date we still do not know everything about the human brain, why a body can cure itself of a disease, but we do know that Science is a living thing, and it is always evolving as well as human language.

Our journey took us to Mayo Clinic after a period of once a week counseling. At Mayo Clinic in Rochester, MN, that is where the team of doctors and nurses, psychiatrist looked at my child. We then sat down and discussed what the team concluded. My child is transgender. I asked how this happened and it was explained to us that it happens in utero; the body forms first, the brain then forms but it is during this stage of gestation is when it is thought that the mother's body has an unexplained surge of hormones which disrupts the brain formation and thus the brain forms the opposite gender than what

the body had already been assigned. This isn't a choice but in fact something that happens and has happened since the beginning of time. Transgender is not a fad, it is not new and nor is it a choice. What transgender means an individual's body and brain not being in synch with each other. The doctors told me that under an MRI image, my daughter's brain is that of a female. Male brains are physically built different than females and those differences can be seen using MRI imaging.

HB #1254 targets people who are born differently. HB #1254 ostracizes transgender people from others who are born as CIS individuals. CIS is the term used to describe people who identify with the gender they were born as.

My child has been treated under medical supervision, and she is a happy person. If her treatment and care had been kept from her more than likely I would only have one daughter with me today. My daughter DOES NOT have the male muscle mass nor did she ever seek to be an athlete. My daughter just wants to enjoy life and be the happy female she is identifies with as I do and as you do. The treatments and medication help the minor child until the age of 18 and it is then and only then that any surgery can be discussed and undergone. There is NO REASON for the State of North Dakota to intervene with transgender care whatsoever.

This bill does put citizens of North Dakota, who are already dealing with a very hard situation because of the bigotry and hatefulness that CIS individuals doll out, but this is adding a whole new level of distress. What happened to parents' rights? Do you think you know my daughter better than I do? Are you living with these transgender people, do you hear their concerns and fears or struggles? No, none of you know any of these. What the authors of this bill do concern themselves with is the false narrative that the news media like Fox News, social media like Facebook and the religious radicals have to say. Where do these entities glean their expertise from? Gossip pages on Facebook, Tucker Carlson or a religious leader who knows nothing but what they read from the foresaid false narrative spinners?

If any of you really were interested in doing what is best for the transgender youth in North Dakota, you would seek out time with the doctors who treat these individuals. You also would want to talk to the transgender community. How many of you have done that? I daresay none of you. What are you scared of? What harm has a transgender person ever done to any of you? Yet you posed to set in motion a bill that would tell this very small group in North Dakota that they can't seek help to become whole, that their doctor can be penalized for treating them. How many of you are doctors? What do you know of what the doctors do and their process or steps that transgender people have to go through to become complete? The blockers are reversable. The hormones are given after only a criterion has been met. Parent(s) and transgender person must both agree to go forward with blockers before they are given. So why do you, as authors and supporters of this bill, think you know best? Remember your interaction with the transgender community is nonexistent.

If you deny treatment for this group of individuals, then who is next? These people are born this way, by no fault of their own. So, in keeping pace with thought process with this bill and knowing who your target group is, anyone born with a discrepancy should be denied care or treatment. That means those who are born with any abnormalities, because isn't that how God made them? Also, then why allow anyone treatment for anything? After all isn't it God's will that a person develop cancer, have a heart

attack, suffer a stroke, I can go on and on. Why is anyone then allowed medical treatment if you want to say it is God's will?

I grew up Catholic. I have experienced many different religions and backgrounds of others having lived in other states as well. How I view HB #1254 it is a bill that is targeting transgender people so they can't receive life affirming care, to make these individuals a non-issue in your mind. Why not make a law then to prevent young girls and their parents from seeking breast enlargement surgery? Why not make a bill that would outlaw anyone who has acne issues from going to a dermatologist and seeking derma treatments because after all, isn't that how God made them? No acne medication, also no medication at all since that is how our Lord and Savior created us, right? I ask you how many of you have had medical attention in the past? Why, isn't that illness, disease or maybe even body deficit the way God made you?

This bill is hypothetical and very much like what Hitler did do the Jews. I am sure all you know what Hitler did, he tormented the Jews. He removed every bit of humanity from them, then tried to erase them from existence. Is that your plan here? Is your vision for North Dakota to become a state that is eventually an Aryan state? That's the direction that this bill is going.

HB #1254 lacks any Christ like characteristic that Jesus would show transgender people. Christ embraced those who were considered cast outs. Jesus had empathy, compassion and love for those who were marginalized. Jesus sought to help and care for those who were suffering. This bill has none of those qualities and nor did the authors and supporters of this bill intend to have this bill offer any of what Christ taught.

I strongly challenge you all to sit back and really think of your motives and what direction these motives will take the State of North Dakota. Do you really want North Dakota to be known as a state that hates individuals and discounts those who are marginalized? How did that work out for Hitler? Don't pass a vote that affects people and causes harm to those whom you don't know. Step out of your comfort zone, examine yourselves, your motives and open yourself to the fact that what modern Science, 21st Century Science, proves is that the world isn't black and white, that what we were taught was wrong, the world is not flat as what once was thought, and that people who are transgender are born this way. The false narrative is that this is a choice or that this is a way to erase CIS female from sports is laughable and shows how little the authors of these bills and supporters know about the topic.

I encourage you to vote DO NOT PASS on HB #1254. Anything else is a hate bill and sends the wrong message to the citizens of North Dakota. You owe it to the transgender community and their families to seek knowledge and first hand experiences from these individuals . It is only then that you can say you are doing the citizens of North Dakota due diligence.

Thank you,
Kristie Miller
Parent of Transgender

DO PASS - HB 1254

Dear Members of the House Human Services Committee,

Please render a DO PASS on House Bill 1254.

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 writing as a life-long retired resident of North Dakota and as a mother, grandmother and community member to express my opposition to HB 1254 which prohibits the medical treatment of gender dysphoria in minors and makes it a felony for a medical professional to provide the care a young person needs. 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 can dictate best medical practice better than the experts. This is one more example of a bill that is an answer to a problem that does not exist, goes against current standards 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. A 2020 study of 300 gender incongruent young people found that mental and emotional distress increased as they went through puberty as their bodies started displaying attributes associated with the gender they did not identify with. We know that suicidal attempts occur in 35-50% of transgender people in the world but a recent study showed that they are 73% less likely to be suicidal if they receive puberty blocking medications. If this bill passes the legislature, I fear for the mental health of young people who are struggling with gender dysphoria.

This bill would make a health care provider guilty of a class B felony if they willfully violated this law. You are comparing someone who is following their medical training and standards of care for their specialty to help their patient physically and mentally to someone who commits armed robbery, manslaughter or sexual imposition. That would mean that the medical provider would have to choose between being guilty of malpractice by not following "standard of care" for their profession or being guilty of a felony by providing the care needed by their patient. If this bill is passed, I would propose that the legislators who vote for this bill be held accountable for the increased depression, anxiety and suicidal thoughts of the young people who are not allowed to obtain the therapy they need. If a suicide attempt by one of those vulnerable teens is successful, those legislators should be charged with manslaughter.

I believe the sponsors of this and other bills that attack transgender youth this session 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. HB 1254 along with HB 1301 make it illegal for medical professionals to assist young people to make that transition medically in a safe manner following the standards set by their medical profession.

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 the testosterone blocking drugs that need to be given can have numerous negative side effects on adults. 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 the patient's mental and emotional health before any puberty blocking treatment is started. There are no known irreversible effects of puberty blockers and are used to treat precocious puberty as well as gender dysphoria. If a patient chooses to stop the treatment, puberty starts back within 6 months of ending the therapy. In contrast, if a young person is not allowed to have gender affirming care, once puberty begins, the effects are not reversible. Testosterone and estrogen are normally not given before the age of 16 and surgical procedures are rarely done on minors in our state. Bottom surgeries are very expensive, medically complicated and only performed by a handful of surgeons in our country on consenting adults. By denying young people in our state with gender dysphoria an opportunity to transition gradually and safely 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

Members of the House Human Services Committee,

My name is Shelby Downey and I reside in District #38. I am asking that you please render a DO PASS on House Bill 1254.

We must protect the physical bodies of young people who are falling victim to an ideology gone wild in today's culture. Countless studies have proven that children who are NOT affirmed in their gender dysphoric beliefs will most often not pursue a gender change into adulthood. But we are seeing now with the affirmation of this dysphoria at young ages, children no longer have the reasoning ability to walk away from these false ideologies as adults.

We cannot allow minors to disfigure their bodies, sterilize themselves, and make life altering decisions that cannot be reversed later in life. Pediatric medicine has been hijacked by activists and the recommendations of the American Academy of Pediatrics should be dismissed as socially constructed pseudoscience.

I urge you to vote DO PASS on House Bill 1502.

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

- Shelby Downey

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 1254. 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 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.

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 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.

Wade Pulkrabek

Members of the House Human Services Committee,

My name is [First & Last Name] and I reside in District 34. 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.

Andrea Leingang

Mariah Bates
Williston, North Dakota
House Bill 1254

Members of the Senate Judiciary 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 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.

Mariah Bates

Members of the House Human Services Committee,

My name is Cionda (C.C.) Holter and I reside in District 3. 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.

Cionda N Holter

701-580-4746

Members of the House Human Services Committee,

My name is Jacob R. Holter and I reside in District 3. 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.

Jacob R. Holter

701-580-7800

Regarding House Bill 1254

Dear House Member,

My testimony is in strong opposition to HB1254. 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 HB1254.

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 1254. I ask that you give this bill a **Do Not Pass.**

Transgender children are not undergoing surgeries to change their genders in North Dakota. Transgender children are cared for under the guidance of their parents and medical professionals. This bill is ridiculous and a waste of taxpayer money.

Gender affirming healthcare can save lives. 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 24, 2023

Human Services Committee
HB 1254

Chairman Weisz and Committee members:

Let the record reflect my support for House Bill 1254 ("HB 1254"), as written and introduced by Representatives Tveit, Anderson, Bellew, Prichard, Rohr, and VanWinkle, and Senators Boehm, Clemens, Estenson, Luick, Myrdal, and Vedaa.

We must never allow the victimization of the most defenseless in our society because we buy into the "appeal to authority" logical fallacy and cede our better judgement to those who stand to financially benefit from that which they are providing their "expertise".

Our society cedes the moral high ground when pointing out the barbarism of the genital mutilation of minors by other cultures--which we all agreed was pure evil up until about 5 minutes ago--when we condone the same practices under the misguided auspices of "affirmation."

We have a moral obligation to defend children. Mutilation, disfigurement, chemical castration and every other "Island of Doctor Moreau" horror being perpetrated upon those whose prefrontal cortex has not yet fully developed and are in every way incapable of legally making these decisions for themselves is abhorrent and should be thoroughly rejected, renounced, and defeated. Full stop.

"The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped."
--Vice President Hubert Humphrey

"Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience."
--C.S. Lewis

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

Respectfully,

Matthew S. Simon

January 23, 2023

Chairperson Lee and Committee Members,

I strongly urge a Do NOT Pass on HB 1254. 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 1254.

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

Testimony Against Bill 1254

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 1254 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 1254, 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 1254, 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 1254. 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 1254 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 1254.

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 1254 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 1254. 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 1254 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 1254. 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 1254

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 1254. 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 1254

Dear ND House Human Services Committee,

My testimony is in opposition to House Bill 1254. 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.

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 will increase stress and lead to increased cases of harm and even death.

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

Respectfully,

Will Lovelace
ND District 18 Resident

January 23, 2023

Re: HB 1254

Dear ND House Human Services Committee,

I am writing in opposition to HB 1254. This bill targets an already vulnerable group of people and has been proposed not out of knowledge or understanding but out of fear and ignorance. We need to lean into legislation that is **evidence-based**. This bill is not. 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 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.

Kayla Johnson

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

My testimony is in opposition to House Bill 1254. 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 1254.

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

Best regards,

Rev, Grace Morton

01/23/2023

HB 1254
Testimony in Opposition

Chairperson and Member of the 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 relate to mental health, specifically focusing on client who identity as transgender and/or gender expansive.

I oppose HB 1254 for several reasons. First and foremost, this bill seeks to obstruct medical patients from accessing best practice, effective, and lifesaving care. This bill disregards the legitimacy of gender dysphoria and the medically necessary care as outlined by current leading medical and mental health professional organizations, such as the World Professional Association for Transgender Health (WPATH SoC8) as well as the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). If this bill passes and successfully prevents licensed healthcare providers from providing evidenced-based, effective care to their minor patients, we are doing a grave disservice to our youth and their families. Untreated gender dysphoria leads to worsened mental health, physical health, substance abuse, school performance, and increased risk for self-injury and/or suicide. The state of North Dakota has collected their own evidence to support this. The 2021 Youth Risk Behavior Survey ND found that transgender middle schoolers in ND are six times more likely to attempt suicide than their straight and cisgender peers. High schoolers in ND who identify as transgender are five times more likely than their straight and cisgender peers to have had attempted suicide within the last 12 months at the time of completing the survey. The transgender youth in our state are already in acute need of lifesaving care. We cannot roll back progress to meet the mental health and physical health needs of our youth.

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I would remind the committee that for youth to access gender affirming care, they must first be assessed by a licensed professional, receive education on the process and outcomes of receiving care, and consent must be obtained from their parent or guardian to access care. That means, youth in our state who receive gender affirming care have already been properly assessed and diagnosed, parents have been informed and consented to care, and health providers have done their due diligence in administering care.

Another objection I have to this bill is the language used. "Minor's perception of the minor's sex is inconsistent with the minor's sex" is very confusing and misleading. It first tells me that the writers of this bill do not have the appropriate language or knowledge to use in legislating against the gender diverse population as well as the medical professionals who serve this community. I must assume they are referring to gender dysphoria or gender incongruence and not "perception of sex" as a patient's sex in not in question when performing gender-affirming care. I would advise the writers of this bill to consult with medical and mental health professionals when attempting to legislate healthcare law in this state.

Additionally, I object to this bill as it is driven by personal and/or religious values and beliefs in an attempt to discriminate against a group of people with differing values, beliefs, and medical needs. For example, this bill allows an exception for male circumcision. Why would that be? If the supporters of this bill want to discontinue all sex or gender related care to ND minors, why are we allowing male circumcision? The answer is that this bill only impedes the healthcare of LGBTQ+ communities. This is about prohibiting medical practices for targeted groups. Let us not be swayed to think the intent of this bill is for the health and benefit of the youth in North Dakota. As a mental health professional, I can assure you that if we deny care to those in need, we will experience an increase in youth suicides, risky behaviors and outcomes, increase in substance abuse, decline in academic performance, increase in youth runaways and human trafficking, and/or overall decline in youth health.

Furthermore, I oppose the penalty of a class B felony to health care providers to continue providing sound, ethical, and medically necessary care to gender diverse minors. Please think carefully about the group of professionals you are looking to target. We have entered the healthcare field to help, care for, and serve our communities. We do not derve to be treated with such threat and insult. This bill is meant to threaten and scare away good, caring, trained, education professionals from performing the healthcare. If this bill passes, it could drive away healthcare professionals from serving in ND.

I urge you to vote DO NOT PASS for HB 1254. Thank you for your time.

Naomi Tabassum, LPCC
Mental Health Counselor
New Story Counseling Services
naomi.tabassum@newstoryfargo.com

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

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

This proposed bill is ridiculously punitive to medical personnel, who would be thrown in jail for providing a requested and healthy dose of testosterone or estrogen to a young person. It also will further erode the desire for families with transgender children to move to or remain in the state. Please give House Bill 1254 a Do Not Pass!

Thank you for your consideration.

Sincerely,

Christopher Gable

Grand Forks

Dear Legislators,

I am writing to express my strong opposition to HB 1254, which seeks to criminalize the treatment of transgender patients under the age of 18. This bill is not only discriminatory, but it also flies in the face of established medical science and the overwhelming consensus of the medical community.

I am one of the few Plastic Surgeons in North Dakota providing gender-affirming procedures, specifically chest masculinization and chest feminization, to treat gender dysphoria. I can personally attest the significant positive impact these treatments have on transgender patients, their quality of life, and their gender dysphoria. These results are not isolated to my own personal experiences. A plethora of peer-reviewed, published data have repeatedly shown the benefits of transgender care, for minors and adults. This is not opinion; these are data collected through rigorous scientific studies. It is studies such as these that guide and direct physicians and providers in the treatment of disease, disorders, and conditions affecting all people. As physicians and scientists, we follow these principals in the care of our patients. We are the experts. The intrusion of politics and government into the care of patients has no basis, refutes the standard of care, is discriminatory, and is dangerous for patients, not to mention is extremely hypocritical to the basic premise of the group of legislators supporting this bill.

There is a wealth of primary literature that supports the benefits of transgender care for minors. For example, the American Academy of Pediatrics (AAP) states that "affirmative care for transgender and gender-diverse youth is necessary to promote health and well-being." The AAP also notes that "denying or delaying care can lead to significant mental health problems, such as depression and suicidality."

Additionally, the World Professional Association for Transgender Health (WPATH) states that "gender-affirming care for transgender and gender nonconforming children and adolescents is safe and effective." The WPATH also notes that "such care can improve mental health outcomes, including reducing suicidality."

Furthermore, the American Medical Association (AMA) has adopted a policy stating that "transgender individuals should have access to medically necessary care" and that "public and private health insurance plans should cover gender transition treatment."

In light of this overwhelming evidence, it is clear that HB 1254 is not only discriminatory, but it is also detrimental to the health and well-being of transgender minors. I urge you to reject this bill and instead work to ensure that all children, including transgender children, have access to the care they need.

Sincerely,

Nicholas Adams, MD
Board-Certified Plastic Surgeon

Members of the House Human Services Committee,

My name is Rosemary Ames and I reside in District 9B. 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.

Rosemary Ames

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 licensed social worker, community organizer, a mother, and as someone who cares very much about the LGBTQIA+ community.

I strongly oppose HB 1254 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.

I urge you to vote Do Not Pass on HB 1254.

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 1254. 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

January 23, 2023

Chairperson Lee and Committee Members,

I urge a Do Not Pass on HB 1254. 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

Members of the House Human Services Committee, my name is Camille Kiefel and I am asking that you move forward with a do pass for House Bill 1254. I am, as I know you are, concerned about the wellbeing of those suffering from gender dysphoria, especially children. I've come here today to share my story in hopes of preventing this from happening to others.

Prior to my transition, I had spent 20 years of mental health therapy with conventional modalities. I didn't respond well to medications, saw a gender therapist, and had two rounds of TMS (transcranial magnetic stimulation therapy). I was diligent and wanting to heal- but nothing my doctors offered had healed me because they always saw my issue strictly as a mental one.

I was 30 and at the end of my rope when I transitioned. At the time I believed I was non-binary. I struggled with severe mental illness and suicidal ideation. I had a trauma history: when I was in 6th grade, my best friend had been raped by her brother. Being a girl meant I was vulnerable. I started to present more masculine.

This should have been a red flag. Yet within a few months of requesting top surgery, it was performed on me. I developed complications after my surgery. There were many times I didn't know if I would make it through the night.

If I made this mistake as an adult, a young girl could, too. Not only did my surgery exacerbate my mental health issues. I now struggle with physical complications as well. Presenting and taking on another gender was a way for me to escape womanhood. Escape is not a valid way of dealing with trauma; You will have to deal with it eventually.

I was able to work through these difficult emotions and improve my mental health through a holistic approach. I had physical health issues that had been previously overlooked. Had that been managed, I would have never gotten the surgery. This surgery was an abhorrent misdiagnosis. The goal of healthcare should always be to get to the root cause of the problem.

Today I am more grounded than I have been my entire life, but I am mutilated. Between my carved-up body and the physical complications, I often question if there's anything on the other side. Where my breasts were are hollow. I can never get them back. I can never fit a dress the same way again. I can never breastfeed. Who will love me?

You know what keeps me going? Stopping this from happening to someone else.

Thank you for your time. You all have a lot to consider, and I know you will make the right decision.

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

My testimony is in opposition to House Bill 1254. 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 1254 which prohibits gender-affirming medical care.

Everyone deserves to have the best medical care and the state of North Dakota is known for our excellent medical care. To prohibit medical care for LQBTQ will increase the mental health risks for our LGBTQ youth. Right now 72.7% of LBGBTQ youth did not feel safe at school most of the time or always. Gender-affirming medical is a path to feeling safe for many youth, and you are cruelly denying them the opportunity to be safe as they walk around the streets of our beautiful state.

Please keep our LGBTQ youth safe and vote Do Not Pass on this bill.

Sincerely,

Kathy Hintz
Minot, ND

January 23, 2023

Opposition to House Bill 1254

Dear House Members,

My testimony is in opposition to HB 1254. 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 1254.

Shawn Nixon

In support of 1254

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.

Erin J McSparron

January 23, 2023

Re: HB 1254

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 1245.** 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 1254.

Sincerely,
Kara Gloe, LMSW
Canopy Medical Clinic

As real, true science shows we are all born as either female or male. Our chromosomes bear this out. Yes, on a rare occasion – about only 500 cases in history – is someone born with hermaphroditism (both male and female chromosomes). It is impossible to change what is imprinted into our cells from conception onwards. No amount of hormones, puberty blockers (which the FDA is warning can cause brain swelling, vomiting, headaches, blindness, and brain tumors), or removal of healthy organs can change someone's sex. But what it can do is cause irreparable harm and damage to otherwise healthy individuals, including creating a generation of sterile children. To do this to children is child mutilation.

Planned Parenthood advertises gender transitioning services with drugs prescribed and delivered after a remote 30-minute telehealth session starting at $59 a month. Unsubstantiated claims are being made without the conclusive, long-term clinical safety findings normally required. To do this and promote this to minors is reprehensible. Minors do not have the cognitive development to understand the life altering effects transitioning treatments will have upon their body and emotional wellbeing.

You may be able to make someone appear more male or female, but you cannot change the sex in humans no matter what treatment or surgeries you perform on them. Please support HB 1254 and prohibit the medical gender transitioning of minors. Thank you.

Dear Senators, I am writing in opposition to HB 1254. I ask that you give this bill a Do Not Pass.

This bill is a dangerous and harmful affront to the human rights of North Dakotans. HB 1254 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.

I firmly believe that HB 1254 would not protect North Dakotan youths, but rather further disenfranchise them from successful and prosperous futures by not providing transgender individuals the lifesaving health care they deserve. We all want the future generations of North Dakota to grow up happy, healthy, and hopeful to give back to their communities, but HB 1254 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 give HB 1522 a Do Not Pass.

Do Pass Testimony
of Doug Sharbono, citizen of North Dakota
on HB1254
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 HB1254 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 HB1254 a Do Pass.

Thank you,

Doug Sharbono
1708 9th St S
Fargo, ND 58103

Testimony in Support of HB 1254

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 1254 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

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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 1254 and again recommend a "Do Pass."

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

Once again I write my testimony in opposition to a House Bill, this time HB 1254, I'd love to one day write a testimony in favor but yet here we are 2 A.M. and again begging that you give this bill a Do Not Pass, because it does nothing but limit the rights of a marginalized group like so many other bills today. The more of these that are attempted to be push through the more i realize how little the sponsors actually care about the children they claim to protect between offering conflicting promises/penalties from one bill to another, Threatening to punish schools where kids are playing pretend, and wanting to make it legal to torture children they deem defective. Maybe that wasn't some of their intents but that was very clearly not written that way. This bill once again will put a strain on the mental health of children who already have it hard enough in this world. I think I have said it six ways to Sunday by this point, but don't vote in favor of this. Some words a wise man once said that tell me and drive me to be better and do better that maybe will help you all in this decision. “Remember Hate is always foolish and love is always wise. Always try to do good, but never fail to be kind.”
-Nate Brown

Testimony in Support of HB 1254

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

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We appreciate the opportunity to provide testimony on HB 1254 and again recommend a "Do Pass."

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House Human Services Committee
HB 1254
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 HB1254.

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. HB1254 raises several concerns regarding the care I provide my patients.

The bill defines "sex" as a biological state of being female or male based on sex organs, chromosomes or hormones present at birth. Sex is typically broken down into two categories: genotypic and phenotypic. Genotypic sex is based on an individual's chromosomes. Phenotypic sex is determined by internal and external genitalia and by the expression of secondary sex characteristics. Furthermore, sex is not synonymous with gender.

Gender is defined as a person's subjective perception of their sex.

Disorders can occur when the genotypic sex, phenotypic sex and/or gender do not align.

These disorders can be at the chromosomal level (Klinefelter syndrome, Jacob syndrome, Turners syndrome) or even with the physical (phenotypic) expression of sex (Androgen Insensitivity syndrome).

These conditions are medically recognizable disorders of sexual development. They each have criteria for diagnosis, and each require medical (and sometimes surgical) therapies.

Disorders can also occur with gender. Gender Dysphoria is the marked incongruence between one's experienced/expressed gender and their assigned gender.

Gender Dysphoria is no different from the conditions I mentioned above. It carries an ICD code and a DSM definition. It is a medically verifiable disorder with diagnostic criteria deserving of 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 treatment for other disorders of sexual development. 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.

Transgender children and adolescents deserve the same quality healthcare as other individuals with disorders of sex development. They deserve equal access to therapies irrespective of their chromosomal make up. 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 1254.

Thank you for time,

Heather Sandness Nelson, MD (She/Her)

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

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

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 1:00 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

Testimony of Mia Halvorson

In Opposition to HB 1254: "Relating to the prohibition of certain practices against 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 1254 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

Please give a DO PASS to HB1254. 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 1254 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 honor and integrity.

Thank you for your time and consideration
Christina

Kayla Schmidt – Interim Executive Director, North Dakota Women's Network
Opposition – HB 1254
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 1254.

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.

North Dakotans deserve healthcare that preserves their personal liberty, dignity, and privacy. House Bill 1254 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 1254 receives a Do Not Pass Recommendation.

Thank you.

Kayla Schmidt
director@ndwomen.org

Olivia Data
Testimony on HB 1254
January 24, 2023

RE: Testimony in Opposition to HB 1254

Greetings, 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 1254.

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 1254 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 1254 is an extremely concerning bill. Many people who support it claim to want to protect children, but HB 1254 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 1254 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 1254. 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. 1254**, which would make the medical treatment of transgender minors a felony offense.

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

Hello. My name is Adam Miller, a resident of Bismarck. I am writing in opposition to HB1254.

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 HB1254 and every other bill attacking the LGBTQ+ community.

The motion to make providing gender affirming care a felony is a gross misuse of power over mental health practices. For a state to step in a declare what type of mental health care is appropriate or “legal” without training or considering of ethics to further their own political agenda and personal/religious beliefs is an overstep and blurring of lines.

2023 HOUSE BILL 1254

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 1254. 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 1254.

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

Respectfully submitted,

Danial Sturgill, PhD
Clinical psychologist

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 1254 – DO PASS

Andrew Alexis Varvel

Written Testimony

North Dakota State Capitol Pioneer Room

January 24, 2023 2:30PM

Chairman Weisz and Members of the Committee:

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

Here is a story from page 131 of "*The Last Madam: A Life in the New Orleans Underworld*", a sympathetic biography about the notorious madam Norma Wallace.

"The younger sister of one of the girls asked for a job at Norma's. She was a very pretty girl, younger looking than her seventeen years, small boned and delicate, her face a sweet and perfect oval.

On the girl's first night of work, just before four in the morning, a car slid up in front of 1026 Conti and parked. When the girl finished with her last trick shortly after four, she ran quickly to the car, got into the backseat, and the car drove off. The next evening the car arrived again, same time, parking so that part of Norma's driveway was blocked. Norma looked from the window as her new girl ran out and opened the passenger door. A man and a woman sat in front. It dawned on Norma that the girl's parents were picking her up after work every morning.

Norma figured out that the parents didn't want their daughter running in the Quarter, getting mixed up with dope fiends, and she was sympathetic for a while. But after a few weeks she began to get irritated. 'It looked like hell,' she said. 'My parents knew what business I was in, but even when I was hustling, they didn't come pick me up.' She finally buttonholed the mother one night and asked her what the deal was.

'Well,' the woman said apologetically, 'our daughter has always lived a very sheltered life.'"

This incident is from the late 1950's. That adolescent girl, if alive today, would be in her nineties. Yet, the moral questions she faced then also face adolescents now.

Should we regard the parents who chauffeured their daughter to and from Norma Wallace's brothel to be people who cared deeply enough about their daughter to affirm her choice to become who she wanted to be, or were they abetting child prostitution?

Were these parents helping their daughter's mental health, or were they complicit in putting their daughter into an abusive industry which took advantage of her?

Regardless of libertarian objections that would portray a personal right to rent out access to one's genitalia to paying customers to be basic right and an integral feature of personal autonomy, I think we still have a societal consensus in North Dakota that permitting an under-aged girl to prostitute herself would constitute child abuse.

Even with her seeming consent.

Even with a psychologist's certificate claiming that prostitution helps her mental health.

Even if being a prostitute were integral to that person's gender identity.

And if you were told that prohibiting an under-aged girl from prostituting herself would lead her to commit suicide, would that change your opposition to child prostitution?

Yet, in comparison to prostitution which merely involves renting out access to one's genitalia to paying customers, removal of those genitalia would constitute far more severe, permanent, and intrusive damage. Sterilization cannot be undone.

In North Dakota, even adults are banned from prostituting themselves. (NDCC 12.1-29-03) In contrast, House Bill 1254 is remarkably moderate and restrained, for it only bans sterilization of children. Adults can still turn themselves into eunuchs if they so desire.

House Bill 1254 would class genital removal as a Class B felony. In contrast, existing law against female genital mutilation only calls it a Class C felony. (NDCC 12.1-36-01)

Sex trafficking of an adult is a Class A felony. Sex trafficking of a minor is a Class AA felony. (NDCC 12.1-41-02) In comparison to these offenses, the penalties proposed by House Bill 1254 – merely a Class C felony – would still be comparatively mild.

Not only is the topic of prostitution a good analogy to sterilization, but it is a mild one.

I have read that people can recover from their time working as prostitutes, but I know of no circumstance under which the surgical removal of genitalia can be reversed.

Sweden has turned against puberty blockers. Finland has turned against puberty blockers. Sweden has turned against transgender surgery. Finland has turned against transgender surgery. If the Biden administration truly believed that these new policies constitute human rights abuses, it would not be welcoming them into NATO. The United Kingdom is increasingly restricting these procedures too.

So, it is possible to be a good socialist and oppose the sterilization of children. It is possible to be a good liberal, in the tradition of Mr. Rogers no less, and oppose the sterilization of children. It is possible to be staunchly anti-authoritarian and oppose the sterilization of children. You don't need to be a conservative to take this stand.

Please provide House Bill 1254 with a **DO PASS** recommendation.

Thank you, and I welcome questions from the committee.

Andrew Alexis Varvel
2630 Commons Avenue
Bismarck, ND 58503
701-255-6639
mr.a.alexis.varvel@gmail.com

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 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.

Thea Holter

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

UK — Independent Review of Medical Care of Gender-Confused Youth: Interim Protocols and Results

In 2023, on the basis of the UK's National Health Service Cass Review, the only pediatric gender clinic in the UK, Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (Tavistock), will shut down. It will be replaced with regional hospital-based services. This change resulted from a number of whistle-blowers within the Tavistock who noted that it hid negative outcomes from puberty blockers and complaints that the children were being fast-tracked to transition without exploratory therapy.

The UK's National Health Service released its interim service specifications for specialist gender dysphoria services for children and young people on October 20, 2022:

THE NHS REJECTS THE AMERICAN "GENDER AFFIRMING CARE MODEL"

- Instead of affirming a minor's gender identity as valid, the medical providers MUST perform an in-depth comprehensive mental health assessment led by a broad team of medical experts which must include pediatric, autism, neurodiversity and mental health experts. This is to ensure that the child's complex mental health presentations are addressed.
- The comorbid mental health issues will be the primary focus of the treatment.
- The whole child must be fully assessed, not just the gender incongruence. Causality of gender ideation will be explored.
- Schools, colleges, health and social services staff and non-profits/advocacy groups will no longer be able to refer minors to the GIDS, thus removing some of the ideological basis for referrals.
- Only minors that are referred to the GIDS have the possibility of being medicalized, and not all minors with gender ideation will be referred.

THE NHS RECOGNIZES GENDER DYSPHORIA AND REJECTS WPATH'S "GENDER INCONGRUENCE"

- A "gender dysphoria" diagnosis requires significant distress or functional impairments. "Gender Incongruence" requires only for a person to desire the physical attributes of their internal gender belief.

THE NHS REJECTS SOCIAL TRANSITION OF PREPUBERTAL CHILDREN

- In recognition of social transition as a medical intervention and the possible significant adverse effect of social transition on a child's psychological functioning, the NHS strongly discourages social transition in prepubertal children, and under the rare instances that it is recommended, only in conjunction with an explicit informed consent process.
- The NHS notes that in most cases, gender incongruence/dysphoria resolves with puberty.
- Only where there is "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" should social transition occur.

THE NHS ADVOCATES FOR PSYCHOTHERAPY AND PSYCHOEDUCATION AS THE PRIMARY TREATMENT FOR GENDER-CONFUSED MINORS

- Puberty blockers will only be prescribed in a research setting.
- Data will be collected into adulthood.

THE NHS STRONGLY DISCOURAGES PARENTS FROM SEEKING BLACK-MARKET HORMONES

- The NHS will not treat any such patients on hormones obtained outside of the GIDS.
- Those parents permitting the use of illicit hormones will be investigated.

Some of the more salient bases for the new protocols:

- In 2009, there were 50 youth referred; this jumped to 2,500 with 4,600 on the waitlist in 2020. (Section 3.10 of Cass Review)
- During the wait time — typically a delay of 2 years or more, the child's gender identity can become more fixed making psychotherapy more difficult. (Ibid., at section 4.36)
- The reversal of the historic sex ratio of predominately males with gender dysphoria to females is notable, with females presenting with later onset of dysphoria. (Ibid., at section 3.11)
- Children who are in "foster care" are overrepresented. (Ibid.)
- **One-third of children/youth have autism or other types of neurodiversity. (Ibid.)**
- **Over-emphasis on transition is problematic, considering the poor quality evidence of efficacy and safety of Affirmative Care treatments. (Ibid., at section 3.21)**
- **Certainty of stable gender identity is difficult to predict since identity can remain fluid into the mid-20s. (Ibid., at section 3.22)**
- The Tavistock did not keep adequate data on outcomes. (Ibid., at section 3.34)
- Little is known about the long-term outcome of the new cohort of females that transitioned. (Ibid., at section 3.23)
- The Tavistock failed to have a systematic, formal mental health or neurodevelopmental assessment or formal diagnosis of companion metal health issues. (Ibid., at section 3.38)
- **Unknown whether puberty blockers do indeed provide valuable time for children and young people to consider their options, or whether they effectively 'lock in' children and young people to a treatment pathway which culminates in progression to feminising/masculinising hormones by impeding the usual process of sexual orientation and gender identity development. Children placed on puberty blockers have a 96.5% to 98% chance of proceeding to cross-sex hormone treatments. (Puberty blockers cannot be described as a pause button but a scaffolded step.) (Ibid., at section 3.31)**
- The effect of cessation of puberty could retard the development of the brain and further concretize gender confusion. Further study is needed. (Ibid., at sections 3.32 and 3.33)
- **The long-term outcomes of medicalization of children are unknown and there is no established protocol to determine which child would benefit or be harmed by gender interventions. (Ibid., at section 3.34)**
- The lack of quality controls on the treatments is problematic. (Ibid., at section 5.3)
- **The appropriate treatment for gender dysphoric youth is not clear. (Ibid., at section 6.1)**

THE UK RECOGNIZES THAT MEDICALIZING GENDER-CONFUSED CHILDREN IS NOT THE BEST TREATMENT. THE RISKS OUTWEIGH THE BENEFITS.

Medical Care of Gender-Confused Youth Beyond the UK

FINLAND

2020, Council for Choices in Health Care in Finland (PALKO/COHERE)[1], *Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors* (report regarding gender dysphoric youth under age 25) — findings and recommendations:

- **No medical treatment for gender dysphoria is evidence-based.**
- Gender reassignment on minors is experimental.
- Gender reassignment does not alleviate comorbid mental health issues.
- Hormone therapy can interfere with an adolescent's natural process of identity development
- Autistic youth are overrepresented among those suffering from gender dysphoria.
- The first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders.
- Minors must have their mental and behavioral health issues resolved before determination of their stable gender identity.
- All gender treatments for youth shall be performed in research settings.
- With pre-pubescent children, if the gender dysphoria is severe, persistent, and increases at puberty, on a case-by-case basis the child may be sent to the research group for suppression of puberty or halting of menses with a prerequisite of in-depth assessment.
- For adolescents with dysphoria at puberty, provided the distress is not typical for normal child development, does not subside after psychotherapy, and appears to be the stable identity, the child can be sent to the research group for possible hormones.
- Hormonal interventions on minors must be done with a great deal of caution.
- **"No decisions should be made that can permanently alter a still-maturing minor's mental and physical development."**
- **MINORS ARE NOT PERMITTED SURGICAL INTERVENTIONS.**

SWEDEN

February 2022, Swedish National Board of Health and Welfare (SNBHW), findings and updated recommendations for hormone therapy in gender dysphoria in young people under the age of 18:

- **"[T]he risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits…"**
- There are a growing number of gender dysphoric youth with significant mental health issues.
- The cause of the substantial increase in gender dysphoric youth is unknown and the flip in sex ratio from traditionally gender dysphoria males to females is not understood.
- **There are an increased number of regretters/detransitioners.**
- Restraint is needed with hormone therapy.
- The first line of treatment is psychotherapy.
- Psychological treatment should not affirm or disavow a gender identity.
- Those with comorbid mental health issues need more extensive psychotherapy.

1 Finnish Studies – (1) a study of 70 adolescents placed on puberty blockers, **resulted in no decrease in gender dysphoria**; (2) a study of 201 adolescents, of the 100 who just received psychological inventions, they showed improvements in global functioning at 6 months. The other 101 were placed on puberty blockers combined with psychological inventions. They showed improvements at 12 and 18 months; and (3) a study of cross-sex hormones showed that hormones did **not** alleviate developmental and psychiatric symptoms in youth. Thus, the Fins saw **no benefit** in putting a child on puberty blockers or hormones.

- Any hormone treatments shall be in a research setting and only in extraordinary cases where the dysphoria occurs prior to puberty and persists for years (~5 years) with a marked psychological strain.
- Gender dysphoric adolescents with no history of childhood dysphoria may receive puberty blockers in extraordinary cases, but not cross-sex hormones.

AUSTRIALIA AND NEW ZEALAND

September 2021, Royal Australia New Zealand College of Psychiatrists (RANZCP), the registration body for psychiatrists — findings and recommendations:

- Non-exploratory affirmative model without high quality evidence requires caution.
- "Research on Gender Dysphoria is still emerging. At present, **there is a paucity of quality evidence** on the outcomes of those presenting with Gender Dysphoria. In particular, there is a need for better evidence in relation to outcomes for children and young people."
- Do not merely affirm the gender identity — "Psychiatrists should engage with people experiencing Gender Dysphoria in a way which is person-centred, non-judgmental and cares for their mental health needs."
- Causality of the dysphoria must be assessed — "Assessment and treatment should be based on the best available evidence and fully explore the person's gender identity and the biopsychosocial context from which this has emerged."
- Long-term studies are needed in relation to wellbeing and quality of life during and after medical and surgical interventions.

FRANCE

February 2022, Académie Nationale De Médicine, *Medicine and gender transidentity in children and adolescents* — findings and recommendations:

- "There is no test to distinguish 'structural' gender dysphoria from transient dysphoria in adolescence. Moreover, the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to 'detransition'."
- There is a relationship of social media with the "epidemic-like phenomenon" in the cases or clusters of friend groups with gender dysphoria.
- The psychological support phase should be extensive.
- A multi-discipline assessment is needed before those with persistent gender dysphoria can be placed on puberty blockers or hormones.
- Great medical caution must be taken with children and adolescents.

BELGIUM

July 2022

— A major publication printed an open letter from psychiatrists entitled, "Is it justified, and desirable, to allow children and adolescents the right to change gender based only on feeling?"

— A European manifesto, signed by scientists, doctors and academics of the humanities and social sciences calls upon the media of France, Belgium, Germany, the United Kingdom, Switzerland and other European countries "to faithfully represent serious studies and scientifically established data concerning 'gender dysphoria' of children in programs intended for a large audience," recognizing the social contagion. Gender reassignment is not a miracle cure.

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.

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.

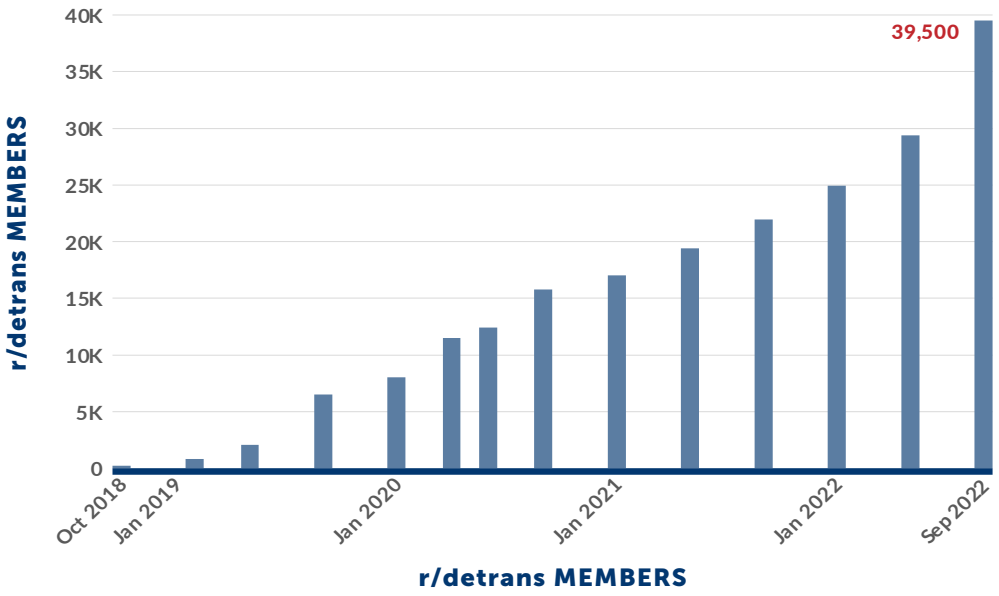
- A **detransitioner** is someone who identified as trans, non-binary, or another gender identity but then regrets the medical interventions and re-identifies with their natal sex.
- A **desister** is someone who identified as transgender but stopped identifying before medicalizing.
- There are also 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%)

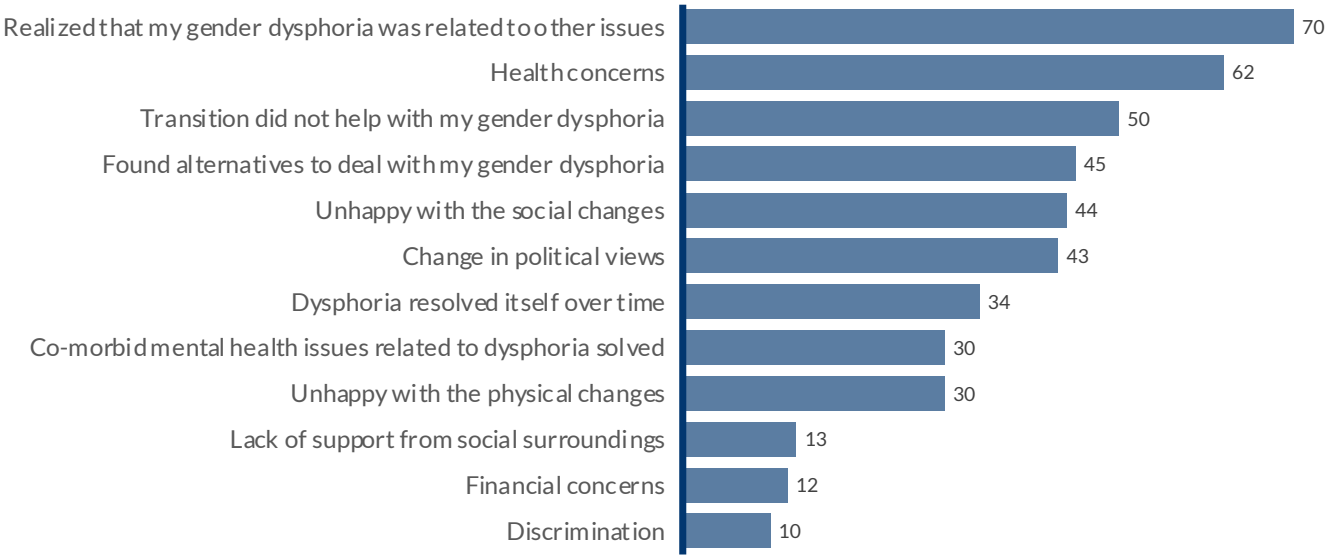
**May select more than one answer*

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)

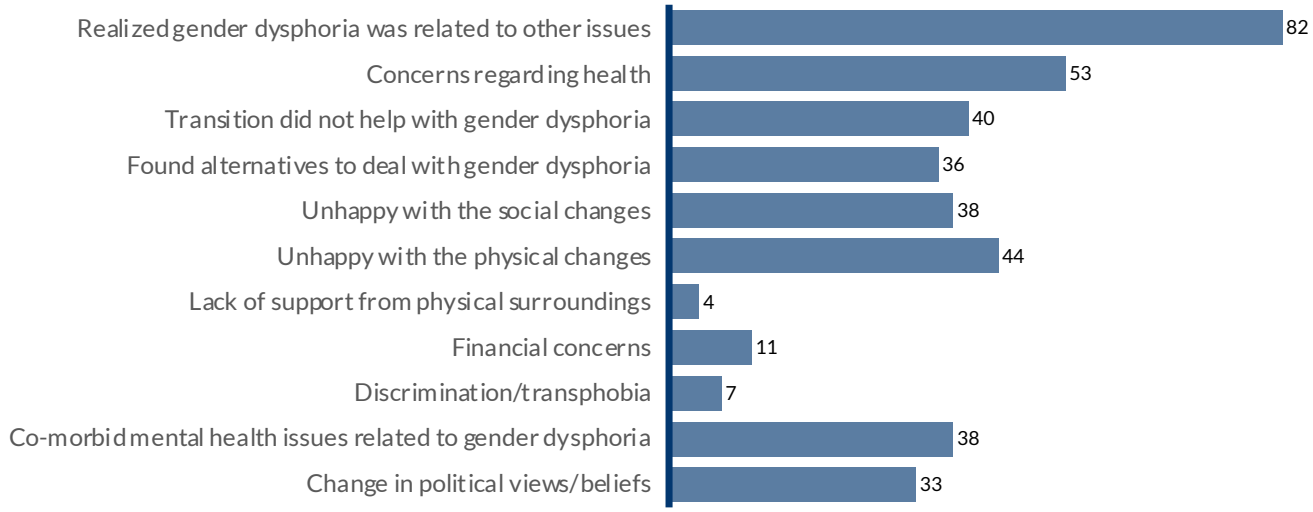


"After years of struggling with gender dysphoria, along with diagnosed anorexia, bulimia, anxiety, and depression, I thought that pursuing medical transition and living as the opposite sex would bring me happiness. I believed what trans activists told me: that transitioning was my best option and the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

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

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[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).

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.

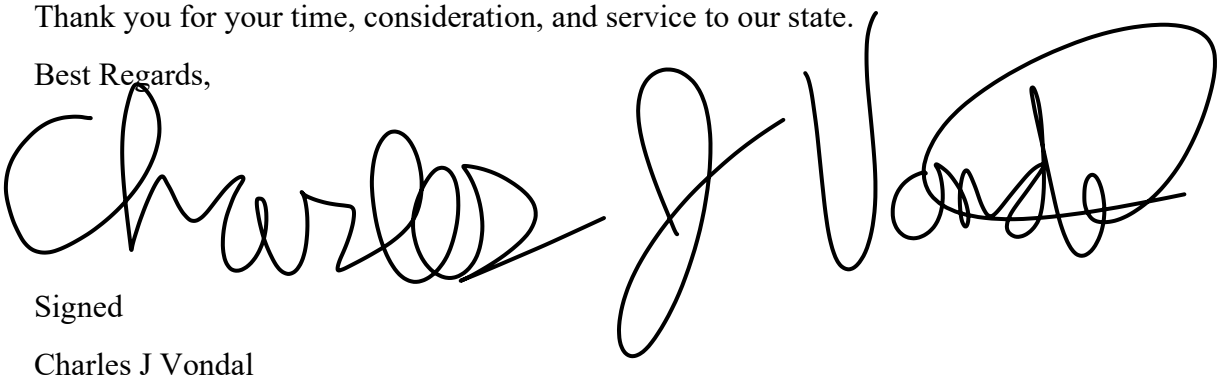
I however never got to experience medical care some children got to experience with gender-therapy till I was 18 years old due to my mother though it would be best to wait to transition when I came out around 14 or 15. Yet, I can still remember wishing I had the chance to experience puberty blockers 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

MD, C. M. (2022, March 14). *The care that transgender youth need and deserve*. Harvard Health. https://www.health.harvard.edu/blog/the-care-that-transgender-youth-need-and-deserve-202203142704

Miller, C. (2019, January 9). *Transgender Kids and Gender Dysphoria*. Child Mind Institute; Child Mind Institute. https://childmind.org/article/transgender-teens-gender-dysphoria/

Jan 24, 2023

Dear ND 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

House Human Services Committee
HB 1254
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. The NDMA Policy Forum recently passed a policy opposing the criminalization of medical practice. This policy states as follows:

> NDMA should take all reasonable and necessary steps to ensure that evidence-based medical decision-making and treatment, exercised in accordance with evidence-based standards of care, does not become a violation of criminal law.

This bill makes evidence-based medical decision making and treatment of transgender individuals a violation of law. There are physicians here today to testify as to the details of that treatment, and why patients would be harmed if it was made a crime.

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?

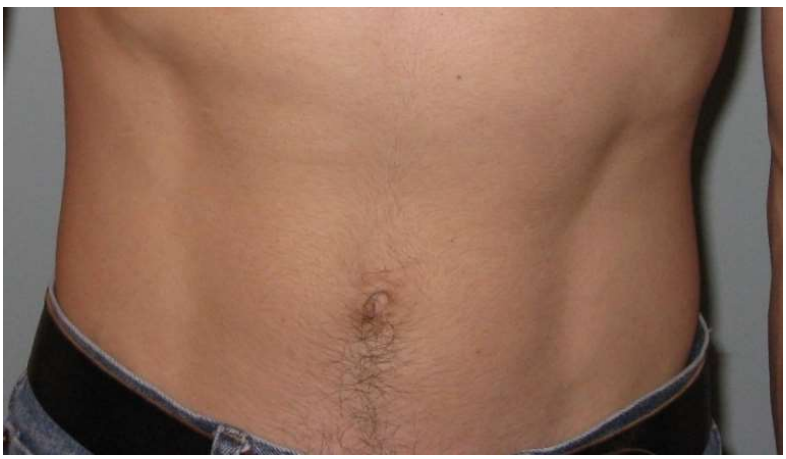
How did the therapists and medical researchers fail me? What were my underlying mental health problems?

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.

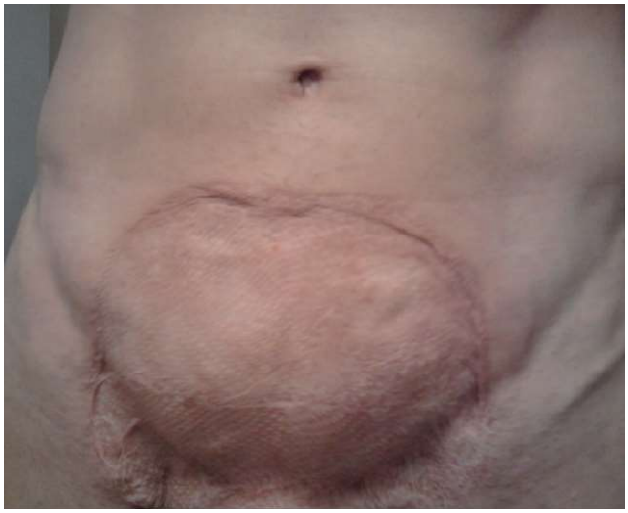
Addendum: When I was transitioning from identifying and presenting as a female back to male, male being my birth gender, I needed a means to change all my documentation from Female back to Male. Having a Phalloplasty would provide the needed document. Long story short – I asked the doctor many times 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

Jan 24, 2023

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Sincerely

Beth Bourne

North Dakota Catholic Conference

Representing the Diocese of Fargo and the Diocese of Bismarck

103 South Third Street
Suite 10
Bismarck ND 58501
701-223-2519
ndcatholic.org
ndcatholic@ndcatholic.org

To: House Human Services Committee
From: Christopher Dodson, Executive Director
Subject: House Bill 1254 - Protection of Minors from Gender Transitioning Interventions
Date: January 24, 2023

The North Dakota Catholic Conference supports the intent of House Bill 1254 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 1254, 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 1254

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 1254 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.

This bill prevents 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 1254.

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

[2] https://acpeds.org/position-statements/gender-dysphoria-in-children
[3] https://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=1&ContentID=3051

“My name is Fred J. Braun and I reside in District 13. 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.

Fred Braun

House Bill 1254 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. 1254 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.

January 24th, 2023
From: ND Psychiatric Society
Re: In Opposition to HB 1254

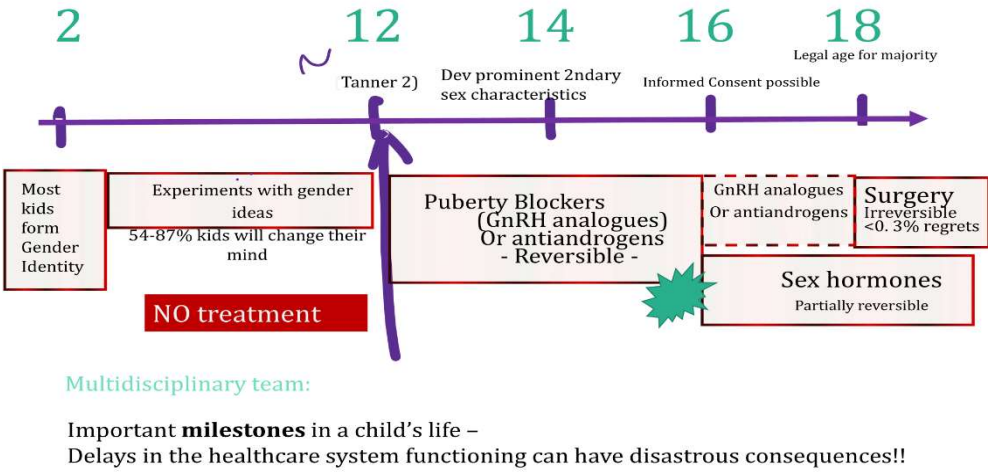
NORTH DAKOTA PSYCHIATRIC SOCIETY
A District Branch of the American Psychiatric Association

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.**



Important **milestones** in a child's life –
Delays in the healthcare system functioning can have disastrous consequences!!

*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
Assoc Clin Prof – UND School of Medicine – Behavioral Sciences and Psychiatry Dept
ND Psychiatric Society Past-President
World Professional Association Transgender Health member

Selected References:

1. Hahn A, Kranz GS, Küblböck M, et al. Structural Connectivity Networks of Transgender People. Cereb Cortex [Internet] 2015 [cited 2021 Jan 25];25(10):3527–34. Available from: https://doi.org/10.1093/cercor/bhu194

2. Hatzenbuehler ML, Pachankis JE. Stigma and Minority Stress as Social Determinants of Health Among Lesbian, Gay, Bisexual, and Transgender Youth: Research Evidence and Clinical Implications. Pediatr Clin North Am 2016;63(6):985–97.

3. Turban JL, Beckwith N, Reisner SL, Keuroghlian AS. Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. JAMA Psychiatry 2020;77(1):68–76.

4. Grossman AH, D'Augelli AR. Transgender youth and life-threatening behaviors. Suicide Life Threat Behav 2007;37(5):527–37.

- 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)

Intro: HB 1254 - Prohibition of Medical or Chemical procedure on an individual under 18

****

Distinguished Chairman Weisz, Vice Chairman Ruby, Committee Members, and other interested parties.

For the record, I am Representative Bill Tveit, District 33, Hazen. District 33 includes all of Mercer & all of Oliver County, as well as the best parts of McLean and Morton Counties.
District 33 is the Heart of Coal Country, we produce and furnish your lights, heat and air conditioning, for your comfort, on a daily basis.

I am here to introduce HB 1254, which will prohibit future Medical or Chemical procedures being administered to those under 18 years of age.

****

As a disclaimer, I AM NOT a health care professional. I AM NOT a psychologist. I AM Not an expert.
I AM, however, a concerned Grandparent, Great-grandparent, a concerned citizen, a lawmaker tasked with the protection of the innocent, our youth and our future generation, your/my future care givers.

To begin with, how many of you, your family members or acquaintances, have ever followed a trend or childhood fantasy? Maybe even researched it as best you could, then made a decision, sometimes with the advice and encouragement from trusted acquaintances, parents or professionals, only to deeply regret that decision later?

Bill Maher once said: "If kids knew what they wanted to be at age eight, the world would be filled with cowboys and princesses. I wanted to be a pirate. Thank goodness nobody took me seriously and scheduled me for eye removal and peg leg surgery."

HB 1254 is not a judgement on any group of people. HB is not an attack on the LGBTQ+ agenda or any individual. HB 1254 is not a restriction to "Health Care", as some would have us believe. HB 1254 is not about restriction of the rights of individuals.

HB 1254 is about letting our youth be youth; HB 1254 is about us being adults.

HB 1254 is about being there, for our minors, during the most vulnerable time of their innocent and formative years.

HB 1254 is about us protecting our young from irreversible harm to their body, mind and spirit

****

HB 1254 is concern about our "Trusted" Health Care System seeing Dollar Signs, seeing opportunity to cash in on this fad, and maybe cash in, again, when realization sets in and these young, vulnerable, victims have hopes for and seek the gruesome, nearly impossible, reversal procedure.

Sanford Health, the largest healthcare provider in the Dakotas, is actively promoting gender-affirming care. Sanford follows the guidelines of the World Professional Association of Transgender Health (WPATH), which is led by ideologically and financially-motivated activists, preying on our youth, who seek to circumvent parental authority, if needed, and to medically transition as many children as possible.

WPATH recently released their Standards of Care guidelines, which removed the minimum age recommendations for medical intervention, removed a chapter on ethics, and introduced a new Eunuch gender identity.

(for those who don't believe this is an issue for us in the Dakotas, please see the attached "3rd Annual Midwest Gender Identity Summit" advertisement, attached, and the Health Care company involved)

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HB 1254 is about youth like Chloe Cole, somewhat of a "Tom Boy" in her own words, a 11 year old, who began believing she was born in the wrong body. At 13, she began taking Puberty-Blockers & Testosterone, who at 16 had a double mastectomy.

The trusted adults in her life, parents, healthcare personal and others, rather than protect her in her innocence and try to help her to understand the fantasy she was believing and living, they encouraged and aided her on this path of personal physical and emotional destruction.

Chloe, now 18 today, regrets the decisions she made. She struggles with the advice and the relationships, the trust in/of those who gave that advice.

Chloe is speaking out about the path she chose, her now regret of the double mastectomy and hormone treatments to change her gender. Chloe recently said, with desperate, pleading, hope and desire that, in reality, she some day will be able to have children: "I will never be able to nurse my babies", considering what was done to her young and innocent body.

https:www.prageru.com/vidio/child-regrets-transitioning-soon-after-mastectomy-and-hormones

Chairman Weisz, Committee Members:

With all that is within your power, conscience, and ability, PLEASE send HB 1254 forward with a Do Pass Recommendation.

Please do this in defense of our innocent youth, who in their delicate, vulnerable and formative years, **depend on you**, other trusted adults and professionals, **not to exploit them,** but **to defend** & **protect** every part of their being.

It is imperative to the safety and welfare of our youth of North Dakota, those under 18, that **YOU** give HB 1254 a unanimous "**Do Pass**", sending this "Protection Bill" forward, and the message you sincerely care about their future health, wellbeing and prosperity.

I will stand for any questions.

3RD ANNUAL

MIDWEST GENDER IDENTITY SUMMIT

JANUARY 13TH, 2023 | 8:30AM-4:30PM
SANFORD RESEARCH CENTER & ONLINE

GENERAL SESSIONS:

"Transgender Cultural Competency"

"Learning to Address Implicit Bias Towards LGBTQ+ & 2S Patients"

"Lessons from Transgender Patients"

"How My Journey as a Transgender Provider Has Impacted Patient Care"

"Sanford's DE&I Patient Experience Journey"

"Creating a Gender Inclusive Practice: Improving the Patient/Provider Relationship with Practical Applications"

As a Licensed Associate Professional Counselor in North Dakota, I urge you to oppose HB 1254.

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) and LGBTQ Youth are more than 4 times as likely to attempt suicide than their peers (Johns et al., 2019; Johns et al., 2020).

This is 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 by further marginalizing this population.

I urge the committee to listen to the testimony from experts in the field, who are well versed in the standards of care for transgender individuals as the results of passing these will be costly, time consuming, and brings on increased risk for citizens, while the need for such bills in just not supported.

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. Furthermore, North Dakota stands to lose economically and in the quality of health care provided as families and health care providers will move out of state to get the care they need. This will affect the well-being of all citizens.

This 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.

North Dakota cannot afford to pass legislation that contributes to this.

I strongly urge you to oppose HB 1254.

Dear Legislators,

I am writing in opposition of HB 1254. This bill is dangerous, discriminatory, and fails to consider the scientific literature and data that guides the best practice for treating gender dysphoria.

I am a Licensed Professional Clinical Counselor in North Dakota, with nearly 10 years of experience in the field. To propose this bill under the guise of protecting youth is an insult. Access to gender affirming care is quite literally life saving. Taking away this access will cause harm. If you sincerely care about the youth in this state, as I hope most of you do, then you will have no choice but to vote DO NOT PASS on HB 1254.

I am extremely concerned about the negative implications on mental health outcomes for not only youth but all people in our state if a discriminatory bill such as this passes. Every human being deserves the right to bodily autonomy. Lawmakers have no business taking it away due to personal beliefs and fear of something they haven't taken the time to understand.

Please leave healthcare treatment to healthcare professionals.

Sincerely,

Andi Wheeler, MS, LPCC, LPC

Dear Honorable Members of the North Dakota senate,

My name is Lilly Funk, and I live in Minot, North Dakota. I am a federal employee at Head Start (as an assistant teacher). The purpose of this written testimony is to persuade members of the North Dakota senate to support HB 1254.

I am in support of this bill because it protects children from the devastating effects of gender-related medical intervention. It is imperative that this bill be passed due to the fact that there are a plethora of negative effects of this type of medical intervention including an increased risk for diabetes and heart disease in adulthood, infertility, the inability to feel sexual pleasure in adulthood, the inability to breastfeed (if the person is still able to bear children that is), the unknown risks of unnaturally prematurely ending puberty, a higher risk for cancer, blood clots, strokes, liver damage, and many more negative impacts (still being uncovered).

Thank you for considering making the moral decision and passing HB 1254.
Lilly Funk

DO PASS - HB 1254

Dear Members of the Senate Human Services Committee,

I am writing to urge a **DO PASS** on **HB 1254**.

Gender Dysphoria is an intense loathing and discomfort with one's biological sex[1] and trans ideology makes a mockery of it. People truly suffering from Gender Dysphoria deserve compassion, truth, and doctors that will help them on a path to self-love, not mutilation and sterility.

Obviously, it is wrong to mutilate the genitals of children, to chemically castrate children, and to make children sterile so they may never have their own children. Why would anyone oppose a bill banning this?

Equally as obvious is the amount of money the medical community stands to make by putting children on a path of "gender-affirming" care and creating lifelong problems that will need continual medical treatment.

We must be part of the vanguard. If we love our children, then we must stand at the forefront of this cultural war and fight for the truth – that no one can change their biological sex.

Jesus said, "Let the little children come to me, and do not hinder them, for the kingdom of God belongs to such as these." Even in my nightmares, I am unable to imagine the horrendous fate awaiting those who butcher children.

Protect our kids. Please PASS HB 1254.

Sincerely,

Mary Saxer

District 5

[1] Dr. Grossman, Matt Walsh Documentary What is a Woman?, 2022

As a mother of a transgender teen in North Dakota, I strongly oppose HB 1254. 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 1254 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.

Testimony Against Bill 1254

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 1254 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 1254, 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 1254, 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.

I am testifying against House Bill 1254.

I think we all know that this bill is not about saving children from a danger. It is about othering and discriminating against transgender people. This bill is meant to incite fear to those who are vulnerable, and inspire hatred towards them. I would like you to consider this outrageous bill from my perspective.

I am transgender. I have been on life-saving hormones since I was 17. I was suicidal, and had made active plans to kill myself. I had been in in-patient psychiatric treatment, I had tried anti-depressants and therapy. I had friends and loving family, but I was still so utterly depressed that I thought about how to kill myself daily. It was Hormone Replacement Therapy, or HRT, that saved my life. Had I not been able to find a therapist who listened, who respected me and my identity, and an endocrinologist who did the same, I would not be here to write this to you.

I am not the only one. I am not an exception. Gender Affirming Care is vital to the livelihoods of countless transgender people here in North Dakota. This bill seeks to take away not only the happiness, but the lives of others. So I ask of you, do you want to be responsible for death? Can you live with your conscious? And WHO are you protecting?

House Bill 1254

Relating to the prohibition of gender-affirming care for minors

Dear Members of the Senate Human Services Committee,

My name is Shawna Grubb and I reside in District 35. I am writing to urge a DO PASS recommendation on HB 1254 which prohibits gender-affirming care for minors.

- 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.

Thank you for your service to the people of North Dakota,

Shawna Grubb

NORTH DAKOTA ASSOCIATION OF SCHOOL PSYCHOLOGISTS
NDASP

The North Dakota Association of School Psychologists (NDASP) asks lawmakers to oppose the harmful policies outlined in the table below that target LGBTQ+ youth. These policies disallow students from using school facilities consistent with a student's gender identity; require parental consent to have a student's gender identity affirmed and acknowledged in school; mandatory parental notification when a student discloses they may be questioning their sexuality or gender identity; prohibition of classroom instruction on nonheteronormative sexual orientations and gender identities; removal of classroom materials that are inclusive of LGBTQ+ students and families; and afford protections for individuals who refuse to affirm a student's identity and punitive measures for individuals who do. The following bills are discriminatory, against best practices, and do not reflect the peace and tranquility North Dakota is known for.

Vote NAY on House Bills			**Vote NAY on Senate Bills**
HB1249 HB1254 HB1297 HB1301 HB1332	HB1333 HB1403 HB1473 HB1474 HB1488	HB1489 HB1522 HB1526	SB2199 SB2231 SB2260

These proposed bills are in direct conflict with NDASP's adopted position statement from the National Association of School Psychologists (NASP) which states that:

> Positive educational and social outcomes for all children and youth are possible only in a society—and schools within it—that guarantees **equitable treatment to all people**, regardless of race, class, culture, language, gender, gender identity, religion, sexual orientation, nationality, citizenship, ability, and other dimensions of difference (NASP, 2019).

Additionally, school psychologists are guided by an ethical code that calls for beneficence, through which they respect the rights and dignity of all persons, and nonmaleficence, which requires that they do no harm. NASP's ethical standards require school psychologists to validate and affirm a young person's authentic lived experience, value their integrity, ensure their safety, and promote their well-being (NASP, 2020b). The proposed laws would prohibit school psychologists from practicing ethically.

Our LGBTQ+ youth need our support now more than ever. Some alarming statistics from The Trevor Project 2022 Survey include:

- 45% of LGBTQ youth seriously considered attempting suicide in the past year.
- 60% of LGBTQ youth who wanted mental health care in the past year were not able to get it.
- 73% of LGBTQ youth reported experiencing symptoms of anxiety
- 58% of LGBTQ youth reported experiencing symptoms of depression

NDASP also vehemently supports the use of evidence-based practice through an ethical lens. Conversion 'therapy' is not evidence based and has been determined to be fraudulent by several states. In fact, "The present-day scientific consensus is that such practices are not only ineffective, but highly harmful and fundamentally unethical." (Conine, Campau, Petronelli, 2022). Examples of historical unethical practices used in conversion therapy include corporal punishments such as spanking and electroshock therapy, among other questionable practices. The United Nations Human Rights Council (2020) goes as far to say that these practices are not only a public health problem, but also "violate the prohibition of torture and ill-treatment." 17% of LGBTQ youth reported being threatened with or subjected to conversion therapy (The Trevor Project, 2022), which can have life-threatening effects.

Support for LGBTQ+ youth leads to better outcomes for them and society as a whole. LGBTQ+ youth report that when adults talk to them respectfully about their LGBTQ+ identity and use their names and pronouns correctly, they feel supported. Research indicates that LGBTQ+ youth are more resilient when they have supportive people in their lives. Further, LGBTQ+ youth with higher resilience are 59% less likely to attempt suicide and 69% less likely to consider suicide (The Trevor Project, 2022). NDASP supports legislative actions to increase access to mental health for all individuals, including LGBTQ+ youth.

Please join NDASP in supporting our LGBTQ+ youth by voting "nay" on the house and senate bills listed above.

Sincerely,

Alannah Valenta, PsyS, NCSP
NDASP President, on behalf of North Dakota Association of School Psychologists

References:

Conine, D. E., Campau, S. C., & Petronelli, A. K. (2022). LGBTQ+ conversion therapy and applied behavior analysis: A call to action. *Journal of Applied Behavior Analysis (55*, 6-18).

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National Association of School Psychologists. (2019). Prejudice, Discrimination, and Racism. [Position Statement].

The Trevor Project. (2022). 2022 National Survey on LGBTQ Youth Mental Health. www.thetrevorproject.org/survey-2022/assets/static/trevor01_2022survey_final.pdf

United Nations Human Rights Council. 2020, Report on Conversion Therapy, https://www.ohchr.org/en/calls-for-input/report-conversion-therapy. Accessed 27 Jan. 2023.

Dear Legislators and Committee Members,

My testimony is to ask that you give this bill a Do Not Pass.

I am a public school educator and a 29 year resident of North Dakota. This bill actively harms members of community.

Thank you for your time and consideration.

Sincerely,

Christopher Brown

HB #1254

68th Legislative Session

Senators: Boehm, Clemens, Estenson, Luick, Myrdal and Vedaa.
Representatives: Tveit, D. Anderson, Bellew, Prichard, Rohr and Van Winkle

I am writing this in opposition to HB #1254. I, like some of you, was born and raised in North Dakota. I also am a parent of a transgender person who is also a citizen of North Dakota. I am like you but with one huge difference, this bill, HB #1254, affects people I know personally. How any of you know a transgender person or have talked to a person or parent of a transgender person? While none of you know a transgender person so you have no experience to draw from, I do. I gave birth to a child who is transgender as well as know others in the State of North Dakota who are transgender. I do believe, after reading this bill, that none of you are acting in the best interests of children who are transgender, quite contrary, your on a mission to seek out and annihilate any chance of these individuals of ever becoming whole. I want to give you my personal experience since your bill clearly shows none of you have had any interactions or conversations with a transgender person or a parent who is raising a transgender child in the State of North Dakota.

I noticed very early on that my child was not a rough and tumble boy. My youngest was very feminine and at a very early age gravitated to girl items such as dolls, clothing, books and movies that my oldest child liked. This didn't alarm me, being a farm kid, I spent plenty of time playing in the sandbox with my brothers Tonka Trucks and other boy toys. My youngest continued to show interest in girl items and even though we exposed both of our kids to gender neutral things like T-ball, Taekwondo, swimming lessons and gender neutral activities, our youngest still gravitated towards items that you would consider girlie.

Later in Fifth Grade, my child later understood herself and what she was seeing in the mirror and was then able to tell me that she was a girl trapped in a boy's body. I admit that I was very upset. I am ashamed to say that my child saw the worst in her mother that day. However, I am a person who has to find answers and so I got an appointment with a counselor that very week. It's with this family counseling did we learn that my daughter was transgender. That she was finally able to articulate who she was and we had learned to do because what we were all taught by others in school, at home then was that there were only heterosexuals and homosexuals. That concept is antiquated and what we learned is that there is a spectrum to human sexuality as well as the idea that we know everything about the human body. To date we still do not know everything about the human brain, why a body can cure itself of a disease, but we do know that Science is a living thing, and it is always evolving as well as human language.

Our journey took us to Mayo Clinic after a period of once a week counseling. At Mayo Clinic in Rochester, MN, that is where the team of doctors and nurses, psychiatrist looked at my child. We then sat down and discussed what the team concluded. My child is transgender. I asked how this happened and it was explained to us that it happens in utero; the body forms first, the brain then forms but it is during this stage of gestation is when it is thought that the mother's body has an unexplained surge of hormones which disrupts the brain formation and thus the brain forms the opposite gender than what

the body had already been assigned. This isn't a choice but in fact something that happens and has happened since the beginning of time. Transgender is not a fad, it is not new and nor is it a choice. What transgender means an individual's body and brain not being in synch with each other. The doctors told me that under an MRI image, my daughter's brain is that of a female. Male brains are physically built different than females and those differences can be seen using MRI imaging.

HB #1254 targets people who are born differently. HB #1254 ostracizes transgender people from others who are born as CIS individuals. CIS is the term used to describe people who identify with the gender they were born as.

My child has been treated under medical supervision, and she is a happy person. If her treatment and care had been kept from her more than likely I would only have one daughter with me today. My daughter DOES NOT have the male muscle mass nor did she ever seek to be an athlete. My daughter just wants to enjoy life and be the happy female she is identifies with as I do and as you do. The treatments and medication help the minor child until the age of 18 and it is then and only then that any surgery can be discussed and undergone. There is NO REASON for the State of North Dakota to intervene with transgender care whatsoever.

This bill does put citizens of North Dakota, who are already dealing with a very hard situation because of the bigotry and hatefulness that CIS individuals doll out, but this is adding a whole new level of distress. What happened to parents' rights? Do you think you know my daughter better than I do? Are you living with these transgender people, do you hear their concerns and fears or struggles? No, none of you know any of these. What the authors of this bill do concern themselves with is the false narrative that the news media like Fox News, social media like Facebook and the religious radicals have to say. Where do these entities glean their expertise from? Gossip pages on Facebook, Tucker Carlson or a religious leader who knows nothing but what they read from the foresaid false narrative spinners?

If any of you really were interested in doing what is best for the transgender youth in North Dakota, you would seek out time with the doctors who treat these individuals. You also would want to talk to the transgender community. How many of you have done that? I daresay none of you. What are you scared of? What harm has a transgender person ever done to any of you? Yet you posed to set in motion a bill that would tell this very small group in North Dakota that they can't seek help to become whole, that their doctor can be penalized for treating them. How many of you are doctors? What do you know of what the doctors do and their process or steps that transgender people have to go through to become complete? The blockers are reversable. The hormones are given after only a criterion has been met. Parent(s) and transgender person must both agree to go forward with blockers before they are given. So why do you, as authors and supporters of this bill, think you know best? Remember your interaction with the transgender community is nonexistent.

If you deny treatment for this group of individuals, then who is next? These people are born this way, by no fault of their own. So, in keeping pace with thought process with this bill and knowing who your target group is, anyone born with a discrepancy should be denied care or treatment. That means those who are born with any abnormalities, because isn't that how God made them? Also, then why allow anyone treatment for anything? After all isn't it God's will that a person develop cancer, have a heart

attack, suffer a stroke, I can go on and on. Why is anyone then allowed medical treatment if you want to say it is God's will?

I grew up Catholic. I have experienced many different religions and backgrounds of others having lived in other states as well. How I view HB #1254 it is a bill that is targeting transgender people so they can't receive life affirming care, to make these individuals a non-issue in your mind. Why not make a law then to prevent young girls and their parents from seeking breast enlargement surgery? Why not make a bill that would outlaw anyone who has acne issues from going to a dermatologist and seeking derma treatments because after all, isn't that how God made them? No acne medication, also no medication at all since that is how our Lord and Savior created us, right? I ask you how many of you have had medical attention in the past? Why, isn't that illness, disease or maybe even body deficit the way God made you?

This bill is hypothetical and very much like what Hitler did do the Jews. I am sure all you know what Hitler did, he tormented the Jews. He removed every bit of humanity from them, then tried to erase them from existence. Is that your plan here? Is your vision for North Dakota to become a state that is eventually an Aryan state? That's the direction that this bill is going.

HB #1254 lacks any Christ like characteristic that Jesus would show transgender people. Christ embraced those who were considered cast outs. Jesus had empathy, compassion and love for those who were marginalized. Jesus sought to help and care for those who were suffering. This bill has none of those qualities and nor did the authors and supporters of this bill intend to have this bill offer any of what Christ taught.

I strongly challenge you all to sit back and really think of your motives and what direction these motives will take the State of North Dakota. Do you really want North Dakota to be known as a state that hates individuals and discounts those who are marginalized? How did that work out for Hitler? Don't pass a vote that affects people and causes harm to those whom you don't know. Step out of your comfort zone, examine yourselves, your motives and open yourself to the fact that what modern Science, 21st Century Science, proves is that the world isn't black and white, that what we were taught was wrong, the world is not flat as what once was thought, and that people who are transgender are born this way. The false narrative is that this is a choice or that this is a way to erase CIS female from sports is laughable and shows how little the authors of these bills and supporters know about the topic.

I encourage you to vote DO NOT PASS on HB #1254. Anything else is a hate bill and sends the wrong message to the citizens of North Dakota. You owe it to the transgender community and their families to seek knowledge and first hand experiences from these individuals . It is only then that you can say you are doing the citizens of North Dakota due diligence.

Thank you,
Kristie Miller
Parent of Transgender

Testimony on HB 1254

I urge you to vote no – do not pass – on this interference with parenting and private, intensely personal medical issues. You should not pass legislation attacking residents of this state to force them to fit into your opinion of "normal." Leave such decisions up to medical professionals and parents, who support their child struggling with gender identity. Such surgeries are not performed on minors, so this is a hot-button non-issue inspired by a Florida politician. Focus on issues of importance to North Dakotans and hands off legislating medical practices.

Testimony HB 1254

Dear Members of the Senate Human Services Committee,

My name is Sheila Glaser and I am a registered voter from District 7. I am asking for a DO PASS on HB 1254. Never would I have thought this would be an issue in North Dakota or the United States of America. If a minor is not to smoke a cigarette prior to age 18, deemed rape if having sex prior to age 18, and cannot drink alcoholic beverages prior to 21 due to the development of the brain; why on God's green earth, would we allow a minor to make a life altering, irreversible decision. My mind cannot wrap around why anyone would support such irreversible actions to a human being that doesn't have "water under the bridge"? Life can have its uncertainties and its hurts through all ages, so taking advantage of a young mind is just wrong. The struggle they are in may need a shoulder to lean on; but I do not see how the introduction of a gender change could even enter into the discussion as a solution. PLEASE PASS HB 1254!

I would like to share a letter my colleague recently wrote to a legislator that sponsored this bill. I was shocked to see the lack of education our representatives hold on the top of Trans Medicine. Since her job position does not allow her a public voice, I would like to share her response to our unfortunately misguided legislator. I have included references for your convenience.

Firstly, the notion that banning transgender medicine is a form of protection for youth 18 and under is inaccurate. Transgender medicine, including hormone therapy and gender-affirming surgeries, has been shown to significantly improve the quality of life and mental health outcomes for transgender youth. Banning these treatments denies them access to essential care and places them at a higher risk for depression, anxiety, and suicide.

Secondly, the claim that "trans youth 7 out of 9 times will regret this decision later" is unfounded and unsubstantiated. The research on regret among transgender individuals is complex and varies depending on a variety of factors, including age, support networks, and access to medical care. However, studies have consistently shown that the majority of transgender individuals who undergo gender-affirming treatments experience significant improvements in their mental health and overall well-being.

Furthermore, it is important to note that medical decisions regarding transgender youth should be made on an individual basis, in consultation with medical professionals and the youth themselves, rather than being dictated by a blanket ban. Banning transgender medicine not only denies necessary care to those who need it but also perpetuates harmful stigmatization and discrimination against the transgender community.

In conclusion, transgender medicine should not be banned as it is essential for the well-being and health of transgender youth. Decisions regarding medical care should be based on individual needs and informed by medical professionals. Claims of regret among transgender individuals are unsubstantiated, and denying care based on these false assumptions is harmful and discriminatory.

References

A systematic review and meta-analysis of 19 studies found that gender-affirming hormone therapy was associated with a significant reduction in depressive symptoms and anxiety among transgender individuals (Radix et al., 2019).

A study of 871 transgender individuals found that those who had undergone gender-affirming surgery had a significant decrease in their odds of experiencing psychological distress (De Cuypere et al., 2006).

A longitudinal study of 103 transgender youth found that those who received gender-affirming medical care had better mental health outcomes and reported higher life satisfaction than those who did not receive such care (Olson et al., 2016).

References:

De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., & Monstrey, S. (2006). Sexual and physical health after sex reassignment surgery. Archives of Sexual Behavior, 35(6), 669-677.

Olson, J., Schrager, S. M., Belzer, M., Simons, L. K., & Clark, L. F. (2016). Baseline physiologic and psychosocial characteristics of transgender youth seeking care for gender dysphoria. Journal of Adolescent Health, 59(4), 491-496.

Radix, A., Sevelius, J., Deutsch, M. B. (2019). Transgender women, hormonal therapy and HIV treatment: a comprehensive review of the literature and recommendations for best practices. Journal of the International AIDS Society, 22(1), e25201.

I would like to submit my opposition to this bill and request a no vote on this measure. I am a physician, and healthcare executive for the largest provider of pediatric and adult subspecialty care in the state of North Dakota. I am also the parent of a transgender son.

Gender affirming care is medically accepted and appropriate care for children that need this care. Like all medical care it should not be entered into lightly. It is collaborative and the decision should be left up to patients, parents in conjunction with their physicians. This care is no less important than providing care for diabetes, thyroid, or adrenal diseases. These are all cases that pediatric endocrinologists treat.

Making medically proven care that improves the quality of life for children with gender dysphoria a criminal action is unconscionable. If enacted North Dakota will likely lose such specialists, and perhaps many more fearful of a state that would seek to control the practice of medicine in such a way. This will harm many children across the state.

I understand the discomfort that people may have with transgender people, and believe me my wife and I struggled to understand this in my son, it was something we never expected. However, seeing our son happy, feeling the best he has in years and a productive health adult is a joy. Having, him feel it is not comfortable to live in North Dakota is a disappointment.

Please, don't listen to misinformation and inflammatory comments on transgender agenda. Vote no on this measure. Listen to medical experts, show compassion for all children and families in this state, even if you don't understand them all.

Thank you for reading,

Doug Griffin, MD
Vice President Sanford Clinic-Fargo

To My Fellow North Dakotans,

My name is Jessica, and I was born and raised right here in North Dakota. One of my grandfathers helped to build many of the buildings you'll see all around Bismarck. My other grandfather owned the barber shop on Main Street in Mandan for nearly forty years. As a child, I roamed around Mandan, visiting the library, getting a cookie from the bakery, and enjoying that small town feeling. A feeling of being protected, cared for, even by neighbors who didn't know me. And that is what North Dakota is to me. A place where we take care of each other, and treat each other with fairness and kindness, regardless of the other person's characteristics. Like the Good Samaritan in my Sunday school classes, I have always imagined my home state as a place that could show empathy and understanding towards everyone, even if they were different.

Fast forward to now, thirty years later, and all those beliefs I have held in my heart are being challenged by not only this legislation, but all the other agenda items of a similar nature. All these items are targeting people who are percieved as different, as "other", as "not like us." Where are the Good Samaritans now? Where is the compassion that surpasses understanding?

There are those who claim this is all about protecting children. But how much do they actually know about any of this? Have they actually talked to a parent of a trans child? Have they talked to a trans youth about their experiences, or feelings, or even the process of what they are going through?

This brings us to the testimony I am actually bringing you today-my son's. This bill is personal to me, not only as someone who loves her state and knows that this is not who we are. This bill is personal to me as the mother of a trans child. Someone who has been through this process-which was done carefully and cautiously and took years. Someone who has watched her dearly loved child struggle and fight for the simple right to be who he is. I wanted to allow him to have a chance to have his voice heard; ultimately, this decision will affect him and those like him far more than it would affect anyone else. And he deserves to be heard.

"Good day, everyone who is either hearing or reading this. I am a transgender man aged fourteen, turning fifteen in July. I attend high school as a freshman and have been taking testosterone for about 630 days as of writing this, almost two years. Contrary to some people's belief, this has not affected me negatively. In fact, my mental health has improved drastically since beginning testosterone. I'm an honour roll A student, excelling in all of my classes, and all of my teachers say I'm a pleasure to have in class. The only difference between me and the average valedictorian is that I am transgender. This poses a problem to many people- I do not cause disruptions in class, I get my work done, and I usually don't talk to many other people. Yet, I find myself harassed to some degree almost every day I come to school, to the point of not wanting to come to school despite my love of learning. For me to be taken off hormones, and for some of these other bills to pass, would mean destroying my whole life and wellbeing even though I am just a kid trying to live his life.

As for the perceived concerns, there is proven research describing that hormone replacement treatment is safe. No child is going on actual hormones until they are at least a teenager, and even then, they must go through many appointments to get hormone replacement treatment. In my case, it took two years of gender exploration, six months of speaking to a medical health professional, being diagnosed with gender dysphoria, and then another two weeks of waiting to get my first shot of testosterone. Even then, my doctor had me sign a multiple-page agreement after reading it aloud, describing the effects it would and could cause. People, and youth, are not being thrown into this blind as some may describe. All are made aware of the risks, and many of them are small risks- none of the negative effects described to me has shown in my journey. Along with that, transgender youth are not being "forced to get surgeries". In fact, I'm incapable of getting surgery until I'm sixteen, and that's with parental permission, just like plastic surgery, tattoos, or any similar body modification.

It would mean the world for me, and many other transgender youths I know, for these bills to be rejected, and more transgender-safe bills to be proposed. For some, it may mean the difference between life and death. The National Institute of Health states 'Data indicates that 82% of transgender individuals have considered killing themselves and 40% have attempted suicide, with suicidality highest among transgender youth.' And the suicide rate isn't that high because we're transgender, it is because society refuses to accept us.

Thank you for your time, and I hope this letter persuades you to reconsider your decision."

And I hope that my son's words have given you some insight into the life of a transgender youth, and I encourage you to think long and hard about the future of our state. We have always been a state with the courage of Teddy Roosevelt and his Roughriders. A state of harmony and compassion to our neighbors, the Peace Garden state. Are we a state that allows the fear of "otherness" to betray these values? Or can we stand proud and say that hate and fear do not belong here?

Thank you for your consideration; I will be praying that you make the right decision.
Jessica R. Babin

Dear legislators,

I write to you as a transgender individual who has received treatment to help me transition in North Dakota. I will stress this as much as I can. Providing treatment for individuals who need to transition saves lives. If I may get personal, I was extremely suicidal and depressed before I realized that I had meant to be a man my whole life; everything I had done aligned with masculine energy. After years of therapy and doctors, I was able to start testosterone! My first shot was probably one of my best days ever. I felt like after all that time being uncomfortable in my own body, things were gonna finally start feeling right like they should. And they did. I have never been more content with who I am. These doctors know what they're talking about, they wouldn't be doctors if they didn't. Treating transgender patients saves lives, we risk medical neglect and loss of lives if we ignore their pain.

I receive treatment in North Dakota as a transgender patient, and I am in opposition of HB1254.

Thank you,
Oliver G Jensen
Fargo, ND

March 11, 2023

Dear Chair Lee and members of the Senate Human Service Committee

I respectfully ask that you give HB 1254 a DO NOT PASS recommendations.

My name is Luis Casas. I am one of two pediatric endocrinology specialists in the state of North Dakota. Although I was not born or raised in Kindred, North Dakota, I have been a proud resident for the past 10 years. My wife was born and raised in North Dakota and serves as the only medical geneticist in North Dakota. My training after medical school included four years of a combined pediatric and internal medicine residency and an additional four year combined pediatric and adult endocrine fellowship. After completion of my training, I became boarded in all four specialties that included Pediatrics, Internal Medicine, Pediatric Endocrinology and Endocrinology & Metabolism (Adult endocrinology). Upon graduation from medical school, I swore to the Hippocratic Oath (an oath of ethics) to first do no harm. As a practicing endocrinologist, I am trained to follow the research backed guidelines and standards of care by reputable medical societies that include the Endocrine Society, American Association of Clinical Endocrinology and the Pediatric Endocrine Society.

An endocrinologist has specialized training in the field of medicine that studies conditions related to hormones, including the hormone treatments of adolescents with gender dysphoria. Hormone treatments for gender dysphoria that includes hormones to suppress puberty, hormone blockers and hormone replacements (cross hormone therapy) have been extensively studied and are part of the recommendations endorsed by the World Professional Association for Transgender Health and supported by the aforementioned endocrine medical societies.

Gender dysphoria is a condition where a person experiences discomfort or distress because there is a mismatch between their biological sex and gender identity. Being transgender is not a disorder and is not a condition I am treating; I am involved in the treatment of gender dysphoria. Pediatric endocrinologist treatment of mental health disorders with hormones is not new. Since the 1950's, we have been treating height dysphoria (a type of body image anxiety disorder) with growth hormone to affect the growth and final height of children and adolescent who are short, distressed about their height and seek treatment to alleviate their mental distress. We also use hormones to treat adolescent girls with polycystic ovarian syndrome who are distressed by unwanted facial hair growth and severe acne that comes from excessive androgen hormones. The hormone treatment for gender dysphoria is similar in concept, but more complex because of the social stigma of this disorder.

Gender dysphoria can be present as early as two years of age and can present at anytime during childhood. However, only about 30% of all children who present with symptoms of gender dysphoria in childhood (before entering puberty) will go on to have gender dysphoria as adolescents and adults and ultimately transition to a different gender. It is for this reason that hormone therapy or pubertal blockers play no role in the treatment of pre-pubertal children. Despite what you may hear from supporters of this Bill, pediatric endocrinologists DO NOT treat pre-pubertal children with any hormone therapy; it simply does not make sense to do so and is not in the recommended guidelines.

In prior testimonies, there are claims that young or pre pubertal children are being treated with pubertal suppression drugs and that the drugs have deleterious and irreversible effects. -First, when an

adolescent enters puberty the symptoms of gender dysphoria will either go away or intensify along with symptoms of increasing anxiety and depression. It is that 30% whose symptoms intensify who are the focus of my care. The rest will NOT go on to receive endocrine or hormone care. For those younger adolescents who have clinically entered puberty and whose dysphoria has intensified, pubertal hormone blockers are offered but NOT hormone affirmation treatment (cross hormones). Pubertal hormone blockers are meant to put "a pause" on puberty to give that adolescent time to work closely with their parents and behavioral health providers to explore their gender experience. After a few years of hormone therapy, some may decide to not move forward with hormone transition and pubertal blockers can be stopped. These adolescents will resume puberty normally and there would be no permanent adverse effects of their treatment to "pause puberty" (It is fully reversible). For those who continue to experience gender dysphoria and reach an age where hormone transition is appropriate, hormone affirmation treatment options are then considered. Of note, pubertal suppression treatment is also a standard of care used for children with premature or early puberty (for which >95% of pubertal blockers is used in children) and yet we don't hear concerns of these treatments in this group of children who receive the same medications. Hormone blockers which is different than that of pubertal blockers are also used in the care of gender dysphoria to block the feminizing effects of natural estrogen or the masculinizing effects of natural testosterone. Use of hormone blockers do not affect estrogen or testosterone levels (we simply block the hormone affects, rather than block the hormone's productions). This treatment is also fully reversible and once the medications are stopped, the hormones will no longer be blocked and its effects on the body will continue.

Before an adolescent is offered hormone affirmation treatment, they must first have an evaluation by a mental health provider experienced in the area of gender health who must state that this adolescent meets the Diagnostic and Statistical Manual of Mental Health (DSM-5) criterial for gender dysphoria and that the gender dysphoria has been long lasting. They must show that the adolescents' general / overall mental health is reasonably well controlled and that they can have the capacity to make an informed consent. Finally, their parent or legal guardian must be involved in their care and able to consent to treatment. Under no circumstance is an adolescent treated with hormone affirmation therapy without the involvement of a mental health provider and their explicit recommendations for treatment. As an endocrinologist, we must also believe that treatment with hormones is in their best interest. Many adolescents do not receive treatment with hormones if we deem that the treatment is unlikely to alleviate their gender dysphoria (such as an adolescent who may identify has gender fluid or non-binary and has no strong desire to be either masculine or feminine).

Other arguments by those favoring this Bill include treatments that result in "chemical" or surgical "castration". The fact is that the use of hormone affirmation treatment (cross hormones) or pubertal suppression makes them temporarily infertile. This is to adolescent girls who are treated with birth control pills. Infertility in the first 10 years of treatment is considered reversible in the same way that stopping birth control pill would restore fertility. The risk of infertility increases with long term use of cross hormone therapy which takes many years of treatment and only in those who as adults, chose to continue cross hormone therapy. Regarding surgical hysterectomy or orchiectomy (removal of testicles), these surgical treatments are NOT recommended before the age of 18 years and have NOT occurred in North Dakota for treatment of gender dysphoria.

As a pediatric and adult endocrinologist, I also have the unique experience of seeing first-hand the transition from distressed adolescents to happy and successful adults. I see many adolescents presenting with significant depression, anxiety and suicidal thoughts who are struggling with school and friendships because of their gender dysphoria. After undergoing treatments that include behavioral

health therapy and hormone affirmation therapy, they go on to succeed in college and/or productive jobs and long-term relationships.

Finally, I have heard by oral and written testimony by many favoring this Bill that this Bill is intended to "protect our children". Once again, we are not treating being transgender, we are treating the mental health disorder of gender dysphoria that increases risk for self-harm and death through suicide. How are we protecting these adolescents by removing the treatments that alleviate their gender dysphoria and reducing their risk of suicide (proven effect of treatment)? We are in fact hurting our adolescents by removing the proven treatments that alleviates their distress.

To truly protect our children, I urge you to give this Bill a DO NOT PASS.

Thank you for your time,

Luis Casas, MD
Pediatric and Adult Endocrinologist

AACAP Statement Responding to Efforts to ban Evidence-Based Care for Transgender and Gender Diverse Youth

November 8, 2019

Variations in gender expression represent normal and expectable dimensions of human development. They are not considered to be pathological. Health promotion for all youth encourages open exploration of all identity issues, including sexual orientation, gender identity, and/or gender expression according to recognized practice guidelines (1, 2). Research consistently demonstrates that gender diverse youth who are supported to live and/or explore the gender role that is consistent with their gender identity have better mental health outcomes than those who are not (3, 4, 5).

State-based legislation regarding the treatment of transgender youth that directly oppose the evidence-based care recognized by professional societies across multiple disciplines is a serious concern. Many reputable professional organizations, including the American Psychological Association, the American Psychiatric Association, the American Academy of Pediatrics, and the Endocrine Society, which represent tens of thousands of professionals across the United States, recognize natural variations in gender identity and expression and have published clinical guidance that promotes nondiscriminatory, supportive interventions for gender diverse youth based on the current evidence base. These interventions may include, and are not limited to, social gender transition, hormone blocking agents, hormone treatment, and affirmative psychotherapeutic modalities.

The American Academy of Child and Adolescent Psychiatry (AACAP) supports the use of current evidence-based clinical care with minors. AACAP strongly opposes any efforts – legal, legislative, and otherwise – to block access to these recognized interventions. Blocking access to timely care has been shown to increase youths' risk for suicidal ideation and other negative mental health outcomes. Consistent with AACAP's policy against conversion therapy (2), AACAP recommends that youth and their families formulate an individualized treatment plan with their clinician that addresses the youth's unique mental health needs under the premise that all gender identities and expressions are not inherently pathological.

1. Adelson, S. L., & the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 51, 957– 974. http://dx.doi.org/10.1016/j.jaac.2012.07.004.
2. American Academy of Child and Adolescent Psychiatry (AACAP) Sexual Orientation and Gender Identity Issues Committee. (2018). Conversion Therapy Policy Statement. Retrieved from: https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.
3. Olson KR, Durwood L, DeMeules M, McLaughlin KA. (2016). Mental health of transgender children who are supported in their identities. Pediatrics, 137(3).

4. Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. (2010) Family acceptance in adolescence and the health of LGBT young adults. J Child Adolesc Psychiatr Nurs., 23(4):205–213.
5. Substance Abuse and Mental Health Services Administration, A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children. (2014). HHS Publication No. PEP14-LGBTKIDS. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from: https://store.samhsa.gov/system/files/pep14-lgbtkids.pdf.

Jared J Solomon M.D.

March 14, 2023

House Human Services Committee
HB1254

Chairman Weisz and Committee Members,

My name is Jared Solomon. I am a Board Certified Child and Adolescent Psychiatrist licensed by the state of North Dakota. I am writing to state my opposition to this bill as supported by myself, my professional association the American Association of Child and Adolescent Psychiatrists (AACAP) and the North Dakota Medical Association.

The provisions of this bill would not allow me to provide evidence-based care to children experiencing normal development both physically, and emotionally. When children and adolescents do not receive the best care that modern medicine has evidence for, we compound the financial and productivity burdens on the state that can be prevented. Early access while symptoms are milder have a proven return on investment (1).

I have also supplied the position statement of AACAP as additional testimony in opposition to HB1254.

I also wish to lodge protest to making this bill an emergency measure. The circumstances and timing of this bill are ones of political choice by the sponsors and run counter to the actual need in the current declared child mental health crisis and emergency passage would serve to worsen the crisis by speeding the criminalization of a good investment in our population's mental health.

I request you DO NOT PASS this bill. Thank you for your consideration of my testimony.

Sincerely,

Jared J Solomon M.D.

1. Stelmach R, Kocher EL, Kataria I, et alThe global return on investment from preventing and treating adolescent mental disorders and suicide: a modelling studyBMJ Global Health 2022;7:e007759

I am writing in opposition of House Bill 1254. I ask that you give this bill a Do Not Pass.

As an advocate for suicide prevention in our state, I feel this legislation is discriminatory and does not reflect the values of inclusion and compassion that our state should represent. Our transgender community is already at a much higher risk for suicide and self-harm and this bill will only increase that risk by denying them access to gender affirming care. This bill is also a huge government overreach into the doctor-patient relationship as well as the parent-child relationship.

Transgender people deserve to live as themselves in a state that respects and supports them.

Please oppose HB 1254.

Thank you,
Brenda Weiler

The BMJ
jblock@bmj.com
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BMJ INVESTIGATION

Gender dysphoria in young people is rising—and so is professional disagreement

More children and adolescents are identifying as transgender and are being offered medical treatment, especially in the US—but some providers and European authorities are urging caution because of a lack of strong evidence. Jennifer Block reports

Jennifer Block *investigations reporter*

Last October the American Academy of Pediatrics (AAP) gathered inside the Anaheim Convention Center in California for its annual conference. Outside, several dozen people rallied to hear speakers including Abigail Martinez, a mother whose child began hormone treatment at age 16 and died by suicide at age 19. Supporters chanted the teen's given name, Yaeli; counter protesters chanted, "Protect trans youth!" For viewers on a livestream, the feed was interrupted as the two groups fought for the camera.

The AAP conference is one of many flashpoints in the contentious debate in the United States over if, when, and how children and adolescents with gender dysphoria should be medically or surgically treated. US medical professional groups are aligned in support of "gender affirming care" for gender dysphoria, which may include gonadotrophin releasing hormone analogues (GnRHa) to suppress puberty; oestrogen or testosterone to promote secondary sex characteristics; and surgical removal or augmentation of breasts, genitals, or other physical features. At the same time, however, several European countries have issued guidance to limit medical intervention in minors, prioritising psychological care.

The discourse is polarised in the US. Conservative politicians, pundits, and social media influencers accuse providers of pushing "gender ideology" and even "child abuse," lobbying for laws banning medical transition for minors. Progressives argue that denying access to care is a transphobic violation of human rights. There's little dispute within the medical community that children in distress need care, but concerns about the rapid widespread adoption of interventions and calls for rigorous scientific review are coming from across the ideological spectrum.[1]

The surge in treatment of minors

More adolescents with no history of gender dysphoria—predominantly birth registered females[2]—are presenting at gender clinics. A recent analysis of insurance claims by Komodo Health found that nearly 18 000 US minors began taking puberty blockers or hormones from 2017 to 2021, the number rising each year.[3 4] Surveys aiming to measure prevalence have found that about 2% of high school aged teens identify as "transgender."[5] These young people are also more likely than their cisgender peers to have concurrent mental health and neurodiverse conditions including depression, anxiety, attention deficit disorders, and autism.[6] In the US, although Medicaid coverage varies by state and by treatment, the Biden administration has warned states that not covering care is in violation of federal law prohibiting discrimination.[7] Meanwhile, the number of private clinics that focus on providing hormones and surgeries has grown from just a few a decade ago to more than 100 today.[4]

As the number of young people receiving medical transition treatments rises, so have the voices of those who call themselves "detransitioners" or "retransitioners," some of whom claim that early treatment caused preventable harm.[8] Large scale, long term research is lacking,[9] and researchers disagree about how to measure the phenomenon, but two recent studies suggest that as many as 20-30% of patients may discontinue hormone treatment within a few years.[10 11] The World Professional Association for Transgender Health (WPATH) asserts that detransition is "rare."[12]

Chloe Cole, now aged 18, had a double mastectomy at age 15 and spoke at the AAP rally. "Many of us were young teenagers when we decided, on the direction of medical experts, to pursue irreversible hormone treatments and surgeries," she read from her tablet at the rally, which had by this time moved indoors to avoid confrontation. "This is not informed consent but a decision forced under extreme duress."

Scott Hadland, chief of adolescent medicine at Massachusetts General Hospital and Harvard Medical School, dismissed the "handful of cruel protesters" outside the AAP meeting in a tweet that morning. He wrote, "Inside 10 000 pediatricians stand in solidarity for trans & gender diverse kids & their families to receive evidence-based, lifesaving, individualized care."[13]

Same evidence, divergent recommendations

Three organisations have had a major role in shaping the US's approach to gender dysphoria care: WPATH, the AAP, and the Endocrine Society (see box). On 15 September 2022 WPATH published the eighth edition of its Standards of Care for the Health of Transgender and Gender Diverse People, with new chapters on children and adolescents and no minimum age requirements for hormonal and surgical treatments.[2 12] GnRHa treatment, says WPATH, can

be initiated to arrest puberty at its earliest stage, known as Tanner stage 2.

The Endocrine Society also supports hormonal and surgical intervention in adolescents who meet criteria in clinical practice guidelines published in 2009 and updated in 2017.[14] And the AAP's 2018 policy statement, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, says that "various interventions may be considered to better align" a young person's "gender expression with their underlying identity."[15] Among the components of "gender affirmation" the AAP names social transition, puberty blockers, sex hormones, and surgeries. Other prominent professional organisations, such as the American Medical Association, have issued policy statements in opposition to legislation that would curtail access to medical treatment for minors.[16-19]

These documents are often cited to suggest that medical treatment is both uncontroversial and backed by rigorous science. "All of those medical societies find such care to be evidence-based and medically necessary," stated a recent article on transgender healthcare for children published in *Scientific American*.[20] "Transition related healthcare is not controversial in the medical field," wrote Gillian Branstetter, a frequent spokesperson on transgender issues currently with the American Civil Liberties Union, in a 2019 guide for reporters.[21] Two physicians and an attorney from Yale recently opined in the *Los Angeles Times* that "gender-affirming care is standard medical care, supported by major medical organizations . . . Years of study and scientific scrutiny have established safe, evidence-based guidelines for delivery of lifesaving, gender-affirming care."[22] Rachel Levine, the US assistant secretary for health, told National Public Radio last year regarding such treatment, "There is no argument among medical professionals."[23]

Internationally, however, governing bodies have come to different conclusions regarding the safety and efficacy of medically treating gender dysphoria. Sweden's National Board of Health and Welfare, which sets guidelines for care, determined last year that the risks of puberty blockers and treatment with hormones "currently outweigh the possible benefits" for minors.[24] Finland's Council for Choices in Health Care, a monitoring agency for the country's public health services, issued similar guidelines, calling for psychosocial support as the first line treatment.[25] (Both countries restrict surgery to adults.)

Medical societies in France, Australia, and New Zealand have also leant away from early medicalisation.[26,27] And NHS England, which is in the midst of an independent review of gender identity services, recently said that there was "scarce and inconclusive evidence to support clinical decision making"[28] for minors with gender dysphoria[29] and that for most who present before puberty it will be a "transient phase," requiring clinicians to focus on psychological support and to be "mindful" even of the risks of social transition.[30]

Box: The origins of paediatric gender medicine in the United States

The World Professional Association for Transgender Health (WPATH) began as a US based advocacy group and issued the first edition of the Standards of Care in 1979, when it was serving a small population of mostly adult male-to-female transsexuals. "WPATH became the standard because there was nobody else doing it," says Erica Anderson, a California based clinical psychologist and former WPATH board member. The professional US organisations that lined up in support "looked heavily to WPATH and the Endocrine Society for their guidance," she told *The BMJ*.

The Endocrine Society's guidance for adolescents grew out of clinicians' research in the Netherlands in the late 1990s and early 2000s. Peggy Cohen-Kettenis, a Utrecht gender clinic psychologist, collaborated with endocrinologists in Amsterdam, one of whom had experience of prescribing gonadotrophin releasing hormone analogues, relatively new at the time. Back then, gender dysphoric teens had to wait until the age of majority for sex hormones, but the team proposed that earlier intervention could benefit carefully selected minors.[40]

The clinic treated one natal female patient with triptorelin, published a case study and feasibility proposal, and began treating a small number of children at the turn of the millennium. The Dutch Protocol was published in 2006, referring to 54 children whose puberty was being suppressed and reporting preliminary results on the first 21.[41] The researchers received funding from Ferring Pharmaceuticals, the manufacturer of triptorelin.

In 2007 the endocrinologist Norman Spack began using the protocol at Boston Children's Hospital and joined Cohen-Kettenis and her Dutch colleagues in writing the Endocrine Society's first clinical practice guideline.[42] When that was published in 2009, puberty had been suppressed in just over 100 gender dysphoric young people.[40]

American Academy of Pediatrics (AAP) committee members began discussing the need for a statement in 2014, four years before publication, says Jason Rafferty, assistant professor of paediatrics and psychiatry at Brown University, Rhode Island, and the statement's lead author. "The AAP recognised that it had a responsibility to provide some clinical guidance, but more importantly to come out with a statement that said we need research, we need to integrate the principles of gender affirmative care into medical education and into child health," he says. "What our policy statement is not meant to be is a protocol or guidelines in and of themselves."

"Don't call them evidence based"

"The brief history of guidelines is that, going back more than 30 years ago, experts would write articles and so on about what people should do. But formal guidelines as we think of them now were seldom or non-existent," says Gordon Guyatt, distinguished professor in the Department of Health Research Methods, Evidence, and Impact at McMaster University, Ontario.

That led to the movement towards developing criteria for what makes a "trustworthy guideline," of which Guyatt was a part.[31] One pillar of this, he told *The BMJ*, is that they "are based on systematic review of the relevant evidence," for which there are also now standards, as opposed to a traditional narrative literature review in which "a bunch of experts write whatever they felt like using no particular standards and no particular structure."

Mark Helfand, professor of medical informatics and clinical epidemiology at Oregon Health and Science University, says, "An evidence based recommendation requires two steps." First, "an unbiased, thorough, critical systematic review of all the relevant evidence." Second, "some commitment to link the strength of the recommendations to the quality of the evidence."

The Endocrine Society commissioned two systematic reviews for its clinical practice guideline, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*: one on the effects of sex steroids on lipids and cardiovascular outcomes, the other on their effects on bone health.[32,33] To indicate the quality of evidence underpinning its various guidelines, the Endocrine Society employed the GRADE system (grading of recommendations assessment, development, and evaluation) and judged the quality of evidence for all recommendations on adolescents as "low" or "very low."

Guyatt, who co-developed GRADE, found "serious problems" with the Endocrine Society guidelines, noting that the systematic reviews

didn't look at the effect of the interventions on gender dysphoria itself, arguably "the most important outcome." He also noted that the Endocrine Society had at times paired strong recommendations—phrased as "we recommend"—with weak evidence. In the adolescent section, the weaker phrasing "we suggest" is used for pubertal hormone suppression when children "first exhibit physical changes of puberty"; however, the stronger phrasing is used to "recommend" GnRHa treatment.

"GRADE discourages strong recommendations with low or very low quality evidence except under very specific circumstances," Guyatt told *The BMJ*. Those exceptions are "very few and far between," and when used in guidance, their rationale should be made explicit, Guyatt said. In an emailed response, the Endocrine Society referenced the GRADE system's five exceptions, but did not specify which it was applying.

Helfand examined the recently updated WPATH Standards of Care and noted that it "incorporated elements of an evidence based guideline." For one, WPATH commissioned a team at Johns Hopkins University in Maryland to conduct systematic reviews.[34 35] However, WPATH's recommendations lack a grading system to indicate the quality of the evidence—one of several deficiencies. Both Guyatt and Helfand noted that a trustworthy guideline would be transparent about all commissioned systematic reviews: how many were done and what the results were. But Helfand remarked that neither was made clear in the WPATH guidelines and also noted several instances in which the strength of evidence presented to justify a recommendation was "at odds with what their own systematic reviewers found."

For example, one of the commissioned systematic reviews found that the strength of evidence for the conclusions that hormonal treatment "may improve" quality of life, depression, and anxiety among transgender people was "low," and it emphasised the need for more research, "especially among adolescents."[35] The reviewers also concluded that "it was impossible to draw conclusions about the effects of hormone therapy" on death by suicide.

Despite this, WPATH recommends that young people have access to treatments after comprehensive assessment, stating that the "emerging evidence base indicates a general improvement in the lives of transgender adolescents."[12] And more globally, WPATH asserts, "There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures," procedures that "are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of a patient. They are safe and effective at reducing gender incongruence and gender dysphoria."[12]

Those two statements are each followed by more than 20 references, among them the commissioned systematic review. This stood out to Helfand as obscuring which conclusions were based on evidence versus opinion. He says, "It's a very strange thing to feel that they had to cite some of the studies that would have been in the systematic review or purposefully weren't included in the review, because that's what the review is for."

For minors, WPATH contends that the evidence is so limited that "a systematic review regarding outcomes of treatment in adolescents is not possible." But Guyatt counters that "systematic reviews are always possible," even if few or no studies meet the eligibility criteria. If an entity has made a recommendation without one, he says, "they'd be violating standards of trustworthy guidelines." Jason Rafferty, assistant professor of paediatrics and psychiatry at Brown University, Rhode Island, and lead author of the AAP statement, remarks that the AAP's process "doesn't quite fit the definition of systematic review, but it is very comprehensive."

Sweden conducted systematic reviews in 2015 and 2022 and found the evidence on hormonal treatment in adolescents "insufficient and inconclusive."[24] Its new guidelines note the importance of factoring the possibility that young people will detransition, in which case "gender confirming treatment thus may lead to a deteriorating of health and quality of life (i.e., harm)."

Cochrane, an international organisation that has built its reputation on delivering independent evidence reviews, has yet to publish a systematic review of gender treatments in minors. But *The BMJ* has learnt that in 2020 Cochrane accepted a proposal to review puberty blockers and that it worked with a team of researchers through 2021 in developing a protocol, but it ultimately rejected it after peer review. A spokesperson for Cochrane told *The BMJ* that its editors have to consider whether a review "would add value to the existing evidence base," highlighting the work of the UK's National Institute for Health and Care Excellence, which looked at puberty blockers and hormones for adolescents in 2021. "That review found the evidence to be inconclusive, and there have been no significant primary studies published since."

In 2022 the state of Florida's Agency for Health Care Administration commissioned an overview of systematic reviews looking at outcomes "important to patients" with gender dysphoria, including mental health, quality of life, and complications. Two health research methodologists at McMaster University carried out the work, analysing 61 systematic reviews and concluding that "there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people." The body of evidence, they said, was "not sufficient" to support treatment decisions.

Calling a treatment recommendation "evidence based" should mean that a treatment has not just been systematically studied, says Helfand, but that there was also a finding of high quality evidence supporting its use. Weak evidence "doesn't just mean something esoteric about study design, it means there's uncertainty about whether the long term benefits outweigh the harms," Helfand adds.

"Evidence itself never tells you what to do," says Guyatt. That's why guidelines must make explicit the values and preferences that underlie the recommendation.

The Endocrine Society acknowledges in its recommendations on early puberty suppression that it is placing "a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm."[14]

WPATH acknowledges that while its latest guidelines are "based upon a more rigorous and methodological evidence-based approach than previous versions," the evidence "is not only based on the published literature (direct as well as background evidence) but also on consensus-based expert opinion." In the absence of high quality evidence and the presence of a patient population in need—who are willing to take on more personal risk—consensus based guidelines are not unwarranted, says Helfand. "But don't call them evidence based."

An evidence base under construction

In 2015 the US National Institutes of Health awarded a $5.7m (£4.7m; €5.3m) grant to study "the impact of early medical treatment in transgender youth."[36] The abstract submitted by applicants said that the study was "the first in the US to evaluate longitudinal

outcomes of medical treatment for transgender youth and will provide essential evidence-based data on the physiological and psychosocial effects and safety" of current treatments. Researchers are following two groups, one of participants who began receiving GnRHa in early puberty and another group who began cross sex hormone treatment in adolescence. The study doesn't include a concurrent no-treatment control group.

Robert Garofalo, chief of adolescent medicine at the Lurie Children's Hospital in Chicago and one of four principal investigators, told a podcast interviewer in May 2022 that the evidence base remained "a challenge . . . it is a discipline where the evidence base is now being assembled" and that "it's truly lagging behind [clinical practice], I think, in some ways." That care, he explained, was "being done safely. But only now, I think, are we really beginning to do the type of research where we're looking at short, medium, and long term outcomes of the care that we are providing in a way that I think hopefully will be either reassuring to institutions and families and patients or also will shed a light on things that we can be doing better."[37]

While Garofalo was doing the research he served as "contributor" on the AAP's widely cited 2018 policy statement, which recommends that children and adolescents "have access to comprehensive, gender-affirming, and developmentally appropriate health care," including puberty blockers, sex hormones, and, on a case-by-case basis, surgeries.[15]

Garofalo said in the May interview, "There is universal support for gender affirming care from every mainstream US based medical society that I can think of: the AMA, the APA, the AAP. I mean, these organisations never agree with one another." Garofalo declined an interview and did not respond to *The BMJ*'s requests for comment.

The rush to affirm

Sarah Palmer, a paediatrician in private practice in Indiana, is one of five coauthors of a 2022 resolution submitted to the AAP's leadership conference asking that it revisit the policy after "a rigorous systematic review of available evidence regarding the safety, efficacy, and risks of childhood social transition, puberty blockers, cross sex hormones and surgery." In practice, Palmer told *The BMJ*, clinicians define "gender affirming" care so broadly that "it's been taken by many people to mean go ahead and do anything that affirms. One of the main things I've seen it used for is masculinising chest surgery, also known as mastectomy in teenage patients." The AAP has told *The BMJ* that all policy statements are reviewed after five years and so a "revision is under way," based on its experts' own "robust evidence review."

Palmer says, "I've seen a quick evolution, from kids with a very rare case of gender dysphoria who were treated with a long course of counselling and exploration before hormones were started," to treatment progressing "very quickly—even at the first visit to gender clinic—and there's no psychologist involved anymore."

Laura Edwards-Leeper, a clinical psychologist who worked with the endocrinologist Norman Spack in Boston and coauthored the WPATH guidelines for adolescents, has observed a similar trend. "More providers do not value the mental health component," she says, so in some clinics families come in and their child is "pretty much fast tracked to medical intervention." In a study of teens at Seattle Children's Hospital's gender clinic, two thirds were taking hormones within 12 months of the initial visit.[38]

The British paediatrician Hilary Cass, in her interim report of a UK review into services for young people with gender identity issues, noted that some NHS staff reported feeling "under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters."

Eli Coleman, lead author of WPATH's Standards of Care and former director of the Institute for Sexual and Gender Health at the University of Minnesota, told *The BMJ* that the new guidelines emphasised "careful assessment prior to any of these interventions" by clinicians who have appropriate training and competence to assure that minors have "the emotional and cognitive maturity to understand the risks and benefits." He adds, "What we know and what we don't know has to be explained to youth and their parents or caregivers in a balanced way which really details that this is the evidence that we have, that we obviously would like to have more evidence, and that this is a risk-benefit scenario that you have to consider."

Joshua Safer, director of the Center for Transgender Medicine and Surgery at Mount Sinai Hospital in New York and coauthor of the Endocrine Society guidelines, told *The BMJ* that assessment is standard practice at the programme he leads. "We start with a mental health evaluation for anybody under the age of 18," he says. "There's a lot of talking going on—that's a substantial element of things." Safer has heard stories of adolescents leaving a first or second appointment with a prescription in hand but says that these are overblown. "We really do screen these kids pretty well, and the overwhelming majority of kids who get into these programmes do go on to other interventions," he says.

Without an objective diagnostic test, however, others remain concerned. The demand for services has led to a "perfunctory informed consent process," wrote two clinicians and a researcher in a recent issue of the *Journal of Sex and Marital Therapy*,[39] in spite of two key uncertainties: the long term impacts of treatment and whether a young person will persist in their gender identity. And the widespread impression of medical consensus doesn't help. "Unfortunately, gender specialists are frequently unfamiliar with, or discount the significance of, the research in support of these two concepts," they wrote. "As a result, the informed consent process rarely adequately discloses this information to patients and their families."

For Guyatt, claims of certainty represent both the success and failure of the evidence based medicine movement. "Everybody now has to claim to be evidence based" in order to be taken seriously, he says—that's the success. But people "don't particularly adhere to the standard of what is evidence based medicine—that's the failure." When there's been a rigorous systematic review of the evidence and the bottom line is that "we don't know,'" he says, then "anybody who then claims they do know is not being evidence based."

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LETTER TO THE EDITOR

Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom

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Introduction

Surveys show that adolescents who identify as transgender are vulnerable to suicidal thoughts and self-harming behaviors (dickey & Budge, 2020; Hatchel et al., 2021; Mann et al., 2019). Little is known about death by suicide. This Letter presents data from the Gender Identity Development Service (GIDS), the publicly funded clinic for children and adolescents aged under 18 from England, Wales, and Northern Ireland. From 2010 to 2020, four patients were known or suspected to have died by suicide, out of about 15,000 patients (including those on the waiting list). To calculate the annual suicide rate, the total number of years spent by patients under the clinic's care is estimated at about 30,000. This yields an annual suicide rate of 13 per 100,000 (95% confidence interval: 4–34). Compared to the United Kingdom population of similar age and sexual composition, the suicide rate for patients at the GIDS was 5.5 times higher. The proportion of patients dying by suicide was far lower than in the only pediatric gender clinic which has published data, in Belgium (Van Cauwenberg et al., 2021).

Suicidality in Transgender Adolescents

"About half of young trans people…attempt suicide," declared the United Kingdom Parliament's Women and Equalities Committee (2015). Similar figures are cited by news media and campaigning organizations. The *Guardian* reported Stonewall's statistic that "almost half" of transgender young people "have attempted to kill themselves" (Weale, 2017). "Fifty percent of transgender youth attempt suicide before they are at age 21" stated the mother of the most famous transgender youth in the English-speaking world (Jennings & Jennings, 2016). As a transgender theologian has observed, "the statistic about suicide attempts has, in essence, developed a life of its own" (Tanis, 2016).

Representative surveys of students in high schools provide one source of evidence for this statistic. In New Zealand, 20% of transgender students reported attempting suicide in the past 12 months, compared to 4% of all students (Clark et al., 2014). In the United States, 15% of transgender students reported a suicide attempt requiring medical treatment in the last 12 months, compared to 3% of all students (Centers for Disease Control & Prevention, 2018; Jackman et al., 2021; Johns et al., 2019). In another American survey, 41% of transgender students reported having attempted suicide during their lifetime, compared to 14% of all students (Toomey et al., 2018).

To what extent are self-reported suicide attempts reflected in fatalities? The connection is not straightforward. Respondents who report suicide attempts are not necessarily indicating an intent to die. One survey of the American population found that almost half the respondents who reported attempting suicide subsequently stated that their action was a cry for help and not intended to be fatal (Nock & Kessler, 2006). In two small samples of non-heterosexual youth, half the respondents who initially reported attempting suicide subsequently clarified that they went no further than imagining or planning it; for the remainder who did actually attempt suicide, their actions were usually not life-threatening. To an extent, then, "the reports were attempts to communicate the hardships of lives or to identify with a gay community" (Savin-Williams, 2001). Although such elaborate survey methods have not been used to study transgender populations, there is anecdotal evidence for a similar disjuncture. The pediatric endocrinologist who established the first clinic for transgender children in the United States stated that "the majority of self-harmful actions that I see in my clinic are not real suicide attempts and are not usually life threatening" (Spack, 2009).

Suicide mortality has been studied in the transgender population using registry data. The annual suicide rate is calculated by dividing the number of suicides by the total number of years each person was at risk. An individual who was observed for 20 years, for instance, contributes 20 person-years to the denominator. The

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largest study covers over 8,000 patients who visited the gender clinic in Amsterdam from 1972 to 2017 (Wiepjes et al., 2020). The annual suicide rate was 29 per 100,000 for transmen, quadruple the rate for the female population, and 64 for transwomen, quadruple the rate for the male population. A Swedish study of 324 individuals who had undergone genital surgery between 1973 and 2003 found much higher annual suicide rates: 250 per 100,000 for transmen, 43 times the rate for matched female controls, and 285 for transwomen, 16 times the rate for matched male controls (M. Boman, personal communication, 12 April 2021; Dhejne et al., 2011). Only one published study has reported suicide fatalities among transgender adolescents. Belgium's pediatric gender clinic provided counseling to 177 youth aged from 12 to 18 years, who had been referred between 2007 and 2016: five of them (2.8%) committed suicide (Van Cauwenberg et al., 2021). The mean age of referral was 15, implying a mean duration of 3 years before transition to an adult clinic, which translates to an annual suicide rate of 942 per 100,000. This is the highest suicide mortality recorded for any transgender population.

Method

This Letter estimates the suicide rate at the world's largest pediatric gender clinic. Based in London, the GIDS is part of the Tavistock and Portman NHS Foundation Trust, and serves youth under 18 from England, Wales, and Northern Ireland who are "experiencing difficulties with their gender identity development" (Carmichael & Davidson, 2009). Like all such services throughout Western Europe and North America, it has experienced enormous growth; referrals increased from 100 in 2009 to a peak of 2700 in 2019. The waiting list in April 2021 exceeded 5300.

The GIDS patients manifest typically high rates of self-harming behavior. In a sample of 900 adolescents (aged from 13 to 17) admitted to the clinic from 2009 to 2017 and given the Youth Self-Report questionnaire, 44% answered that they sometimes or very often "deliberately try to hurt or kill myself" (de Graaf et al., 2020). Unfortunately, both behaviors are combined in this question. In a different sample of over 700 children and adolescents (aged from 4 to 17) assessed by the GIDS in 2012 and 2015, 10% were flagged by clinicians as having attempted suicide (Morandini et al., 2021).

Suicides

Since the early 2000s, the National Health Service has implemented mandatory reporting of "serious incidents" (Department of Health, 2001, 2010). The death of any patient—including those on the waiting list—suspected to be suicide is reported to the Tavistock's Board of Directors. The Tavistock cooperates with a comprehensive surveillance system for every death classified as suicide or (after an open verdict by the coroner) probable suicide in the United Kingdom (National Confidential Inquiry into Suicide & Homicide by People with Mental Illness, 1999; National Confidential Inquiry into Suicide and Safety in Mental Health, 2019). Papers for the Tavistock's Board meetings are available from April 2007 onwards; those not on the Trust's website were acquired by a Freedom of Information request. The pdf files of the *Agenda and Papers* (through September 2021) were searched for the keyword "suicid"; all 442 instances were inspected. From 2007 to 2020, four patients of the GIDS died by suspected suicide: two on the waiting list, in 2016 and 2017; and two after having been seen, in 2017 and 2020. The last case was described as "likely" to be suicide, because the inquest has not yet been held. These figures were confirmed by Freedom of Information requests to the Tavistock.

Triangulation is possible from two sources. Comprehensive mortality data on all adolescents aged from 10 to 19 who committed suicide in the United Kingdom from 2014 to 2016 include five transgender individuals (Rodway et al., 2020). Due to confidentiality restrictions, it is not possible to disaggregate these further by age or by country. Presumably, one of these is the patient of GIDS who died in 2016. The remaining four might have been 18 or 19—the risk of suicide increases significantly in the late teens—or might have lived in Scotland. Alternatively, they might have been eligible for the GIDS but had not sought a clinical referral (made by the local Child and Adolescent Mental Health Service, the child's general practitioner, social worker, or teacher) or had not obtained it.

Another source is the Transgender Day of Remembrance website, which aims to record all deaths by suicide or violence (Metcalfe, 2021). For the United Kingdom between 2007 and 2020, the website names 3 adolescents under the age of 18 who committed suicide. One was one of the GIDS patients (the match is certain because they were named in the *Agenda and Papers*). The other two had no involvement with the GIDS (or any other gender clinician), as was evident from their inquests, though one was under the psychiatric care of another NHS Trust (BBC News, 2021; Bunyan, 2008). In addition, the website lists suicides by two "young" transgender people, sourced from Twitter, without information on their name or age. In one case, it is not clear whether the person lived in the United Kingdom.

Patients

With suicides as numerator, two denominators are relevant. Because comprehensive data on patient numbers became available from 2010, the period will be the 11 years from 2010 to 2020. (These are financial years; thus, 2020 runs from April 2020 to March 2021.) The first denominator is the total number of individual patients, estimated by summing the annual number of referrals to the GIDS from 2010 to 2020—excluding those aged 18 or over, as they are not accepted. The total number is 15,032. This sum omits patients at the clinic who had been referred before

2010, and so is a slight underestimate. (The Online Supplement provides full details.)

The second denominator is the total number of patient-years: the sum of the number of years spent by each individual as a patient of the GIDS. The number of patients seen by the GIDS each year was available from 2014 to 2020. Before 2014 only the number of patients first seen was available. From 2014 to 2016, the number of patients seen was consistently double the number first seen, and so the former number for 2010 to 2013 was estimated by doubling the latter. All these numbers exclude patients on the waiting list. The number waiting at the beginning of each year from 2016 to 2020 was obtained by Freedom of Information request. Before then the number was not available, and so must be treated as zero. This leads to an underestimate, of course, but the waiting list became appreciable only from 2015. The total number of patient-years over this period is estimated as 30,080. In other words, patients spent on average 2 years at the GIDS (including time on the waiting list). Time on the waiting list contributed 41% of the total patient-years.

Results

From 2010 to 2020, the four suicide deaths equate to 0.03% of the 15,032 patients. Taking the denominator as 30,080 patient-years, the annual suicide rate is calculated as 13 per 100,000 (95% confidence interval: 4 to 34 per 100,000). For comparison, the annual suicide rate in England and Wales between 2010 and 2020 for adolescents aged from 15 to 19 years averaged 4.7 (Office for National Statistics, 2021). This does not quite correspond to the age range of the GIDS patients, however. At referral, the patients ranged in age from 3 to 17 years; only 7% were younger than 10. The mean was 14 years and the median 15. Most patients stay with the GIDS until transitioning to an adult service. Therefore, the average age of patients at any point in time will lie somewhere between 14 and 17. A better comparison is therefore the overall suicide rate for adolescents aged from 14 to 17 (available only for the entire United Kingdom for 2015–2017), which was 2.7 per 100,000 (Office for National Statistics, 2018; Rodway et al., 2020). Comparison should also account for the difference between the sexes, because males are more likely to commit suicide than females. Of the GIDS patients, 69% were female. Adjusting for sex, the GIDS patients were 5.5 times more likely to commit suicide than the overall population of adolescents aged 14 to 17.

Discussion

How reliable are these estimates? The chief uncertainty about the numerator is whether the fourth death will be ruled as suicide when the inquest is eventually held. It could be speculated that there were further suicides unknown to the Tavistock and to the National Confidential Inquiry into Suicide and Safety in Mental Health. All that can be said is that the single suicide by a GIDS patient from 2014 to 2016 is not out of line with comprehensive mortality data on suicides by transgender adolescents in the United Kingdom which counted five suicides in a longer age range and wider geographical area. The denominator for the annual suicide rate, however, is pieced together from various series and so is inevitably approximate. Statistics from the early 2010s are less reliable, though they make only a small contribution to the grand total; the last three years contribute more than half of the total number of patient-years. The most significant limitation is the lack of information on the age and sex of all the patients who committed suicide.

Direct comparison can be made with the Belgian pediatric gender clinic (Van Cauwenberg et al., 2021). Its annual suicide rate was about 70 times greater than the rate at the GIDS. This is especially puzzling because patients at the Belgian clinic scored better, on average, than those at the GIDS on tests of psychological functioning (de Graaf et al., 2018). The explanation for the huge disparity in suicide is not clear. The Amsterdam's clinic annual suicide rate was four times greater than the rate at the GIDS. The higher rate is not surprising, however, because the Dutch clinical population was dominated by older adults: the median age at first visit was 25 (Wiepjes et al., 2020). Suicide rates peak in middle age, and so a population of older adults would be at higher risk than a population of adolescents.

The suicide rate of the GIDS patients is not necessarily indicative of the rate among all adolescents who identify as transgender. On the one hand, individuals with more serious problems (and their families) would be particularly motivated to seek referral and more likely to obtain it, and so the clinical subset would be more prone to suicide. One study suggests that a child who frequently attempted suicide was more readily referred to the GIDS (Carlile et al., 2021). On the other hand, young people facing hostility from their families would be less able to seek referral, and this hostility could make them especially vulnerable to suicide.

Taking into account these limitations, the estimated suicide rate at the GIDS provides the strongest evidence yet published that transgender adolescents are more likely to commit suicide than the overall adolescent population. The higher risk could have various causes: gender dysphoria, accompanying psychological conditions, and ensuing social disadvantages such as bullying. Studies of young people referred to the GIDS in 2012 and 2015 found a high prevalence of eating disorders, depression, and autism spectrum conditions (ASC) (Holt et al., 2016; Morandini et al., 2021)—all known to increase the probability of suicide (Simon & VonKorff, 1998; Smith et al., 2018). Eating disorders and depression could be consequences of transgender identity and its ensuing social repercussions, but this is implausible for ASC insofar as it originates in genes or the prenatal environment. From a sample of over 700 referrals to the GIDS in 2012 and 2015, 14–15% were diagnosed with ASC (Morandini

et al., 2021). This compared to 0.8–1.1% of students in England (Department for Education, 2012, 2015). The association between autism and gender dysphoria is found in many populations (Socialstyrelsen, 2020; Warrier et al., 2020). Autism is known to increase the risk of suicide mortality, especially in females (Hirvikoski et al., 2016; Kirby et al., 2019; Socialstyrelsen, 2020). To some extent, therefore, the elevated suicide rate for transgender youth compared to their peers reflects the higher incidence of ASC. The same holds for other psychiatric disorders associated with gender dysphoria (Dhejne et al., 2016). Ideally, the suicide rate for patients of the GIDS would be compared to the suicide rate for patients in contact with other NHS mental health services, but the latter rate is not available.

One final caveat is that these data shed no light on the question of whether counseling or endocrinological interventions—gonadotropin-releasing hormone agonist or cross-sex hormones—affect the risk of suicide (Biggs, 2020; Turban et al., 2020). Although two out of the four suicides were of patients on the waiting list, and thus would not have obtained treatment, this is not disproportionate: the waiting list contributed nearly half of the total patient-years.

Conclusion

Data from the world's largest clinic for transgender youth over 11 years yield an estimated annual suicide rate of 13 per 100,000. This rate was 5.5 times greater than the overall suicide rate of adolescents of similar age, adjusting for sex composition. The estimate demonstrates the elevated risk of suicide among adolescents who identify as transgender, albeit without adjusting for accompanying psychological conditions such as autism. The proportion of individual patients who died by suicide was 0.03%, which is orders of magnitude smaller than the proportion of transgender adolescents who report attempting suicide when surveyed. The fact that deaths were so rare should provide some reassurance to transgender youth and their families, though of course this does not detract from the distress caused by self-harming behaviors that are non-fatal. It is irresponsible to exaggerate the prevalence of suicide. Aside from anything else, this trope might exacerbate the vulnerability of transgender adolescents. As the former lead psychologist at the Tavistock has warned, "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" (Wren, 2015).

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Declarations

Conflict of interest I acted as an expert witness (without payment) for the claimant in the case of Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274.

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Honorable Members of the State Senate:

My name is Bryon Herbel, M.D. After completing medical school at UND in 1986, I completed a four year residency in general psychiatry at the Menninger Clinic in Kansas and then completed a two year fellowship in child and adolescent psychiatry at Duke University in Durham, North Carolina. I worked for 25 years as a staff correctional and forensic psychiatrist at FCC Butner, a federal mental health and medical prison complex. My duties included providing psychiatric care to convicted inmates housed at the prison complex, as well providing evaluations for the federal court system on the the issues of competency to stand trial, insanity at the time of the alleged offense, need for involuntary treatment, and risk of future dangerousness. During my career, I was a co-author of two articles published the peer-reviewed forensic journals describing the outcomes of involuntary medication treatment for restoration of competency for selected groups of pretrial detainees. Along with a forensic psychology colleague, I submitted over 2000 reports to the federal court system and testified in federal court over 150 times as an expert witness on the disputed mental health issues. Hence I have considerable professional experience with careful scrutinization of evidence, including medical data. During my career in the Federal Bureau of Prisons, I provided psychiatric assessment or consultation for several adult inmates who had been diagnosed as transgender or had a history of cross-dressing as women. After retiring from the Bureau of Prisons in 2017, I returned to Bismarck, where I operate a small part-time outpatient psychiatric clinic for adults suffering from anxiety and depressive disorders.

I am testifying in support of House Bill 1254. In my opinion a false and misleading narrative is being foisted on the American public. This false narrative asserts the use of puberty blockers and surgery to treat transgenderism in children and adolescents is a noncontroversial and medically necessary intervention to treat the mental distress of minors suffering from transgender dysphoria, is relatively free from significant burden of side effects, and results in positive outcomes for the target population, including consistently good mental health outcomes.

More specifically, in my opinion this **false and misleading narrative is not being drawn out of the evidence, but rather is being imposed upon the evidence by several American medical organizations.** My main

intent is to summarize two recent medical articles published within the past few weeks in high-quality medical journals, which assert the bulk of the opposition testimony has been relying on weak or biased evidence from various international datasets **In other words, the information in these articles demonstrates the treatment paradigm for transgender minors being promoted by WPATH and other American medical associations is <u>opinion</u> based, NOT <u>evidence</u> based.**

In my opinion, part of this misleading narrative includes exaggerated fears of suicide in this clinical population. While there is no dispute that adolescents with gender dysphoria report markedly elevated rates of suicidal ideation and suicide attempts on surveys compared to their non-clinical same age peers, the surveys do not stratify suicide risk by differentiating between non-lethal self-harm behavior, such as superficial self-mutilation (which may be an expression of distress or a "cry for help") from highly lethal self-harm behaviors such as attempted hanging. There is very little empirical data about how many of these distressed transgender adolescents with self-harm ideation and behaviors go on to actually commit suicide, According to one report from a gender clinic in England described below, there were four suicides among 15,000 clinic patients over a ten year period. The author noted this suicide rate was much higher than that expected from a non-clinical comparison population, but the reported rate of suicide deaths among the clinic patients was still considered "rare."

The history of American psychiatry is replete with creative interventions by compassionate and well-meaning clinicians which were ultimately found to be ineffective or harmful. Some more recent examples include infecting patients with malaria in the 1920s to treat neurosyphilis, as well as the use of insulin coma therapy and prefrontal lobotomy to treat schizophrenia in the 1950s. In my opinion, the use of hormones, puberty blockers and surgery to treat gender dysphoria in children and adolescents is another unfortunate example of inappropriate and harmful treatment recommended to people suffering mental disorders by well-meaning but overzealous clinicians.

The first paper is "Gender dysphoria in young people is rising - and so is professional disagreement," which was published in the British Medical Journal (BMJ) on February 23, 2023.

There is no dispute that widespread support exists among American medical organizations for routine use of hormone and surgery to treat transgenderism in minors. However **the current American position is markedly different from the governing bodies in several other countries, such as Finland and Sweden, which restrict surgery for adults only.** France, Australia, and New Zealand have been moving away from early medicalization. **A review in the National Health Service of England recently concluded there was "scarce and inconclusive evidence to support clinical decision making" for minors with gender dysphoria and that for most who present before puberty it will be a "transient phase."**

In order to assess the quality of the treatment guidelines used by the American medical organizations, the BMJ article consulted with two experts on evidence-based guidelines, namely Dr. Gordon Guyatt, distinguished professor in the Department of Health Research Methods, Evidence and Impact at McMaster University and Dr. Mark Helfand, professor of medical informatics and clinical epidemiology at Oregon Health and Science University. **Dr. Guyatt found "serious problems" in the Endocrine Society guidelines, such as lack of evidence of the impact of the intervention on gender dysphoria itself, and at times pairing strong recommendations, phrased as "we recommend" - with weak evidence.**

Dr. Helfand reviewed the guidelines by the World Professional Association for Transgender Health (WPATH) and identified several deficiencies, including the lack of a grading system and lack of transparency for the number and results of the commissioned systematic reviews. Dr. Helfand also noted several instances in the WPATH guidelines in which the strength of evidence presented to justify a recommendation was "at odds with what their own systematic reviewers found." For example the WPATH guidelines praised the "strong evidence" which they claimed had demonstrated benefits in quality of life and well being of gender-affirming treatment in

minors, including endocrine and surgical procedures, which they asserted were safe and effective and not experimental. **However one of the commissioned systematic reviews referenced in this guideline found "low" evidence for the assertion that hormonal treatment may improve quality of life, depression and anxiety among transgender people and emphasized the need for more research, especially among adolescents. The review also concluded that "it was impossible to draw conclusions about the effects of hormone therapy" on death by suicide.**

The "gold standard" for evidence based medicine is an international organization named Cochrane, which has a highly respected reputation for delivery of independent evidence reviews on a wide variety of medical topics. **According to the BMJ article, Cochrane has never published a systematic review of gender treatments in minors and last year rejected a proposal to review puberty blockers in 2021 because "That review found the evidence to be inconclusive, and there have been no significant primary studies published since."**

In 2022 the state of Florida commissioned two an overview of systemic reviews looking at outcomes "important to patients" with gender dysphoria, including mental health, quality of life, and complications. **Two health research methodologists at McMaster University carried out the work, analyzing 61 systematic reviews and concluding that "there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people." The body of evidence was "not sufficient" to support treatment decisions.**

Dr. Robert Garofalo is chief of adolescent medicine at Lurie Children's Hospital in Chicago and a principal investigator in a study of the effects of hormone treatment in adolescents and children in early puberty. **In a podcast interview in May 2022, Dr. Garofalo stated the evidence based remained, "a challenge…it is a discipline where the evidence basis now being assembled" and that "it's truly lagging behind [clinical practice], I think, in some ways."**

The BMJ article ended with a short description of concerns in the **informed consent process** for the use of gender-affirming therapies. One

was the long-term impacts of the treatment, and the other involved whether a young person will persist in their gender identity.

The second paper is "The Myth of 'Reliable Research' in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies - and research that has followed, " which was published in the Journal of Sex and Marital Therapy (JSMT).

In my opinion, the authors present a devastating and extremely detailed critique of the research data underlying gender transition in minors. The authors assert the original two Dutch studies published in 2011 and 2014 were methodologically flawed and suffer from such profound limitations that they should never have been used as justification for propelling these interventions into general medical practice. The authors assert 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.

The authors of the JSMT article describe methodological biases which undermine the Dutch research. They also discussed the significant risk of harm from the Dutch research, as well as the lack of applicability of the Dutch protocol to the current escalating incidence of adolescent-onset, non-binary, psychiatrically challenged youth, who are preponderantly natal females. The authors also assert "spin" problems in in subsequent research from transgender clinics that are actively administering hormones and surgical interventions to youth, which is a tendency to present weak or negative result as certain and positive.

In summary, these two articles present credible and converging data from multiple sources, which conclude there is scanty or no scientific evidence to support the use of hormones, puberty blockers, and surgery to treat gender dysphoria in children and adolescents. These sources range from several European countries to multiple rigorous academic reviews by third-party experts on evidence based medicine. This data demonstrates the treatment guidelines by the World Professional Association for Transgender Health (WPATH), the

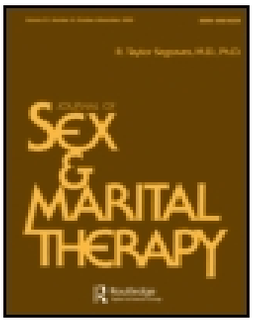
Endocrine Society, and other American medical associations are NOT based on solid scientific evidence and should NOT be viewed as impeccable authoritative guides for clinicians who treat transgender patients.

Another relevant article is a Letter to the Editor by Michael Biggs, published in the Archives of Sexual Behavior on 01/18/22, titled "Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom." The letter presented data from the Gender Identity Develop Service, in which four suicides occurred in a cohort of about 15,000 patients between 2010 and 2020, which corresponded to an annual suicide rate of 13 per 100,000. Two suicides occurred in the waiting list group and two occurred in the treatment group. The author noted the suicide rate of this population was 5.5 times higher than the comparable United Kingdom population of similar age and sexual composition, but was also orders of magnitude smaller than the proportion of transgender adolescents who report having attempted suicide during surveys. In his conclusion, the author wrote "**The fact that deaths were so rare should provide some reassurance to transgender youth and their families, though of course this does not detract from the distress caused by self-harming behaviors that are non-fatal. It is irresponsible to exaggerate the prevalence of suicide.**"

Based upon the above information, I urge the members of the senate committee to vote in favor of House Bill 1254.

Thank you for your attention to this matter.

Bryon Herbel, M.D.



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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

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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) 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) 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.

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I am writing in opposition of House Bill 1254. I ask that you give this bill a Do Not Pass.

As an advocate for suicide prevention in our state, I feel this legislation is discriminatory and does not reflect the values of inclusion and compassion that our state should represent. Our transgender community is already at a much higher risk for suicide and self-harm and this bill will only increase that risk by denying them access to gender affirming care. This bill is also a huge government overreach into the doctor-patient relationship as well as the parent-child relationship.

Transgender people deserve to live as themselves in a state that respects and supports them.

Please oppose HB 1254.

Thank you,
Mary Weiler

I am writing in opposition of House Bill 1254. I ask that you give this bill a Do Not Pass.

As a health care provider and an advocate for suicide prevention in our state, I feel this legislation is discriminatory and does not reflect the values of inclusion and compassion that our state should represent. Our transgender community is already at a much higher risk for suicide and self-harm and this bill will only increase that risk by denying them access to gender affirming care. This bill is also a huge government overreach into the doctor-patient relationship as well as the parent-child relationship.

Transgender people deserve to live as themselves in a state that respects and supports them.

Please oppose HB 1254.

Thank you,
Dr. Derek Harnish

Testimony in Opposition to HB 1254. I ask that you DO NOT PASS.

I'm a clinical psychologist who had practiced in the state of North Dakota for over 20 years. I treat individuals across the lifespan. Prior to being a clinical psychologist, I was an RN for 15 years.

This bill will be harmful to citizens of North Dakota and its citizens.

Care of individuals with gender dysphoria is complex, nuanced, and individual. Such care involves a team of providers, including mental health providers. Complex, research-based guidelines exist to make decisions about care. Decisions to provide gender affirming care come about over time with the best outcome for the individual in mind throughout care. Individuals without proper training and experience working with individuals with gender dysphoria should not be making decisions about care.

A substantial body of literature exists documenting the benefits of gender-affirming medical interventions, where indicated, for adolescents with gender dysphoria. Over a dozen studies have collectively linked such care to improvements in depression, anxiety, and suicidality. Studies of long term and short-term benefits support this. Additionally, resilience-promoting factors for mental health include having a good relationship with parents, social support, school safety and belonging, and the ability to use one's chosen name. Bills such as HB 1254 will tend to alienate those that identify as gender dysphoric or transgender and potentially worsen mental health issues including suicidality.

I hope you will make thoughtful informed votes on proposed legislation that will be harmful and vote DO NOT PASS.

Brenda J. King, Ph.D., L.P.
Clinical Psychologist

Senate Human Services Committee
March 15th, 2023
HB 1254- Testimony in Opposition

Chair Lee and members of the Senate Human Services Committee, my name is Whitney Oxendahl and I am writing in opposition to HB 1254. I hope that if one of my three children or any of their friends comes out as transgender or nonbinary, they are accepted in North Dakota. If this bill is passed, it would cause kids to feel unwelcome and unsafe to live in our state.

I hope that you will choose to keep the state government out of medical decisions that should be made by transgender youth, their parents, and their medical providers. There are medical standards that are already followed in regards to gender-affirming medical care, and medical providers across the state have spoken out against this bill.

Please give House Bill 1254 a Do Not Pass recommendation. This bill is not about the safety of children. It only serves to make them feel unsafe to be themselves in North Dakota. Thank you for the opportunity to share my testimony.

Regarding HB 1254

Dear members of the Senate Human Services Committee,

My testimony is in strong opposition to HB 1254.
I respectfully ask that you DO NOT PASS this bill.

My name is Dr. Amanda Dahl and I am a board-certified Pediatric Endocrinologist who chose to come back to practice in the state of North Dakota. I live with my husband and 2 children in District 16. I was born in North Dakota and have lived here my entire life apart from the 6 years I completed specialty medical education before returning to this state to practice. While growing up, my dad was a Lutheran pastor and my mom was a high school choir teacher. My training after college includes 4 years of medical school at the University of North Dakota, 3 years of Pediatric & Adolescent Medicine and an additional 3 years of Pediatric Endocrinology fellowship. As one of two pediatric endocrinologists in the state, I have the distinct privilege and pleasure of caring for patients throughout the state with hormone problems. My scope includes caring for those with diabetes, thyroid disorders, adrenal problems, endocrine tumors, bone metabolism problems, growth concerns, early/late puberty, and gender affirming medical care for transgender individuals.

As a board-certified physician, I follow expert committee guidelines and strictly follow best practices established by these governing bodies. The expert committee guidelines that I follow for gender affirming medical care for transgender adolescence are compiled, validated, and supported by to name a few: American Academy of Pediatrics, Endocrine Society, Pediatric Endocrine Society, and World Professional Association for Transgender Health. WPATH and Endocrine society guidelines have been in use for over 3 decades and are updated regularly by expert committees.

As one of two Pediatric Endocrinologists in the state, I work with a multidisciplinary team to provide medical care for transgender individuals. I would like to describe our multidisciplinary team approach to the committee.

Stakeholders involved in the care of transgender adolescents in this state include Pediatric Endocrinology, Psychologist trained in gender care, Psychiatry/Psychologist/therapist/counselor trained to assess, diagnose, and treat other mental health conditions, primary care providers, Reproductive Endocrinology, and most importantly the patient and parents/guardians.

Our relationship with these individuals starts after a primary care provider or mental health provider places a referral to Pediatric Endocrinology & a Gender specialized psychologist. Our first visit is the longest of any endocrine visits. During this visit we are evaluating for any hormone imbalance (like we would for any other patient), then gathering more information as to when the patient and family members noticed signs of gender dysphoria. We have a lengthy discussion on their stage of transition which first starts with the social transition then hormone transition. Some with gender dysphoria will go through all the transition stages, some of the

transition changes or none. It is recommended that before starting hormone transition, the adolescent socially transition for at least 1 year before starting hormone treatment. In my experience, by the time they present to me, they have been exploring their gender identity and have started the social transition for years.

During our visit, we discuss the typical puberty timing and pace. Depending on their stage of puberty, we modify our next discussion. For any pre-pubertal patient, we are only providing information. We do not provide puberty suppression when they are prepubertal because there is no point since there's nothing to block. Once a patient has started puberty, we then consider puberty suppressors where we are pausing the signal from the pituitary to the ovaries/testes. **This is 100% reversible.** Once we stop this medication, normal puberty resumes.

For a patient born girl, if he has had his first period, he has fully developed breasts, the hourglass figure, and is bleeding every month. These 3 features are incredibly distressing for these patients. The first thing we discuss is menstrual management. We discuss different forms of birth control to help lighten or make periods less frequent.

For a patient born boy, if she is fully pubertal, she will have a deep voice, have body/facial hair, and possibly have an Adams apple. In these individuals, the deep voice, excessive hairiness and Adams apple are exceptionally distressing. We can provide a medication that is an androgen receptor blocker. The point of this medication is to decrease acne and hair growth in transgender females (both of which are caused by testosterone).

All of things I have discussed so far are 100% reversible and are not cross hormones which is where we are giving the hormone that is in line with their gender identity – for example estrogen for transgender female and testosterone for transgender males.

Also at their first visit, each patient and family member is given a 4-page consent form outlining the changes they will notice with gender affirming hormone therapy and the risks associated. We go over this in detail to address the specific physical changes, emotional changes, reproductive changes, and sexual changes they will notice after starting gender affirming therapy. We obtain baseline labs which we will then follow during treatment. We discuss that if/when we are starting gender affirming treatment, depending on what changes they've noticed, some aspects will not be reversible because even natural puberty is not reversible. We have a lengthy discussion regarding the impact this might have on future adult fertility and recommend a referral to Reproductive Endocrinology. I educate on the way the medications are given – estrogen as a daily pill, testosterone as an intramuscular injection. We mimic puberty by starting at a low dose and slowly titrate up so that it is a gradual transition. We see these patients every 3-4 months when on gender affirming hormone therapy and at each visit are assessing both their mental and physical health and changes they've noticed while being on hormone therapy.

BUT BEFORE ANY HORMONES ARE PRESCRIBED, 3 things must be completed:

1. The individual must be evaluated by a gender care psychologist who has assessed their mental health & proven that they meet WPATH 8 guideline criteria for gender dysphoria
2. Collaboration between mental health and medical providers to determine whether gender affirming medical care is appropriate
3. The 4 page consent form is reviewed and a parent/guardian signs. The adolescent signs saying they are assenting to gender affirming therapy.

The process of starting gender affirming hormone therapy can take months to years.

The reason why we don't wait until 18 years old is because some of the normal effects of puberty are irreversible. For example, testosterone makes the voice deepen by lengthening the vocal cords. Estrogen causes breast development and once these have developed, they are present forever. By providing puberty suppression, we are protecting them from seeing these irreversible effects and allowing them more time to work with their mental health providers to assess if they meet criteria for the medical diagnosis of gender dysphoria.

My all-time favorite visit with an adolescent is the first visit AFTER starting gender affirming hormone therapy. Typically, during our first visit, the adolescent is withdrawn and has poor eye contact. They describe feeling uncomfortable in their own skin causing severe depression, anxiety, and suicidal ideation. **When they hear they are ready to start gender affirming therapy, I usually see their smile for the first time as they start to see some semblance of hope.** The first visit after starting hormone therapy, they walk in with confidence, have great eye contact, and can tell me all the positives they've noticed including improvements in their mental health. This experience is with EVERY adolescent I have provided gender affirming hormone therapy care to.

In my practice, I personally have had zero of my patients detransition.

All medical treatments have risks.

There was a recent peer reviewed article published in New England Journal of Medicine on January 2023 addressing the impact of gender affirming hormones on transgender adolescents. This was a prospective study of psychosocial functioning during 2 years after gender affirming hormones. A total of 315 transgender and nonbinary participants aged 12-20 (average age 16) were enrolled in the study. ALL WERE PUBERTAL. All were involved in a multidisciplinary team. 25 participants had already received puberty suppression. During the study, all received either testosterone or estrogen for their respective gender affirming medical care. Measures analyzed were transgender congruence scale, depression inventory, anxiety scale, and positive affect and life satisfaction scores. Appearance congruence is when someone's physical appearance aligns with their gender.

Appearance congruence, positive affect, and life satisfaction significantly increased, and depression and anxiety symptoms significantly decreased. An important clinical finding from the study is that participants who received pubertal suppression before gender affirming

hormone therapy or who started gender affirming hormone therapy at earlier pubertal stages reported great appearance congruence and better psychosocial functioning at baseline than those with no puberty suppression or who started gender affirming hormone therapy at a later stage, suggesting earlier intervention could have a protective effect.
If this bill passes, patients and families will still seek gender affirming medical care which could result in a large exodus of families to other states or families resorting to the black market on the web for gender affirming therapy. Further, removing doctors' ability to follow established standards of care in their medical practices will drive some physicians away and impede recruitment efforts going forward.

HB 1254 proponents say this bill was created to protect children. It does just the opposite. The medications I use to help those experiencing gender dysphoria are the same medications I prescribe to treat numerous other conditions related to hormone imbalances. It is evidence-based care I was trained to provide. Denying patients access to this life-changing care is an unnecessary state law that will take away hope from the patients I serve and their families.

Coming from a family of faith, science helps to see what God created and God doesn't make junk. Please listen to the science that has been proven to be effective for these individuals.

Thank you for allowing me to speak and for your time in this important matter. I trust that the ND senate will do what is best for the state and that includes **opposing HB1254.**

Sincerely,

Dr. Amanda Dahl
Pediatric Endocrinologist

Dear Chair Weisz and members of the House Human Services Committee

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

When I moved to the United States 24 years ago the republican party stood for small, limited government, freedom for the individual right and self-determination and the right for parents to determine what is right for their children. This bill does not follow any these principles but is an example of government interference, government overreach and interference with parental decision making for raising their children and is contrary to the principles most of the committee members claim to adhere to. For this alone the bill should have a Do Not Pass recommendation.

In addition, I adhere to three principles in my Christian faith: do good, do no harm, and serve God. This bill does not do any of this. This bill does significant harm as it goes against the advice of the medical experts and prevents parents and care givers from making appropriate decision about health care for their children. Government has no business in this decision-making process. In addition, extensive research has shown it will decrease the mental health of transgender and questioning individuals and will increase suicide risk for transgender children as is documented in the 2021 ND Youth Risk Behavior Survey. The bill claims to protect children, but the opposite is truth, it will harm children and parent and reduces the ability of parents and doctors to do what is right for their children. This bill also does not serve God as it goes against the Golden Rule proclaimed by Jesus during his Sermon on the Mount: "Do unto others as you would have them do unto you". Members of the committee, you want the freedom to make your own medical decision. Jesus calls you to extend that same courtesy to others. This bill interferes with the freedom to make decisions about health care.

Taken together this bill is harmful and therefore deserves a Do Not Pass recommendation.

Hilde van Gijssel
Valley City

DO NOT PASS ON HB 1254

Chair Lee and members of the Senate Human Services Committee:

I urge you DO NOT PASS HB 1254. I am the founder of an organization called Project RAI, we work with gender queer children ages 3-14. We work to provide them resources, advocacy, and community so kids are able to when feeling lonely and reduce the risk of suicide.

Kids in our program have known they were gender queer from a young age. Research shows that children start realizing this as early as three years old. I have had the absolute pleasure of meeting kids that attend Project RAI events who are confident, self-assured and are living their most authentic lives as their authentic selves. Our kids just want to be kids and live their childhood as who they know they are.

Health care for queer and trans youth involves a robust healthcare team, therapy, and consultation with experts who understand the unique needs of growing children. Those opposed to trans healthcare would say that children are being mutilated, tricked, and manipulated by some “liberal agenda”, which cannot be farther from the truth. In reading the many of the letters submitted today, I was really moved by the healthcare experts who are incredibly concerned that the government is stepping into something they have no business or expertise in.

Healthcare decisions need to remain between a family and their provider, not the government. Rates of teen suicide are higher for trans and queer kids, especially when they have no support system. I hate to think what will happen in North Dakota if our queer kids are forced to stay hidden and not celebrated as their cis peers.

Again, I urge a DO NOT PASS on this bill.

Good morning, Chairwoman Lee and members of the committee. My name is Mayson Bedient, and I am a family medicine physician in Fargo. I have been providing gender affirming care as well as general primary care for the past 5 years. I am here today in opposition to HB1254.

My colleagues have already given you a lot of information on the science of the care that we provide, but I'd like to speak briefly from the point of view of a primary care provider, someone who gets to take care of the whole patient over the span of a lifetime. I get to have a special relationship with my patients, getting to know the patients and their families in a way that many specialists do not have the opportunity to know them. Because of that relationship, I may be the first medical provider with whom a patient feels comfortable discussing gender identity, either their own or that of their child. I am the one they will look to for guidance and it is critical that I am able to help them in the way that is best for that patient, that family. If that means helping to explore gender identity and ultimately assisting in their transition, I need to be able to do that. The key here is helping, not directing; I am not the only voice in the room, and that is something we all bear in mind when dealing with transgender youths and their families. I have spent many appointments sitting with an adolescent and their parents, answering questions and addressing concerns from both sides, "what if I do" as well as "what if I don't." As a provider, I will sit with that family as long as it takes to reach a consensus on the best next steps. The patient and the parents always get a say; no one is assisting in transition without consent from both of those parties.

In primary care, we deal quite a bit with the care of mental health disorders, particularly anxiety and depression. While it is not uncommon for transgender patients to suffer from these things, anxiety disorders and major depression are very different diagnoses than gender dysphoria, and each individual diagnosis must be treated appropriately in order for the patient to feel better. Gender dysphoria will not be alleviated with antidepressants; it is a problem with the physical body and therefore must be treated with a medication that will change the physical traits that cause the dysphoria. By the same token, depression in a cisgender person would not be solved with hormonal treatment. I have personally been in that position, trying to treat my own gender dysphoria with antidepressants and hoping it goes away, and I can tell you that it does not work. You trust in your doctor to know the difference between a cold virus and a bacterial infection, and to treat either of those appropriately, so trust us to be confident in the difference between gender dysphoria and depression as well.

It is also important to realize how access to care would be affected by the passage of bills such as this one, not only for transgender patients but for all patients. The majority of my practice is general family medicine for all people. Bills like this certainly play a role in determining where we want to practice, for me personally and for many physicians across the country. When the government inserts itself into the doctor-patient relationship, it is a red flag to many providers, who may then decide to practice elsewhere, depriving all patients of their care. You are asking us to choose between practicing in the way that our profession encourages and expects us to practice, to the widely accepted standard of care, or practicing in a way that obeys the law but is not best practice.

Thank you for listening to the doctor who cares for the whole family, the whole community. I urge you to give a DO NOT PASS to HB1254, and I stand ready for questions.

Senate Human Services Committee
3/15/23
HB 1254

Chair Lee, 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. They have usually been referred to me by their mental health provider. 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. I review their prior work with their counselor or mental health provider and ensure they meet criteria for hormonal medications.

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. Often times, my clinic is simply 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.

With any procedure or treatment there are risk of regret or desire to stop treatment. Detransition does happen. As medical providers of this care we want to make sure we are ready to manage this as well. It is also absolutely essential that we continue to work closely with our patients so they have a safe place to come if they desire to pause or stop treatment.

Multiple studies have been completed on this topic for both adults and adolescents.

A study done in Amsterdam from 1972 to 2015 looked at 6793 patients. Of those 70% started gender affirming medications (and of those 78% underwent gender affirming surgery). They found a rate of 0.6% regret for transwomen and 0.3% regret for transmen. Of those 7 out of 6793 reported true regret. The remainder (5 patients) reported their regret was due to social acceptance issues and 2 were non binary. They still considered themselves transgender or non-binary. An additional study out of Spain that looked at 796 patients from 2008-2018 showed only 8 cases where detransition was desired.

A survey done in the US in 2015 looked at regret and desire for detransition or completed detransition. 27, 715 people answered this survey. Eight percent reported either temporarily or permanently detransitioning. Most of these people reported their detransition was temporary and was related to parental pressure (36%), the process of transition was too difficult (33%), harassment/discrimination (31%), and difficulty getting a job (26%). Again, these patients still considered themselves transgender however they stopped medications

related to social pressures. Other potential reasons for stopping medication may including cost, medication shortages, satisfaction with most changes but discomfort with others (happy with voice changes, unhappy with facial hair), and inability to access safe care. Medical issues may also prevent use of hormonal medications.

In adolescents there was a large study done in Amsterdam regarding their protocols which are very consistent with US protocols for treatment. They looked at 1766 adolescents. Those who started with the clinic prior to age 10, about half started puberty blockers and those that started after age 10 about 2/3 started puberty blockers. Of note, these puberty blockers were not started at age 10, the patients just established at the clinic at those ages. Once started 1.4% decided to stop puberty blockers, of those most were due to resolved gender dysphoria while the rest stopped due to medical, social, or compliance issues. Of those in the clinic over these years, 707 patients were eligible to start gender affirming medications and 93% did go on to start these medications. This study really illustrates how puberty blockers can work well for those who are working through gender dysphoria vs other mental health issues. These adolescents were given a pause on puberty and were able to safely work with their medical providers to identify if they had gender dysphoria. When these patients were noted to have resolution of their gender dysphoria the medication was stopped and puberty was allowed to continue on as expected.

To compare to other common medical/surgical treatment, specifically in my scope as a gynecologist, rates of regret for permanent sterilization in form of tubal ligation or bilateral salpingectomy are between 1-26%. For vasectomy the rate of regret is around 6%. For hysterectomy, commonly used to treat heavy periods, pelvic pain, endometriosis, and prolapse, the rate of regret is between 7-13%. Salpingectomy and hysterectomy are irreversible procedures that are often performed with 1-4 pre surgery visits and do not require any mental health evaluation. Follow up varies but is usually 1-2 visits after surgery. This is opposed to gender affirming care which involves significant counseling, involvement of mental health providers, and is closely monitored lifelong. Gender affirming genital surgeries and removal of the uterus, ovaries, and testicles are not done under age 18.

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.

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. 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. In the creation of these bills it was even discussed on the house floor that no provider of gender affirming care was consulted prior to writing the bill.

In summary, I cannot recommend strongly enough a DO NOT pass on HB 1254. 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

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1254

Page 1, line 12, after "individual" insert "3. "Pre-pubertal" means an individual who has not yet entered puberty, the period during which secondary sex characteristics start to develop."

Page 1, line 13, replace "3." With "4."

Page 1, line 22, after "mastectomy;" insert "c. Prescribe any hormone treatment unless the minor has received a mental health evaluation and parental or guardian consent."

Page 2, line 1, insert "2. Except as provided in Section 12.1-36.1-03, a health care provider may not engage in any of the following practices for the purposes of changing the sex of a pre-pubertal individual;"

Page 2, line 1, replace "c." with "a."

Page 2, line 2, replace the word "minor's" with "prepubertal's" three times

Page 2, line 3, replace "minor's" with "prepubertal's"

Page 2, line 9, replace "2." with "3."

Senate Human Services Committee
HB 1254
March 15, 2023

Chair Lee 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. The NDMA Policy Forum recently passed a policy opposing the criminalization of medical practice. This policy states as follows:

> NDMA should take all reasonable and necessary steps to ensure that evidence-based medical decision-making and treatment, exercised in accordance with evidence-based standards of care, does not become a violation of criminal law.

This bill makes evidence-based medical decision making and treatment of transgender individuals a violation of law. NDMA has concerns about the legislature getting between the physician/patient relationship and the accepted medical standard of care. There are physicians and a psychologist here today to testify as to the details of that treatment, and why patients would be harmed if it was made a crime.

NDMA requests a DO NOT PASS recommendation on the bill. In the alternative, NDMA would offer an amendment, which conforms to accepted medical practice in this area of medicine. Thank you for the opportunity to testify today. I would be happy to answer any questions.

1. Gabriela Balf, MD, MPH – Psychiatrist, Internist, Public Health agent
    - **Gender Dysphoria is real**
    - **Science informs understanding of the biological underpinnings**
    - **Care for transgender youth has been around for decades**
    - **When care is not available, harm is done**

2. Danial Sturgill, PhD – Clinical Psychologist in Gender Care
    - **Major Medical Organizations (both local and national) support care guidelines**
    - **Gender assessments are comprehensive**
    - **Gender Care involves ongoing, multi-disciplinary review**
    - **Parents and providers work collaboratively in decision-making**
    - **Youth do have capacity to assent to treatment**

3. Amanda Dahl, MD – Pediatric Endocrinologist
    - **Review of patient and family journey through medical process**
    - **We have positive outcomes**

4. Luis Casas, MD – Pediatric and Adult Endocrinologist
    - **Puberty blocking is safe and reversible**
    - **Hormone usage is safe and only initiated for those meeting criteria**
    - **Detransitioning is almost never related to regret**

5. Rachel Peterson, MD – Ob-Gyn
    - **Detransition is rare and almost never related to regret**
    - **Success in treatment is higher than in many other areas of medicine**

6. Mayson Bedient, DO – Family Medicine
    - **Family Medicine identifies needs for care**
    - **Gender dysphoria is not the same as depression**

Dear House Committee,
I ask that you give this bill a Do Not Pass.

The harm that will result due to malicious ignorance will be catastrophic. Transgender children will die as a result of this bill passing. The harm that this bill will inflict is unconscionable. I urge the committee to consider the lives lost and lives negatively impacted by the passing of this bill. This bill will have real life consequences that will take lives.

Liam Blanford

Testimony in opposition to #1254

The definition of "sex" is too restrictive. Some people are born with characteristics of both sexes. If you need to create a definition, perhaps we could add a phrase: "or biological state that the person most identifies with."

The restrictions on the medical community and the patients they serve are too extreme. Medical providers need to provide services that are in the best interest of the patient. This statute will hinder their ability to do that. This bill also interferes with every parent's right to seek the best care available for their children.

These restrictions serve no purpose other than to reinforce discriminatory viewpoints. They will discourage qualified medical professionals from practicing in North Dakota.

2023 House Bill 1254
Senate Human Services Committee
Senator Judy Lee, Chairman
March 15, 2023

Chairman Lee and members of the Senate Human Services Committee, I am Danial Sturgill, PhD, a clinical psychologist at Sanford Health Fargo. I am testifying on behalf of the North Dakota Hospital Association (NDHA) which represents hospitals and health care systems across the state. I testify in opposition to House Bill 1254. 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 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.

Prior to recommending any gender care, a thorough assessment is required. This involves parents, mental health providers, medical providers, and others. A number of domains are

addressed, such as history of trauma, other mental health conditions, experiences with the Internet and other media, social experiences, attitudes towards gender stereotypes, experiences with puberty, emotional and intellectual maturity (decision-making ability), and thoughts about emerging adulthood. If there are any areas of concern that emerge, these are discussed with parents and team members. This can lead to a recommendation for other services, rather than gender care. In some cases, we encourage the youth and family to explore other options for relieving distress. Only when other alternative interventions have been explored would the team move forward with gender-related interventions.

There are no known medical treatments for patients who have not yet entered puberty. Once someone enters puberty, puberty blocking agents can provide patients, families, and physicians time for ongoing observation and assessment. Effects of puberty suppression are fully reversible and do not preclude later fertility. With additional 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. There are no genital surgeries provided to youth 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 1254.

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

Respectfully submitted,

Danial Sturgill, PhD
Clinical psychologist

2023 House Bill 1254
Senate Human Services Committee
Senator Judy Lee, Chairman
March 15, 2023

Chairman Lee and members of the Senate Human Services Committee, I am Melissa Hauer, General Counsel/VP of the North Dakota Hospital Association (NDHA). I testify in opposition to House Bill 1254 and ask that you give the bill a **Do Not Pass** recommendation.

We believe this bill represents a dangerous intrusion into the practice of medicine. We have grave concerns any time there is an attempt to criminalize medical care. The bill fails to take into consideration that clinical guidelines have been established by professional medical organizations for the care of minors experiencing gender dysphoria. These treatment interventions are based on evidence that every major medical association in the United States recognizes as the medical standard for transition-related care for improving the physical and mental health of transgender people. These guidelines establish the criteria for who is competent to provide gender-affirming care as well as the comprehensive processes that should be followed prior to initiating care. This is the same process for developing evidence-based standards for any type of medical care – whether that be for treatment of cancer, diabetes, asthma, or any other disease.

Several health care professionals who are here today will explain the standard of care for gender diverse minors but, at a high level, the care may include mental health counseling, non-medical social transition, and hormone therapy. This bill, however, would prevent trans youth from receiving medically necessary care for which learned professional societies have established evidence-based clinical treatment guidelines. If we truly believe that parents have a fundamental right to direct the care, custody, and control of their children, it necessarily includes the right to seek medical care for their children. Parents, in conjunction with their adolescent child's input and their doctor's recommendation, should be allowed to make a judgment that medical care is necessary in a given situation. This bill would have the state insert itself into that relationship and prevent the provision of care that is evidence-based, meets clinical guidelines, and takes place in circumstances where

the parent, adolescent, and healthcare providers are all aligned and supportive of what they view as the best medical treatment for a given adolescent.

At its most basic level, this bill allows the government to prohibit one type of medical care while allowing health care professionals, parents, and adolescents to together decide the best course of action for *other* treatments that also pose potential risks. It raises the question of what other areas of medical care could be subject to government intervention. For example, if a child has pediatric cancer, should the government dictate the type of medical treatment that child may receive? Should the government dictate how a parent must manage their child's Type I diabetes? We do not believe the government should prohibit a certain type of care and impose criminal penalties on a health care provider for providing medical care that follows evidence-based guidelines.

This bill will put health care providers in a very difficult position: follow evidence-based medical standards of care to provide healthcare services that are in the best interest of their patients or obey the state directive by withholding care and potentially violating their duty to patients and professional ethics.

We ask that you consider the evidence-based clinical guidelines that will be explained by the others who will testify today. These guidelines set out the treatment for gender dysphoria and the evidence that shows the benefits of gender-affirming medical interventions, where indicated, for adolescents with documented gender dysphoria. We ask that you trust the process established in the standard of care and the individual medical decisions of parents, adolescents, and healthcare providers.

Please give the bill a **Do Not Pass** recommendation. Thank you.

Respectfully Submitted,

Melissa Hauer, General Counsel/VP
North Dakota Hospital Association

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March 14, 2023

Re: HB 1254 - Relating to the Prohibition of Gender Affirming Medical Care for Minors

Dear Chair Lee and members of the Senate 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 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 1254.** 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 part of the 2021 Youth Risk Behavior Survey. These are the stats before the 2023 North Dakota legislature introduced multiple bills 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 1254.

Sincerely,
Kara Gloe, LMSW
Canopy Medical Clinic

701.557.1500 » info.naswnd@socialworkers.org » naswnd.socialworkers.org

NASW
National Association of Social Workers
NORTH DAKOTA CHAPTER

TESTIMONY on HB 1254
from the
NATIONAL ASSOCIATION OF SOCIAL WORKERS—NORTH DAKOTA CHAPTER
to the
ND Senate Human Services Committee

March 15, 2023

Chairman Lee and members of the Senate Human Services Committee:

The Advocacy Committee of the NASW-ND submits this testimony in opposition to House Bill 1254. We appreciate the opportunity to share our perspective.

NASW-ND urges the members of the Senate Human Services Committee to vote DO NOT PASS on HB 1254 for the following reasons:

1. HB 1254 confuses sex and gender.

Section 1, point 3 (p1 lines 13-14) reads, "*sex is defined as the biological state of being female or male based on nonambiguous sex organs, chromosomes, and endogenous hormone profiles at birth*." An individual's sex is defined by the biological reproductive organs assigned at birth. In contrast, gender is the social, psychological, cultural, and behavioral aspects of being a man, woman, or other gender identity.

This bill confuses sex with gender in Section 1, point 2 (p1 lines 16-19) where it states, "if a minor's perception of the minor's sex is inconsistent with the minor's sex, a health care provider may not engage in any of the following practices for the purpose of changing or affirming the minor's perception of the minor's sex." In this example, the "minor" is not asking to change their sex, merely to be allowed to align with the gender that is true for them.

2. HB 1254 attempts to criminalize gender-affirming surgery on minors, despite North Dakota's current policy.

Under Section 1, point 4 a & b (p.1 lines 20-22), this bill would prohibit North Dakota health care providers from performing castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty orchiectomy, penectomy, phalloplasty, vaginoplasty or mastectomy on a minor for the purposes of changing their sex. It is our understanding that currently North Dakota medical providers cannot currently perform gender-affirming surgeries on minors. That would make this portion of the bill unnecessary.

3. HB 1254 will jeopardize the health of North Dakota minors through the prohibition of medical care, even though that care is consistent with over a dozen studies and the American Medical Association.

Under Section 1, point 4 c (p2 lines 1-6) removes all gender-affirming care to minors, including puberty blockers and hormones.

This is an incredibly harmful, cruel, and dangerous bill. Data from more than a dozen studies of more than 30,000 transgender and gender-diverse young people consistently show that access to gender-affirming care is associated

with better mental health outcomes—and that lack of access to such care is associated with higher rates of suicidality, depression, and self-harming behavior. Most major 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 , have published policy statements and guidelines on how to provide age-appropriate gender-affirming care. All those medical societies find such care evidence-based and medically necessary.

The National Association of Social Workers (NASW) supports policies that "promote [...and] strengthen young adult health care." NASW also supports evidence-based practice and research, so based on the above data and testimony from numerous individuals across our state telling us this legislation will drastically remove their quality of life for no reason. There is no recorded violence or sexual offense in our state attributed to a transgender individual. NASW Code of Ethics supports clients' well-being and respects and promotes clients' right to self-determination. Social workers assist their clients in their efforts to identify and clarify their goals.

HB 1254 directly opposes that effort and will jeopardize the health of North Dakota minors. You can be confident this is true because of the testimony submitted by North Dakota clinicians including Dr. Balf, Dr. Dahl, Dr. Selzler-Echola, Dr. Peterson, Dr. Sturgill, Dr. Thurlow, and the North Dakota Medical Association, all opposing this HB 1254. Additionally, you have heard testimony from transgender community members and parents of transgender children begging you to vote against this legislation.

Thank you for the opportunity to share our objections to this bill, and the **NASW-ND respectfully urges the Senate Human Services Committee to vote DO NOT PASS on HB 1254.**

Submitted by:

Elizabeth Loos
NASW-ND Lobbyist

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Members of the Senate Human Services Committee,

My name is Lisa Pulkrabek and I live outside of Mandan in District 31. I am writing to you today to ask you to please render a Do Pass recommendation on HB 1254 Relating to the prohibition of certain practices against a minor; to provide a penalty; and to declare an emergency.

Women are women and men are men. An adult man can take 100 hormone shots, grow his hair out, wear a dress, put on lipstick and change his name but he will always be a man. An adult woman can take 100 male hormones, have her breasts removed, cut her hair short and change her name but she will still be a female. This is a fact of biology.

Children who are confused about their gender need loving psychological therapy not genital altering surgeries, hormones and puberty blockers. These are dangerous, permanent and we don't know the long term effects on the overall health of the individual. Think of a student who is suffering from anorexia, should the school officials play along with the student and call him or her fat, withhold food and encourage excessive exercise because the student might feel offended if they do not? Should the students be sure that the individual sits at lunch with no food on their plate? That would be considered abuse. It is psychological abuse to play along with a student who has gender dysphoria.

I support this bill because children under the age of 18 need to have time, a few more years to truly wait and see if their gender dysphoria will go away as it often does. Kids and teenagers are easily persuaded to do things that are not healthy. There is an agenda out there pushing transgenderism on kids and lonely, isolated, abused, neglected and ostracized confused kids can fall prey to this agenda. The state on ND needs to protect these kids from mutilation and hormone therapy that can truly harm their bodies. Let them wait until they are 18 to decide to take these treatments and surgeries. I think that teens with gender dysphoria need love and encouragement to look outside of themselves. Let's get these youngsters psychotherapy just like we give to those who have depression, anxiety, anorexia, bulimia and other mental disorders.

I am attaching many links to testimonies of individuals who have transitioned from one sex to the other and now regret it. This is a real thing. In fact, there are studies that show that trans people are no happier after their transitions than they were beforehand. So if begs the question, was their gender really the problem or are they truly psychologically unwell?

These are videos! You don't even have to read them. Real life stories from the people who went through this trauma themselves. Grab a box of tissues.

https://youtu.be/6O3MzPeomqs

https://youtu.be/27qjn0v4Av4

https://youtu.be/fDi-jFVBLA8

https://youtu.be/QbXyyq1333I

https://youtu.be/OmsYKSiBZzU

https://youtu.be/mRh80xSI8QQ

https://youtu.be/U7hxYBDcElc

https://youtu.be/ZTzkqZUNK0c

https://youtu.be/doaHPFWEa7E

These are articles.
https://www.hli.org/resources/what-percentage-of-transgenders-regret-surgery/

https://www.nationalreview.com/2021/06/how-transgender-ideology-takes-children-hostage/

https://www1.cbn.com/cbnnews/world/2019/october/a-tidal-wave-of-transgender-regret-for-hundreds-of-people-they-dont-feel-better-for-it

Again I kindly urge you to render a Do Pass recommendation on HB 1254

Thanks ! Lisa Pulkrabek

Senate Human Service Committee
HB1254
March 15, 2023

Chair Lee, Vice Chair Cleary, and Committee members:

The American Civil Liberties Union of North Dakota strongly opposes HB 1254.

By categorically banning all medical care for minors related to "gender transition", HB 1254 discriminates 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 violates 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 State."[7] The North Dakota legislature's only purported justification for the bill is

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[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).
[7] *Virginia*, 518 U.S. at 531.

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 would 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 keep their children alive and well. As the Arkansas court held in Brandt about Arkansas's

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[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.*

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 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).

March 14, 2023

RE: Opposition to HB 1254

Dear Chair Lee and Members of the Senate Human Services Committee:

My husband and I grew up in rural Central North Dakota. We have strong North Dakota work ethics and spiritual values. We have spent our careers contributing to and promoting of the agricultural economy and technical education of our State. We are proud of our heritage. We likely live our life like most of you.

We are also parents of a transgender young adult. We never anticipated navigating this journey as a family. It is a journey not taken lightly or in haste. You have heard the statistics from the medical professionals providing testimony to DO NOT PASS. We lived in fear of losing our child for a long time. Once the dysphoria was disclosed, our child knew with 100% conviction who they are and have not waivered once in the past 8 years. We educated ourselves and our child for many years. We counseled with over 19 different medical experts from psychiatrists, phycologists, counselors, family practitioners, endocrinologists, fertility, religious leaders, school administrators and adult transgender human beings in various stages or years in and post transition along with other families. We read and watched materials from all sides of the issue, including pouring over medial studies from sources around the globe. We took the transition slow, as directed by the many professionals caring for our family and always trusting our hearts and minds as parents who love without condition. We have witnessed the agony of living misaligned between brain and body and how the staggering statistics you read and hear about from experts on rates of depression and harm can drop substantially by having one trusted adult and a proper support network around them – community, access to proper medical and therapy teams. We have also witnessed the devasting impact of what living misaligned and without support or under intentional rejection can have on a person that by no fault of their own was born this way. Trust us as parents, no one would choose to live this life. No parent or transgender person navigates this journey without caution and care. No one wants to feel outside themselves, told by your “home” that you are not valued, you are not wanted, you are not deserving of the same basic rights and care of the broader community.

Attempts to erase human beings that are different than the cultural ideation of normal have always proven to be the wrong moral choice throughout history. We invite you to place fear aside and get to know a family living this life. Access to proper care saved the life of our child, who is thriving, involved in community, and a contributing tax payer to the State of North Dakota.

Please, give others the chance at a productive and fulfilling life. **Do not pass HB 1254.**

Thank you sincerely for reading our story,

Tara Jensen

Fargo ND 58102

House Human Services Committee,

The Fargo Human Rights Commission passed a resolution at its February 16 meeting in which we went on record opposing all anti-transgender bills, on the basis that they separately and collectively hurting our kids and they are restricting freedoms. Fargo has an incentive to make its citizens feel safe and welcome where they live, and this bill detracts from the ability of trans youth and families of trans youth to access medically necessary care. It is difficult, essentially impossible, to tell people that we live in an affirming city that actively welcomes people from all walks of life, when we our state is telling people that it is illegal to seek out gender affirming care with their medical providers.

This bill does not reflect the values of the community that it purports to serve. We believe that our community members are capable of having discussions with their medical teams, parents, and any other individuals that they trust to make decisions about their bodies. We respect and trust our community to make their own decisions.

As you have heard and will hear from multiple medical professionals, this bill will hinder their ability to provide care to their patients to the best of their abilities. If there is going to be a directive for licensed medical professionals to adhere to, it should come out of the appropriating accrediting body.

Thank you,

Cody Severson

Fargo Human Rights Commission Chair

Dear members of the Senate Human Services Committee,

My name is Mariah Ralston Deragon, and I am writing in strong opposition to HB1254. I respectfully ask that you VOTE NO on this bill.

I would point to the testimony of Dr. Amanda Dahl, a board-certified Pediatric Endocrinologist, who likewise strongly urges you to vote DO NOT PASS.

I would also point to testimony provided by transgender individuals themselves, and their families.

What this bill is trying to do, is ban life affirming medical care for an extremely vulnerable population. No one who pursues gender affirming care does so on a whim- it is usually after years of suffering, confusion, and isolation.

To deny access to these procedures and medications would be inhumane.

I trust that the ND senate will listen to medical professionals and the lived experiences of your constituents. Please join me in opposing HB1254.

Sincerely,
Mariah Ralston Deragon
Bismarck, ND

Dear Chair Lee and the members of the Senate Human Services Committee,

I urge a “Do Not Pass” on HB 1254.

I personally know three youth that have started their transition in their teens. Their parents are loving, caring, and responsible people. They have sought the help of professional counselors and doctors and have supported their teenage children during this whole process. These parents are no different than you and I. They want what’s best for their children. No one has recruited them or forced this decision upon them.

I feel that people who have never listened to a trans person tell their full story will never really understand what a life-saving procedure transitioning can be.

I feel blessed that they have been willing to share their stories.

Naomi Franek

Fargo, ND

Senate Human Service Committee
March 15th, 2023 HB 1254
Testimony in Opposition

Dear Chair Lee and the members of the Senate Human Service Committee,

I'm writing to you as the leading suicide prevention advocate for LGBTQ+ populations within North Dakota and I urge a "Do Not Pass" on HB 1254. Please consider the three following items:

1. **The Care is Medically Necessary and Life Saving**
    a. The guidelines took 5 years to develop from 119 medical experts and features 1,500 citations with full transparency for every decision made.
    b. Care has not been banned in other countries, only restricted, often with the goal of training more mental health professionals and improving quality of care. (Sweden, Britain, Finland, France)
    c. All puberty is irreversible, whether through natal or hormone intervention, which is why it's essential we have treatment options to stop the irreversible harm caused to trans youth by a natal puberty that will require surgery to fix later in life.
    d. Consideration for studies and limits:
        i. No large-scale studies tracking outcomes of medical care have been published yet
        ii. No large-scale study has ever been conducted to show the possible harm of removing trans care entirely. (The direction these bills take us in is less researched and understood than the care we provide.)
        iii. The majority of small-scale evidence points to benefit - 2 year clinical
2. **North Dakota Trans Youth in Particular are Struggling**
    a. According to the Youth Risk Behavior Survey of North Dakota, trans youth are significantly more likely to experience suicidality, violence, homelessness, depression, and bullying:
        i. Data: 2021 High School Trans / 2021 Middle School Trans
    b. The North Dakota LGBTQ+ School Climate Report, that I spent a year researching and putting together, indicates these outcomes are related to minoritized stress, experiences of discrimination, and lack of support with schools or through school policy.
    c. The outcome data above includes individuals who aren't out or are questioning, meaning that many of these youth are suffering in silence. This further indicates it isn't transition that causes the outcomes, but rather isolation, stigma, and prejudice that makes youth feel scared and unwelcomed.

3. **Addressing Common Fears**
    a. Social contagion, a 2018 study, is a large component of current fear that kids are being tricked into identifying as trans and then pursuing irreversible regrettable choices.
        i. It only polled parents feelings of their youth
        ii. It didn't account for clinical diagnosis
        iii. It didn't ask youth questions on their feelings
        iv. The phenomenon has been a refuted through follow-up studies
    b. Large scale population studies show equal levels of trans girls and boys
        i. Alleged increase for trans boys (assigned female at birth) is a result of small-scale review of clinics and other factors that can skew understanding when operating with limited data
    c. Long journalistic and asserted as unbiased review in Reuters shows detransition as likely rare, but important to address.

I've spent the last ten years working to improve outcomes in North Dakota for LGBTQ+ populations. In my time engaging in this work, I discovered that what I really cared about was suicide prevention. As a survivor of suicide, I understand the place these kids get to. I understand how hopeless it can feel. I understand not wanting to be here and not planning to have a future. Everything I do, everything I fight for, is to make sure all kids have hope. That no youth ever goes through that pain or struggle.

Everything I do is data driven and I'm often the person doing the research, advocating for the data, and making sure we're doing the best we can for kids. If you asked me if we need this bill, I can flatly tell you no. If you asked me if trans care could be better, I would tell you absolutely. If you asked me if I care about people who detransition, my heart breaks for them. And if we were to sit at a table to talk about solutions that help everyone, the answer we come away with is better access to mental healthcare for all our youth.

Taking away trans care from the people who need it, doesn't help that little girl who thinks she has gender dysphoria but really is dealing with depression, anxiety, or body image issues. What helps her is more access to mental healthcare. If we pass this bill, we can't respond to new research or better guidelines. We would be sitting our boat to sail and hoping we have the supplies to make it to 2025 without losing any passengers.

It's for these reasons that I ask you to please give this one a "Do Not Pass".

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

March 14,2023

Testimony in Opposition to HB No. 1254

Dear Chairman Lee and Members of the Senate Human Services Committee,

I am a native North Dakotan returning to the state in retirement. I urge you to give this bill a DO NOT PASS. I appreciate the conviction of the bill's supporters. I believe medical decisions should be left to the patient/guardian and their medical providers, not the State of North Dakota. There is a great deal of public attention given to this topic and I urge you as our elected representatives to heed the information as presented by the medical professionals and not yield to political pressure. Please consider the potential unintended consequences on already stressed health care systems and education facilities of legislating and criminalizing even the most specialized fields. Please give your constituents a vote of confidence to support our health care with your Do Not Pass vote on HB 1254.

Thank you for your time and service to our state.

Regards,

Michael J. Southam

Below are excerpts from a recent Medscape article from earlier this year regarding regret and other ill effects of transition therapies. Detransitioners are individuals who have undergone sex reassignment surgery/hormone therapy, and later on change their mind and wish to return to their original genetic sex.

Medscape REUTERS

Robin Respaut, Chad Terhune and Michelle Conlin January 04, 2023

In the past year, MacKinnon and his team of researchers have talked to 40 detransitioners in the United States, Canada and Europe, **many of them having first received gender-affirming medical treatment in their 20s or younger**. Their stories have upended his assumptions.
Many have said their gender identity remained fluid well after the start of treatment, and **a third of them expressed regret about their decision to transition from the gender they were assigned at birth**. Some said they avoided telling their doctors about detransitioning out of embarrassment or shame. Others said their doctors were ill-equipped to help them with the process. Most often, they talked about how **transitioning did not address their mental health problems.**

For this article, Reuters spoke to **17 people who began medical transition as minors and said they now regretted some or all of their transition**. Many said they realized only after transitioning that they were homosexual, or they always knew they were lesbian or gay but felt, as adolescents, that it was safer or more desirable to transition to a gender that made them heterosexual. Others said sexual abuse or assault made them want to leave the gender associated with that trauma. **Many also said they had autism or mental health issues** such as bipolar disorder **that complicated their search for identity as teenagers.**

Echoing what MacKinnon has found in his work, **nearly all of these young people told Reuters that they wished their doctors or therapists had more fully discussed these complicating factors before allowing them to medically transition.**

"There's a real need for more long-term studies that track patients for five years or longer," MacKinnon said. **"Many detransitioners talk about feeling good during the first few years of their transition. After that, they may experience regret."**

Doctors and detransitioners also described the challenging physical and emotional consequences of the process. **For example, patients who had their ovaries or testes removed no longer produce the hormones that match their gender assigned at birth, risking bone-density loss and other effects unless they take those hormones the rest of their lives.** Some may undergo years of painful and expensive procedures to undo changes to their bodies caused by the hormones they took to transition. Those who had mastectomies may later undergo breast reconstruction surgery. As parents, they may regret losing the ability to lactate.
Detransitioners also may need counseling to cope with the process and any lingering regret.

Still skeptical that regret was a significant issue, MacKinnon in the autumn of 2021 embarked on his latest study and began talking to more people about their decisions to detransition. In July, he published a paper based on formal interviews with 28 of the **more than 200 detransitioners he and his colleagues have found. A third expressed either strong or partial regret about their transition.** Some said their transitions should have proceeded more slowly, with more therapy**. Others expressed regret about the lasting impact on their bodies.** Some said their **mental health needs weren't adequately addressed before transitioning**. **"They felt like their consent wasn't informed because they didn't initially understand what was going on** that might have explained their feelings and suffering," MacKinnon told Reuters.

Source: Medscape. Respaut, Jan 2023
https://www.medscape.com/viewarticle/986476?ecd=mkm_ret_230305_mscpmrk_endo_trans&uac=220282AX&impID=5212280#vp_1

Testimony in Support of HB 1254

Dr. Daniel Scrimshaw, DO, Emergency Medicine Physician
Dr. Lovita Scrimshaw, DO, Emergency Medicine Physician
American Academy of Medical Ethics, North Dakota State Directors
March 14, 2023

Good morning Madam Chair Lee and honorable members of the Senate 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 1254 and respectfully request that you render a "DO PASS" on this bill.

First and foremost, this bill is about the protection of children. We cannot state this any simpler- this bill is about protecting children in our state of North Dakota. These hormone therapies and surgeries are documented in the literature to be harmful and regretful. This bill does not apply to adults, who are no longer minors.

Consider this example: the state does not allow a minor (less than age 21) to purchase, possess, or consume alcohol or cigarettes (even with a parent's consent). Likewise, we should not allow a minor to make this life altering decision of sex reassignment surgery/hormone therapy. Please understand and do not forget that the cornerstone of this bill is about protecting children.

In our practice of emergency medicine, we have cared for many transgender patients who have undergone surgeries and/or hormonal therapies. They still experience depression, suicidal ideation, and have suicide attempts. 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 treatment of overdoses, self-inflicted injuries, and admission to inpatient psychiatric hospitals 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 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. The Constitution of North Dakota states that the government has a responsibility to protect the people (Constitution of North Dakota, Article I, Section 2).

We were pleased to see that this bill passed the North Dakota House with such a large majority supporting it. We hope for the same level of support from the North Dakota Senate and Governor's Office. Failure to pass this bill would be unethical. All of those in office/authority have an obligation to care for and protect the children in our state. We would like to provide further information[1] related to the medical impact of these procedures which will explain in

detail medical reasons for our support of this bill. The data below provides evidence that children are being harmed by this surgical/medical therapy.

> "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] „

We appreciate the opportunity to provide testimony on HB 1254 and 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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North Dakota
House of Representatives
STATE CAPITOL
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BISMARCK, ND 58505-0360

Representative Brandon Prichard
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COMMITTEES:
Human Services
Agriculture

House Bill 1254
Senate Health and Human Services Committee
Senator Lee, Chairman
March 15, 2023

Chairman Lee and members of the Senate 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 1254 which would ban transition surgeries, hormone therapy, and puberty blockers on children with the intent to change the gender of the minor or stop development to consider gender transition. If passed, HB 1254 would create a Class B Felony for doctors who perform transgender surgeries on children and a Class A Misdemeanor for doctors who prescribe puberty blockers with the intent to change a child's gender.

Transition surgeries and medications have a brutal and life-altering impact on 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.[1] In fact, some drugs like Lupron or Leuprolide Acetate are used to chemically castrate convicted pedophiles. Yet Lupron and similar drugs are widely accepted as the best option to give to children to transition to the opposite gender or disrupt puberty.[2]

In truth, there are no credible long-term studies that confirms the claim that transition surgery, hormone therapy, or puberty blockers help children overcome gender dysphoria, depression, anxiety, or any other mental health problem. The reason for this discrepancy is that the widespread push to transition the gender of children is a new phenomenon. Even the National President of the pro-transgender organization titled the World Professional Association for Transgender Health publicly warned about "rapid-onset" gender dysphoria where a person – often young women – develop an identity attachment to the opposite sex rapidly, but later revert their identity to the sex assigned at birth.[3] Many researchers acknowledge the phenomenon that "onset-gender dysphoria" describes: A huge increase in the Western world of teenagers and young adults suddenly expressing a transgender identity seemingly out of the blue, when previously there had been no indication that they were uncomfortable with their biological sex. Beyond the issue of a rapid onset of a dysphoria, the existing research has done little to no comparison between transgender surgery, hormone therapy, and puberty blockers compared to counseling services that are traditionally used to treat mental illnesses and other forms of dysphoria. Therefore, to suggest that invasive surgery or experimental

[1] Study: Effects of puberty-blockers can last a lifetime | WORLD (wng.org)
[2] Doctors Give Kids Drugs That Can Chemically Castrate Them - Just Like Pedophiles (westernjournal.com)
[3] Transgender Docs Warn About Gender-Affirmative Care for Youth (webmd.com)

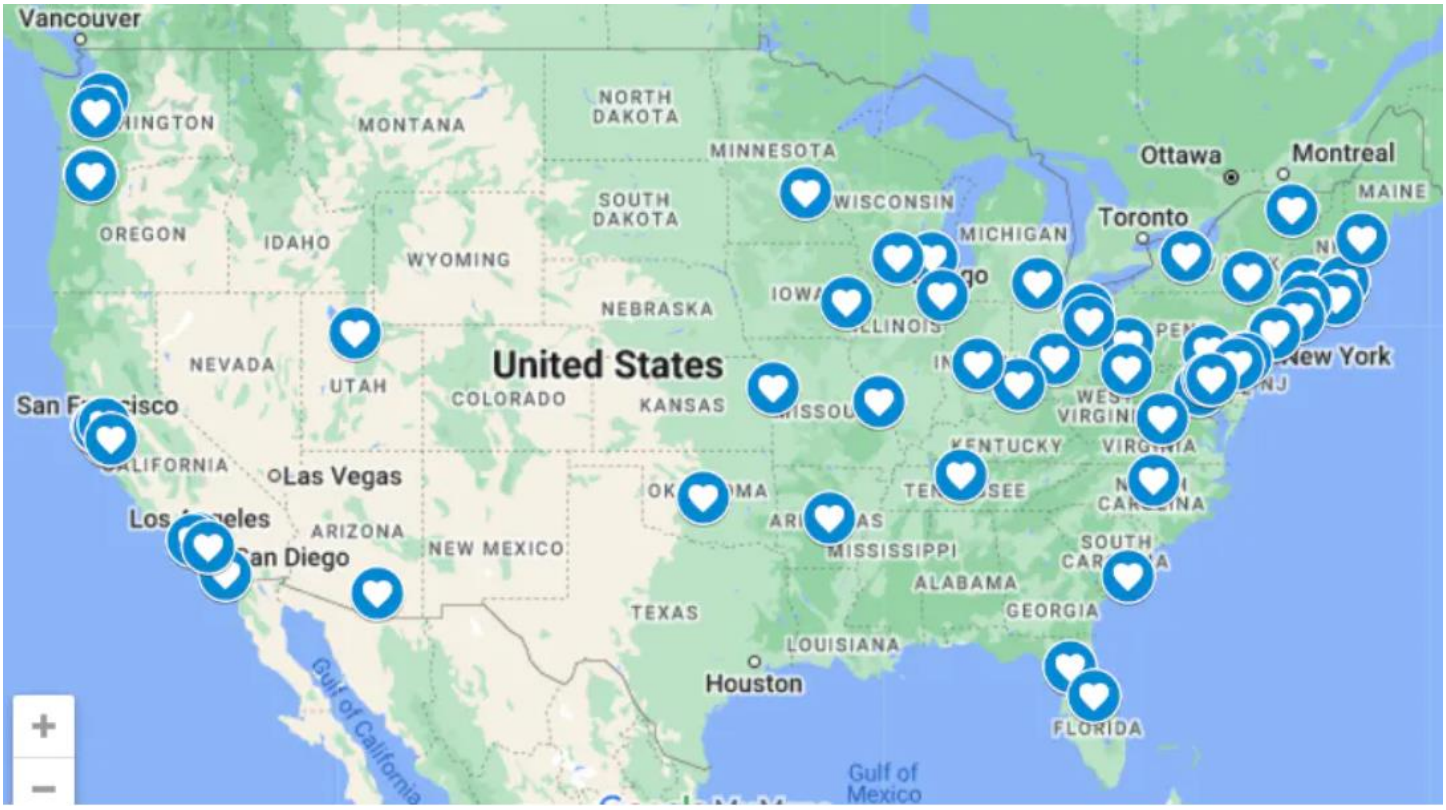
drugs are the correct way to treat gender dysphoria is grounded in no long-term research and instead finds its most compelling argument in political activism and appeals to emotion.

Transgender surgeries and medications are used on children around the country in clinics set up to exploit children with gender confusion. In Attachment A, a list of gender affirming clinics as compiled by the Human Rights Campaign are listed.[4] You can see that there are several dozen gender affirming clinics around the country that operate on children, including in Minnesota. The problem with this list is that it misses one clinic that began practicing in February of 2023. This clinic was in North Dakota. According to the Fargo Forum on February 5, 2023, an all-ages family physician from Fargo is opening a clinic to focus on providing gender-affirming care to members of the LGBTQ+ community, including children. Transitioning children before they can drive, smoke, drink, attend college, etc. is not an out-of-state issue. Instead, the movement to exploit children with mental illness is at our doorstep and it will succeed without action.

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 1254 by giving the bill a "Do Pass" recommendation.

[4] Interactive Map: Comprehensive Care Programs for Gender-Expansive Children and Adolescents - Human Rights Campaign (hrc.org)

Attachment A – Map of Transgender Clinics in US



Testimony of Mia Halvorson

In Opposition of HB 1254: “Relating to the prohibition of certain practices against a minor; to provide a penalty; and to declare an emergency.”

March 15th, 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.

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 1254 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

While I do not live in North Dakota, the company I work for (AE2S) is headquartered in Grand Forks and has several offices throughout the state. In my role as Water Resources Practice Leader, I often travel to the state to help communities plan for flood and drought resiliency.

As a trans woman and as a parent to a trans kid, I am appalled at this legislation. My daughter, who is almost 14, came out as trans last year. Prior to coming out, she was a tentative, anxious kid, but the confidence that I've seen her gain in the last several months has been breathtaking. She went from someone who didn't like school to an 8th grader who is self teaching herself calculus, infinite series, and computer programming so that she (in her words) "can do cooler math". She also initiated the process to apply to a pre-college computer programming and information technology program at the local university. I could not have imagined this is the same kid that was my "son" a year ago.

My daughter also has access to appropriate healthcare. She is currently on puberty blockers, and will likely choose to start adult hormones in the next year so that she can have an adolescence that matches her peers. The puberty blocker is Lupron. This drug has literally been on the market for decades and used successfully to treat (mostly young girls) who start puberty way too early. Its effectiveness is proven. It's safety is proven. It is not life altering. It is merely a pause.

Finally, I have heard many times from transphobic "well meaning" adults that we can't let kids go through irreversible changes. I'm telling you – going through the wrong puberty as a trans person is irreversible changes.

Please, I'm begging you, vote this bill down.

Testimony in opposition of HB 1254

Relating to the prohibition of certain practices against a minor; to provide a penalty; and to declare an emergency.

Senate Human Services Committee March 15, 2023

Senator Lee and committee members. My name is Stephen McDonough. I am providing testimony in opposition to HB 1254.

I am a board certified pediatrician who worked in North Dakota for forty years, from 1980 to 2020. I worked at the NDDoH from 1985 to 2000 and served at times as the State Epidemiologist, AIDS/Project Director, Director of Maternal and Child Health and Chief Medical Officer. As a pediatrician, I provided primary care to LGBTQ adolescents and treated them with dignity and respect.

In 1989, the North Dakota Legislature passed AIDS/HIV legislation which balanced good public health and compassion and led our state to have the LOWEST HIV cumulative case rate in the United States for the next 30 years. We reached out to the LGBTQ community to reduce HIV transmission.

At that time there were extremist haters that called HIV the "Gay Plague" and would have been pleased if HIV wiped out the gay community. At the time, these haters were a very small minority and not a major component of a prominent political party.

Now we have a Legislature considering around 20 anti-transgender bills, all based on lies and misinformation. These terrible bills have given our state the reputation of being anti-science and one of intolerance and hate. Nearly 70 religious leaders and over 200 medical providers have recently published letters to the editor opposing these hateful bills.

This bill is not needed. This bill is state-sponsored child abuse. Transgender individuals should receive the health care that they need.

The North Dakota Legislature should not be bullying transgender individuals. HB 1254 needs to be defeated.

Stephen McDonough MD

North Dakota Catholic Conference

Representing the Diocese of Fargo and the Diocese of Bismarck

103 South Third Street
Suite 10
Bismarck ND 58501
701-223-2519
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ndcatholic@ndcatholic.org

To: Senate Human Services Committee
From: Christopher Dodson, Executive Director
Subject: House Bill 1254 - Protection of Minors from Gender Transitioning Interventions
Date: March 15, 2023

The North Dakota Catholic Conference supports House Bill 1254, especially as it relates to surgeries.

The Catholic Church affirms the God-given dignity of every human life. Persons with gender dysphoria or feelings of gender incongruence are due respect, love, and care.

As in all things, however, respect, love, and care sometimes mean placing limits. Two sets of facts illustrate why this is one of those cases.

The first set concerns the medical interventions themselves. 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. Each harms or suppresses healthy bodily functions, tissue, or organs. They do not treat any disease. No illness is averted and no pathology is treated. In the case of surgery, it is the alteration or removal of healthy organs and tissue, an act also known as mutilation. The consequences are permanent, can cause sterilization, and lead to the inability to physically enjoy sex in later years.

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 ignore that the act itself harms the body and that the act does not directly treat (not medically indicated for) the feeling of gender incongruence.

The second set concerns our development as a human person. Medical science confirms that sex is determined at conception and is genetically present in every cell. It is manifested throughout the body, including a person's endocrinology, brain, and anatomy. All of this interacts within the body, particularly while a person is reaching maturity.

At the same time, young persons grow and develop emotionally, mentally, socially, and sexually in relation to their sex. A child's sex is inseparable from the child's progress toward maturity and their fuller understanding of themselves and the world.

Recognition of this progress toward maturity is why we have laws preventing minors from engaging in certain acts or having certain acts done to them. It is out of care and respect for minors that we enact such laws.

House Bill 1254 falls within this area. According to North Dakota law, minors cannot legally consent to sex because they lack the ability to fully comprehend their actions. If they lack the ability to fully comprehend their actions, why would we allow having procedures done to them that cause the loss of fertility or full sexual function in later years?

Children with issues of gender/body incongruence are with us. They are among our relatives, neighbors, and our own children's friends. No matter what are our views on gender ideology, they should be welcome in our homes, churches, and community no differently than any other child.

But as we do for all children, sometimes society, out of love and care, has an obligation to say, "Not this. Not yet."

We urge a **Do Pass** recommendation on SB 1254.

Do Pass Testimony
of Doug Sharbono, citizen of North Dakota
on HB1254
in the Sixty-eighth Legislative Assembly of North Dakota

Dear Madam Chair Lee and members of the Senate Human Services Committee,

I am writing as a citizen and believe HB1254 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 HB1254 a Do Pass.

Thank you,

Doug Sharbono
1708 9th St S
Fargo, ND 58103

Senate Human Services Committee

House Bill 1254 – **DO PASS**

Andrew Alexis Varvel

Written Testimony

North Dakota State Capitol — Fort Lincoln Room

March 15, 2023 — 9:45AM

Madame Chairman Lee and Members of the Committee:

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

> “The younger sister of one of the girls asked for a job at Norma's. She was a very pretty girl, younger looking than her seventeen years, small boned and delicate, her face a sweet and perfect oval.
>
> On the girl's first night of work, just before four in the morning, a car slid up in front of 1026 Conti and parked. When the girl finished with her last trick shortly after four, she ran quickly to the car, got into the backseat, and the car drove off. The next evening the car arrived again, same time, parking so that part of Norma's driveway was blocked. Norma looked from the window as her new girl ran out and opened the passenger door. A man and a woman sat in front. It dawned on Norma that the girl's parents were picking her up after work every morning.
>
> Norma figured out that the parents didn't want their daughter running in the Quarter, getting mixed up with dope fiends, and she was sympathetic for a while. But after a few weeks she began to get irritated. 'It looked like hell,' she said. 'My parents knew what business I was in, but even when I was hustling, they didn't come pick me up.' She finally buttonholed the mother one night and asked her what the deal was.
>
> 'Well,' the woman said apologetically, 'our daughter has always lived a very sheltered life.'”

“The Last Madam: A Life in the New Orleans Underworld”, page 131.

If parents in North Dakota were doing the same thing to their daughter, they could be prosecuted for sex trafficking. And they probably should be.

I think that North Dakota still has a societal consensus that a minor cannot consent to prostituting himself or herself, and that parental consent for such behavior would constitute child abuse. Even if mental health professionals were to claim that engaging in prostitution would keep a child from committing suicide.

Yet, sterilization is far worse. As difficult as it may be for people to recover from sex trafficking, sterilization is permanent. Sterilization cannot be undone.

Critics of House Bill 1254 insist on calling it "authoritarian." Yet, banning child sterilization is no more or less authoritarian than banning child prostitution. House Bill 1254 is remarkably mild in comparison to North Dakota's existing laws against sex trafficking. In North Dakota, even adults are prohibited from prostituting themselves. (NDCC 12.1-29-03) In contrast, this legislation would still permit adults to sterilize themselves. At present, sex trafficking of an adult is a Class A felony and sex trafficking of a minor is a Class AA felony. (NDCC 12.1-41-02) In contrast, this legislation classifies genital removal to be a Class B felony.

Interestingly the Criminal Code section which concerns Female Genital Mutilation only deems it to be a Class C felony. (NDCC 12.1-36-01)

NDCC 12.1-36-01 states, "A custom, ritual, religious practice, or the consent of the parent or guardian of a minor is not a defense against a violation under this section." The committee should consider adding that language to this bill.

The committee should also consider incorporating language originally from House Bill 1301 to permit civil relief, both public and private, for minor victims of sterilization drugs or surgery. It is important to allow victims of genital removal to have avenues of redress for what has been done to them, as well as disincentivize medical industries which regard these drugs and surgeries to be revenue stream.

It is trendy on the cultural left to proclaim to the primacy of "lived experience". But whose lived experience? Are some lived experiences more equal than others? Should we listen to the lived experience of Ted Halley of Prattville, Alabama? Should we listen to the lived experience of Erin Friday of Palo Alto, California, whose daughter narrowly avoided getting herself sterilized in the name of a social trend? Should we listen to the lived experience of those who have lived under the care of an adult who is tries to change that child's gender?

I can assure you – if you don't know what it is like to live under the care of an adult who is trying to change your gender, you don't know the full story.

Sweden and Finland have turned against puberty blockers. Sweden and Finland have turned against transgender surgery. The United Kingdom is increasingly restricting these procedures too. So, it is possible to be a good socialist and oppose the sterilization of children. It is possible to be a good liberal such as Mr. Rogers, and oppose the sterilization of children. It is possible to be staunchly anti-authoritarian and oppose the sterilization of children.

This is not about right or left. This is about right or wrong.

I think it would be authoritarian to refuse to defend the rights of children who get pushed into sterilizing themselves to please parents who derive social prestige from having a “trans kid”. Sadly, there is little that can be done to keep fanatical parents from traveling to other states to get their children sterilized.

Gender dysphoria is a first world problem. Most people throughout the world do not have the financial resources to afford the puberty blockers and the plastic surgery of sex organs that have become so fashionable today. There is a class conflict implicit in expecting society at large to be on the hook for the medical aftermath of sterilization procedures which get called “sex reassignment”.

Our society should not push tomboys to become fake boys, nor to push boys who may fantasize about wearing dresses to become fake girls. Indulging fantasies is one thing, but mutilating one's self in the name of a social trend is quite another.

To quote Mr. Rogers,

Some are fancy on the outside.
Some are fancy on the inside.
Everybody's fancy.
Everybody's fine.
Your body's fancy and so is mine.

Thank you for your time. I am now open for questions.

Testimony in Opposition to HB 1473, HB 1254, HB 1522

Christina Sambor, *Lobbyist No. 312 – Legislative Coordinator, North Dakota Human Rights Coalition, Human Rights Campaign, Youthworks*

North Dakota Sen Human Services Committee

January 24, 2023

Chairman Lee and Members of the Committee:

My name is Christina Sambor, I am submitting testimony on behalf of the North Dakota Human Rights Coalition, the Human Rights Campaign and Youthworks to oppose the various bills set for hearing this morning that seek to exclude transgender students from facilities and limit their medical care.

HB 1473 and HB 1522 both deny a transgender person or student's ability to use the bathroom that corresponds to their gender. First of all, these types of policies are rooted in the idea that allowing a trans person, in particular a trans woman, access to the women's bathroom poses some sort of threat to the safety of women generally. There is no evidentiary support for this inflammatory and discriminatory position. Second, there is no reason that these issues can't and shouldn't be left up to individual school boards to handle. Conservative principles purport to value local control. School Boards and administrators are in a much better position to assess how a particular school district can handle these matters in a way that diffuses harmful speculation and considers the rights of the trans student as well as any concerns of the other students. There is no evidence that this is a statewide problem that requires a broad, discriminatory response.

Additionally, these policies go against the recommendations of many national education organizations such as National School Boards Association, the National Association of Secondary School Principals, the American School Counselor Association, the National Education Association, and the National Federation of High School Associations.

Most importantly, we know that affirming transgender students and respecting their rights shows them they are equal members of society, that they are welcome here, and that their worth is not diminished by their school. This is the position that the Legislature should be taking, that we can and will hear from, and uphold the rights of, a group of our citizens who are being unfairly attacked on a coordinated national level.

As to HB 1522, a group of doctors have testified to the scientific validity of safe and well managed care for transgender individuals. Our state policy should be guided by their expertise and compassion, not by fear. Societal changes certainly can be difficult, especially when they involve children, and the desire to make sure we are condoning practices that are helpful, not harmful, is a valid and understandable concern. Those with expertise in this area have provided their clinical knowledge to this committee, and we encourage our policy makers to give their expertise the respect and acceptance it deserves.

For all of these reasons, please vote do not pass on HB 1473, HB 1254, and HB 1522.

Senate Education Committee
March 15th, 2023
HB 1254 - Testimony in Opposition

Dear Chair Lee and the members of the Senate Human Service Committee,

My name is Shannon Krueger, District 3 resident, life-long North Dakota resident, educator and mother. I am writing in opposition of HB 1254.

Support Transgender children. Listen to the experts who have testified. Listen to the people who have spoken about the effects of this damaging bill. Listen to your constituents whose friends, family, and loved ones are affected. Listen to anything other than the personal opinions and misinformation you might hold in higher regard than the words of people of North Dakota who live their truth every day.

Thank you.

Intro: HB 1254 - Prohibition of Medical or Chemical procedure on an individual under 18

****

Distinguished Chairwoman Lee, Vice Chair Cleary, Committee Members, and all others.

For the record, I am Representative Bill Tveit, District 33, Hazen. District 33 includes all of Mercer & all of Oliver County, as well as the best parts of McLean and Morton Counties.
District 33 is the Heart of Coal Country, we produce and furnish your lights, heat and air conditioning, for your comfort, on a daily basis.

I am here to introduce HB 1254, which will prohibit future Medical or Chemical procedures being administered to those under 18 years of age.

****

As a disclaimer, I AM NOT a health care professional. I AM NOT a psychologist. I AM Not an expert.

I AM, however, a concerned Grandparent, Great-grandparent, a concerned citizen, a lawmaker tasked with the protection of the innocent, our youth and the future generation, your/my future care givers.

To begin with, how many of you, your family members or acquaintances, have ever followed a trend or childhood fantasy? Maybe even researched it as best you could, then made a decision, sometimes with the advice and encouragement from trusted acquaintances, parents or professionals, only to deeply regret that decision later?

Bill Maher once said: "If kids knew what they wanted to be at age eight, the world would be filled with cowboys and princesses. I wanted to be a pirate. Thank goodness nobody took me seriously and scheduled me for eye removal and peg leg surgery."

HB 1254 is not a judgement on any group of people. HB is not an attack on the LGBTQ+ agenda or any individual. HB 1254 is not a restriction to "Health Care", as some would have us believe. HB 1254 is not about restriction of the rights of individuals.

HB 1254 is about letting our youth be youth; HB 1254 is about us being adults.

HB 1254 is about being there, for our minors, during the most vulnerable time of their innocent and formative years.

HB 1254 is about us protecting our young from irreversible harm to their body, mind and spirit

****

HB 1254 is concern about our "Trusted" Health Care System seeing Dollar Signs, seeing opportunity to cash in on this fad, and maybe cash in, again, when realization sets in and these young, vulnerable, victims have hopes for and seek the gruesome, nearly impossible, reversal procedure.

Sanford Health, the largest healthcare provider in the Dakotas, is actively promoting gender-affirming care. Sanford follows the guidelines of the World Professional Association of Transgender Health (WPATH), which is led by ideologically and financially-motivated activists, preying on our youth, who seek to circumvent parental authority, if needed, and to medically transition as many children as possible.

WPATH recently released their Standards of Care guidelines, which removed the minimum age recommendations for medical intervention, removed a chapter on ethics, and introduced a new Eunuch gender identity.

(for those who don't believe this is an issue for us in the Dakotas, please see the attached "3rd Annual Midwest Gender Identity Summit" advertisement, attached, and the Health Care company involved)

****

HB 1254 is about youth like Chloe Cole, somewhat of a "Tom Boy" in her own words, a 11 year old, who began believing she was born in the wrong body. At 13, she began taking Puberty-Blockers & Testosterone, who at 16 had a double mastectomy.

The trusted adults in her life, parents, healthcare personal and others, rather than protect her in her innocence and try to help her to understand the fantasy she was believing and living, they encouraged and aided her on this path of personal physical and emotional destruction.

Chloe, now 18 today, regrets the decisions she made. She struggles with the advice and the relationships, the trust in/of those who gave that advice.

Chloe is speaking out about the path she chose, her now regret of the double mastectomy and hormone treatments to change her gender. Chloe recently said, with desperate, pleading, hope and desire that, in reality, she some day would be able to have children: "I will never be able to nurse my babies", considering what was done to her young and innocent body.

https:www.prageru.com/vidio/child-regrets-transitioning-soon-after-mastectomy-and-horm

Chair Lee, Committee Members:

With all that is within your power, conscience, and ability, PLEASE send HB 1254 forward with a Do Pass Recommendation.

Do this in defense of our innocent youth, who in their delicate, vulnerable and formative years, **depend on you**, other trusted adults and professionals, **not to exploit them**, but **to defend** & **protect** every part of their being.

It is imperative to the safety and welfare of our youth of North Dakota, those under 18, that **YOU** give HB 1254 a unanimous "**Do Pass**", sending this "Protection Bill" forward, and the message you sincerely care about their future health, wellbeing and prosperity. I will stand for any questions.

@JoshWalkos

If a surgeon uses their scalpel to permanently alter the reproductive organs of a young girl in the name of religious or cultural traditions, in the West we call it "female genital mutilation".

However, if that exact same surgeon uses their scalpel to permanently alter the reproductive organs of a young girl in the name transgender ideology, in the West we call it "gender-affirming care".

THE TRANSFORMATION PROJECT &
SANFORD HEALTH PRESENT:

3RD ANNUAL MIDWEST GENDER IDENTITY SUMMIT

JANUARY 13TH, 2023 | 8:30AM-4:30PM
SANFORD RESEARCH CENTER & ONLINE

Educating, Empowering & Supporting the transgender community through the lens of healthcare.

CLICK HERE TO REGISTER ›

Sanford employees: If the registration fee is a barrier to attending, please contact Roxanne.Vandendries@sanfordhealth.org for a financial waiver.

Registration fee will be refunded, mi… $10.00 cancellation fee, if you choo… cancel before January 2, 2023 . No re… will be given for cancellations after January

Nonambiguous: adjective; non-am-bi-gye-wes: not capable of being understood in two or more possible senses or ways: UNAMBIGUOUS

Endogenous: en-dog-e-nous /en'dajenes/ growing or originating from within an organism

Castration: any action, surgical, chemical, or otherwise, by which an individual loses use of the testicles.

Vasectomy: the surgical cutting and sealing of part of each vas deferens, typically as a means of sterilization.

Hysterectomy: the surgical removal of the uterus and most likely the cervix

Oophorectomy: o-o-pho-rec-to-my /oofe'rekteme/ surgical removal of one or both ovaries

Metoidoplasty: is a type of gender affirmation surgery, also referred to as a "bottom surgery" or a meta". Metoidioplasty uses a testosteribe-enlarged clitoris to form a penis. This gender affirmation surgery can be done with or without lengthening the urethra.

Orchiectomy: or-chi-ec-to-my /orke'elteme/ ; surgery to remove one or both testicles.

Penectomy: pe-nec-to-my /pe'nekteme/ Surgical amputation of the penis

Phalloplasty: phal-lo-plas-ty /'falo,plaste/ plastic surgery performed to construct, repair, or enlarge the penis.

Vaginoplasty: vag-i-no-plas-ty /vajene,plaste/ plastic surgery performed to create or repair a vagina

Supraphysiological: Of or relating to a dose of a medicine that is larger than that of an equivalent hormone or other compound normally present in the body.

Eunuch: eu-nuch ; a man who has been castrated; (an "invisible gender" – Prof.Thomas W. Johnson, CSU, Chico, "the oldest recognized gender outside the binary")

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ACPeds Releases New Evidence-Based Position Statement on Teen Brain Development; High Risk Behaviors, Abortion, Gender-Transition Surgeries Can Have Adverse Effects

17 May 2022

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Gainesville, FL— Today, the American College of Pediatricians (ACPeds) announced the publication of a its evidence-based Position Statement entitled **"The Teenage Brain: Under Construction"** with research showing that adolescents' brains are under construction during these formative years, and this should inform parents' role to protect the best interests of their children.

The evidence-based research on brain development shows that the adolescent brain is under construction and can be adversely affected by high-risk behaviors and by the negative environmental influences the brain experiences. The judgment center is immature, leading to poor decision making. High-risk behaviors and permanent medical decisions such as abortion and gender-transition surgeries that are encountered during these vulnerable years can have lasting adverse consequences. The importance of parental supervision, sound coaching, and assistance in decision making cannot be overstated.

Dr. Jane Anderson, MD, FCP, board member of the ACPeds and retired faculty in Pediatrics at University of California San Francisco released the following statement:

"High-risk, addictive behaviors such as drug use, gambling, video gaming, pornography, sexual experiences and permanent medical decisions such as abortion and gender-transition surgeries can have lasting adverse consequences on the teenager. Parents can positively impact the brain development of adolescents as they assist in sound decision-making, provide structure to the adolescent's environment, and monitor the adolescent's activities.

If you would like to set up an interview with Dr. Jane Anderson, please contact **connect@acpeds.org** or call (352) 376-1877.

About the American College of Pediatricians

The American College of Pediatricians (ACPeds) is a national medical association of licensed physicians and healthcare professionals who specialize in the care of infants, children, and adolescents. It was founded by a group of concerned physicians who saw the need for a pediatric organization that would not be influenced by the politically driven pronouncements of the day. The mission of the ACPeds is to enable all children to reach their optimal physical and emotional health and well-being. The ACPeds is committed to fulfilling its mission by producing sound policy, based upon the best available research, to assist parents and to influence society in the endeavor of childrearing.

Share on Facebook and Twitter.

An Ounce of Prevention for Teen Depression

AUGUST 6, 2018

In its newly released statement, Decreasing the Risk of Depression in Youth, the American College of Pediatricians (ACPeds) alerts parents and health professionals to the many protective factors against child and adolescent depression. These include parents maintaining a loving low-conflict marriage (1) , practicing authoritative parenting, maintaining family connectedness, discouraging drug use, promoting sexual abstinence (2), restricting and monitoring the use of social media and screen time, attending weekly religious activity as a family (3), encouraging children to keep a gratitude journal, and ensuring that children eat well, exercise regularly and get adequate sleep.

In addition to encouraging the protective factors discussed in the paper, ACPeds advises parents to monitor their children for signs of depression. Although moodiness is a feature of normal adolescence, there are signs that should alert parents to the risk of child depression. Prolonged sadness for no apparent reason, withdrawal from family and friends, falling grades, the inability to enjoy activities enjoyed in the past, insomnia or excessive sleeping, anorexia, and drug and alcohol use, may all indicate that a child is depressed and needs help (4).

Dr. Jane Anderson, principal author of the ACPeds statement says, “Depression is a growing problem among adolescents today, but there are steps parents can take to help their teens thrive.”

While a number of valuable screening tools are available for physicians, ACPeds recommends that pediatricians and other child health professionals go further and ask both adolescents and their parents about factors known to be associated with adolescent depression. These factors include a family history of depression, sexual activity (5), the use of hormonal contraceptives (6),

abortion (7), drug use (including tobacco, alcohol and marijuana (8)), falling grades, cohabitation (9), bullying (10), and recent loss, such as breaking up with a boyfriend or girlfriend, parental separation or divorce (11), and a death in the family. For more information and resources visit www.acpeds.org.

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The Myth About Suicide and Gender Dysphoric Children

Why would parents allow a gender-confused child to undergo these dangerous medical interventions? In many cases the answer is untruths and emotional blackmail. "If you don't let me do this, I'll kill myself," they hear from their child. The threat of suicide is then reinforced by members of the transgender industry: "Would you rather have a live son or a dead daughter?"

This latter from health professionals is deeply troubling. In no other medical or psychological condition is a suicidal patient – let alone a child – expected and allowed to dictate treatment. Children are cognitively immature to begin with; their thinking is further impaired when suicidal. This is gross medical negligence.

The suicide of anyone, especially a young person, is a tragedy, and all suicide threats should be taken seriously. However, the occurrence of completed suicide among trans-identified youth is rare and comparable to that of other at-risk groups of youth, such as those with anorexia and autism.[1] More importantly, there is no long-term evidence that puberty blockers, cross-sex hormones or "transition" surgeries prevent suicide. On the contrary, the best long-term research shows that *individuals who do go through medical transition kill themselves at a rate 19 times greater than the general population.*

What's the scientific bottom line?

Swedish child and adolescent psychiatrist Sven Roman (who is no conservative) sums up the research: "***There is currently no scientific support for gender-corrective treatment to reduce the risk of suicide***."[2]

Psychologists Dr. Michael Bailey (Northwestern University) and Dr. Ray Blanchard (University of Toronto) agree: "***[T]he best scientific evidence suggests that gender transition is not necessary to prevent suicide. . . . There is no persuasive evidence that gender transition reduces gender dysphoric children's likelihood of killing themselves***."[3]

LET'S LOOK AT THE EVIDENCE:

1 **Suicide risk among trans-identified youth is less than or comparable to that of other at-risk groups of youth.**[4]

a. Being trans-identified increases suicide risk by a factor of 13
b. Anorexia increases risk by a factor of 18-31
c. Depression multiplies it by a factor of 20
d. Autism raises the risk by a factor of 8

2 **Children with gender dysphoria often also have depression, anorexia, autism, and other psychological conditions predisposing them to suicide.**[5] Suicide among trans-identified youth may be due to the dysphoria, but maybe not – it could stem from the other psychological conditions or a combination of both.

3 **Prevention of suicide for trans-identified youth is the same as for other youth: talk therapy and FDA-approved psychiatric medications.**[6] As reported by the American Foundation for Suicide Prevention, "Ninety percent of people who die by suicide have an underlying — and potentially treatable — mental health condition."[7] One study found that 96% of U.S. adolescents who attempt suicide suffer from at least one mental illness.[8] *There is no evidence trans-identified children who commit suicide are any different.*

4 **The most up-to-date research shows the effectiveness of psychotherapy for resolving gender dysphoria in children and adolescents.**[9] A 2019 study confirms the findings of 16 studies dated 1969-2012, all showing that psychotherapy can be highly effective in treating underlying causes of gender incongruence such that trans-identifying patients embrace their biological sex.[10]

5 **Puberty blockers actually cause depression and other emotional disturbances related to suicide.**[11] Discussing an experimental trial of puberty-blockers in the U.K., Oxford University Professor Michael Biggs wrote, "There was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on [puberty blockers] children reported greater self-harm, and that girls experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers exacerbated gender dysphoria."[12]

6 **Cross-sex hormones (testosterone for women; estrogen for men) may disrupt mental health.** Women who identify as men are given enough testosterone to raise their levels 10-40 times above the female reference range. Past studies have documented multiple psychiatric problems with similar high doses of anabolic steroids like testosterone such that 23% of subjects met DSM criteria for a major mood syndrome such as mania, hypomania, and major depression, and 3.4-12% developed psychotic symptoms.[13] Estrogen also impacts mood in complex ways. Post menopausal women treated with estrogen often experience severe anxiety despite being placed on physiologic doses of the hormone.[14] Men who identify as women are given supraphysiologic doses of estrogen; theoretically, this has the potential to worsen both depression and anxiety.

7 **The most reliable research shows that in the long run, medical transition does not reduce and may even exacerbate the psychological distress that could lead to suicide.** "The two largest and most complete studies (one from the Netherlands and one from Sweden), which show significantly elevated rates of completed suicides among gender-dysphoric individuals, both studied adults who had already transitioned to imitation of the opposite sex."[15] These studies thus support the conclusion that transitioning does not reduce the risk of suicide and may even increase it. Transitioning merely masks the underlying psychological problems that are producing the dysphoria – it treats the symptoms rather than the disease.

8 **Suicide is prone to social contagion, meaning the more it occurs and is talked about, the more likely vulnerable kids will kill themselves.**[16] One medical researcher (an epidemiologist who himself transitioned to feminized male until he detransitioned after 13 years) calls out the manipulative use of the suicide threat to bully parents and legislators:

"The trans industry's insistence and hype that [trans-identified adolescents] are constantly on the brink of transphobia-related suicide at rates that far exceed those of other highly relevant populations is a shameful social engineering strategy to keep society's focus preferentially on transgenderism – perhaps to cast themselves as visionary pioneers in the field. . . . trans activist adults and some clinicians effectively threaten suicide on behalf of the young people. They do this to socially-engineer, manipulate and intimidate non-industry doctors, politicians, community leaders and families of [these adolescents]. They are well aware of the emotional responses they will get with this rhetoric."[17]

9

Trans-identified teens may be encouraged, by social media and members of the transgender industry, to threaten suicide if their parents resist medical transition. Psychotherapist Dr. Wallace Wong offered such advice during a presentation in Canada: ""So what you need is, you know what? Pull a stunt. Suicide, every time, [then] they will give you what you need." Wong added that trans-identified kids "learn that. They learn it very fast."[18]

BUT WHAT ABOUT STUDIES SUPPOSEDLY SHOWING THAT MEDICAL INTERVENTIONS ARE MORE EFFECTIVE THAN PSYCHOTHERAPY IN REDUCING SUICIDE ATTEMPTS?

1

Medical professionals who engage in statistical research have identified multiple problems with studies purporting to reach these conclusions. These problems include unreliable sampling, manipulated numbers, and admitted political intent.[19]

- A report co-authored by the American Foundation for Suicide Prevention (Haas et al. 2004), which claimed that 41% of gender-dysphoric individuals have attempted suicide, was based on flawed data.[20]

- Along with two other studies that found a suicide-attempt rate of around 40%, the Haas study used "convenience sampling," which statisticians agree cannot be used to draw conclusions about the general population.[21]

- The *Haas* authors admitted the 41% number may have been significantly inflated because only one question, without clarifying questions, was asked about the issue.

- The authors further admitted "the survey did not directly explore mental health status and history, which have been identified as important risk factors for both attempted and completed suicide in the general population." In other words, the study provided no reliable information about whether suicide attempts were caused by gender dysphoria or by other mental health issues, which are extremely common among dysphoric individuals.

- The study did not determine if the claimed suicide attempts occurred *before* or *after* seeking medical transition services.

- The study found that for female respondents, "being stealth" or successfully "passing" as male did not alleviate the tendency to self-harm. The study therefore offered no reason to conclude that undergoing medical transition will resolve the distress that leads to suicide attempts.

- As one analyst of the study concluded, "***Given the flawed data available to us, the leap in logic to assume the only viable choice is to medically transition or die ought to shame any provider, researcher, or journalist worth their salt***. The [study] data, if looked at honestly, should instead spur providers to offer effective psychological health evaluation and treatment for both young people and their families, and the least invasive intervention possible."[22]

- The Williams Institute, which also produced and promoted the Haas report, was contracted by the state of California to use appropriate survey methods and found the

trans-identified suicide attempt rate was 22%.[23] That is comparable to rates for people with psychological illness and general LGB-identification.[24]

2 The conclusions of a recent study -- supposedly finding that surgical "gender affirmation treatment" reduces psychological distress—have been shown to be unsupported by the data. Dr. Mark Regnerus observed that these conclusions signal "an abandonment of scientific rigor and reason in favor of ***complicity with activist groups seeking to normalize infertility-inducing and permanently disfiguring surgeries. . . . Clinicians are being bullied into writing a radical prescription based on fear, not on sensible conclusions from empirical data***."[25]

3 Similar studies from the U.K. have been debunked for similar reasons. One widely touted study supposedly found a 48% rate of attempted suicide in young people with "gender issues" – but it turned out that this "study" was based on only 27 patients.[26]

4 Psychologist Dr. James Cantor found that ***the American Academy of Pediatrics (AAP) misrepresented large numbers of studies to justify its claim that medical transition is necessary to prevent suicide***.[27]

AREN'T TRANS-IDENTIFIED TEENS LIKELY TO COMMIT SUICIDE BECAUSE OF THE STIGMA THAT SOCIETY PUTS ON THEM? RESEARCH DOES NOT SUPPORT THAT CLAIM.

- A 2014 Australian study reported that a leading reason for suicide among "LGBTI" individuals was stress from romantic partners rather than societal rejection.[28]
- ***A 2014 study by Hatzenbuehler, et al., claimed an average life expectancy reduction of 12 years for sexual minorities living in areas with suspected prominent anti-gay sentiment.***[29] ***But this study was so thoroughly debunked by the scientific community that the medical journal eventually retracted it***: "Re-analysis confirmed that the original finding was erroneous and the authors wish to fully retract their original study accordingly." Nevertheless, citations of Hatzenbuehler's false conclusions persist, including in Supreme Court briefs.
- An exhaustive review of all the research on this topic by psychiatrist Dr. Paul McHugh and epidemiologist Dr. Lawrence Mayer reached this conclusion: "***[I]t is impossible to prove through these studies that stigma leads to poor mental health, as opposed to, for example, poor mental health leading people to report higher levels of stigma, or a third factor being responsible for both poor mental health and higher levels of stigma.***"[30]
- Even without these studies, the argument that "stigma" drives trans-identified youth to suicide simply doesn't make sense. Epidemiologist Hacsi Horvath points out that the suicide rates for such adolescents were significantly lower in 1950, "when gender roles, sex-specific dress codes, laws regulating sexuality and other aspects of social control were much more rigidly 'enforced'" than they are now.[31] If social rejection didn't cause suicide then, why would a much diminished level of social rejection cause suicide now?

State law should encourage the use of psychotherapy to help young people explore and resolve the underlying causes of the psychological rejection of their body and avoid a lifetime of expensive, radical, painful, sterilizing, dangerous, and potentially deadly interventions.

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Child & Parental Rights

3/15/23
Patti Armstrong
Journalist, TV Talk show host for BEK News and former Social Worker in MI & MT.
Testimony in favor of HB 1254.

Our society has become saturated with the idea that people can be born in the wrong bodies. The contagion of children identifying as the opposite sex is emotional and being encouraged on the Internet and in schools and the wider culture. Suddenly teen girls claiming to be transgender is skyrocketing.
I ghost wrote 2 books for 2 different women who are happily married with children and very thankful they did not grow up today, because they truly wanted to be boys. But they grew out of it as most children do. (Jess Echeverry & Judy Heir)

If a 12-year old was thin but told his therapist he was overweight and wanted to lost 20 pounds, the therapist would not ignore reality and put him on a diet. So why with gender Dysphoria—when a person is disconnected from the reality of their body, would therapists play along? Since when do patients with mental problems direct their own treatment and in this case, we are talking about children.

Kids, do not have the capacity to understand the gravity of the decision that they're making on their long term sexual and life function. MRI's show the rational thinking portion of the brain is not fully developed in children's prefrontal cortex.

I've interviewed Walter Heyer who lived as a woman for 8 years before the idea that he was in the wrong body was rejected after he received real help and real understanding. His grandmother would dress him like a girl and he had an uncle who sexually abused him. He is a speaker on this issue and helps people detransition of which 75% he said, were sexually abused.

So often the real reason children want to be the opposite sex is not being uncovered because there's a rush to transition them

From the Daily Caller , March 11: 'We Were Wrong': Pioneer In Child Gender Dysphoria Treatment Says Trans Medical Industry Is Harming Kids

Dr. Susan Bradley, a Canadian psychiatrist and pioneer in child gender dysphoria treatment started a pediatric gender clinic in 1975 aimed at treating children with gender dysphoria offering a therapy-focused approach; most patients outgrew their feelings of being transgender over time. Around 2000, the clinic began prescribing puberty blockers to gender-dysphoric children as a way to alleviate their distress, a model which has since become widely adopted by medical establishments around the world, including in the U.S.

Bradley has expressed regret that the clinic had participated in the administration of puberty blockers for gender dysphoria, which she now believes can cement a child's sense of confusion out of which they would likely otherwise grow. She also expressed concern about the drugs' side effects.

"We were wrong," she said. "They're not as reversible as we always thought, and they have longer term effects on kids' growth and development, including making them sterile and quite a number of things including bone growth."

Bradley opened the Clarke Institute of Psychiatry Child Youth and Family Gender Identity Clinic (GIC) in 1975, and she went on to become the head of Child Psychiatry at the Hospital for Sick Children and the psychiatrist-in-chief and head of the Division of Child Psychiatry at the University of Toronto.

She chaired the Subcommittee on Gender Dysphoria for the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the official manual of the American Psychiatric Association, which is used for classifying and diagnosing mental disorders.

She also produced research, along with other clinic doctors, showing that 87.8% of boys referred to their clinic for gender identity issues eventually "desisted," meaning they stopped believing they were actually girls and came to terms with their sex.

Bradley came to believe that most child patients who identified as transgender were actually on the autism spectrum or suffering from borderline personality disorder, which she believes should be classified as part of the autism spectrum. Autistic adolescents are particularly prone to obsessive thinking and body image issues, and they struggle to change their minds once convinced something is true, all of which make them more vulnerable to being convinced they are actually the opposite sex and should seek medical interventions such as puberty blockers or hormones.

Bradley retired around 2012, and the clinic shut down several years later amid intense pressure from transgender activists who believed that the clinic, which did not automatically affirm children's gender identity or transgender status, was transphobic.

I highly recommend everyone watching, ***Dysconnected: The Real Story Behind the Transgender Explosion***. It is an exposé of the transgender tsunami sweeping the U.S. and irreversibly altering hundreds of thousands of lives, especially among girls. *Dysconnected* features 18 professional perspectives using compelling evidence as blowback to cultural winds pushing children into thinking they can change their gender.

The film opens with Daisy Strongin, a young women who has detransitioned. She speaks in a permanently lowered voice about deep regrets for having been led so far astray.

I interviewed Patrick Lappert, a medical doctor who is a plastic and reconstructive surgeon in the Diocese of Birmingham, Alabama, served 24 years in the U.S. Navy and is now in private practice. Some European countries are waking up and beginning to stop transitioning children, Lappert noted. "The long-term database in Great Britain and Sweden

found that you are 19 times more likely to kill yourself if you are fully transitioned," he said. The U.S. rarely follows patients more than three years, according to him.

"Those claiming 'affirmation care' is evidenced-based have no science to back them up," he said. "It's absolute junk science. It's just like lobotomies, and it's making them a lot of money. It's absolute insanity what they are doing to children."

He thinks that as more lawsuits take place against doctors and hospitals and others pushing gender reassignment, insurance companies and the medical community will back away from gender transitioning minors.

NORTH DAKOTA Family Alliance LEGISLATIVE ACTION

Faith · Family · Freedom

Testimony Supporting House Bill 1254

Mark Jorritsma, Executive Director
North Dakota Family Alliance Legislative Action
March 15, 2023

Good morning, Madam Chair Lee and honorable members of the Senate Human Services Committee. My name is Mark Jorritsma and I am the Executive Director of North Dakota Family Alliance Legislative Action. I am testifying on behalf of our organization and its constituents in favor of House Bill 1254 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 often all that's required.[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 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/

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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; and
- 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; and
- 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.

This bill prevents these harmful consequences from 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 1254.

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

[2] https://acpeds.org/position-statements/gender-dysphoria-in-children
[3] https://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=1&ContentID=3051

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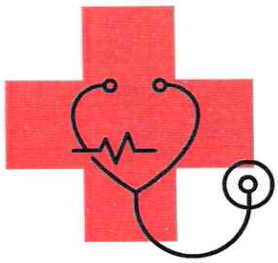
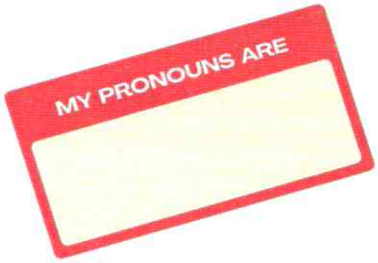
What is gender-affirming care?



Gender-affirming care is **medically necessary health care that helps transgender people be seen, safe, and comfortable in who they are.**[1] Access to this life-saving care allows transgender people to thrive and experience joy living as their authentic selves.[2]

Supporting transgender youth in their gender identity **improves mental health and overall well-being,** as evidenced in decades of peer-reviewed scientific research studies.[3,4]



Treatment for transgender youth before puberty never includes medical or surgical interventions.[5] Instead, **pre-pubescent youth need social support that respects their chosen name, pronouns, and gender identity.**[6] Social support is recommended by pediatricians and is fully reversible.[7]

Once puberty begins, **expert standards of medical care** recommend puberty delay medication, a safe and temporary pause that allows young people to explore and understand their gender.[8] Care for transgender youth **always involves their parents, their doctors, and mental health professionals.**[9]

Gender-affirming care is **safe, medically necessary, and supported by every major professional medical association** in the United States.[10-14]

WHITMAN-WALKER

WHITMAN-WALKER Institute

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References

What is gender-affirming care and what can policy makers do?

[1] Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. *International Journal of Pediatric Endocrinology, 8.* https://doi.org/10.1186/s13633-020-00078-2

- Transgender adolescents and young adults who received gender-affirming medical treatments reported improved mental health and quality of life over time.

[2] Heylens, G., Verroken, C., De Cock, S., T'Sjoen, G., & De Cuypere, G. (2014). Effects of Different Steps in Gender Reassignment Therapy on Psychopathology: A Prospective Study of Persons with a Gender Identity Disorder. *The Journal of Sexual Medicine, 11*(1). 119-126. DOI:https://doi.org/10.1111/jsm.12363

- Patients followed for more than three years at a Gender Clinic in Belgium saw significant decreases in psychoneurotic distress (including anxiety and depression) after receiving hormone therapy.
- Patients indicated they had a better mood and increased happiness after receiving gender-affirming treatment.

[3] deVries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics, 134*(4). 696-704. doi: 10.1542/peds.2013-2958

- Transgender youth who received gender-affirming medical care in adolescence had alleviated gender dysphoria and improved psychological functioning in young adulthood.

[4] Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2022). Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *Journal of Adolescent Health, 70*(4). 643-649. https://doi.org/10.1016/j.jadohealth.2021.10.036

- Transgender youth who received gender-affirming hormone therapy had lower odds of depression and suicidal thoughts compared to youth who wanted this care but did not receive it.
- For transgender youth under 18, receipt of gender-affirming hormone therapy was associated with 40% lower odds of attempting suicide.

[5] Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hanemma, S. E., Meyer, W. J., Murad M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T'Sjoen, G. G., (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinology and Metabolism, 102*(11). 3869-3903. doi:10.1210/jc.2017-01658

- The Endocrine Society advises that decisions regarding the social transition of prepubertal youths with gender dysphoria/gender incongruence are made with the assistance of a mental health provider or another experienced professional.
- They recommend *against* puberty blocking and gender-affirming hormone treatment in prepubertal children with documented gender dysphoria/gender incongruence.

[6] Fontanari, A. M. V., Vilanova, F., Schneider, M. A., Chinazzo, I., Soll, B.M., Schwarz, K., Lobato, M.I.R., & Costa, A.B. (2020). Gender Affirmation Is Associated with Transgender and Gender Nonbinary Youth Mental Health Improvement. *LGBT Health, 7*(5). 237-247. http://doi.org/10.1089/lgbt.2019.0046

- Transgender young people (aged 16-25) who were socially affirmed, including having their parents use their chosen name, reported having less anxiety and fewer depressive symptoms compared to trans youth whose parents never used their child's chosen name.

[7] Rafferty, J., Yogman, M., Baum, R., Gambon, T. B., Lavin, A., Mattson, G., Wissow, L. S., Breuner, C., Alderman, E. M., Grubb, L. K., Powers, M. E., Upadhya, K., Wallace, S. B., Hunt, L., Gearhart, A. T., Harris, C., Lowe, K. M., Rodgers, C. T., & Sherer, I. M. (2018, October 1). *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. American Academy of Pediatrics. Retrieved December 29, 2022, from https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive Care-and-Support-for

- Social affirmation is a reversible intervention for children to express their gender identity through their chosen name, pronouns, hairstyle, clothing, etc.

[8] Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M.B., Ettner, R., Fraser, Goodman, L., Green, M. J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L.,…Arcelus, J. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health, 23.* S1-S259. DOI: 10.1080/26895269.2022.2100644

- The Standards of Care for transgender youths recognize that youth may have mental health concerns separate and distinct from their gender affirmation and strongly recommends mental and behavioral health assessments and care in advance of prescribing gender-affirming hormone therapies.
- Social gender affirmation means facilitating affirmation of a person's gender identity and expression through their hair, clothing, and name.

- Gender-affirming hormone treatments are not prescribed for prepubescent patients. The standards of care recognize that the onset of puberty can intensify feelings of gender incongruence or, for some youth, resolve feelings of gender incongruence.

[9] UCSF Gender Affirming Health Program, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available at transcare.ucsf.edu/guidelines.

The following statements from the five major medical associations demonstrate a consensus among medical practitioners that the current practice of gender-affirming care is well-within the boundaries of careful, patient-centered medical practice:

[10] American Academy of Pediatrics (March 16, 2021). American Academy of Pediatrics speaks out against bills harming transgender youth. https://services.aap.org/en/news-room/news-releases/aap/2021/americanacademy-of-pediatrics-speaks-out-against-bills-harming-transgender-youth/

[11] American Medical Association (March 26, 2021). AMA fights to protect health care for transgender patients. https://www.ama-assn.org/health-care-advocacy/advocacy-update/march-26-2021-state-advocacy-update

[12] American Psychiatric Association (April 2, 2021). Frontline physicians oppose legislation that interferes in or criminalizes patient care. https://www.psychiatry.org/newsroom/news-releases/frontline-physicians-opposelegislation-that-interferes-in-or-criminalizes-patient-care

[13] The Endocrine Society (April 14, 2021). Endocrine Society condemns efforts to block access to medical care for transgender youth. https://www.eurekalert.org/pub_releases/2021-04/tes-esc041421.php

[14] American Psychological Association, Division 54. Position Statement: Support Access to Gender-Affirming Care for Transgender and Gender-Diverse Youth. https://www.apa.org/topics/lgbtq/division-54-statement-gender-affirmative-care.pdf

Last updated December 2022

North Dakota Healthcare Providers Stand Up for Trans Youth

As North Dakota Healthcare Providers, we oppose legislation that would forbid healthcare professionals from providing gender-related care to our transgender young people. North Dakota needs to be a state where parents and families are free to pursue the best possible healthcare for our youth. As providers, we recognize the seriousness of Gender Dysphoria. Treating this condition improves functioning and saves lives. To ignore these needs would constitute medical neglect.

We use well-established best practices and ethical guidelines based on decades of scientific research in transgender care. We receive guidance from multiple professional sources including the American Academy of Pediatrics, the American Psychological Association, the Endocrine Society, the American College of Obstetricians and Gynecologists, and the World Professional Association of Transgender Health. This evidenced-based care needs no legislative action.

Healthcare professionals who provide gender care do more than just serve transgender youth. We are diabetes providers, mental health providers, pediatricians, and more. If this ban on transgender youth care goes into effect, providers will consider leaving our state, decreasing access to care for everyone.

When providing this care, we see things like a student going from barely being able to raise their hand in class to competing on the debate team. We see kids finding themselves and thriving. This care, when medically appropriate, helps kids to be safe, happy, and healthy.

Please trust us, as medically trained and licensed healthcare providers. We urge our law-makers to vote "NO" on HB1254.

Healthcare Providers
Alana Semchenko, PsyD
Alyssa Weber, PsyD
Amanda Blake, LCSW
Amanda Dahl, MD
Amanda Lynn Hinrichs, RN
Amanda Storey, PsyD
Amy Ochsendorf, PsyD, LP
Amy Oksa, MD
Ana Luz Pagan Jaramillo, MD
Ana Tobiasz, MD
Ana Tracey Morgan-Harris, MD
Andra Wheeler, MS, LPCC, LPC
Andrew McLean, MD
Angela Stephens, MD
Anika Mundal, LPC, LAPC
Anna Miller, OD

Anna Schimmelpfennig, PhD LP
Annabel Jiran, Medical Student
Annette Vazquez, LPC
Anthony Marucco, LCSW
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Austen McFarren, LPCC
Barbara K Stanton, PhD, LPCC
Brandi Hoffart, MSIV
Brandon Meyer, MD, FAAP
Brenda J King, PhD, LP
Brennan Forward, MD
Brian Gale, DPM, FACFAS
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Brianne M Marion, PsyD, LP, SEP
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Carrie Brower-Breitwieser, PhD, BCBA-D
Chase Gauthier, Medical Student
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Chris Tiongson, MD
Christopher Failing, MD
Cody Baxter, PA-C
Cody Riggle, MS-IV Medical student
Covey Wong, B.S. MS3
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David Tupa, PhD
Della Ann Martinsen, PhD, LP
Dena Wanner-Perry, PsyD, LP
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Desiree Zielke, PhD, LP
Diana Slivensky PhD
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Dorian Dodd, PhD, LP
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Molly C. Linn, DO
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Nicole Cross Hillman, PsyD, LP
Noelle Berg, PA-C
Parker Rosenau, MD Medical Student
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Stephanie Antony, MD
Stephanie Jallen, MD
Stephanie M. Hanson, M.D. FAAP
Steven Strinden, MD
Sue A Russell, PHD
Susan Spivey, LCSW
Tanya Baity, APRN, CNM
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Taylor Pearson, MSW, LMSW, LGSW
Taylor Smart LPC, LAPC
Tim Moore, MS4
Traci Schlag, LBSW

Tracie Newman, MD, MPH
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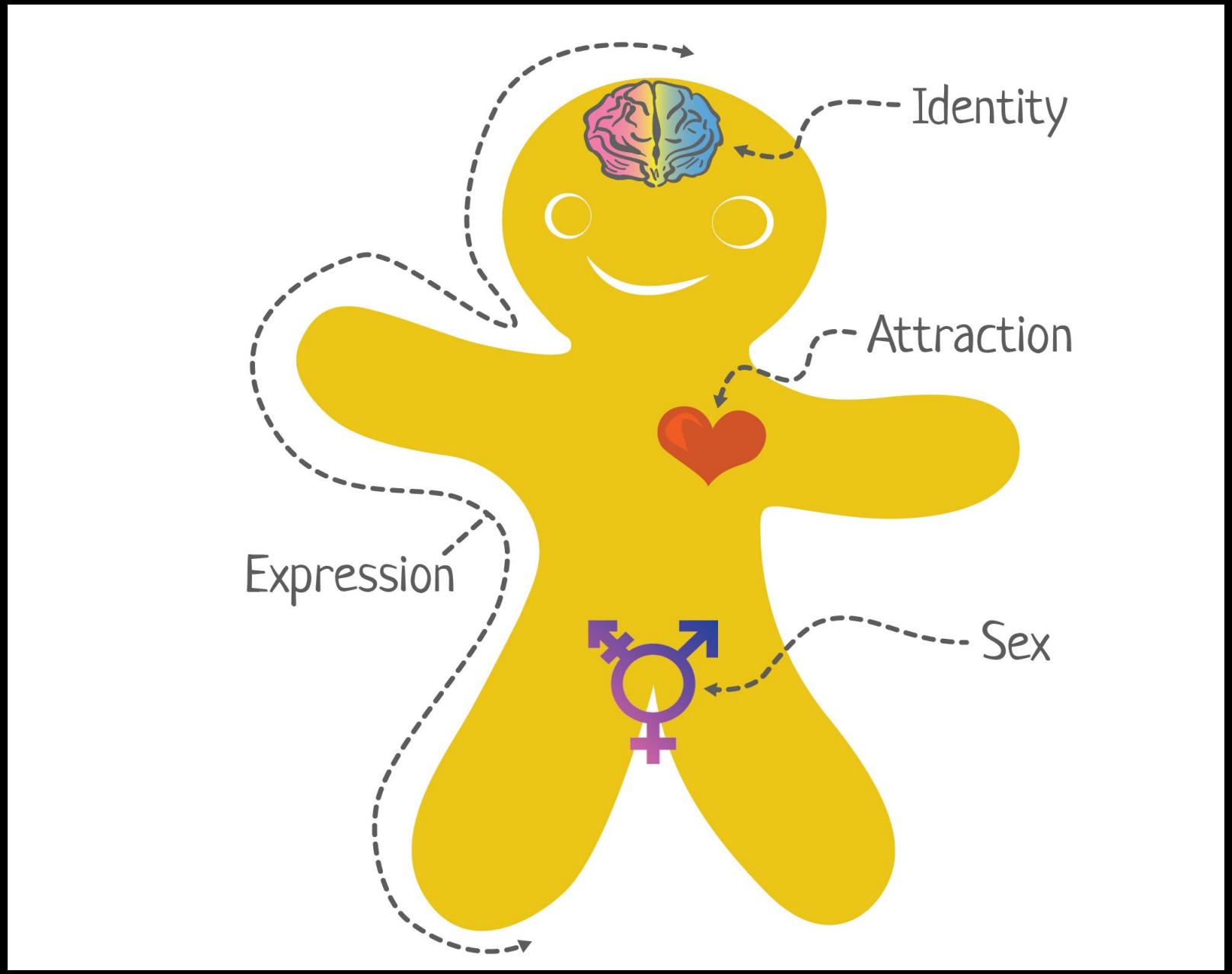
Vanessa Magstadt, MD
Vanessa Nelson, MD
Whitney Fear MSN, PMHNP-BC
Winnie Austin, MS, LMFT
Wyatt Limke, MS4

Organizations
Beacon Behavioral Health
Becoming Balanced
Canopy Medical Clinic
Dakota Foot & Ankle Clinic
New Story Counseling Services
North Dakota Chapter of the American Academy of Pediatrics
Planned Parenthood North Central States
Sweetbrier Behavioral Health
Volk Human Services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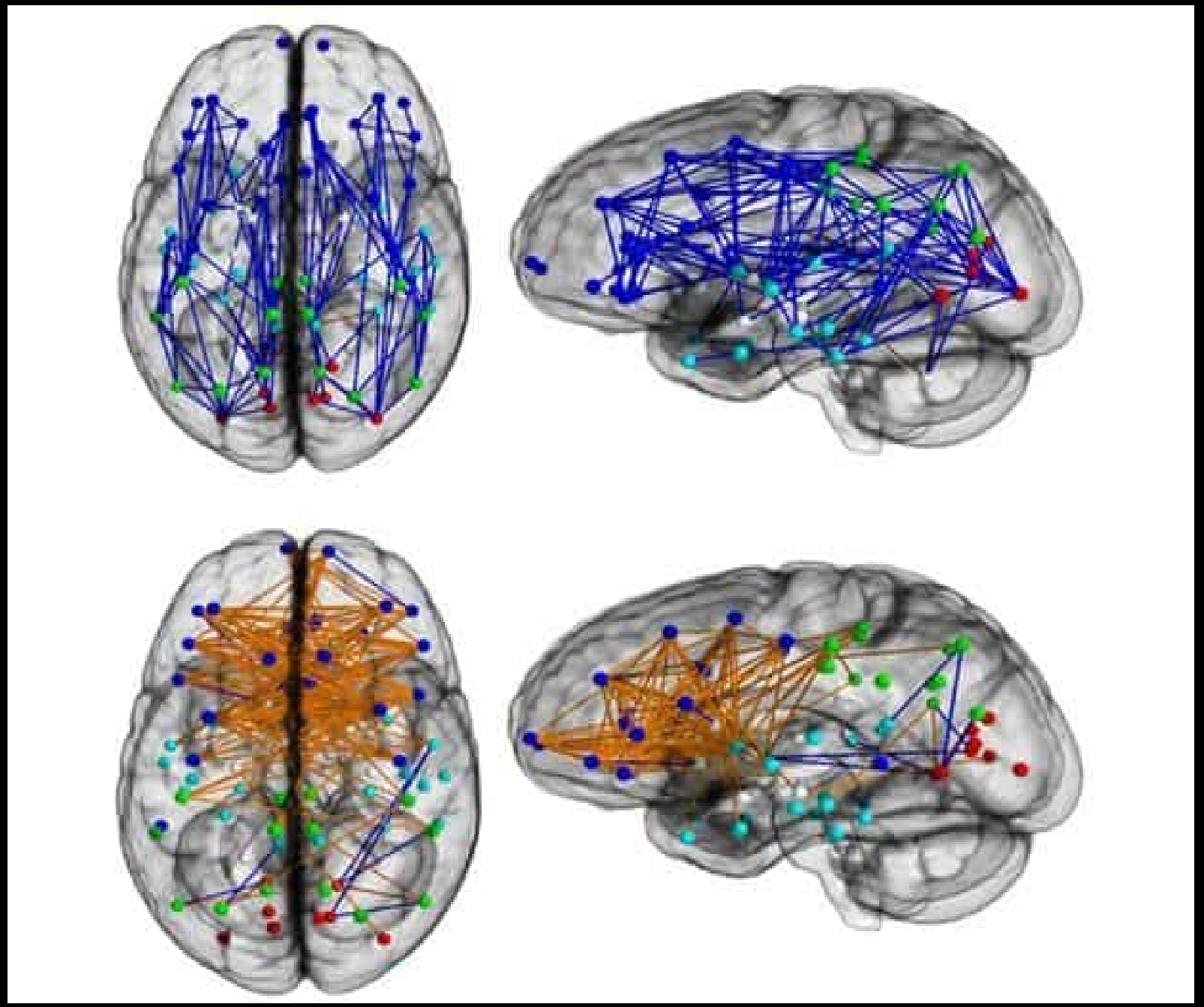
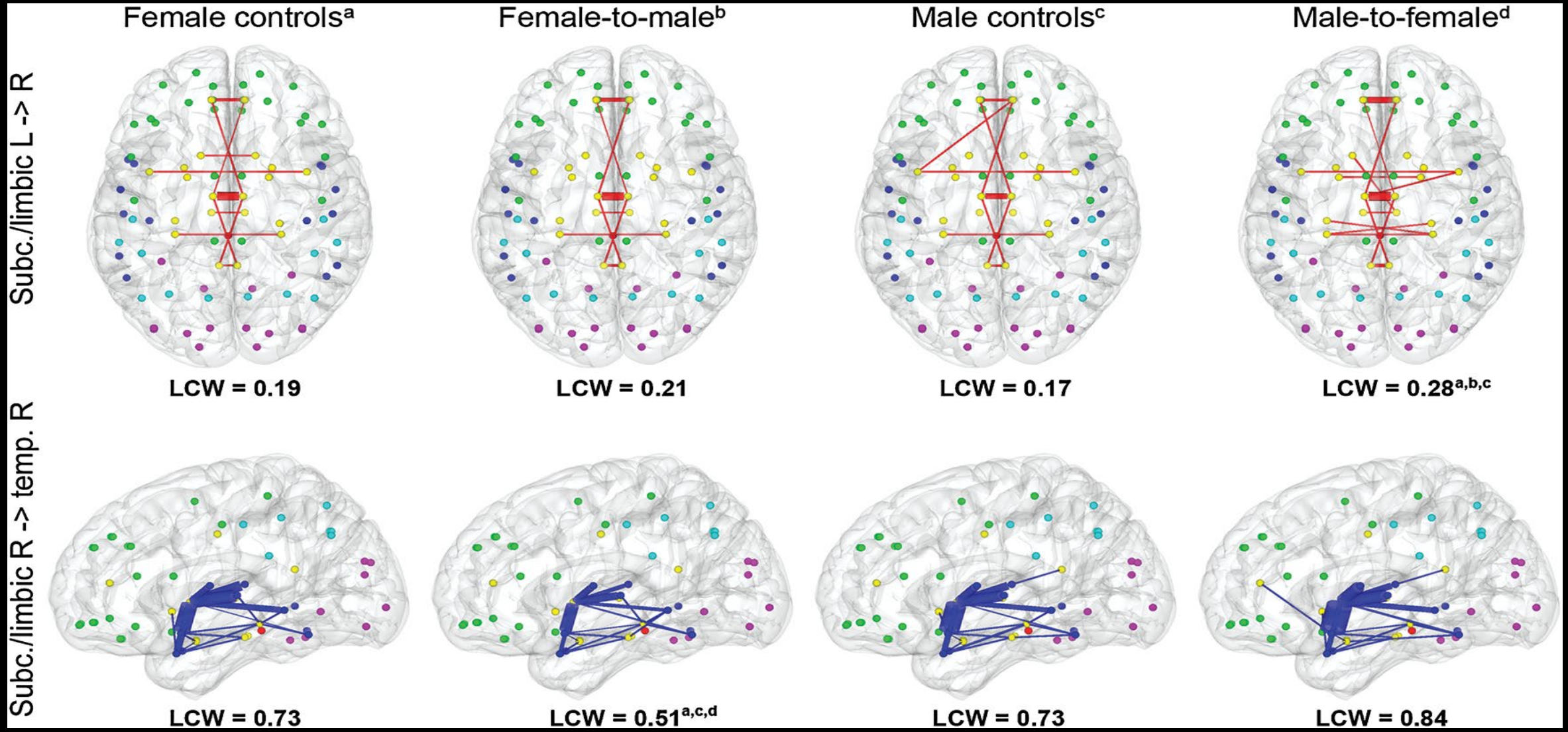
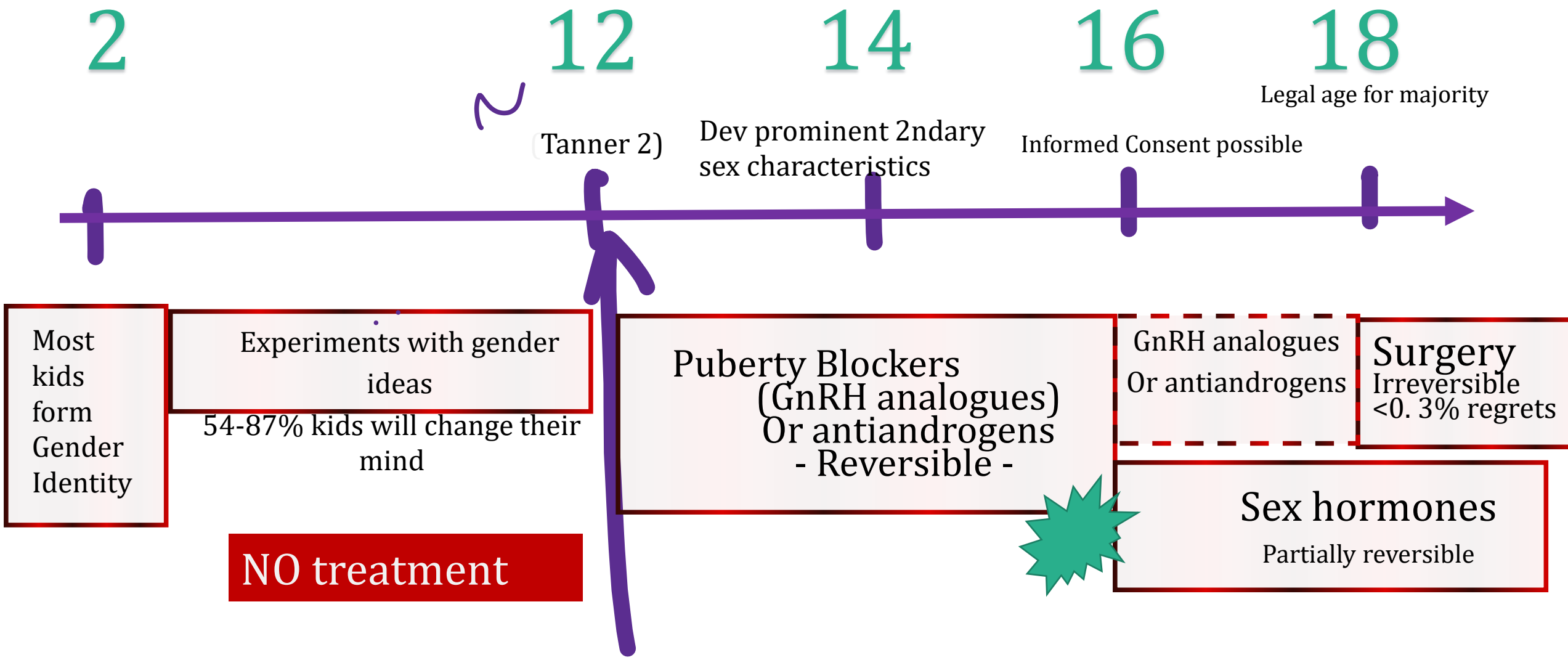


Verma et al 2013

Average structural connectivity for female controls, female-to-male transsexuals, male controls, and male-to-female transsexuals
Female and MtF have more **inter-lobar** and Males and FtM have more **intra-lobar** connectivity weight



Cerebral Cortex, Volume 25, Issue 10, October 2015, Pages 3527–3534, https://doi.org/10.1093/cercor/bhu194



Multidisciplinary team:

Important **milestones** in a child's life –
Delays in the healthcare system functioning can have disastrous consequences!!

March 15th, 2023
From: ND Psychiatric Society
Re: In Opposition to HB 1254

NORTH DAKOTA PSYCHIATRIC SOCIETY
A District Branch of the American Psychiatric Association

Madam Chair Lee, Esteemed Committee Members

My name is Gabriela Balf, I am currently a psychiatrist in Bismarck, I worked as an internist for 9 years, I have a Master's Degree in Public Health, and I am an Associate Clinical Professor at UND. Although I have many hats, I speak today on behalf of my psychiatric society, as well as on my behalf.

I have prepared a separate text that contains the main points of my testimony today:

- The Transgender Condition is a **real medical condition**
- Recent advances in medical science have also produced massive information about its biological causes – I will briefly review the brain imaging data
- Transgender healthcare is a **thorough medical process,** sanctioned by decades of research and massive data gathering
- There are **severe** consequences of **NOT** respecting the medical standard of transgender healthcare
- There are overwhelmingly **POSITIVE consequences** of providing the gender-affirming care

In sum, we thank you for the opportunity to bring this section of our medical association presentation.

We urge you to consider the amendments to the HB 1254 that would respect our patients and families' healthcare decisions AND would address the grave concerns and bring reassurance to all concerned ND citizens that only the most rigorous, correct care is provided in our state.

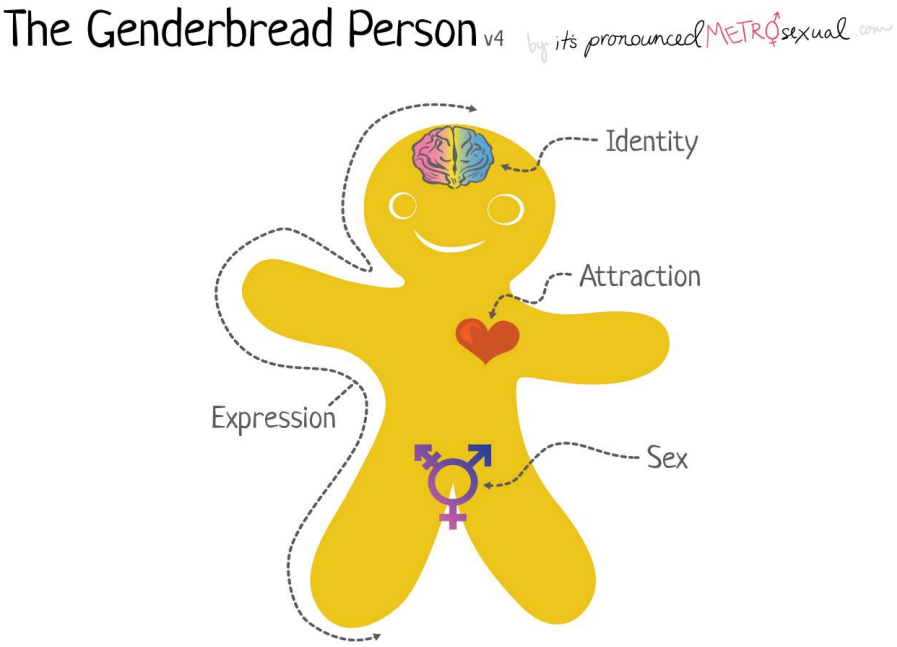
Thank you and I stand for questions.

Gabriela Balf-Soran, MD, MPH
Assoc Clin Prof – UND School of Medicine – Behavioral Sciences and Psychiatry Dept
ND Psychiatric Society Past-President
World Professional Association Transgender Health member

Brief Points on
The Transgender Condition
and The Consequences of Related Bills.

Scan th

1. Terminology

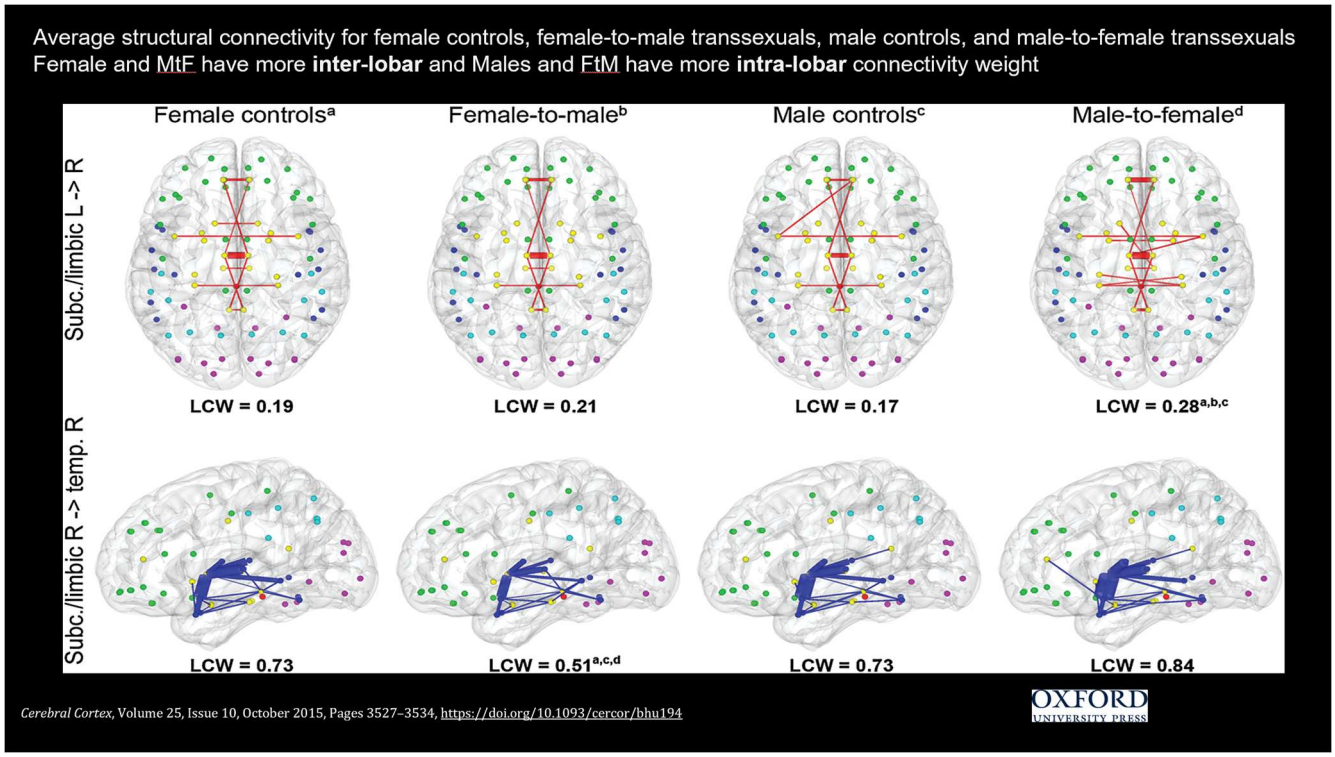


2. What does it mean to be a woman/man? Transgender?

Complex efforts underway to define complex sociological, anthropological, economical, physiological, psychological, spiritual and religious concepts that, in certain cultures, or circumstances, are not even binary. Neuroimaging studies – see below

- Transgender condition is a **real medical condition** – in many aspects akin to a congenital malformation– the medical term is **Gender Incongruence**. 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 ". 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".

- Imaging studies 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(Hahn et al., 2015).

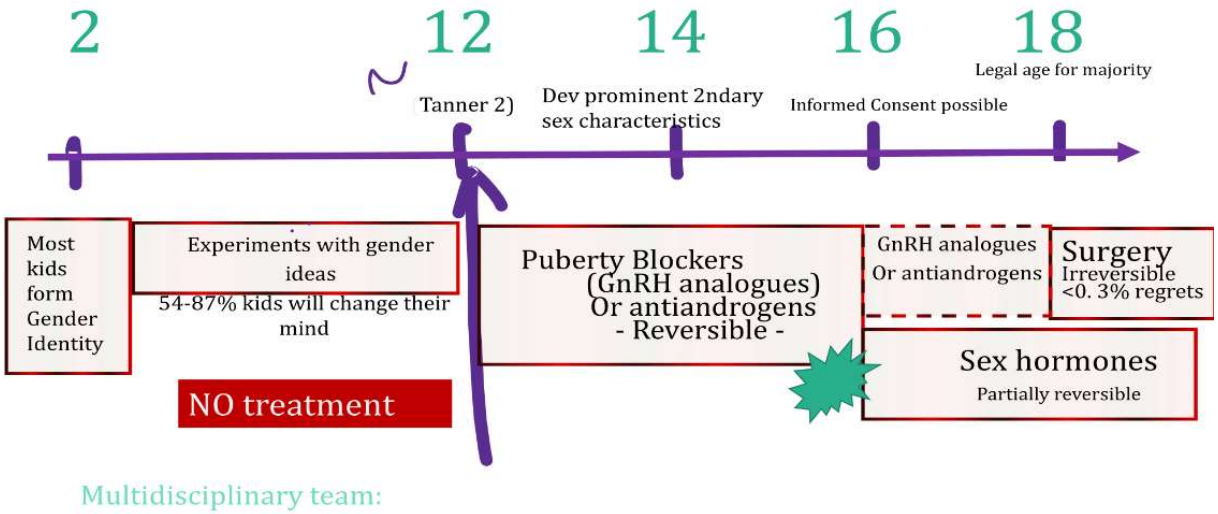


- The mental distress that some transgender people experience as a result of Gender Incongruence condition + non-affirming conditions = Gender Dysphoria in the Diagnostic and Statistical Manual of Mental Disorders DSM5 (available on APA website at https://dsm.psychiatryonline.org/)

3. Transgender Healthcare is a thorough process, sanctioned by decades of research and data gathering, and facilitated by well-established protocols.

The treatment for Gender Dysphoria according to the standards of care of
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. Bans of evidence-based medical care like current bills have been strongly condemned by professional associations: AACAP, AMA, APA, etc.

There are several **misunderstandings** that I would like to clarify, because some provisions in the current bills address non-existent situations. The figure below may help visualize the **real timeline of the regular transgender care.**



Important **milestones** in a child's life –
Delays in the healthcare system functioning can have disastrous consequences!!

a. Minors have **NEVER** received gender-affirming surgeries in our state.
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, with **parental consent.**
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.
h. "**Let's wait until they reach maturity, they are confused**." While providing at least some type of gender-affirming care has impressive benefits – see below, withholding gender-affirming treatment is an active choice with severe consequences.

4. Consequences of not receiving care -

The stats are sobering: this inner despair translates into feeling inadequate, less than everybody else, unable to enjoy many activities in our binary world (very similar to the definition of depression), worrying about their future and how they will ever play by the society's rules, and being the subject of thorough bullying like only kids (or insensitive adults) can provide. Several sources summarized in 2020(Price-Feeney et al., 2020):

- Lifetime prevalence of depression in transwomen at 51%, 48% for transmen.
- Anxiety lifetime prevalence at 40% for transwomen, 48% transmen.
- PTSD up to 42% in trans adults.
- Serious suicide ideation 87% and suicide attempts 41% (general population suicide attempts are 0.2%.)
- In LGBT Youth, discrimination doubles the risk of suicide. Youth's ideation about suicide is 3 times that of their peers (up to 65%) and attempted suicide rate is 4 times that of their peers (see attachment below).
- Our own youth data - North Dakota LGBTQ+ School Climate Report (2021) Faye Seidler.

Suicide:

- 61.6% Seriously considered attempting suicide
- 48.5% Made a plan to attempt suicide
- 33.3% Attempted suicide

Mental Health

- 84.6% Do not turn to adult when feeling sad, empty, hopeless, angry, or anxious
- 26.7% Have no idea who to talk to when experiencing distress
- 51.7% Can identify one adult to talk to if they have a problem
- 61.1 % Reported bad mental health for one week or more each month.

Bullying

- 45.6% Experience electronic bullying
- 59.6% Experience bullying on school property
- 8.7% Straight students bullied due to perception they were LGBTQ+

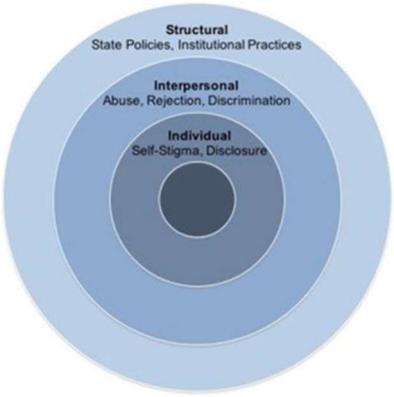
Sexual health

- 21.3% Have had sexual thing done to them they did not want
- 9.8% Texted, e-mailed, or posted electronically a revealing or sexual photo
- 13.4% Have had sex

Are these people intrinsically damaged in some way?! The answer is clearly **NO**: once they get gender-affirming treatment, be that surgery or just hormones**, their mental health becomes actually better than that of the general population(de Vries et al., 2014)!!**

Furthermore, if they receive social affirmation, one adult in their environment respecting their preferred nouns, etc, their suicide likelihood rate goes down by 70%.

The concept of Minority Stress(Hatzenbuehler, 2009; Hatzenbuehler & Pachankis, 2016) - The environment – related stressors – will cause chronically high levels of adrenaline, coupled with internal stress – expectation of rejection. When coping is maladaptive (which is the normal case), society unsupportive and one internalizes the negative cognitions (stigma). The result is psychopathology, despite the fact that the individual's condition is NOT pathological.



Stigma as a multi-level construct

5. Consequences of receiving gender affirming care are overwhelmingly positive

More data pertinent to mental health issues in the transgender people and how gender-affirming measures and care influence those

Prepared by Gabriela Balf, MD, MPH – Email gabriela.balf@aya.yale.edu

Factors that influence mental health in youth

Family acceptance/rejection - cca **26%** of the variability (Khaleque & Ali, 2017)

Gender Affirming Care: Comprises – (see timeline in pamphlet)

- **Social-Affirming Measures**– pronouns, school records, hospital records, legalization of name, etc
- **Gender-Affirming Hormone Therapy** (GAHT)- recommended only after 16 yo, sex-hormones – (partially reversible) – odds of depression decrease, quality of life increases significantly in meta-analysis (Baker 2021)- youth and adults, (Green 2022,) – youth, (Turban 2022)- youth
- **Gender-Affirming Surgeries** – Only after age 18 - top surgery more often: 25% of TGNC, bottom surgery less frequent - (Almazan & Keuroghlian, 2021) - 2015 US Transgender Survey
-

For a **comprehensive list of studies that led to the statements of recommendations** from this chapter (CH 2 Global Applicability – in Standards of Care v8 of wpath.org/soc8) see the scanned page Appendix 1 at the end of this document.

Mental health stats for baseline before treatment– worldwide and US – see source for stats Appendix 2

Transgender (TG) Mental Health:

Depression: 51% trans women, 48% trans men;

Anxiety: 40% trans women, 48% trans men;

PTSD: 17.8-42% have PTSD;

Suicide attempts – general population 4%; LGB adults 11-20%, transgender adults 41%

Suicide ideation youth – 38-65%

Suicide attempts – 30-40%

After treatment, the mental health of the transgender people is better than that of their peers due to the mandatory psychotherapy

<u>Baseline mental health stats for ND</u> –2021 ND LGBT+ School Climate Survey – Faye Seidler

ND Data LGBT+ youth

Suicide: 61.6% Seriously considered attempting suicide

48.5% Made a plan to attempt suicide

33.3% Attempted suicide

Mental Health

84.6% Do not turn to adult when feeling sad, empty, hopeless, angry, or anxious

26.7% Have no idea who to talk to when experiencing distress

51.7% Can identify one adult to talk to if they have a problem

61.1 % Reported bad mental health for one week or more each month.

ND Comparative Data Between LGBT+ and Straight Youth

Suicide – LGBT+ Youth Are:

222% More likely to consider attempting suicide

270% More likely to plan suicide attempt

354% More likely to attempt suicide

Mental Health – LGBT+ Youth Are:

22.0% More likely to not turn to adult to turn to when feeling distress

37.8% More likely to have no idea who to talk to when experiencing distress

21.4% More likely to not be able to identify one adult to talk to if they have a problem

192% More likely to report bad mental health for one week or more each month.

Selected studies

(Khaleque & Ali, 2017) – Family acceptance/rejection account for cca 26% of the variability in youth mental health outcomes - **meta-analysis** of 551 studies (48% unpublished (!) and 52% published). The studies were conducted over period of 42 years, from 1975 through 2016. They represent an aggregate sample of 149,440 respondents, including males and females, children and adults. Respondents were taken from 31 countries on five continents.

(Baker et al., 2021): – **meta-analysis** of 20 studies, number participants 20 - 1331 from 8 countries + European Network for the Investigation of Gender Incongruence (ENIGI) – depression scores decreased significantly in all studies, regardless of the scales used (BDI II, Zung, HADS, SCL-90 R, PHQ 9 etc.) quality of life increased, tendency to lower suicide rates.

(**Green et al., 2022)** –2020 **survey** of 34,759 lesbian, gay, bisexual, transgender, queer, and questioning youth aged 13–24, including **11,914 transgender or nonbinary youth**.

Half of transgender and nonbinary youth said they were not using GAHT but would like to, 36% were not interested in receiving GAHT, and 14% were receiving GAHT. Parent support for their child's gender identity had a strong relationship with receipt of GAHT, with nearly 80% of those who received GAHT reporting they had at least one parent who supported their gender identity.

Use of GAHT **decreases odds of recent depression by 73%** and **seriously considering suicide by 74%** compared to those who wanted GAHT but did not receive it. For youth under age 18, GAHT was associated with decrease in the odds of recent depression by 61% and of a past-year suicide attempt by 62%.

Table 5. Multivariate adjusted logistic regression of gender-affirming hormone therapy on depression and suicidality among transgender and nonbinary youth

	Overall sample		Ages 13–17	
	aOR (95% CI)	*p*-value	aOR (95% CI)	*p*-value
Depression	0.73 (0.61–0.88)	<.001	0.61 (0.43–0.86)	<.01
Seriously considered suicide	0.74 (0.62–0.88)	<.001	0.74 (0.52–1.03)	.08
Attempted suicide	0.84 (0.66–1.07)	.16	0.62 (0.40–0.97)	.04

Adjusted for age, socioeconomic status, census region, gender identity, sexual orientation, race/ethnicity, parent support for gender identity, gender identity-based victimization, gender identity conversion efforts, and history of puberty blocker use.

aOR = adjusted odds ratio; CI = confidence interval.

(Turban et al., 2022) Gender Affirming Hormone Therapy GAH accessed in youth influences mental health outcomes adults

Past year suicidal ideation **decreases by 40%** if accessed GAH age 14-15**, by 50%** if accessed GAH by 1-17 and **by 80%** if accessed at >18y (benefit is huge in youth, and even ore so in adults)

Past year severe suicide attempt – decreases by **220%** if accessed between 16-17yo

Lifetime illicit drug use also decreases

	Participants who Accessed GAH											
	N = 12,598											
	Accessed GAH at Age 14 or 15				Accessed GAH at Age 16 or 17				Accessed GAH at Age ≥ 18			
	n = 119				n = 362				n = 12257			
	OR (95% CI)	p	aOR (95% CI)	p	OR (95% CI)	p	aOR (95% CI)	p	OR (95% CI)	p	aOR (95% CI)	p
Suicidality (Past 12 months)												
Past-year suicidal ideation [a]	0.5 (0.3–0.7)	.0001	0.4 (0.2–0.6)	< **.0001**	1.0 (0.8–1.2)	.73	0.5 (0.4–0.7)	< **.0001**	0.5 (0.5–0.6)	< .0001	0.8 (0.7–0.8)	< **.0001**
Past-year suicidal ideation with plan [b]	1.3 (0.8–2.4)	.31	0.8 (0.4–1.6)	.58	1.1 (0.9–1.5)	.41	0.9 (0.7–1.2)	.49	0.8 (0.8–0.9)	< .0001	0.9 (0.8–1.0)	.09
Past-year suicide attempt [c]	1.0 (0.5–2.2)	.99	0.4 (0.2–1.1)	.08	1.4 (1.0–2.0)	.04	0.9 (0.6–1.4)	.79	0.8 (0.8–0.9)	.002	1.0 (0.9–1.1)	.89
Past-year suicide attempt requiring inpatient hospitalization [d]	––	––	––	––	2.2 (1.2–4.0)	.01	2.2 (1.2–4.2)	.01	1.4 (1.1–1.7)	.002	1.2 (0.9–1.5)	.26
Mental Health & Substance Use												
Past-month severe psychological distress (K6 ≥ 13) [c]	0.5 (0.3–0.7)	.0004	0.3 (0.2–0.4)	< **.0001**	0.6 (0.5–0.8)	< .0001	0.3 (0.3–0.4)	< **.0001**	0.4 (0.3–0.4)	< .0001	0.6 (0.5–0.6)	< **.0001**
Past-month binge drinking [e]	1.6 (1.1–2.3)	.02	1.6 (1.0–2.4)	.04	0.8 (0.6–1.1)	.17	0.9 (0.6–1.1)	.27	1.2 (1.1–1.2)	< .0001	1.2 (1.1–1.3)	< **.0001**
Lifetime illicit drug use [f]	1.8 (1.2–2.6)	.003	1.5 (1.0–2.2)	.08	1.2 (1.0–1.6)	.08	1.3 (1.0–1.6)	.07	2.1 (1.9–2.2)	< .0001	1.7 (1.6–1.8)	< **.0001**

Mental health outcomes of transgender adults who recalled access to gender-affirming hormones (GAH) during various age groups. Reference group for all analyses is participants who desired GAH but did not access them. All models adjusted for age, partnership status, employment status, K-12 harassment, and having experienced gender identity conversion efforts.

Abbreviations: OR (odds ratio), aOR (adjusted odds ratio), 95% CI (95% confidence interval).

[a] Model also adjusted for gender identity, sex assigned at birth, sexual orientation, race/ethnicity, family support of gender identity, educational attainment, and total household income.

[b] Model also adjusted for sexual orientation, race/ethnicity, educational attainment, and total household income.

[c] Model also adjusted for gender identity, sex assigned at birth, sexual orientation, race/ethnicity, family support of gender identity, educational attainment, total household income, and having received pubertal suppression.

[d] Model also adjusted for family support of gender identity. Only one participant in the GAH < 16 group endorsed a past–year suicide attempt requiring inpatient hospitalization, precluding calculation of an aOR for this outcome.

[e] Model also adjusted for gender identity, sex assigned at birth, sexual orientation, family support of gender identity, educational attainment, and total household income.

[f] Model also adjusted for gender identity, sex assigned at birth, sexual orientation, race/ethnicity, family support of gender identity, and educational attainment.

https://doi.org/10.1371/journal.pone.0261039.t002

(Almazan & Keuroghlian, 2021) - 2015 US Transgender Survey, the largest existing data set containing comprehensive information on the surgical and mental health experiences of TGD people. The survey was conducted across 50 states, Washington, DC, US territories, and US military bases abroad. A total of 27 715 TGD adults, outcomes psychological distress (Kessler Psychological Distress Scale), past month binge alcohol

After adjustment for sociodemographic factors and exposure to other types of gender-affirming care, undergoing 1 or more types of gender-affirming surgery was associated with **lower past-month psychological distress** (aOR, 0.58; 95% CI, 0.50-0.67; *P* < .001), past-year smoking (aOR, 0.65; 95% CI, 0.57-0.75; *P* < .001), and **past-year suicidal ideation** (aOR, 0.56; 95% CI, 0.50-0.64; *P* < .001).

Table 2. Association Between History of Gender-Affirming Surgery and Mental Health Outcomes[a]

Variable	aOR (95% CI)[b]	*P* value
Severe psychological distress (past month)[c]	0.58 (0.50-0.67)	<.001
Substance use		
Binge alcohol use (past month)[d]	0.83 (0.72-0.96)	.01
Smoking (past year)	0.65 (0.57-0.75)	<.001
Suicidality (past year)		
Ideation	0.56 (0.50-0.64)	<.001
Attempt	0.65 (0.47-0.90)	.009

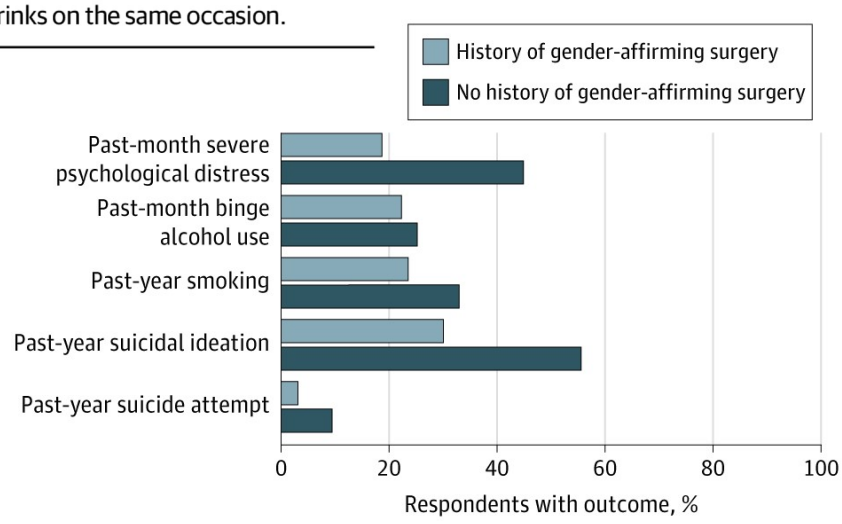
Abbreviation: aOR, adjusted odds ratio.

[a] Adjusted for age, education, employment status, family rejection, gender identity, health insurance, household income, race/ethnicity, sex assigned at birth, sexual orientation, history of gender-affirming counseling, pubertal suppression, and history of gender-affirming hormone therapy.

[b] Reference/control group (n = 16 401) is composed of individuals who desired at least 1 type of gender-affirming surgery but had not received any surgeries. Exposure group (n = 3559) is limited to respondents who had their first surgery at least 2 years prior to submitting survey responses.

[c] Defined as a score of at least 13 on the Kessler Psychological Distress Scale.

[d] Defined as consuming at least 5 alcoholic drinks on the same occasion.



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Khaleque, A., & Ali, S. (2017). A systematic review of meta-analyses of research on interpersonal acceptance–rejection theory: Constructs and measures. *Journal of Family Theory & Review*, *9*, 441–458. https://doi.org/10.1111/jftr.12228

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Appendix 1

interventions. In many countries, medically necessary gender-affirming care is documented by the treating health professional as treatment for Gender Incongruence (HA60 in ICD-11; WHO, 2019b) and/or as treatment for Gender Dysphoria (F64.0 in DSM-5-TR; APA, 2022).

There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures, properly indicated and performed as outlined by the Standards of Care (Version 8), in TGD people in need of these treatments (e.g., Ainsworth & Spiegel, 2010; Aires et al., 2020; Aldridge et al., 2020; Almazan & Keuroghlian, 2021; Al-Tamimi et al., 2019; Balakrishnan et al., 2020; Baker et al., 2021; Buncamper et al., 2016; Cardoso da Silva et al., 2016; Eftekhar Ardebili, 2020; Javier et al., 2022; Lindqvist et al., 2017; Mullins et al., 2021; Nobili et al., 2018; Owen-Smith et al., 2018; Özkan et al., 2018; T'Sjoen et al., 2019; van de Grift, Elaut et al., 2018; White Hughto & Reisner, Poteat et al., 2016; Wierckx, van Caenegem et al., 2014; Yang, Zhao et al., 2016). Gender-affirming interventions may also include hair removal/transplant procedures, voice therapy/surgery, counseling, and other medical procedures required to effectively affirm an individual's gender identity and reduce gender incongruence and dysphoria. Additionally, legal name and sex or gender change on identity documents can also be beneficial and, in some jurisdictions, are contingent on medical documentation that patients may call on practitioners to produce.

Gender-affirming interventions are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of a patient. They are safe and effective at reducing gender incongruence and gender dysphoria (e.g., Aires et al., 2020; Aldridge et al., 2020; Al-Tamimi et al., 2019; Balakrishnan et al., 2020; Baker et al., 2021; Bertrand et al., 2017; Buncamper et al., 2016; Claes et al., 2018; Eftekhar Ardebili, 2020; Esmonde et al., 2019; Javier et al., 2022; Lindqvist et al., 2017; Lo Russo et al., 2017; Marinkovic & Newfield, 2017; Mullins et al., 2021; Nobili et al., 2018; Olson-Kennedy, Rosenthal et al., 2018; Özkan et al., 2018; Poudrier et al., 2019; T'Sjoen et al., 2019; van de Grift, Elaut et al., 2018; White Hughto & Reisner, Poteat et al., 2016; Wierckx, van Caenegem et al., 2014; Wolter et al., 2015; Wolter et al., 2018).

Consequently, WPATH urges health care systems to provide these medically necessary treatments and eliminate any exclusions from their policy documents and medical guidelines that preclude coverage for any medically necessary procedures or treatments for the health and well-being of TGD individuals. In other words, governments should ensure health care services for TGD people are established, extended or enhanced (as appropriate) as elements in any Universal Health Care, public health, government-subsidized systems, or government-regulated private systems that may exist. Health care systems should ensure ongoing health care, both routine and specialized, is readily accessible and affordable to all citizens on an equitable basis.

Medically necessary gender-affirming interventions are discussed in SOC-8. These include but are not limited to hysterectomy +/- bilateral salpingo-oophorectomy; bilateral mastectomy, chest reconstruction or feminizing mammoplasty, nipple resizing or placement of breast prostheses; genital reconstruction, for example, phalloplasty and metoidioplasty, scrotoplasty, and penile and testicular prostheses, penectomy, orchiectomy, vaginoplasty, and vulvoplasty; hair removal from the face, body, and genital areas for gender affirmation or as part of a preoperative preparation process; gender-affirming facial surgery and body contouring; voice therapy and/or surgery; as well as puberty blocking medication and gender-affirming hormones; counseling or psychotherapeutic treatment as appropriate for the patient and based on a review of the patient's individual circumstances and needs.

Statement 2.2

We recommend health care professionals and other users of the Standards of Care, Version 8 (SOC-8) apply the recommendations in ways that meet the needs of local transgender and gender diverse communities, by providing culturally sensitive care that recognizes the realities of the countries they are practicing in.

TGD people identify in many different ways worldwide, and those identities exist within a cultural context. In English speaking countries, TGD people variously identify as *transsexual,*

Appendix 2

CHAPTER 18 Mental Health

This chapter is intended to provide guidance to health care professionals (HCPs) and mental health professionals (MHPs) who offer mental health care to transgender and gender diverse (TGD) adults. It is not meant to be a substitute for chapters on the assessment or evaluation of people for hormonal or surgical interventions. Many TGD people will not require therapy or other forms of mental health care as part of their transition, while others may benefit from the support of mental health providers and systems (Dhejne et al., 2016).

Some studies have shown a higher prevalence of depression (Witcomb et al., 2018), anxiety (Bouman et al., 2017), and suicidality (Arcelus et al., 2016; Bränström & Pachankis, 2022; Davey et al., 2016; Dhejne, 2011; Herman et al., 2019) among TGD people (Jones et al., 2019; Thorne, Witcomb et al., 2019) than in the general population, particularly in those requiring medically necessary gender-affirming medical treatment (see medically necessary statement in Chapter 2—Global Applicability, Statement 2.1). However, transgender identity is not a mental illness, and these elevated rates have been linked to complex trauma, societal stigma, violence, and discrimination (Nuttbrock et al., 2014; Peterson et al., 2021). In addition, psychiatric symptoms lessen with appropriate gender-affirming medical and surgical care (Aldridge et al., 2020; Almazan and Keuroghlian; 2021; Bauer et al., 2015; Grannis et al., 2021) and with interventions that lessen discrimination and minority stress (Bauer et al., 2015; Heylens, Verroken et al., 2014; McDowell et al., 2020).

Mental health treatment needs to be provided by staff and implemented through the use of systems that respect patient autonomy and recognize gender diversity. MHPs working with transgender people should use active listening as a method to encourage exploration in individuals who are uncertain about their gender identity. Rather than impose their own narratives or preconceptions, MHPs should assist their clients in determining their own paths. While many transgender people require medical or surgical interventions or seek mental health care, others do not (Margulies et al., 2021). Therefore, findings from research involving clinical populations should not be extrapolated to the entire transgender population.

Addressing mental illness and substance use disorders is important but should not be a barrier to transition-related care. Rather, these interventions to address mental health and substance use disorders can facilitate successful outcomes from

Statements of Recommendations

18.1- We recommend mental health professionals address mental health symptoms that interfere with a person's capacity to consent to gender-affirming treatment before gender-affirming treatment is initiated.
18.2- We recommend mental health professionals offer care and support to transgender and gender diverse people to address mental health symptoms that interfere with a person's capacity to participate in essential perioperative care before gender-affirmation surgery.
18.3- We recommend when significant mental health symptoms or substance abuse exists, mental health professionals assess the potential negative impact that mental health symptoms may have on outcomes based on the nature of the specific gender-affirming surgical procedure.
18.4- We recommend health care professionals assess the need for psychosocial and practical support of transgender and gender diverse people in the perioperative period surrounding gender- affirmation surgery.
18.5- We recommend health care professionals counsel and assist transgender and gender diverse people in becoming abstinent from tobacco/nicotine prior to gender-affirmation surgery.
18.6- We recommend health care professionals maintain existing hormone treatment if a transgender and gender diverse individual requires admission to a psychiatric or medical inpatient unit, unless contraindicated.
18.7- We recommend health care professionals ensure if transgender and gender diverse people need in-patient or residential mental health, substance abuse or medical care, all staff use the correct name and pronouns (as provided by the patient), as well as provide access to bathroom and sleeping arrangements that are aligned with the person's gender identity.
18.8- We recommend mental health professionals encourage, support, and empower transgender and gender diverse people to develop and maintain social support systems, including peers, friends, and families.
18.9- We recommend health care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment, while acknowledging psychotherapy may be helpful for some transgender and gender diverse people.
18.10- We recommend "reparative" and "conversion" therapy aimed at trying to change a person's gender identity and lived gender expression to become more congruent with the sex assigned at birth should not be offered.

With amendments from Senator K. Roers – 1254 *SHS*

SECTION 1. Chapter 12.1-36.1 of the North Dakota Century Code is created and enacted as follows:

12.1-36.1-01. Definitions.

As used in this chapter:

1. "Health care provider" means a licensed physician, physician assistant, nurse, or a certified medical assistant.
2. "Mental health professional" means:
   a. A psychologist with at least a master's degree who has been either licensed or approved for exemption by the North Dakota board of psychology examiners;
   b. A social worker with a master's degree in social work from an accredited program;
   c. A registered nurse with a minimum of two years of psychiatric clinical experience under the supervision of an expert examiner; or
   d. A licensed professional counselor with a master's degree in counseling from an accredited program who has either successfully completed the advanced training beyond the master's degree as required by the national academy of mental health counselors or a minimum of two years of clinical experience in a mental health agency or setting under the supervision of a psychiatrist or psychologist.
3. "Minor" means an individual under the age of eighteen. The term includes an emancipated individual.
4. "Pre-pubertal" means an individual who has not yet entered puberty, the period during which secondary sex characteristics start to develop.
5. "Puberty" means period of a minor's development during which secondary sex characteristics start to develop.

from Title 25 Mental + Physical Illness/Disability

6. "Sex" means the biological state of being female or male, based on the individual's nonambiguous sex organs, chromosomes, and endogenous hormone profiles at birth.

12.1-36.1-02. Perception of a minor's sex – Prohibited practices – Penalty.

1. Except as provided under section 12.1-36.1-03, if a minor's perception of the minor's sex is inconsistent with the minor's sex, a health care provider may not engage in any of the following practices for the purpose of changing or affirming the minor's perception of the minor's sex:
   a. Perform castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, or vaginoplasty;
   b. Perform a mastectomy;
   c. Remove any otherwise healthy or nondiseased body part or tissue, except for a male circumcision;
   d. Prescribe supraphysiologic doses of testosterone to females; or
   e. Prescribe supraphysiologic doses of estrogen to males.
2. Except as provided in Section 12.1-36.1-03, a health care provider may not prescribe puberty-blocking medication to any minor unless:
   a. The minor has received mental health care for at least twelve consecutive months prior, as documented by a mental health provider; and
   b. The minor has begun to experience puberty, as documented by a medical provider.
3. Except as provided in Section 12.1-36.1-03, a health care provider may not, for the purpose of changing the sex of a pre-pubertal, engage in prescribing, dispensing, administering or otherwise supplying any drug for the purpose of aligning the pre-pubertal's sex with the pre-pubertal's perception of the pre-pubertal's sex when the perception is

Minor → transition meds/procedures

Minor → puberty blockers →

Prepubertal (Minor) → no hormone treatment

inconsistent with the pre-pubertal's sex, including puberty-blocking medication to stop normal puberty.

4. A health care provider who willfully violates:
   a. Subdivisions a, b, or c of subsection 1 is guilty of a class B felony.
   b. Subdivisions d or e of subsection 1, subsection 2, or subsection 3 is guilty of an infraction.

12.1-36.1-03. Exceptions.

Section 12.1-36.1-02 does not apply:

1. To the good-faith medical decision of a parent or guardian of a minor born with a medically verifiable genetic disorder of sex development, including:
   a. A minor with external biological sex characteristics that are irresolvably ambiguous, including having forty-six, XX chromosomes with virilization, forty-six SY chromosomes with undervirilization, or having both ovarian and testicular tissue; or
   b. When a physician otherwise has diagnosed a disorder of sexual development in which the physician, through genetic testing, has determined the minor does not have the normal sex chromosome structure for a male or female; or
2. If performance or administration of the medical procedure on the minor began before the effective date of this Act.

12.1-36.1-04. Statutory limitation.

Notwithstanding the limitations of section 29-04-02, prosecution for a violation of section 12.1-36.1-02, prosecution for a violation of section 12.1-36.1-02 must be commenced within three years of the date of the offense or within three years after the offense is reported to law enforcement, whichever is later.

SECTION 2. EMERGENCY. This Act is declared to be an emergency measure.

Do No Harm

North Dakota Senate

Senate Committee on Human Services

HB 1254

Daniel Weiss MD

Opening Statement

Chairwoman Lee and Members of the Committee:

My name is Dr. Daniel Weiss.

I am a board-certified internist and endocrinologist. I am also a senior fellow with the non-profit organization, Do No Harm. My commentary is mine alone and does not represent the views of any medical practice.

I believe my clinical experience is meaningful, in part, because I have provided hormonal treatments for persons with gender dysphoria in the past.

I do not do so now.

Why not? Because I discovered that most of these patients carried stories of traumatic childhoods and co-morbid depression. Their psychologic evaluation was inadequate before they were "cleared" for treatment. Furthermore, opposite sex treatment did not resolve any of their underlying psychologic issues.

I later learned that there is no good scientific or clinical evidence to support hormonal or surgical interventions for minors with gender dysphoria. Instead, there is increasing evidence to show that such treatments for gender dysphoria cause harm. I will briefly summarize key data in the medical literature.

The most-cited studies of hormonal treatment in minors report outcomes using the so-called Dutch protocol. I encourage you to review the references I have provided.

Multiple papers detail the many scientific flaws in the Dutch studies: There was no comparison group. The study subjects were highly selected. The study started with 111 children but only 55 were analyzed at its conclusion. Nonetheless, the small group of children showed no improvement in gender distress, anxiety, or anger after opposite sex hormone treatment. The researchers used an unvalidated measurement tool and manipulated its results. It is also little known that the series included, as a complication of surgery, a patient death. Independent researchers in the United Kingdom attempted to replicate the findings of the Dutch group, but, revealingly, were unsuccessful.

A paper published last year in the Endocrine Society's key journal summarized the evidence on hormonal interventions for "gender diverse adolescents" as sparse and of low quality. In the key authoritative endocrinology textbook, just published in 2023, the chapter on Transgender Healthcare, written by a WPATH member, states that "long-term prospective outcome studies of the effects of GAHT (gender affirming hormone therapy) of any type are lacking. What data that do exist are mostly retrospective and have numerous limitations."

And gender dysphoria resolves in the vast majority of children without any interventions.

I have touched on the lack of data showing benefit. So, what about harm? Many studies show that puberty blockers and opposite sex hormones damage bone health, cardiovascular health, and fertility. There is emerging evidence of increased rates of breast cancer and other adverse effects.

Those who state that puberty blockers are readily reversible and harmlessly "pause" puberty can cite no published data on the reversibility of these drugs in this setting. The FDA has not approved any drug for treatment of gender dysphoria.

How about suicide? The largest study documented 4 suicides out of 15,000 adolescents being treated for gender dysphoria in the United Kingdom. It is not known whether this rate is any different than that seen in adolescents undergoing mental health treatment who do not have gender dysphoria.

The best data suggest that hormonal and surgical interventions increase the risk of suicide. The Dutch study provided no data on suicide. In contrast, a long-term study of transgender persons in Sweden found a 19-fold overall higher suicide rate.

The rate was 40-fold higher in females and a 3-fold higher overall mortality, despite treatment with opposite sex hormones and surgery as compared to the control population. *In a study of over 8000 transgender person, two thirds of those who died by suicide were still receiving treatment at the gender dysphoria center*. In a New England Journal of Medicine article this year, suicide reportedly increased 45-fold with opposite sex hormonal therapy.

For more than a decade, long before opposite sex therapies became popular in the United States, European centers offered these treatments for gender confusion. Now, as increasing data show substantial harm, Finland, Sweden, France, and the United Kingdom have discouraged or terminated opposite sex treatments for minors. Instead, they advise supportive psychotherapy for minors with gender confusion.

Why have physicians and surgeons in the United States resisted the shift occurring among their European counterparts? I do not know the answer. However, I caution legislators to avoid all individual and institutional financial conflicts of interest while finalizing this bill.

In closing, it should be noted that strict international principles prohibit children from providing consent. This is because children cannot fully comprehend risk versus benefit. The United States is a signatory to the United Nations Convention on the Rights of the Child. The *Declaration of the Rights of the Child* states that "the child, by reason of his physical and mental immaturity, needs special safeguards and care." These safeguards are uniquely important when it comes to an experimental medical intervention. The Declaration of Helsinki allows individual parents to consent to experimental treatment for their child. Usually, this choice is made in an extraordinary circumstance, to save that child's life, and with the child's assent. Experimental treatments to change gender appearance should not be an exception to these requirements.

Please help protect the children of North Dakota.

Thank you.

Daniel Weiss MD

Key References:

Lack of efficacy

de Vries A. L. *et al.* Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J. Sexual Medicine 2011; 8: 2276-2283.

"Dutch Study." There was no change in anxiety, depression or gender distress following GnRH therapy (puberty blockers) and opposite sex therapy in children. There was no comparator control group, and all received psychologic support.

de Vries A.L. *et al.* Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics 2014; 134: 696-704.

"Dutch Study." A non-validated assessment tool was used to assess dysphoria, there was no control group, and the 55 patients were tested in such a way that improvements in scores would be seen even without treatment. There was one post-surgical death. Only 55 of the original 111 children were included in the analysis.

Carmichael P. *et. al.* Short-term outcomes of pubertal suppression in a selected cohort of 12- to 15-year-old young people with persistent gender dysphoria in the UK. PLOS One 2021; 16 (2) *These researchers could not confirm any of the claims of DeVries et al in young people treated with the Dutch protocol in the U.K.*

Kaltiala R, *et. al.* Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nord J Psychiatry*. 2020;74(3):213-219.

This retrospective chart review showed no improvement in psychiatric status in 52 adolescents after opposite sex hormone treatments.

Abbruzzese E. *et. al.* 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. January 2023.

This paper is a comprehensive and critical review of De Vries' studies identifying the many flaws and biases in the methodology.

Levine S. *et. al.* Reconsidering informed consent for trans-identified children, adolescents, and young adults. J. Sex and Marital Therapy 2022; 48: 706-727.

This paper describes the challenges in providing full and proper informed consent to children with gender dysphoria and their parents in light of the flaws in the Dutch protocol and limitations in our knowledge base.

O'Connell MA, *et al.* Approach to the Patient: Pharmacological Management of Trans and Gender-Diverse Adolescents. *J Clin Endocrinol Metab*. 2022;107(1):241-

257. *This review stresses the need for improvement in the "evidence base" emphasizing that the "evidence relating to hormonal therapies in youth is low" and that "data on wellbeing in transgender persons is sparse".*

Levine SB, *et. al.* What are we doing to these children? Response to Drescher, Clayton, and Balon commentaries on Levine et. al. 2022. J Sex and Marital Therapy 2023; 49:115-125. *In a response to comments, the authors discuss the benefits of psychotherapeutic interventions and the frequent conflicts of interest of those clinicians who solely promote hormonal and surgical interventions.*

Deutsch, MB. Transgender Healthcare. p 1752-1757 *in* Degroot's Endocrinology. Basic science and clinical practice. 8th edition. 2023.

In this authoritative textbook on endocrinology, *Dr. Madeline Deutsch, a member of the World Professional Association for Transgender Health* (WPATH) *writes that "long-term prospective outcome studies of the effects of GAHT (gender affirming hormone therapy) of any type are lacking. What data that do exist are mostly retrospective and have numerous limitations."*

Role of psychotherapy or non-intervention

Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry*. 2016;28(1):13-20. *85% of children with gender dysphoria show spontaneous resolution of their symptoms and distress without any intervention.*

Clayton, A. Gender-affirming treatment of gender dysphoria in youth: a perfect storm environment for the placebo effect-the implications for research and clinical practice. Arch Sex Behavior Nov. 2022.

This paper provides an overview of the poor data in support of opposite sex hormone treatment, of the harms caused by opposite sex treatment and improvement in response to placebo. For perspective, it describes historical treatments which once were popular, but eventually proved harmful to children.

Costa R. *et. al.* Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. J Sex Med 2015: 12: 2206-2214.

This UK study found that psychological support alone lead to significant improvement in psychological function in adolescents with gender dysphoria, mean age of 15.5.

Psychiatric co-morbidities in youth with gender dysphoria

Becerra-Culquie TA *et. al.* Mental health of transgender and gender nonconforming youth compared with their peers. Pediatrics 2018: 141: e20173845.

Over 60 % of transgender adolescents were diagnosed with depression, autism spectrum disorders, psychoses, substance abuse, anxiety or eating disorders.

Kozlowska, K. et. al. Australian children and adolescents with gender dysphoria: clinical presentations and challenges experienced by a multidisciplinary team and gender service. Human Systems: Therapy, Culture and Attachments 2021; 1: 70-95

88% of these youth had comorbid mental health diagnoses and other indicators of psychological distress and adverse childhood events. 19% had a history of sexual abuse. 54% were bullied. What is the best approach to treating these youth?

Devor, H. Transexualism, dissociation and child abuse: an initial discussion based on nonclinical data. J Psychology and Human Sexuality 1994; 6: 49-72.

In depth interviews disclosed that sixty percent of the natal females disclosed one or more types of child abuse; more than 50% of that abuse was sexual.

Harm

Mortality:

Dhejne C, *et al.* Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;6(2):e16885.

This long-term study found an overall 19-fold higher suicide rate (40 fold in female to male) and a 3-fold higher overall mortality in 324 transgender persons at 11 years after full transition, compared to the control population.

de Blok CJM. *et al.* Mortality trends over five decades in adult transgender people receiving hormone treatment: a report from the Amsterdam cohort of gender dysphoria. *The Lancet Diabetes & Endocrinology*. 2021;9(10):663-670.

This study documented increased rates of mortality in all persons receiving opposite sex hormone therapy.

Bone:

Biggs M. Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *J Pediatr Endocrinol Metab*. Jul 27, 2021;34(7):937-939. *Children treated with puberty blockers showed a marked reduction in bone density in those treated with GnRH analogues (puberty blockers); this change would be expected to increase the risk of fractures.*

Cardiovascular:

Nota NM, et al. Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. *Circulation*. 2019;139(11):1461-1462.

This study found increased rates of heart attacks, strokes, and blood clots in those treated with opposite sex hormone therapy.

Getahun D. *et. al.* Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*. Aug 21, 2018;169(4):205-213.

This study documents increased rates of blood clots as well as strokes and heart attacks in males given opposite sex hormone treatment.

Fertility:

Baram S, *et al.* Fertility preservation for transgender adolescents and young adults: a systematic review. *Hum Reprod Update*. Nov 5, 2019;25(6):694-716.

The authors raise concerns that opposite sex hormone therapies cause infertility, but offer no solutions to this problem.

Cancer:

de Blok, *et. al.* Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands. BMJ 2019; 365: l1652.

Males given opposite sex hormones experience a 46-fold increase in the occurrence of breast cancer.

Gurrala RR, *et. al.* The impact of exogenous testosterone on breast cancer risk in transmasculine individuals. Ann Plastic Surg 2023; 90: 96-105.

Breast cancer occurred 20 yrs earlier than expected in this population of females even though most had mastectomies before the diagnosis. Despite mastectomy, they retained some breast tissue.

Wang, JC et. al. Factors associated with unsatisfactory Pap tests among sexually active trans masculine adults. LGBT Health 2023;

Those females who had received 1 year or more of testosterone were three and half times more likely to have an unsatisfactory Pap test, making early detection of cervical cancer much more difficult.

Breastfeeding:

Gribble, K. *et al.* Breastfeeding grief after chest masculinisation mastectomy and detransition: a case report with lessons about unanticipated harm. Frontiers in Global Women's Health 2023; Feb.

This case report describes the challenges faced by a woman who detranstions and who grieves over being unable to breastfeed her infant. Detransition is discussed and the importance of including in the informed consents before mastectomy the inability to breastfeed.

Brain:

Schneider MA, et. *al.* Brain maturation, cognition, voice pattern in a gender dysphoria case under pubertal suppression. Frontiers in Human Neuroscience Nov 2017; 11. *This patient showed an abnormal failure to increase brain white matter. In addition the patient experienced a reduction in IQ and memory during 22 months of puberty blockers.*

Post-surgical complications

Van der Sluis WB, *et. al.* Genital gender-affirming surgery for transgender women. Best Practice and Research Clinical Obstetrics and Gynecology Dec 2022.

The surgical procedures of vulvoplasty and vaginoplasty typically require 5 day hospital stay. The authors describe the risk of severe complications, the possibility of repeat surgeries and the fact that there is no accepted validated questionnaire to assess postoperative satisfaction.

Ortengren, C. et. al. Urethral outcomes in metoidioplasty and phalloplasty gender affirming surgery and vaginectomy: a systematic review. Translational Andrology and Urology 2022; 11: 1762-1770.

The authors review reports of surgical outcomes including the ability to urinate while standing after surgery. Of those reporting this result, 25% of patients were unable to urinate while standing. Up to 63% had complications including urethral strictures and infections. No description was provided of patient satisfaction after surgery.

Kamal K, *et.al.* Addressing the physical and mental impacts of postsurgical scarring among transgender and gender diverse people. LGBT Health 2023

The authors describe the "dearth of peer-reviewed research" on the "repercussions" of postsurgical scarring and the lack of coverage by insurance for "scar treatment".

Potter, E. et. al. Patient reported symptoms and adverse outcomes seen in Canada's first vaginoplasty postoperative care clinic Neurourol Urodyn 2023; 42: 523-529

Pain, bleeding, sexual dysfunction, and urinary symptoms were common (> 50%) in this series of 80 biologic males who had undergone surgery to create a vagina.

Wang, AMQ, et. al. Outcomes following gender affirming phalloplasty: a systematic review and meta-analysis. Sexual Medicine Reviews 2022; 10: 499-512.

The authors describe a 76% complication rate after attempts to create a penis in biologic females. Goals of surgery include being able to urinate with standing, having sensation, and aesthetics, i.e being similar in appearance to biologic male genitalia. The objective the authors considered did not include having a penis that can function for intromission. Only 6% of those centers reporting results aesthetic results.

Suicide risk

Wiepjes CM, *et. al.* Trends in suicide death risk in transgender people; results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017). Act Psychiatr Scand 2020; 141: 486-491.

This long-term study of 8263 transgender adults, (mean age of 25 at first visit to gender dysphoria center) showed that suicide deaths occur during every stage of gender transitioning. There were 49 suicides out of 8263 persons with average follow-up of 7.5 years. This number is a rate of 40/100,000 which may be compared to 11/100,000 in the general population. Two thirds of those who died by suicide were still receiving treatment at the gender dysphoria center. The average age at the time of suicide was 41. This study provided no additional psychiatric information.

Biggs, M. Suicide by clinic-referred transgender adolescents in the United Kingdom. Arch Sexual Behavior 2021; 51: 685-90.

In this study, of the Gender identity Development Service in the UK, 4 patients committed suicide out of 15,000. This rate was 5.5 times higher than the overall adolescent population without psychiatric diagnoses. The study reached no conclusion as to the best approach to prevent these suicides.

Chen, D. *et. al.* Psychosocial functioning in transgender youth after 2 years of hormones. N Engl J Med 2023; 388: 240-250.

There was no control group in this study of children, aged 12-20 (mean age 16) treated with opposite sex hormones over 2 years in 4 US transgender clinics. Psychiatric care was not described. The biologic males showed no improvement in depression, anxiety, or life satisfaction. There were no reports of adverse physical events but 2 children, on treatment, committed suicide during this short-term study.

The rate of suicide in this group translates into a 45-fold higher rate than the CDC reported suicide rates for those of comparable age in the general population.

Regret and Detransition

Littman L. Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners. Arch. Sex Behavior. 2021; 50: 3353-3369.

This study recruited subjects with gender dysphoria and offered them a 115-question anonymous survey on several social media sites. The response showed that 48% of the natal females had trauma within 1 year before onset of gender dysphoria. 55% felt they did not receive adequate evaluation from a doctor or mental health professional before opposite sex therapy. Only 24% let their clinician know they had chosen to detransition. In 23%, the desire to "transition" was a response to difficulty in accepting themselves as gay, lesbian, or bisexual. Gender dysphoria started on average at age 11 and transition occurred on average at age 22. On average, detransition occurred 4 years later.

Roberts CM, *et. al.* Continuation of gender-affirming hormones among transgender adolescents and adults. J Clin Endocrinol Metab 2022; 107: e3937-e3943.

This study used the US Military Healthcare System database to determine the adherence rates for opposite sex hormone treatment in 952 persons with a mean age 19. 66% of this cohort were natal females. Over 4 years, 36% of the natal females discontinued treatment. Of those who started opposite sex treatment below the age of 18, 26% discontinued within 4 years.

Ethics

https://www.ecfr.gov/current/title-21/chapter-I/subchapter-A/part-50/subpart-D/section 50.52

Code of federal regulations relating to institutional review board requirements for clinical investigations involving children. There must be an anticipated benefit that is as favorable as other available treatments and there must be assent of the children and permission of the parents or guardians.

Declaration of Helsinki (1964) BMJ 313, 1448-1449, 1996

Wolf, Sheldon

From: Lee, Judy E.
Sent: Tuesday, March 21, 2023 9:39 PM
To: -Grp-NDLA Senate Human Services; Wolf, Sheldon; NDLA, Intern 02 - Pouliot, Lindsey; Lahr, Pat
Subject: FW: Do No Harm: North Dakota
Attachments: DNH Reassigned Report.pdf; DNH Gender Transition Treatments.pdf; ND_Testimony_Weiss.pdf; ND_Testimony_Cole.pdf; ND_Testimony_Grossman.pdf; ND_Testimony_Littlejohn.pdf

FYI –

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
Home phone: 701-282-6512
Email: jlee@ndlegis.gov

From: Ari DeWolf <ari@donoharmmedicine.org>
Sent: Tuesday, March 21, 2023 9:33 PM
To: Lee, Judy E. <jlee@ndlegis.gov>
Subject: Do No Harm: North Dakota

Good evening Chairman Lee,

This is Ari DeWolf with Do No Harm.

We are a diverse group of physicians, healthcare professionals, medical students, patients, and policymakers united by a moral mission: *Protect healthcare from a radical, divisive, and discriminatory ideology.* We believe in making healthcare better for all – not undermining it in pursuit of a political agenda.

As North Dakotans continue the important public conversation on HB1254, please allow me to share written testimony from several of our gender ideology senior fellows, in addition to our most recent policy report and white paper. We hope these resources may be of value in your engagement with colleagues, constituents, media and interest groups.

We operate as pro bono consultants to lawmakers and civic organizations on the technical components of this complex issue area. If we may provide additional resources, now or in the future, please do not hesitate letting me know.

Most respectfully,
Ari

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Ari DeWolf

Director of Outreach

Do No Harm

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WHITE PAPER:

WHY STATE LEGISLATURES MUST PROTECT CHILDREN AND ADOLESCENTS FROM HARMFUL "GENDER TRANSITION" TREATMENTS

Prepared by:
COOPER & KIRK, PLLC
David H. Thompson, Brian W. Barnes, John D. Ramer

Do No Harm

I. INTRODUCTION

The United States has seen a recent and dramatic increase in the number of children and adolescents who report serious distress resulting from an inconsistency between their sex and their *perception* of their gender or sex. According to advocates of so-called "gender affirming" care, when physicians and healthcare professionals are confronted with patients suffering from this distress, those medical professionals must affirm the child's perception and take steps to modify the patients' bodies to conform to that perception. By changing the body to match the perception, the argument goes, the inconsistency will be eliminated or reduced, and the patient's distress will decrease.

But there is no reliable scientific evidence that these treatments actually have this effect—as health officials in numerous countries, including England, Finland, and Sweden, have found. Meanwhile, these treatments carry dangerous and lifelong consequences, such as infertility, total loss of adult sexual function, and even death in some instances. Despite the lack of evidence to warrant the use of these treatments on children and adolescents—who are among the most vulnerable individuals in our society—advocates of "gender affirming care" continue to push for these treatments and attempt to stifle all dissent to the "affirming" model.

In the face of the failure of medical organizations to properly safeguard children from these baseless and dangerous treatments, it is the duty of the Legislature to step in and protect the children and adolescents of this State.

II. BACKGROUND

In recent years, there has been a dramatic increase in the number of minors in the United States who report some form of inconsistency between their sex and their perception of their gender or sex. This discordance may sometimes cause serious distress, leading to a diagnosed condition of gender dysphoria.[1] Available data indicate that diagnoses of gender dysphoria in minors ages 6 to 17 rose by about 20% annually between 2017 and 2020, and by 80% between 2020 and 2021, for a total of 121,882 new diagnoses during this five-year period.[2] Indeed, this is likely a conservative estimate because it is based solely on insurance claims.[3]

In the United States, advocates and practitioners of so-called "gender affirming care" for minors (individuals under the age of 18) suggest that, when faced with situations of gender discordance or dysphoria, pediatricians, mental health professionals, endocrinologists, and other healthcare professionals should give precedence to the minor's *perception* instead of the minor's actual sex when attempting to resolve an inconsistency between the two.[4] If the minor's body and the minor's perception are inconsistent, the thinking goes, any treatment to address the inconsistency should affect *the body* and *not* the perception.

The course of this treatment typically involves several sequential steps. First, it commonly begins with adults or peers encouraging the minor to "socially transition."[5] This term encompasses a range of acts other than pharmaceutical or surgical interventions that are undertaken to help the minor present as a member of the opposite sex or something other than the minor's sex. "Socially transitioning" could therefore include changing the minor's preferred pronouns, wearing clothes generally

1. Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 451–52 (5th ed. 2013).
2. Robin Respaut & Chad Terhune, *Putting Numbers on the Rise in Children Seeking Gender Care*, Reuters (Oct. 6, 2022), *available at* https://www.reuters.com/investigates/special-report/usa-transyouth-data/.
3. *See id.*
4. *See, e.g.*, Eli Coleman, et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 International Journal of Transgender Health S1, S50 (2022), *available at* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644 ("WPATH Standards of Care 8") (arguing that healthcare professionals "working with adolescents should promote supportive environments that simultaneously respect an adolescent's affirmed gender identity and also allows the adolescent to openly explore gender needs, including social, medical, and physical gender-affirming interventions"); Jason Rafferty, et al., *Policy Statement, Am. Academy of Pediatrics, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, Pediatrics (Oct. 2018), *available at* https://perma.cc/EE6U-PN66 (advocating for a "gender-affirmative care model" that "is oriented toward understanding and appreciating the youth's gender experience").
5. *See, e.g.*, WPATH Standards of Care 8, *supra* n.4, at S75–76; Diane Ehrensaft, et al., *Prepubertal Social Gender Transitions: What We Know; What We Can Learn—A View from a Gender Affirmative Lens*, 19 International Journal of Transgenderism 251 (Mar. 9, 2018), *available at* https://cogentoa.tandfonline.com/doi/full/10.1080/15532739.2017.1414649?scroll=top&needAccess=true (explaining that "social transitioning" is "often, although not always, the first action a transgender person takes to align with their internal sense of themselves as a gendered person"); *see also* NHS England, *Interim Service Specification for Specialist Gender Dysphoria Servs. for Children and Young People* 11-12 (Oct. 20, 2022) (noting that social transitioning "should not be viewed as a neutral act" but rather "as an 'active intervention' because it may have significant effects on the child or young person in terms of their psychological functioning").

associated with members of the opposite sex, or using specific clothing or devices for the purpose of concealing a minor's secondary sex characteristics.[6] An example of this last category is the use of so-called "chest binders," which females wear to conceal or reduce visibility of their breasts.[7]

The next phase of the treatment occurs when puberty begins or is approaching. At this point, medical professionals often administer long-acting GnRH agonists—also known as "puberty blockers"—to delay the natural onset or progression of puberty.[8] This phase of treatment is sold as an opportunity for the minor to "pause" the natural occurrence of puberty so the minor will have more time to discern his or her "true gender identity."[9] Many proponents of this treatment have publicly asserted that the administration of puberty blockers is "fully reversible."[10]

After puberty blockers are administered (or even sometimes without them), the next phase involves the administration of "cross-sex" hormonal treatments.[11] The goal of using these cross-sex hormones is to induce the development of secondary sex characteristics commonly associated with the opposite sex.[12] For example, a male might take estrogen to develop breasts, or a female might take testosterone to develop more body hair and greater muscle mass.

Finally, the treatment process generally concludes with surgical procedures to create an appearance similar to that of the opposite sex, or at least different from the individual's actual sex.[13] Although these surgeries remain relatively uncommon for minors, evidence shows that they have increased in recent years.[14] These procedures may include "top surgery," a euphemism for surgery such as a bilateral mastectomy, which entirely removes a female's breasts.[15] They may also include "bottom surgery," a euphemism for surgical procedures that include the removal of a minor's healthy reproductive organs, such as a penectomy, which is a removal of a male's penis.[16]

6. WPATH Standards of Care 8, *supra* n.4, at S54, S76.
7. *Id.* at S54 ("Chest binding involves compression of the breast tissue to create a flatter appearance of the chest."); Eugene Kim, et al., *Oxygen Desaturation in a Transgender Man: Initial Concerns and Recommendations Regarding the Practice of Chest Binding: A Case Report*, 16 Journal of Medical Case Reports 333 (Sept. 4, 2022), *available at* https://jmedicalcasereports.biomedcentral.com/articles/10.1186/s13256-022-03527-z.
8. WPATH Standards of Care 8, *supra* n.4, at S45–48, S59–66.
9. *See, e.g.*, Jack Turban, *Texas Officials Are Spreading Blatant Falsehoods About Medical Care for Transgender Kids*, Wash. Post (Mar. 1, 2022), *available at* https://www.washingtonpost.com/opinions/2022/03/01/texas-ken-paxton-greg-abbott-misinformation-transgender-medical-care/.
10. *Id.* ("We start with fully reversible interventions (temporary puberty blockers)").
11. *See, e.g.*, WPATH Standards of Care 8, *supra* n.4, at S46–48, S64–66.
12. UK National Institute for Health Care and Excellence, *Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria* 3 (Oct. 2020), *available for download at* https://cass.independent-review.uk/nice-evidence-reviews/.
13. *See* WPATH Standards of Care 8, *supra* n.4, at S48, S64–66.
14. *See, e.g.*, Annie Tang, et al., *Gender-Affirming Mastectomy Trends and Surgical Outcomes in Adolescents*, Annals of Plastic Surgery (May 2022), *available at* https://journals.lww.com/annalsplasticsurgery/Abstract/2022/05004/Gender_Affirming_Mastectomy_Trends_and_Surgical.4.aspx.
15. WPATH Standards of Care 8, *supra* n.4, at S128.
16. *See* Mang L. Chen, et al., *Overview of Surgical Techniques in Gender-Affirming Genital Surgery*, Translational Andrology and Urology (June 2019), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6626317/#.

After *removing* body parts associated with the individual's sex, the procedures then generally involve the *creation* of artificial body parts to approximate the appearance of the opposite sex.[17] For males, for example, this could involve a "vaginoplasty," which is the construction of a vagina-like structure, typically through something called a penile inversion procedure.[18] For females, it could involve a "scrotoplasty," which is the construction of a penis-like and scrotum-like structure.[19]

In addition to these procedures, surgery may also include non-genital procedures. For example, males may seek so-called "facial feminization" surgery or other aesthetic procedures.[20] And females may seek similar aesthetic procedures like pectoral implants.[21]

In sum, the goal of this treatment process is to alter the minor's body or appearance to conform them to the minor's *perception*. The treatments become increasingly invasive at each step. And the result is a dramatic change in the minor's social and physical appearance.

17. *Id.*
18. WPATH Standards of Care 8, *supra* n.4, at S258.
19. *Id.*
20. *Id.* at S130, S258.
21. *Id.*

III. THE PROBLEMS WITH THE CURRENT APPROACH

There is no reliable scientific or medical evidence that justifies the use of these treatments on children and adolescents for this purpose. In other words, there is simply no basis for concluding that these treatments lead to a benefit that outweighs the known or suspected harms and risks associated with them. Moreover, there is strong reason to doubt that minors and their parents are adequately informed of the risks and lack of benefits before these treatments are administered and inflict irreversible harm.

A. Risks

The known harms and risks of these treatments are significant. As an initial matter, the use of puberty blockers for this purpose has not been approved by the FDA, meaning that the prescription of puberty blockers as part of this treatment is entirely off label.[22] Any claims about the safety and efficacy of puberty blockers are instead based on their use for precocious puberty, which is a different condition where—in contrast to these treatments—normal puberty is allowed to resume once the minor reaches an appropriate age.[23] And the suspected side effects of puberty blockers include diminished bone density, cognitive impairment, and greater risk of infertility.[24] In addition, puberty blockers may have permanent negative effects on adult sexual function.[25] Moreover, the full effect of puberty blockers on brain development and cognition are unknown.[26]

22. Chad Terhune, et al, *As More Transgender Children Seek Medical Care, Families Confront Many Unknowns*, Reuters (Oct. 6, 2022), *available at* https://www.reuters.com/investigates/special-report/usa-transyouth-care/ ("Puberty blockers and sex hormones do not have U.S. Food and Drug Administration (FDA) approval for children's gender care.").

23. *See* Annelou L.C. de Vries & Peggy T. Cohen-Kettenis, *Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach*, Journal of Homosexuality (Mar. 28, 2012), *available at* https://www.tandfonline.com/doi/abs/10.1080/00918369.2012.653300

24. *See, e.g.*, Silvia Ciancia, et al., *Impact of Gender-Affirming Treatment on Bone Health in Transgender and Gender Diverse Youth*, Endocrine Connections (Sept. 28, 2022), *available at* https://ec.bioscientifica.com/view/journals/ec/11/11/EC-22-0280.xml ("Results consistently indicate a negative impact of long-term puberty suppression on bone mineral density, especially at the lumbar spine, which is only partially restored after sex steroid administration."); Philip J. Cheng, et al., *Fertility Concerns of the Transgender Patient*, Translational Andrology and Urology (June 2019), *available at* https://tau.amegroups.com/article/view/26091/24253 ("Suppression of puberty with gonadotropin-releasing hormone agonist analogs (GnRHa) in the pediatric transgender patient can pause the maturation of germ cells, and thus, affect fertility potential."); *see also* Michael Biggs, *Revisiting the Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents with Gender Dysphoria*, Journal of Pediatric Endocrinology and Metabolism (Apr. 26, 2021), *available at* https://doi.org/10.1515/jpem-2021-0180; Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence*, Journal of Sex & Marital Therapy (Sept. 19, 2022), *available at* https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2121238?scroll=top&needAccess=true.

25. *See* David Larson, *Duke Health Emerges as Southern Hub for Youth Gender Transition*, The Carolina Journal (Aug. 31, 2022), *available at* https://www.carolinajournal.com/duke-health-emerges-as-southern-hub-for-youth-gender-transition/ (Former WPATH President Marci Bowers "seemed to acknowledge these challenges, saying that 'really about zero' biological males who block puberty at the typical Tanner 2 Stage of puberty (around 11 years old) will go on to ever achieve an orgasm[.]").

26. Diane Chen, et al., *Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth*, Transgender Health (Dec. 11, 2020), *available at* https://www.liebertpub.com/doi/10.1089/trgh.2020.0006.

The risks associated with the use of cross-sex hormones for this purpose are similarly serious. For males, the use of cross-sex hormones is associated with numerous health risks, such as thromboembolic disease, including blood clots; cholelithiasis, including gallstones; coronary artery disease, including heart attacks; macroprolactinoma, which is a tumor of the pituitary gland; cerebrovascular disease, including strokes; hypertriglyceridemia, which is an elevated level of triglycerides in the blood; breast cancer; and irreversible infertility.[27] For females, the use of cross-sex hormones is associated with risks of erythrocytosis, which is an increase in red blood cells; severe liver dysfunction; coronary artery disease, including heart attacks; depression; hypertension; infertility; and increased risk of breast, cervical, and uterine cancers.[28] And when preceded by the use of puberty blockers, cross-sex hormones may need to be used for the rest of the individual's life because the organs responsible for hormone production—which regulate many aspects of physical and psychological health and function and not just sexual health and function—were never given a chance to fully develop.

The surgeries associated with this treatment also come with significant risks. Although the risks, complications, and long-term concerns are not entirely known, they may include fistulas, chronic infection, the need for a colostomy, atrophy, and complete loss of sensation (sexual or otherwise).[29] As just one example of the potentially fatal risks associated with these procedures, when a young male undergoes puberty suppression—which stunts the growth of his sexual organs and thus reduces the amount of tissue available for subsequent surgeries—a vaginoplasty may require the borrowing of issue from the colon to create a "neovagina."[30] The creation of a second surgical site is associated with a far higher risk of infection and additional complications, including death.[31]

In addition, the risks of treatments later in the process, such as surgeries, cannot be fully separated from the risks of earlier treatment, such as puberty blockers. The reason the risks for these separate treatments cannot be separated is due to what is known as an "iatrogenic" effect, which means that a particular treatment may

27. *See* WPATH Standards of Care 8, *supra* n.4, at S254.

28. *Id.*

29. Wouter B. van der Sluis, et al., *Clinical Characteristics and Management of Neovaginal Fistulas After Vaginoplasty in Transgender Women*, Obstetrics and Gynecology (June 2016), *available at* https://pubmed.ncbi.nlm.nih.gov/27159746/; Jing J. Zhao, *Surgical Site Infections in Genital Reconstruction Surgery for Gender Reassignment, Detroit: 1984–2008*, Surgical Infections (Apr. 2014), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4047849/; Mang L. Chen, et al., *Overview of Surgical Techniques in Gender-Affirming Surgery*, Translational Andrology and Urology (June 2019), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6626317/; Valentin Maurer, et al., *Penile Flap Inversion Vaginoplasty in Transgender Women: Contemporary Morbidity and Learning-Curve Analysis from a High-Volume Reconstructive Center*, Frontiers in Surgery (Feb. 23, 2022), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8906498/; Valeria P. Bustos, et al., *Regret After Gender-Affirmation Surgery: A Systematic Review and Meta-Analysis of Prevalence*, Plastic and Reconstructive Surgery Global Open (Mar. 19, 2021), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8099405/.

30. Vera L. Negenborn, et al., *Lethal Necrotizing Cellulitis Caused by ESBL-Producing E. Coli After Laparoscopic Intestinal Vaginoplasty*, Journal of Pediatric and Adolescent Gynecology (Feb. 2017), *available at* https://www.sciencedirect.com/science/article/abs/pii/S1083318816301747

31. *See id.*; *see also* Biggs, *The Dutch Protocol*, *supra* n.24 (discussing a patient who died because a vaginoplasty was attempted with part of his intestine, which became infected).

actually *create* or *worsen* the condition it is attempting to treat.[32] In this context, advocates of "gender affirming care" say that puberty blockers or cross-sex hormones are necessary to treat an inconsistency between the minor's sex and perception. But delaying a child's natural puberty while his or her peers continue on to develop the characteristics that come from puberty may actually contribute to any existing confusion or discordance related to the child's sex.[33] This iatrogenic effect potentially extends even to social transitioning, where adults "affirming" a minor's perceived gender may inadvertently make it more likely that the minor will continue on to medical interventions such as puberty blockers, cross-sex hormones, and surgery.[34] It is for this reason that the United Kingdom's National Health Service has recognized that social transition is *not* a "neutral act" but rather an "active intervention" that can alter the course of a child's development.[35] Thus, even social transitioning implicates the risks associated with puberty blockers, cross-sex hormones, and surgery.

B. Benefits

There is no reliable evidence to support the conclusion that these treatments result in long-term improvement. Although some studies have shown short-term benefits, especially in terms of reducing feelings of dysphoria, they do not control for the confounding effects of psychotherapy or a placebo effect, so these studies are unable to establish that puberty blockers and cross-sex hormones are superior alternatives to psychotherapy. Thus, proponents of these treatments greatly exaggerate their benefits.

One of the greatest pieces of misinformation associated with these treatments are the unfounded claims that minors in distress who are not able to access drugs and surgeries are at imminent risk of suicide and that drugs and surgeries are needed to reduce that risk.[36]

The purported evidence supporting this assertion is grossly overstated at best and outright misleading at worst. For example, a popular article by one of the most vocal proponents of gender-affirming care cited six studies related to suicidality

32. *See* Leor Sapir, *The School-to-Clinic Pipeline*, City Journal (Autumn 2022), *available at* https://www.city-journal.org/gender-transistions-school-to-clinic-pipeline.
33. Biggs, *The Dutch Protocol*, *supra* n.24.
34. Leor Sapir, *A Cause, Not A Cure*, City Journal (May 10, 2022), *available at* https://www.city-journal.org/new-study-casts-doubt-on-gender-affirming-therapy
35. *See* NHS England, *supra* n.5, at 11–12.
36. *See, e.g.*, Jack Turban, *The Evidence for Trans Youth Gender-Affirming Medical Care*, Psychology Today (Jan. 24, 2022), *available at* https://www.psychologytoday.com/us/blog/political-minds/202201/the-evidence-trans-youth-gender-affirming-medical-care; *see also* Turban, *supra* n.9.

and gender-affirming care.[37] But these studies are riddled with methodological weaknesses that foreclose the claim that "the evidence shows" transitioning treatments cause a reduction in the risk of suicide.[38] Indeed, *the lead author* of one of the studies stated that the article overstated her research and that she "cannot claim that [her] research would have shown that gender affirming hormonal treatment reduces suicidality."[39] Instead, for individuals who have undergone inpatient gender reassignment procedures, the suicide rates, psychiatric morbidities, and mortality rates remain markedly elevated above the background population.[40] In the U.K., where patients were subject to a two-year waiting period, the U.K.'s major gender clinic reported four deaths by suicide out of 15,000 patients.[41] To be clear, every suicide is tragic. But there is no reliable evidence to suggest that *transitioning treatments* are the way to prevent one. And there is even reason to wonder whether these treatments may actually *contribute* to suicidal behavior.[42]

Moreover, although these treatments have been associated with self-reported, short-term improvement in a minor's mental health, there is a strong possibility that this improvement is the result of a placebo effect.[43] Specifically, the mere fact that an adolescent receives these treatments may lead to a self-reported improvement in his or her psychological outlook—even if the physical effects caused by the treatments are not themselves the cause of that improvement. And given the serious and long-term risks associated with these treatments, they cannot be ethically or medically justified on the basis of a placebo effect that leads to self-reported, short-term

37. *See* Turban, *supra* n.36 (citing L.R. Allen, et al., *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*, Clinical Practice in Pediatric Psychology (2019), *available at* https://psycnet.apa.org/record/2019-52280-009?doi=1; R. Kaltiala, et al., *Adolescent Development and Psychosocial Functioning After Starting Cross-Sex Hormones for Gender Dysphoria*, Nordic Journal of Psychiatry (Apr. 2020), *available at* https://pubmed.ncbi.nlm.nih.gov/31762394/; J.L. Turban, et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, Pediatrics (Feb. 2020), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269/; A.E. Green, et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, Journal of Adolescent Health (Apr. 2022), *available at* https://pubmed.ncbi.nlm.nih.gov/34920935/; J.L. Turban, et al., *Access to Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, PLoS One (Jan. 2022), *available at* https://pubmed.ncbi.nlm.nih.gov/35020719/; D.M. Tordoff, et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, JAMA Network Open (Feb. 2022), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423.

38. Leor Sapir, *The Distortions in Jack Turban's Psychology Today Article on 'Gender Affirming Care,'* Reality's Last Stand (Oct. 7, 2022), *available at* https://www.realityslaststand.com/p/the-distortions-in-jack-turbans-psychology.

39. *Id.*

40. Stephen B. Levine, et al., *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, Journal of Sex & Marital Therapy (Mar. 17, 2022), *available at* https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2046221; Cecilia Dhejne, et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLOS One (Feb. 22, 2011), *available at* https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885&utm_source=mandiner&utm_medium=link&utm_campaign=mandiner_202101; Wiepjes CM, et al., *Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoia Study* (1972-2017), Acta Psychiatrica Scandinavica (Feb. 16, 2020), *available at* https://onlinelibrary.wiley.com/doi/pdf/10.1111/acps.13164 (finding that suicides occur at a similar rate at all stages of transition, from pretreatment assessment to post-transition follow-up).

41. *See* Michael Biggs, *Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom*, Archives of Sexual Behavior (2022), *available at* https://pubmed.ncbi.nlm.nih.gov/35043256/.

42. *See* NHS England, *Board of Directors: The Tavistock and Portman* 53 (June 23, 2015) (noting a statistically significant increase in self-harm *after* a year of puberty suppression), *available at* https://tavistockandportman.nhs.uk/documents/142/board-papers-2015-06.pdf.

43. Alison Clayton, *Gender-Affirming Treatment of Gender Dysphoria in Youth: A Perfect Storm Environment for the Placebo Effect—The Implications for Research and Clinical Practice*, Archives of Sexual Behavior (Nov. 14, 2022), *available at* https://link.springer.com/article/10.1007/s10508-022-02472-8.

improvement.[44] Relatedly, the unsupported assertions regarding increased risk of depression, anxiety, or suicide if these treatments are denied possibly creates a nocebo effect—meaning the effect leads to deleterious results rather than beneficial ones (thus the opposite of a placebo effect). An excessive focus on an exaggerated or unsupported risk of suicide could result in a negative self-fulfilling prophecy that actually increases suicidality and suicide risk.[45]

Indeed, other countries have already acknowledged that the benefits of these treatments do not outweigh the risks. Health authorities in Sweden, Finland, and the U.K. have conducted systematic reviews of evidence and, having found that the evidence of benefits is too uncertain to outweigh the risks, have decided to place severe restrictions on medical transition procedures.[46] Finland's public-health body has called hormonal interventions "experimental" medicine.[47] And just recently, Sweden's public-health body has made clear "that the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits because of "the continued lack of reliable scientific evidence concerning the efficacy and the safety of both treatments, the new knowledge that detransition occurs among young adults, and the uncertainty that follows from the yet unexplained increase in the number of care seekers, an increase particularly large among adolescents registered as females at birth."[48] Nevertheless, organizations like the World Professional Health Association for Transgender Health (WPATH), continue to push for these treatments as the standard for all minors.[49] Organizations like WPATH do so for ideological rather than scientific or medical reasons, and they actively stifle dissent in the medical community.[50]

44. Society for Evidence Based Gender Medicine, *Gender-Affirming Treatment of Gender Dysphoria in Youth: Are the Results Compromised by the Placebo Effect?* (Dec. 7, 2022), *available at* https://segm.org/Placebo-effects-of-gender-affirmative-care ("From the methods perspective, the placebo effect puts gender medicine studies at a high risk of bias due to both confounding (the anticipation of improvement affects the results, but its effect cannot be separate from the effect of the treatment) and measurement error (if a study participant expects a positive outcome, they will be more likely to make a positive judgment about the outcome, which will bias their self-reported outcome).").

45. Clayton, *supra* n.43 ("However, an excessive focus on an exaggerate suicide risk narrative by clinicians and the media may create a damaging nocebo effect (*e.g.*, a 'self-fulfilling prophecy' effect) whereby suicidality in these vulnerable youths may be further exacerbated.").

46. *See* UK National Institute for Health Care and Excellence, *supra* n.12; UK National Institute for Health Care and Excellence, *Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria* (Oct. 2020), *available for download at* https://cass.independent-review.uk/nice-evidence-reviews/; The Cass Review, *Interim Report* (Feb. 2022), *available for download at* https://cass.independent-review.uk/publications/interim-report/; Sweden's National Board of Health and Welfare (Socialstyrelsen), *Care of Children and Adolescents with Gender Dysphoria* (2022), *available at* https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf; The Council for Choices in Health Care in Finland, *Summary: Medical Treatment Methods for Dysphoria Associated with Variations in Gender Identity in Minors—Recommendation* (June 16, 2020), *available at* https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474.

47. *See* The Council for Choices in Health Care in Finland, *Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland)* (2020), *available at* https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf.

48. Sweden's National Board of Health and Welfare (Socialstyrelsen), *Summary: Care of Children and Adolescents with Gender Dysphoria* (Dec. 16, 2022), *available at* https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf (English translation of executive summary).

49. *See, e.g.*, WPATH Standards of Care 8, *supra* n.4.

50. For example, the former President of USPATH (the U.S. affiliate of WPATH) stated that she resigned in part because she could "not abide the tactics of muzzling leaders in the USPATH/WPATH"—tactics that were endorsed by some within the organization after she had expressed concern during an interview about the potential for regret among adolescents who transition due to the lack of safeguards under the existing regime of "gender affirming care." *See* Lisa Selin Davis, *A Trans Pioneer Explains Her Resignation from the U.S. Professional Association for Transgender Health*, Quillette (Jan. 6, 2022), *available at* https://quillette.com/2022/01/06/a-transgender-pioneer-explains-why-she-stepped-down-from-uspath-and-wpath/.

The combination of overstated benefits (particularly in the context of preventing suicide), understated risks, and denial of meaningful alternatives (such as psychotherapy) cannot ground an informed consent process. Parents are often faced with the grotesque slogan that they can have "a dead daughter or a live son" (or vice versa).[51] They hear this not just from activists in the media but from the very medical professionals with whom they interact and the professional associations in which their providers hold membership. Despite the fact that there is no reliable evidence suggesting that these treatments actually reduce the risk of suicide,[52] it is unsurprising that parents confronted with this false choice would err on the side of purported "life-saving treatment." Similarly, many of the long-term risks, such as a loss of fertility or adult sexual function, may not be risks that children and adolescents can adequately comprehend[53]—especially when medical institutions downplay those risks.

Given this lack of informed consent, it is unsurprising—though no less tragic—to see the rise of individuals known as "detransitioners."[54] These are people who came to regret the harm caused by undergoing physiological interventions to alter their appearance and bodily functions to align with their perceived sex or perceived gender.[55] Because the current "gender affirming" model is still relatively new, there are no studies on rates of regret and detransition among the cohort that received treatment under this model, but claims about regret being "extremely rare" are based either on studies of adults who transitioned as adults or of minors who were transitioned under highly restrictive and controlled conditions.

C. The Flawed "Dutch Protocol"

Proponents of the safety and efficacy of these treatments often try to defend them by referencing a study published by a group of Dutch clinicians. This Dutch study was among the earliest examples of attempts to document the use of puberty blockers as a treatment for children suffering from gender dysphoria.[56] According to the

51. *See* Kenneth J. Zucker, *Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues*, Archives of Sexual Behavior (July 18, 2019), *available at* https://link.springer.com/article/10.1007/s10508-019-01518-8.

52. Levine, *supra* n.40, at n.47 ("The 'transition or suicide' narrative falsely implies that transition will prevent suicides" but even though, "in the short term, gender-affirmative interventions can lead to improvements in some measures of suicidality, neither hormones nor surgeries have been shown to reduce suicidality in the long-term." (citations omitted)).

53. Antony Latham, *Puberty Blockers for Children: Can They Consent?*, The New Bioethics (June 27, 2022), *available at* https://www.tandfonline.com/doi/full/10.1080/20502877.2022.2088048 ("The brain is biologically and socially immature in childhood and unlikely to understand the long-term consequences of treatment.").

54. Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*, Archives of Sexual Behavior (Nov. 2021), *available at* https://pubmed.ncbi.nlm.nih.gov/34665380/; Elie Vandenbussche, *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, Journal of Homosexuality (Apr. 30, 2021), *available at* https://www.tandfonline.com/doi/full/10.1080/00918369.2021.1919479.

55. Littman, *supra* n. 54; Vandenbussche, *supra* n.54.

56. *See* Annelou de Vries, et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, Journal of Sex Medicine (Aug. 8, 2011), *available at* https://pubmed.ncbi.nlm.nih.gov/20646177/; Annelou de Vries, et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, Pediatrics (Oct. 2014), *available at* https://pubmed.ncbi.nlm.nih.gov/25201798/.

publications describing the study, some subjects of the study who underwent puberty blockade and ultimately surgery reported a resolution of their gender dysphoria 1.5 years after the surgery.[57] Advocates point to the results of this study as the foundation for the "gender affirming care" of today.

Reliance on the Dutch study to justify gender affirming care is misplaced for numerous reasons. Take first the substance of the study itself, which has been strongly criticized for their biased methodology and unimpressive results.[58] For example, the Dutch team used a flawed scale for the purpose of measuring dysphoria, which largely renders the study's observed "improvement" meaningless.[59] Moreover, the results excluded one patient who died during a vaginoplasty, and the study failed to mention that the patient's death was the consequence of puberty suppression—which prevented the patient's penis from growing large enough to facilitate a vaginoplasty, so physicians were forced to use tissue from the patient's intestine.[60] The intestine became infected, which ultimately led to the patient's death.[61]

Second, the only improvement suggested by the study resulted from a follow-up just 18 months after the surgery. This short amount of time is manifestly inadequate for determining the ultimate long-term efficacy and safety of these treatments. Indeed, one of the Dutch researchers who co-authored one of the articles reporting the study admitted that "a truly proper follow-up needs to span a minimum period of 20 years."[62] As of December 2022, the Dutch researchers have yet to publish any long-term outcomes.

Third, the structure of the study meant that it could not reliably distinguish between the effects of the medical interventions and the effects of psychotherapy.[63] The Dutch study required that subjects demonstrate a stable state of mind before receiving puberty blockers or cross-sex hormones and then continuously receive mental therapy throughout the process.[64] Thus, there is no reliable way of knowing how much any reported improvement was attributable to the hormones as opposed to the therapy. Simply put, the Dutch research does not show that hormones are a *superior* treatment to psychotherapy.

57. Levine, et al., *supra* n.40.
58. Biggs, *The Dutch Protocol*, *supra* n.24.
59. *Id.*
60. *Id.*
61. *Id.*
62. *Id.*; *see also* Leor Sapir, *'Trust the Experts' Is Not Enough: U.S. Medical Groups Get the Science Wrong on Pediatric 'Gender Affirming' Care*, Manhattan Institute 5 (Winter 2022), *available for download at* https://www.manhattan-institute.org/how-to-respond-to-medical-authorities-claiming-gender-affirming-care-is-safe.
63. Sapir, *supra* n.62, at 5.
64. *Id.*

Finally, the eligibility criteria for individuals to participate in the Dutch study effectively eliminated any significance of their findings.[65] To be eligible for puberty blockers under the study, subjects had to *also* satisfy the heightened eligibility criteria for cross-sex hormones, thus effectively guaranteeing that any case casting doubt on the safety or efficacy of puberty blockers was excluded at the outset.[66] All these problems likely explain why no study has ever successfully replicated the results of the Dutch study.[67]

Next, even taking the Dutch study at face value, the children and adolescents seeking these treatments today are *far* different from those who participated in the Dutch study. For example, to be eligible for the study, subjects had to fulfill five criteria: (1) they suffered from *early-onset* gender dysphoria, (2) the condition persisted or intensified into adolescence, (3) they were psychologically and emotionally stable with no comorbid psychiatric diagnoses, (4) they had parental approval, and (5) informed consent was obtained as a continuous process, often over the course of months.[68]

In contrast to the prototypical subject for the Dutch protocol, the data today shows a very different set of patients. The majority of minors seeking treatment now are adolescent girls with no prior history of dysphoria and very high rates of mental health comorbidities.[69] Moreover, proponents of these treatments often argue that parental approval should *not* be a requirement for receiving hormones.[70] Under the affirmative model, what appears to drive treatment decisions is gender identity, not gender dysphoria. Given these changes, the Dutch researchers themselves have acknowledged that their research may not apply to the current environment.[71] Thus, the Dutch study has little to tell us about the use of these treatments for the vast majority of children and adolescents who receive them today.

65. Levine, et al., *supra* n.40 ("It is important to realize that the Dutch sample as carefully selected, which introduced a source of bias, and also challenges the study's applicability. From the 196 adolescents initially referred, 111 were considered eligible to start puberty blockers, and of this group, only the 70 most mature and mentally stable who proceeded to cross-sex hormones were included in the study.").

66. *Id.*

67. *Id.* ("A recent attempt to replicate the results of the first Dutch study found no demonstrable psychological benefit from puberty blockade, but did find that the treatment adversely affected bone development. The final Dutch study has never been attempted to be replicated with or without a control group." (citations omitted)).

68. Sapir, *supra* n.62, at 5–6.

69. Sapir, *supra* n.62, at 6.

70. *Id.*

71. *See More Research Is Urgently Needed into Transgender Care for Young People: 'Where Does the Large Increase of Children Come from?*, Voorzij (Feb. 27, 2021), *available at* https://www.voorzij.nl/more-research-is-urgently-needed-into-transgender-care-for-young-people-where-does-the-large-increase-of-children-come-from/ (Translation of Dutch article where Dr. Thomas Steensma said other countries were "blindly adopting [their] research") (cited by Leor Sapir, *The Distortions in Jack Turban's Psychology Today Article on 'Gender Affirming Care,'* Reality's Last Stand (Oct. 7, 2022), *available at* https://www.realityslaststand.com/p/the-distortions-in-jack-turbans-psychology.

Finally, even if the Dutch protocol *were* to provide the proper standard of care, the Dutch protocol is not what is happening on the ground in the United States. For example, the Dutch protocol acknowledges that gender dysphoria in children is very likely to *desist* by adolescence or early adulthood, meaning the dysphoria will resolve on its own without medical intervention.[72] But the treatment model today, as clarified by the American Academy of Pediatrics, assumes that gender identity can be known from a very early age and, once declared, must be affirmed by adults.[73] In other words, proponents effectively claim that gender identity is innate and fixed—which is contrary to what the Dutch researchers stated.[74]

Another significant departure of today's treatment from the Dutch protocol relates to mental health. The Dutch protocol studied only minors who had no serious co-occurring mental health problems.[75] But today, most referrals to pediatric gender clinics have high rates of mental health problems, such as anxiety, depression, ADHD, and autism.[76] The independent study in the U.K. found that up to one third of patients referred to the U.K.'s Gender Identity Development Service have autism or other neuroatypical conditions.[77] By contrast, some American medical professionals advocating the affirmative model have gone so far as to suggest, without citing any evidence, that medical transition can serve as a "treatment" for autism.[78] A legitimate implementation of the Dutch protocol (setting aside the study's numerous flaws) would require addressing these mental health issues through alternative means,

72. Leor Sapir, *Affirming Deception*, City Journal (Dec. 6, 2022), *available at* https://www.city-journal.org/wpath-finally-acknowledges-europes-restrictions-on-gender-affirming-care (noting that the Dutch model "acknowledges that gender dysphoria in children is very likely to desist by adolescence or early adulthood, in many cases resolving into homosexuality").

73. *See, e.g.*, Rafferty, *supra* n.4 (stating that "children who are prepubertal" and assert a gender identity different from their sex "know their gender as clearly and as consistently as their developmentally equivalent peers who identify as cisgender").

74. *See, e.g.*, Cohen-Kettenis, et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, Journal of Sex Medicine (Aug. 2008), *available at* https://pubmed.ncbi.nlm.nih.gov/18564158/ (noting that the pathological basis for gender identity is "poorly understood" and "its diagnosis relies totally on psychological methods").

75. *See* Henriette A. Delemarre-van de Wall & Peggy T. Cohen-Kettenis, *Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects*, European Journal of Endocrinology (Nov. 2006), available at https://eje.bioscientifica.com/view/journals/eje/155/suppl_1/1550131.xml; Annelou L.C. de Vries, et al., *Clinical Management of Gender Dysphoria in Adolescents*, International Journal of Transgenderism (Oct. 17, 2008), *available at* https://www.tandfonline.com/doi/abs/10.1300/J485v09n03_04; de Vries, et al., *supra* n.23.

76. The Cass Review, *supra* n.46, at 30 ("In addition, approximately one third of children and young people referred to IDS have autism or other types of neurodiversity."); Tracy A. Becerra-Culqui, et al., *Mental Health of Transgender and Gender Nonconforming Youth Compared with Their Peers*, Pediatrics (May 2018), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5914494/; Nastasja M. de Graaf & Polly Carmichael, *Reflections on Emerging Trends in Clinical Work with Gender Diverse Children and Adolescents*, Clinical Psychology and Psychiatry (Nov. 28, 2018), *available at* https://journals.sagepub.com/doi/10.1177/1359104518812924; Emily Thrower, et al., *Prevalence of Autism Spectrum Disorder and Attention-Deficit Hyperactivity Disorder Amongst Individuals with Gender Dysphoria: A Systematic Review*, Journal of Autism and Developmental Disorders (Nov. 15, 2019), *available at* https://link.springer.com/article/10.1007/s10803-019-04298-1; Alexis Clyde, et al., *Autism Spectrum Disorder and Anxiety Among Transgender Youth: Use of the Social Communication Questionnaire* (SCQ), Journal of Autism and Developmental Disorders (Nov. 24, 2022), *available at* https://link.springer.com/article/10.1007/s10803-022-05814-6; Aimilia Kallitsounaki, et al., *Links Between Autistic Traits, Feelings of Gender Dysphoria, and Mentalising Ability: Replication and Extension of Previous Findings from the General Population*, Journal of Autism and Developmental Disorders (Aug. 1, 2020), *available at* https://link.springer.com/article/10.1007/s10803-020-04626-w; Lucy McPhate, et al., *Gender Variance in Children and Adolescents with Neurodevelopmental and Psychiatric Condition from Australia*, Archives of Sexual Behavior (Apr. 2021), *available at* https://pubmed.ncbi.nlm.nih.gov/33788061/; Douglas H. Russell, et al., *Prevalence of Mental Health Problems in Transgender Children Aged 9 to 10 Years in the US*, 2018, JAMA Network (July 22, 2022), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794486; Anna I.R. van der Miesen, et al., *Autistic Symptoms in Children and Adolescents with Gender Dysphoria*, Journal of Autism and Developmental Disorders (May 2018), *available at* https://pubmed.ncbi.nlm.nih.gov/29189919/.

77. The Cass Review, *supra* n.46, at 30.

78. *See, e.g.*, Diane Ehrensaft, The Gender Creative Child: Pathways for Nurturing and Supporting Children who Live Outside Gender Boxes 103 (2016).

such as psychotherapy, before turning to transitioning medication and surgery as a last resort.

In sum, the benefits of these treatments are unproven while the risks are numerous and grave. These facts alone counsel against prescribing these treatments to children and adolescents. Moreover, the main study held up by proponents of these treatments contains many flaws that foreclose any ability to rely on its conclusions, is not even applicable to the typical patient receiving these treatments today, and used controls that are not followed in the real world. And modern studies suffer from the same methodological problems[79]—which explains why the countries that have conducted systematic reviews (like Finland, Sweden, and the U.K.) have found the evidentiary support for these treatments too low to justify them. Children and adolescents must be protected from the unscientific and dangerous treatments taking place today.

79. *See, e.g.*, Jesse Singal, "*Science Vs" Cited Seven Studies To Argue There's No Controversy About Giving Puberty Blockers and Hormones to Trans Youth. Let's Read Them.*, Singal-Minded (June 10, 2022), *available at* https://jessesingal.substack.com/p/science-vs-cited-seven-studies-to.

CONCLUSION

Our country has witnessed a recent and dramatic increase in the number of children and adolescents who report a variance between their sex and their perception of their gender or sex. Proponents of so-called "gender affirming" care assert that the way to help these children is by modifying their bodies through the use of puberty blockers, cross-sex hormones, and surgeries. Despite the total lack of evidence to support these types of interventions, the medical establishment has permitted ideology, instead of facts, to govern the administration of life-altering and harmful medical treatments to minors.

As a result, children and adolescents face risks of permanent infertility, lifelong loss of adult sexual function, and even death in some instances. Given the unfortunate reality of medical organizations endorsing unsupported claims and refusing to submit those claims to open and honest scientific debate, State Legislatures must intervene to protect children and adolescents from these dangerous and baseless treatments.

Do No Harm

DONOHARMMEDICINE.ORG

Extreme gender ideology drives the United States to provide transgender medical care to younger children, while Europe goes a safer and more scientific route.

Do No Harm

BACKGROUNDER

The belief that biological sex and gender are socially constructed has made its way into American classrooms,[1] courtrooms,[2] bathrooms,[3] and boardrooms.[4] The mainstreaming of this belief system has coincided with a substantial increase in the number of children receiving transgender medical care. Between 2017 and 2021, the number of children known to be on puberty blockers or cross-sex hormones more than doubled.[5]

Skeptics have raised the alarm, pointing out that the surge in sex reassignment interventions (i.e., puberty blockers, cross-sex hormones, and sex reassignment surgeries) might be explained, at least in part, by social contagion. According to this argument, the increase in interventions for adolescents is caused not by an authentic increase in the incidence of gender incongruence but by the spread of gender ideology across all facets of American life. This concern is exacerbated by the degree to which the medical establishment allows such ideology to compete with or even usurp the scientific method as a guide to research and medical practice.[6]

The American approach to transgender medical treatment for children is known as "gender affirmation," which assumes that gender incongruence can manifest as early as age four and that questioning a minor's gender self-definition is harmful and unethical. The American Academy of Pediatrics has embraced an affirm-only/affirm-early policy since 2018,[7] and most states abide by its guidance despite withering medical and scientific criticism. Gender-affirming care remains the standard across most of the United States.

Yet Northern and Western Europe, which share the United States' broad support for transgenderism, reject the gender-affirming care model for children. In fact, several countries, including the United Kingdom, Sweden, and Finland, have explicitly abandoned it in recent years in part due to fear that medical intervention has become overprescribed (studies show that only 12% to 27% of cases of childhood gender dysphoria persist into adulthood).[8] In a sharp departure from the gender affirmation model employed in the United States, these countries now discourage automatic deference to a child's self-declarations on the grounds that the risks outweigh the benefits, while also calling for months-long psychotherapy sessions to address co-occurring mental health problems. Notably, in the United Kingdom, the Cass Review attributed the lack of safeguards for children at the largest pediatric gender center to the "affirmative model," which "originated in the USA."[9]

The different approaches between the United States and Western and Northern Europe lead to a concerning reality: In the U.S., much younger patients are eligible for invasive surgeries and/or potentially irreversible and medically harmful dispensation of puberty blockers and cross-sex hormones.

This report identifies the different legal requirements for gender change-related treatments and actions between the U.S. and Western and Northern European countries. Most information contains references with web links to original sourcing. Some information was procured through consultation with local experts, often though not exclusively an individual affiliated with a gender clinic. In the interest of their privacy, their identities are kept anonymous.

Overall, our policy review reveals the United States is the most permissive country when it comes to the legal and medical gender transition of children. Only France comes close, yet unlike the U.S., France's medical authorities have recognized the uncertainties involved in transgender medical care for children and have urged "great caution" in its use.

Given the growing body of evidence and the European consensus, which is grounded in medical science and common sense, the United States should reconsider the gender-affirming care model to protect the youngest and most vulnerable patients.

LEGAL REQUIREMENTS TO CHANGE GENDER

CONTEXT: *Many countries now allow individuals to change the gender listed for them on government-issued documents. The requirements imposed for civil registries to recognize individuals as belonging to a gender other than their biological sex sheds light on the degree to which gender affirmation is established in law.*

COUNTRY	REQUIREMENT
United States	Requirements vary from state to state, with the option not available in some. Birth certificate changes are prohibited in Montana, Oklahoma, Tennessee, and West Virginia.[10] Driver's license changes are permitted in all states, but requirements vary. In Massachusetts, for example, a gender change on a driver's license is a matter of self-determination.[11] Tennessee, however, requires "a statement from the attending physician that necessary medical procedures to accomplish the change in gender are complete."[12] U.S. State Department and Social Security Administration documents (i.e., passports and Social Security records) allow for self-determination.[13]
Belgium	Gender-changes in the civil registry are self-determined.[14]
Denmark	Gender changes in the civil registry are self-determined.[15]
Iceland	Gender changes in the civil registry are self-determined.[16]
Ireland	Gender changes in civil registry are self-determined.[17]
Finland	An applicant must have "medical expert evidence of being transsexual" and have "undergone sterilization or is for other reasons infertile."[18]
France	Individuals wishing to change their gender in the civil registry must prove that they socially live as the other gender. Evidence may include family testimonies, photographs, and medical certificates. One piece of evidence is not enough.[19]
Luxembourg	"The applicant must demonstrate, by producing sufficient evidence, that the gender status currently recorded in the civil register does not reflect their gender identity. Such evidence may include: The fact that the person's gender expression matches the gender being applied for; The fact that the person is identified by their family, friends and professional or other personal entourage as the gender being applied for; The fact that the person has previously obtained a change in first name to match the gender being applied for."[20]
Netherlands	The government requires a statement from a doctor, psychologist, or psychotherapist which affirms "that you (the applicant) have declared to this expert that you have the permanent conviction that you belong to another gender than stated on your birth certificate. And that you understand the repercussions of your decision to change your gender identification."[21]
Norway	Gender changes in civil registry are self-determined.[22]
Sweden	Changes require a medical diagnosis of transsexualism. Moreover, "anyone who wants to change their legal gender ... must have been in contact with a gender clinic for at least two years before an application can be sent to the Legal Council."[23]
United Kingdom	Applicants must have a diagnosis of gender dysphoria from a doctor, live as "affirmed" gender for at least 2 years, and intend to live in that gender for the rest of one's life. The requirement that one have a dysphoria diagnosis can be waived if the applicant has been living in their affirmed gender for at least 6 years and had gender affirmation surgery. [24]

MINIMUM AGE TO CHANGE GENDER IN CIVIL REGISTRY

CONTEXT: *Some countries allow individuals to change their gender identity on government-issued documents. But not all of them let minors do this, and practices vary across the countries that permit it.*

COUNTRY	REQUIREMENT
United States	The United States has a piecemeal approach, as both states and the federal government are custodians of civil registration. There is no minimum age for changing gender on passports[25] or in Social Security Administration (SSA) documentation.[26] For minors, changes to either require the consent of both parents. Some states, including New York, California, Colorado, Connecticut, New Jersey, Pennsylvania, and Washington, permit minors to change their birth certificate gender markers with parental consent.[27]
Belgium	Minors aged 16 or 17 must obtain parental consent and consultation with a psychiatrist.[28]
Denmark	The limit is currently 18, though in 2022, the government proposed removing age limits and requiring consent for those under the age of 15.[29]
Iceland	Iceland has no age restrictions, though individuals younger than 18 need parental consent.[30]
Ireland	An individual who is 16 or 17 must have parental consent, approval from a medical practitioner, and an application to the High Court, otherwise, the requirement is 18 years of age.[31]
Finland	The minimum age requirement is 18.[32]
France	The minimum age requirement is 18.[33]
Luxembourg	There is no age limit. For youth under age 5, applications are sent to the Ministry of Justice. For youth over age 5, applications are sent to the "competent district court." Parental consent is required until age 18.[34]
Netherlands	The minimum age requirement is 16.[35]
Norway	Changes are possible, with parental consent, from age 6. Without parental consent, a person must wait until age 16.[36]
Sweden	The minimum age requirement is 18, though there is ongoing debate about lowering it to 16.[37]
United Kingdom	There is no age minimum, though parental consent is required up until age 18.[38]

LEGAL GENDER OTHER THAN MALE OR FEMALE

CONTEXT: *Some countries recognize a gender other than male or female, thereby tacitly endorsing the idea that gender and sex are social constructs.*

COUNTRY	REQUIREMENT
United States	Twenty-two states as well as the District of Columbia allow individuals to place an X (rather than an M or F) on a driver's license; 16 states plus D.C. allow it on birth certificates. Passports offer an X gender option.[39]
Belgium	The government only recognizes male and female, though pending rule changes would remove gender altogether from identity cards.[40]
Denmark	Denmark allows an X marker on IDs, but the civil registry is binary. [41]
Iceland	Government allows for third gender and/or nonbinary designations.[42]
Ireland	Ireland allows a third option on passports but not in the civil registry.[43]
Finland	Male and female are the only recognized genders.[44]
France	Male and female are the only recognized genders.[45]
Luxembourg	Male and female are the only recognized genders.[46]
Netherlands	Gender neutral designation on official documents is possible, but only through request to a district court.[47]
Norway	The X designation is not allowed, though as of August, 2022 it was under consideration.[48]
Sweden	Male and female are the only recognized genders.[49]
United Kingdom	Male and female are the only recognized genders.[50]

NOTABLE REQUIREMENTS FOR MEDICAL TRANSITION

CONTEXT: *Recognizing that gender-affirming care is largely irreversible and that only 12% to 27% of cases of childhood gender dysphoria persist into adulthood,[51] countries impose various barriers to medical intervention. These barriers are intended to screen out cases that are unlikely to persist or in which mental distress would not be improved through gender-affirming care.*

COUNTRY	REQUIREMENT
United States	Diagnosis of dysphoria is required for insurance purposes, but an individual paying out of pocket could medically transition without such a diagnosis.[52] A diagnosis is typically, though not exclusively, made by a psychologist or psychiatrist. Testosterone is a controlled substance, so depending on state law there are restrictions on which practitioners can prescribe it. Clinics that use WPATH guidance impose few or no other limitations to receiving hormonal or physical treatment. For example, the transgender clinic at the University of California San Francisco advises that "Medical providers who feel comfortable making an assessment and diagnosis of gender dysmorphia, as well as assessing for capacity to provide informed consent (able to understand risks, benefits, alternatives, unknowns, limitations, risks of no treatment) are able to initiate gender affirming hormones without a prior assessment or referral from a mental health provider… Prescribing gender affirming hormones is well within the scope of a range of medical providers, including primary care physicians, obstetricians-gynecologists, and endocrinologists, advanced practice nurses, and physician assistants. Depending on the practice setting and jurisdiction, other providers with prescriptive rights (naturopathic providers, nurse midwives) may also be appropriate to prescribe and manage this care."[53]
Belgium	Those seeking gender-affirming healthcare must have a referral letter from a psychologist, psychiatrist, or sexologist before they can receive care from an endocrinologist.[54]
Denmark	Treatment requires diagnosis of dysphoria and treatment by an interdisciplinary team. "When carrying out gender reassignment treatment – as well as in the evaluation hereof – the team must have relevant medical specialist qualifications including obstetrician-gynecologists or endocrinologists (medical specialist doctor in internal medicine in the field of endocrinology). … In relation to the investigation and treatment of gender identity for individuals under the age of 18, the team must be comprised of relevant medical specialists qualified in pediatrics (pediatric endocrinology, growth, and reproduction) as well as in child and adolescent psychiatry."[55]
Iceland	Individuals who want hormone treatment are observed for at least 6 months to ensure that they are psychiatrically fit to receive treatment.[56]
Ireland	Individual seeking gender-affirming surgery or hormones must receive a dysphoria diagnosis and live full time as their preferred gender identity for a significant period of time. An individual seeking sex-reassignment surgery must obtain the approval of a psychiatrist or psychologist.[57]
Finland	The dysphoria of a minor seeking hormone treatment must be deemed "severe" and "permanent." Prescription of puberty blockers or cross-sex hormones to minors requires that no contraindications to early treatment are identified.[58]
France	An endocrinologist or general practitioner can prescribe hormones, but surgery requires consent from the national health insurance fund, an endocrinologist, and a surgeon.[59]
Luxembourg	A psychiatrist must diagnose an individual with transgenderism and rule out other potential pathologies for that individual to receive gender-affirming care. An individual must be seen by a psychiatrist for at least one year before qualifying for surgery.[60]

NOTABLE REQUIREMENTS FOR MEDICAL TRANSITION

COUNTRY	REQUIREMENT
Netherlands	Puberty suppression requires a diagnosis of gender identity disorder, persistent dysphoria since childhood, and no "serious comorbid psychiatric disorders that may interfere with diagnostic assessment."[61]
Norway	If diagnosed with transsexualism, the patient undergoes a "real-life experience" for a minimum of 12 months, during which the person lives in accordance with their gender identity. After the real-life experience, and endocrine and other metabolic examinations, hormones are prescribed. Patients are assessed for surgery after 1–3 years of hormone therapy.[62]
Sweden	Requires diagnosis of gender dysphoria (DSM-5) and treatment from an interdisciplinary medical team. The key prerequisite for hormonal treatment of youth is the prepubertal onset of gender dysphoria that is long-lasting (a 5-year minimum is mentioned), persists into adolescence, and causes clear suffering.[63]
United Kingdom	Surgery requires having socially transitioned at least 12 months before the procedure. Puberty blockers and hormonal treatments require assessment from a multi-disciplinary team "over a period of time" and recommendation from two specialists involved in the client's care, including a consultant endocrinologist and a senior psychosocial clinician.[64]

MINIMUM AGE FOR PUBERTY BLOCKERS

CONTEXT: *Puberty blockers suppress the release of sex hormones so that gender-questioning youth do not sexually develop in a way that diverges from their gender identity. For gender-questioning youth young enough to receive them (they are not administered to individuals who have reached full sexual maturation), puberty blockers are the first medical intervention administered. Blockers are known to decrease bone density[65] and contribute to infertility when administered alongside cross-sex hormones.[66] They may also inhibit cognitive development.[67]*

COUNTRY	REQUIREMENT
United States	Some states restrict minor access to puberty blockers, and lawmakers in others seek such restrictions.[68] The most permissive states do not impose restrictions, and blockers can be administered from the earliest stages of puberty. According to The New York Times, "Many physicians in the United States and elsewhere are prescribing blockers to patients at the first stage of puberty — as early as age 8."[69] In most states, puberty blockers cannot be administered before age 18 without parental consent. Oregon is a notable exception: Children are legally entitled to receive puberty blockers from age 15 and up, and they receive Medicaid assistance in doing so.[70]
Belgium	Puberty blocks are available with parental consent from Tanner Stage II and without parental consent at age 18.[71]
Denmark	Puberty blockers can be prescribed from age 12 with parental consent[72] and from age 15 without parental consent.[73]
Iceland	There is no minimum age for puberty blockers with parental consent, so minimum age is a matter of clinical judgement. Adolescents 15 and younger must obtain parental consent, though they can appeal to the ombudsman for children and receive government permission to bypass parental consent.[74]
Ireland	Available "under 16 years old" with consent, and from 16 without consent.[75]
Finland	Available from "about age 13" with parental consent, and from 18 without consent.[76]
France	In theory, puberty blockers could be prescribed for minors at any age, though in practice it is not done until Tanner Stage II.[77] Blockers are available without consent from age 18.[78]
Luxembourg	No official guidance exists. In practice, adolescents almost always receive blockers in a neighboring country.[79]
Netherlands	According to protocol, blockers are available from age 12 without consent,[80] though younger cases have been recorded. Blockers are available without consent from age 16.[81]
Norway	Puberty blockers are available with consent once physiological signs of puberty manifest.[82] The are available without consent from age 16.[83]
Sweden	Puberty blockers can be prescribed from age 12 with parental consent and from 18 without consent.[84]
United Kingdom	Blockers are available from the earliest stages of puberty, with or without parental consent.[85] Instances of children under 16 receiving blockers without consent are reportedly rare.[86]

MINIMUM AGE FOR CROSS-SEX HORMONES

CONTEXT: *Medical intervention can include cross-sex hormone therapy, whereby sex hormones (estrogen or testosterone) are administered to alter a person's secondary sex characteristics to better align with their gender identity. Observational analysis indicates that biological males who receive hormone therapy might be at elevated risk for cardiovascular problems.*[87] *Some changes that hormones manifest are irreversible.*[88]

COUNTRY	REQUIREMENT
United States	Some states restrict minors' access to gender-affirming hormone treatment, and lawmakers in other states are considering restrictions. In some states, the practice has been documented with parental consent in children under the age of 13.[89] Oregon is the most permissive state, with individuals able to access cross-sex hormones from age 15 without consent and with Medicaid assistance.[90]
Belgium	Cross-sex hormone are available from age 16 with consent[91] or 18 without consent.[92]
Denmark	Available from age 16 with or without parental consent.[93]
Iceland	Available from age 16 with or without parental consent.[94]
Ireland	Available from age 16 with or without parental consent.[95]
Finland	Available from age 16 with consent[96] or 18 without consent.[97]
France	There are no age restrictions on the use of cross-sex hormones, but clinicians generally will not administer them before Tanner Stage II.[98] Use of hormones under age 18 requires parental consent.[99]
Luxembourg	No official guidance exists. Patients almost always receive hormones in a neighboring country.
Netherlands	Cross-sex hormones are available from age 16 with or without consent, though younger cases have been documented in adolescents with consent.[100]
Norway	Available from age 16 with or without consent.[101] However, consent is required for individuals 16-18 if the treatment is considered irreversible.[102]
Sweden	Available from age 16 with consent.[103] Available from age 16 without consent so long as the individual is deemed sufficiently mature.[104]
United Kingdom	Age 16 regardless of consent, but individuals must have been receiving puberty blockers for at least one year.[105]

MINIMUM AGE FOR SEX-REASSIGNMENT SURGERY

CONTEXT: *For some gender-questioning individuals, intervention culminates with sex-affirming surgeries, including mastectomy (breast removal), hysterectomy (uterus removal), vaginoplasty (vagina creation), and phalloplasty (penis creation). These dramatic physical alterations are largely irreversible.*

COUNTRY	REQUIREMENT
United States	Some states restrict minors' access to sex reassignment surgery, and lawmakers in other states are considering it. The World Professional Association for Transgender Health issued more liberal guidance in June 2022, which recommends some surgeries from the age of 15.[106] "Gender-affirming" mastectomy has been performed on children as young as 12.[107]
Belgium	Sex-reassignment surgery is not performed before age 18.[108] Parental consent is not a factor since surgery is not performed on individuals under the age of consent.
Denmark	Not performed before age 18.[109] Parental consent is not a factor since surgery is not performed on individuals under the age of consent.
Iceland	Not performed before age 16.[110] Parental consent is not a factor since surgery is not performed on individuals under the age of consent.
Ireland	Officially, sex-reassignment surgery is not performed before age 16. In practice, it not available until 16.5, as individuals must receive cross-sex hormones for at least six months beforehand. Parental consent is not a factor since surgery is not performed on individuals under the age of consent.
Finland	Not performed before age 18.[111] Parental consent is not a factor since surgery is not performed on individuals under the age of consent.
France	Theoretically permissible from age 14, but researchers say that to their knowledge, torsoplasties are the only surgeries that have been performed on trans youth.[112] Without parental consent, surgery is not available until age 18.
Luxembourg	Sex-reassignment surgery is not available before age 18. Parental consent is not a factor since surgery is not performed on individuals under the age of consent.[113]
Netherlands	Mastectomies are available from age 16, and all other procedures from age 18. Parental consent is not a factor since surgery is not performed on individuals under the age of consent.[114]
Norway	Mastectomies are performed from age 16 with consent.[115] All other procedures are unavailable until age 18.[116]
Sweden	Not performed before age 18. Parental consent is not a factor since surgery is not performed on individuals under the age of consent.[117]
United Kingdom	Not performed before age 18. Parental consent is not a factor since surgery is not performed on individuals under the age of consent.[118]

NUMBER OF YOUTH GENDER CLINICS

CONTEXT: *Some countries relegate the assessment and treatment of minors with gender dysphoria to a handful of clinics or even one. These clinics are not immune from problems—the lone pediatric gender clinic in the United Kingdom is being shuttered because of unsafe practices—but centralizing care has the benefit of greater oversight and accountability.*

COUNTRY	REQUIREMENT
United States	More than 60 pediatric gender clinics and 300 clinics provide hormonal interventions to minors.[119]
Belgium	There are two facilities in the country where patients can be reimbursed for puberty blockers or sessions with a psychologist, which are required for anyone seeking blockers.[120]
Denmark	Hormone therapy is administered to individuals of any age at one of three locations. These clinics are responsible for assessment and coordination of treatment.[121]
Iceland	The assessment and treatment for minors is administered through one hospital.[122]
Ireland	The assessment and treatment for individuals of all ages is administered through one hospital.[123]
Finland	The assessment and treatment for individuals of all ages is administered through two hospitals.[124]
France	Care is decentralized. Any doctor can prescribe treatment for medical transition.[125]
Luxembourg	There is one gender clinic in the country, though treatment is more commonly sought abroad.[126]
Netherlands	One clinic provides sex reassignment interventions to 95% of the population.[127]
Norway	Assessment and treatment for individuals of all ages is administered through one hospital.[128]
Sweden	Assessment and treatment for individuals of all ages is administered through four hospitals. Three of the four hospitals provide surgery.[129]
United Kingdom	Care for adolescents has been exclusively handled at the Tavistock clinic, which is scheduled to close in 2023 after a review deemed it unsafe.[130] Once it closes, assessment and treatment for adolescents will be handled through two clinics.[131]

NOTABLE CHANGES IN PROTOCOLS FOR TREATING MINORS

CONTEXT: *The concern that children are too quickly referred for gender-affirming medical treatment has arisen in several European countries. Given questions about the wisdom and judgement of children to make life-altering and permanent decisions about their health, officials have revised policies and guidance about gender-affirming care.*

COUNTRY	REQUIREMENT
United States	No major medical organization has reversed its guidance.[132] Some states, however, have issued their own guidance to prohibit minors' access to sex reassignment interventions. For example, treatment is banned in Florida following November 2022 guidance issued by the Florida Board of Medicine and the Florida Board of Osteopathic Medicine.[133]
Belgium	No changes[134]
Denmark	No changes[135]
Iceland	No changes[136]
Ireland	No changes yet, but the adult national gender service is urging the Department of Health to drop its support for the World Professional Association for Transgender Health (WPATH) model, noting that a "significant number" of patients who have graduated from the youth to the adult gender service are autistic and exhibit "unclear gender identity."[137]
Finland	In 2020, the Finnish Health Authority (PALKO/COHERE) "deviated from WPATH's 'Standards of Care 7' by issuing new guidelines that state that psychotherapy, rather than puberty blockers and cross-sex hormones, should be the first-line treatment for gender-dysphoric youth. This change occurred following a systematic evidence review, which found the body of evidence for pediatric transition inconclusive."[138]
France	"The National Academy of Medicine in France has issued a press release in which it cautions medical practitioners that the growing cases of transgender identity in young people are often socially-mediated and that great caution in treatment is needed. The Academy draws attention to the fact that hormonal and surgical treatments carry health risks and have permanent effects, and that it is not possible to distinguish a durable trans identity from a passing phase of an adolescent's development."[139]
Luxembourg	No changes[140]
Netherlands	No changes[141]
Norway	No changes[142]
Sweden	In December 2022 the Swedish National Board of Health and Welfare published updated guidance that urges greater caution in administering hormonal treatments or sex reassignment surgeries to minors. Such treatments should only be administered to minors in "exceptional" cases and must be tracked for research purposes. Insufficient evidence, an unexplained increase in dysphoria diagnosis among girls ages 13-17, and occurrences of detransition are specifically cited as reasons for greater caution.[143]
United Kingdom	An official review from the former president of the Royal College of Pediatrics and Child Health deemed the Tavistock youth gender clinic "not a safe or viable long-term option" for children. The National Health Service has begun to implement several notable changes, including: the start of closing the Tavistock youth gender clinic; repudiating the affirmation model in favor of one that treats claims of dysphoria with greater skepticism and uses psychotherapy as the first intervention; discouraging the use of social transition in prepubescent children; limiting the use of puberty blockers to formal research settings; clarifying that a true multidisciplinary team is comprised not only of "'gender dysphoria specialists,' but also of experts in pediatrics, autism, neurodisability and mental health, to enable holistic support and appropriate care for gender dysphoric youth."[144]

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Do No Harm

North Dakota Senate

Senate Committee on Human Services

HB 1254

Chloe Cole

Opening Statement

Chairwoman Lee and Members of the Committee:

My name is Chloe Cole.

I am a detransitioned 18-year-old woman from California who went through the process of medical transition between the ages of 12-16.

The three main interventions I was given were puberty blockers and testosterone, starting at 13, and a double mastectomy at 15. I was treated negligently by my healthcare provider, but the biggest failure they made was encouraging and allowing me to medically transition as a child in the first place.

My therapists and gender specialists failed to address several underlying circumstances and comorbidities that led to the onset of my gender dysphoria. I began puberty when I was no older than 8 or 9. From a very young age I had tremendous discomfort around my developing body. I was afraid to grow from a girl into a woman and experience things like periods, childbirth, and menopause, because I would often only hear about how scary and painful being a woman was from other girls and older women.

I never really had any strong female role models and I often never felt like I fit in with other girls. I had a tomboyish streak due to the influence of my older brothers.

I had previously been diagnosed with ADHD, but I am on the spectrum though I was not diagnosed until age 17. The gender specialist who referred me to surgery was also the same physician who later recommended screening for autism. Because I am autistic, I have some more masculine behaviors and I am more object oriented than most girls. I have some social, cognitive, and sensory processing differences that made school and going through puberty a little more difficult. All things considered, these struggles were all normal but were misrepresented as problems connected to gender.

I have suffered a multitude of complications from the blockers, cross sex hormones, and surgery. My quality of life is still being impacted to this day. I had my puberty blocked when I was already about four years in. In response, I began experiencing some menopause-like symptoms, including severe hot flashes, and itching all over my body. This went away after I stopped taking them, but I still have joint pains and shooting pains in my spine.

During a consultation for testosterone, I was told by my endocrinologist that I would experience vaginal atrophy. I was not informed that this atrophy affects the rest of the organs in the pelvic region. It caused me to experience episodes of severe uterine cramps that were rare, but unpredictable and worse than any menstrual cramps I've ever endured. I was prescribed topical estrogen, but my urinary tract was still affected, and I am still susceptible to dehydration and infection.

The status of my fertility remains unknown, but I do not have the choice of breastfeeding my future children because my breasts are gone. I was told this by my surgeon, but because I, myself was a child, I did not understand the importance of breastfeeding or even being a parent. As an adult, I am now grieving, and on top of that, the areolar skin grafts they used in my surgery began to fail two years afterward. I must wear bandages on my chest every day. The doctors who helped me to transition have not provided me any of the appropriate care for these complications.

You may be wondering what role my parents played in this and whether I was forced by them to endure this path. In fact, they were quite shocked when first hearing about my feelings of discomfort around my birth sex and my desire to be seen as their son. They wanted me to be comfortable, but they were not okay with going beyond shorter hair haircuts and dressing like a boy. They wanted me to explore without intervention. They wanted me to wait until I was a legal adult. Then I should decide my relationship with a medical route. When their intentions were expressed to my doctors, their concerns were dismissed. Instead, my parents were

lied to. Medical professionals insisted that all children are confident in their gender identity from a very young age, with a regret rate of transitioning less than 1-2%.

My parents were warned that if not affirmed in my identity and decision to transition, it was likely I would commit suicide. Medical professionals did not provide my parents with any other option. My legal guardians were forced to make this decision under duress. But even if my parents had supported transitioning medically from the start, no parent, or any adult, ultimately, has a right to determine whether a child gets to be chemically sterilized or mutilated. Under most circumstances, this would constitute abuse. Instead, somehow, we have managed to market procedures eroding function from the body as "necessary, lifesaving healthcare" for children and adults alike.

Legislative intervention will protect other children and families from this medical experimentation. This legislature is being presented an opportunity to defend the greatest right of a child — the right to grow into healthy adults able to live fulfilling lives.

Thank you for choosing to stand up for the health and safety of children.

Chloe Cole

California

Do No Harm

North Dakota Senate

Senate Committee on Human Services

HB 1254

January Littlejohn

Opening Statement

Chairwoman Lee and Members of the Committee:

My name is January Littlejohn.

I am a mother of a teen daughter who, at age 13, suddenly started experiencing distress over her sex. I am also a licensed mental health counselor in the state of Florida. My daughter expressed no previous signs of gender confusion in her childhood. The confusion only began after three other friends at school were identifying as transgender. In the 4th grade, my daughter was diagnosed with ADHD, which makes her emotionally behind her peers. She also has difficulty making and maintaining meaningful, long-lasting friendships.

As we struggled to understand the sudden announcement from our daughter, we elicited the help of a mental health professional. Shortly thereafter, without our knowledge or consent, we discovered our daughter had been socially transitioned by her middle school. The mental health of our daughter quickly deteriorated. She became more angry, withdrawn, and depressed. The school created a dangerous and straining wedge between us and our own child.

After months of research, and with the advice of her counselor, we chose a path of watchful waiting. I was shocked, while investigating the unvarnished details of gender affirming care, to find American children and teenagers routinely

prescribed pharmaceutical drugs. These drugs take the form of puberty blockers and cross sex hormones, causing irreversible changes to their young bodies, posing loss of future fertility and sexual function. There is also no high-quality evidence medical transitioning produces positive outcomes in patients. Why would we risk our young daughter's future, her whole self, including mental health and her fertility, on such low-quality research?

Then I learned that both in my home state of Florida and across our country, even double mastectomies were being performed on minors. I could not understand why parents were consenting to these irreversible changes for their child. I also did not understand why doctors were recommending these "treatments" for children and teens, despite longstanding scientific evidence on adolescent brain development.

Adolescents certainly cannot give informed consent. It is not until age 25, that the human brain is fully developed. Minors do not have the same cognitive ability to weigh the consequences of these choices. This requires thinking through how they may feel in not only 5 or 10 years, but for 20 years and longer.

In the recent past, there were safeguarding in place for medical transitioning of minors. Now, that safeguarding no longer exists. Children are instead *only* affirmed and may do so with any transgender identity they choose. This is the lived reality for adolescent patients in gender clinics, the offices of private physicians and mental health clinicians. They are universally fast-tracking thousands of American youths along a medicalized transition pathway.

Equally alarming as the procedures themselves, we found major medical and psychological associations had blindly supported these radical treatments without ever actually engaging its evidence and research. Many parents who ultimately consent to the medicalized transitioning of their child, do so under great coercion. Parents are told their child's risk of suicide is, and will remain, high unless they are affirmed. Without being offered meaningful, alternative pathways such as psychotherapy or watchful waiting, these parents can never truly give consent. Moreover, how is informed consent given when these medication's long-term consequences are not fully known, yet remain in use without approval by the FDA for gender dysphoria?

Now, we are seeing regret in teens and young adults put on these medical pathways. It did not cure their dysphoria, nor did it resolve the root cause of their distress. Many of these individuals have co-occurring mental health issues such as previous sexual or physical trauma, eating disorders, anxiety, depression, and autism. Some of the detransitioners are now sterilized from the hormones, are experiencing vaginal atrophy, bone density issues from puberty blockers, as well as

a plethora of other negative side effects. Many have no idea about the state of their fertility. There are detransitioners experiencing medical issues for which physicians have no effective treatment plan, especially those with complications from gender surgeries such as phalloplasty. Countries including the United Kingdom, Sweden, and Finland, are moving away from the affirmation-only model. In response to completing a systematic review of existing literature, these nations determined that the risks to their youth far outweigh their benefits of medically transitioning while a legal minor. The United States, meanwhile, is becoming an outlier in the treatment of children with gender dysphoria. We are allowing doctors to experiment on children based on the child's feelings or better put, a self-diagnosis, that could very well change as the child matures in a loving, neutral environment.

Please stop allowing doctors to experiment on America's children. If my spouse and I had affirmed our daughter, she would have unquestionably gone down this path believing medical transitioning would fix her pain. She was convinced her pain would only be solved by hormones and surgeries, despite having no understanding of the short-term or long-term consequences. If we had affirmed her in a false identity, we would have ultimately affirmed her self-loathing, encouraged body disassociation, and put her on a path of a lifelong medical patient. She may have even been led to suicide, given the 7-10 years post transition rate is 19 times that of the larger population.

My daughter has desisted after two years and is on a path of self-love with the body in which she was created. Please protect future children from the harm of experimental transition medications and surgeries. Please restore integrity to the medical establishment. Ensure we are grounded in science and robust evidence-based research instead of subjective and often self-serving political ideology. To that point, there is no longer even a coherent, shared definition of the word "transgender" among our medical community. There is also no test to tell which child will desist and which child will persist in their desire to transition. Neither is there a test telling us which children will regret these irreversible medical treatments and which will not. The emerging generation of American citizens deserve ethical and compassionate care for gender dysphoria. This mental health issue, as evidence supports, requires treatment by mental health professionals, not through hormones and surgeries mutilating and disfiguring the human body.

Thank you for your time and consideration.

January Littlejohn

Tallahassee, Florida

Do No Harm

North Dakota Senate

Senate Committee on Human Services

HB 1254

Miriam Grossman MD

Opening Statement

Chairwoman Lee and Members of the Committee:

My name is Dr. Miriam Grossman.

I am a board-certified child, adolescent and adult psychiatrist who treats young people with distress about their sex.

My message today is simple. North Dakota has an opportunity to protect vulnerable children and teens and put medical science and compassion ahead of extreme ideology.

In North Dakota, and across America, so-called "gender-affirming care" is the standard approach for treating these individuals. Gender-affirming care requires denial of biological reality. It demands unquestioning acceptance of a child's self-diagnosis, something unheard of in every other field of medicine. Gender affirming care typically places a child on a path leading to life-altering and irreversible medical interventions.

This is unethical. A vast majority of children, in one study up to 93%, who develop gender dysphoria before puberty ultimately become comfortable with their bodies and no longer seek medical transition. Depending on the study, as few as 7% will

continue to have severe distress. Yet gender-affirming care would subject 100% of these children to dangerous treatments.

Regarding youth who develop gender dysphoria in adolescence, they are a new phenomenon. They have not been adequately studied, and all medical interventions must be considered experimental.

Experts in this field acknowledge a severe lack of scientific knowledge of gender dysphoria. This is reflected in publications and statements from across the medical literature and other countries' experience. The team at Do No Harm and I can supply the committee with some of those resources as these policy questions continue to be engaged by the General Assembly.

The science regarding the treatment of gender dysphoria is far from settled. There is no consensus whatsoever among doctors and therapists. Yet the consequences of transgender hormones and surgeries are undeniable. They include infertility, sexual dysfunction, osteoporosis, cardiovascular disease, and crippling emotional pain. These treatments may even contribute to suicide among those who regret these procedures later in life.

The better path is to abandon gender-affirming care and promote psychotherapy. European countries have taken this approach, based on the evidence and a desire to protect vulnerable children. In fact, Britain, Sweden and Finland, have nearly abandoned gender-affirming care in the past two years. Why is a teenager in Stockholm protected from risky medical interventions with no evidence of long-term benefit, while the same teenager in Fargo is not?

To allow children and teens, whose minds are still developing, to make life-altering decisions when we have no substantial evidence of long-term benefit is madness.

My colleagues and I at Do No Harm are happy to answer any questions of committee members or meet with you individually to discuss these critical public policy issues further.

Thank you.

Miriam Grossman MD

HB 1254.

From: Affirmation Generation affirmationgenfilm2022@yahoo.com
To: Tveit, Bill btveit@ndlegis.gov
Date: Sat, Mar 18, 2023, 10:30 PM

Hello,

I am writing to ask that you please vote YES on bill HB 1254.

I am a 26 year old de-transitioned woman. Due to medical trauma, de-transitioners like me do not inform our doctors or therapists about our de-transitioning when we feel are responsible for harming us medically, physically, and mentally.

I was suicidal as a trans kid at age 18, but affirmation did not treat my trauma or other mental health conditions, nor did it help my gender dysphoria.

I began taking wrong-sex hormones at age 19 and had a double mastectomy at age 20. I de-transitioned at age 22, and I am still living with CPTSD,

depression, anxiety, autism spectrum disorder, PCOS, PMDD, and grief associated with having a medically-sanctioned identity crisis and losing my breasts and normal female body. Instead of wrong hormones, I should have received proper differential diagnosis and holistic treatment.

Please consider my medical experiences as you make a decision on this Bill.

For reference on updated standards of care for gender dysphoria, please know that several progressive European countries (UK, Sweden, Norway, Finland, France) have recently abolished medical transition (wrong-sex hormones and surgeries) for minors as ineffective, experimental and harmful. American children and teenagers deserve better mental health and medical care.

Please review the Cass Interim Report: https://cass.independent-review.uk
Sweden: https://genderreport.ca/the-swedish-u-turn-on-gender-transitioning/

Norway: Norwegian Medical Watchdog Encourages Country to Ditch 'Gender-Affirming' Care Guidelines | National Review

Norwegian Medical Watchdog Encourages Country to Ditch 'Gender-Affirming...

"The knowledge base, especially research-based knowledge for

Thank you for your understanding,

Sincerely,

Laura B,

Wisconsin Resident

HB1254 Important Message/Information

From: David Arthur K. ibelongamen@gmail.com
To: David Arthur K. ibelongamen@gmail.com
Date: Sat, Mar 18, 2023, 4:38 AM

My name is David A. Kendall and I live in Hancock, Maine. I support HB1254 and here is why;

I am a detransitioner. We are not uncommon, nor are we a "small population" of those who have transitioned as you may have been told. Detransitioners do not report back to the clinics, doctors or therapists that we feel are responsible for the irreversible damage to us medically, physically, emotionally and mentally.

I was the confused "transkid" often mentioned in these debates & discussions. I was suicidal as a transkid but I was also suicidal as a trans-adult because affirmation or acceptance did not change any of my underlying comorbidities or issues.

I began taking wrong sex hormones at age 14 and was on them for over 20 years. I had **Osteoporosis**, diabetes and I was **sterile** all before the age of 30. **PLEASE** consider my own life knowledge & experience in making any decisions on this Bill or any similar Bills.

There is **no consensus among all medical providers** on how to treat gender identity disorders in youth. Without differential diagnoses or treatment of their mental co-morbidities, vulnerable children are being ushered mindlessly by their doctors & therapists towards puberty blockers, synthetic hormones, procedures and surgeries that will cause **irreversible damage**. The evidence proves that these methods **sterilize** youth and **destroy** their **sexual function**, not to mention their mental health.

Progressive European countries that pioneered these trans-affirming medical treatments recently conducted a Systematic Evidence Review and discovered that these treatments are ineffective and harmful because they lead to severe medical & mental health issues as well as social. Consequently, since 2021 a number of European countries began abolishing pediatric transgender medicalization.

UK: https://cass.independent-review.uk

Sweden: https://segm.org/Sweden_ends_use_of_Dutch_protocol

France: https://segm.org/France-cautions-regarding-puberty-blockers-and-cross-sex-hormones-for-youth

Please watch this new award-winning documentary on the medical ethics of pediatric trans medicine, "AFFIRMATION GENERATION." It cites 45 academic medical studies, platforms 12 experts (pediatrician, physicians, mental health professionals, an Oxford sociology professor and others) and features the stories of six detransitioners. Please pass it on to colleagues.

www.vimeo.com/800032857

--Thank you

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In HIS Grip, David Arthur K.
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N.D. Cent. Code § 12.1-36-01

Section 12.1-36-01 - Surgical alteration of the genitals of female minor - Penalty - Exception

1. Except as provided in subsection 2, any person who knowingly separates or surgically alters normal, healthy, functioning genital tissue of a female minor is guilty of a class C felony.

2. A surgical operation is not a violation of this section if a licensed medical practitioner performs the operation to correct an anatomical abnormality or to remove diseased tissue that is an immediate threat to the health of the female minor. In applying this subsection, any belief that the operation is required as a matter of custom, ritual, or standard of practice may not be taken into consideration.

3. Any parent, adult family or household member, guardian, or other custodian of any child who willfully allows a child to be surgically altered under this section is guilty of child abuse under subsection 1 of section 14-09-22.

4. A custom, ritual, religious practice, or the consent of the parent or guardian of a minor is not a defense against a violation under this section.

5. Notwithstanding the limitations of section 29-04-02, prosecution for a violation of subsection 3 must be commenced within three years of the date of the offense or within three years after the offense is reported to law enforcement, whichever is later.

N.D.C.C. § 12.1-36-01

Amended by S.L. 2019, ch. 122 (SB 2222),§ 1, eff. 8/1/2019.

Senate Human Services Committee members:
19 March 2023

The below is the testimony of a recent acquaintance, a girl of 21 who gave this testimony to the Nebraska legislature. She is now a de-transitioner, now attending college in the Twin Cities. This is forwarded to you by her permission. The highlighting and paragraph breaks are mine for emphasis. Thanks for taking the time to hear her cry.

Representative Bill Tveit

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"My name is Luka. I was born in Nebraska and have lived here all my life, and I am here today not only as someone who went through the gender affirming care system as a minor but as a victim of these medical practices. I was a young teenager with a history of mental health issues who had been groomed and preyed upon online, and as a result fell into a spiral of hatred towards both myself and my body.

The medical system did not look into or seem concerned about the underlying issues that were causing the distress that made me feel the need to escape my body at such a young age, instead I was affirmed down a path of medical intervention that I could not fully understand the long term impacts and consequences of due to my both my age and mental health conditions.

At 16 the very first medical intervention I ever had was a double mastectomy, then a few months later I was put on to cross sex hormones. As a result of this so-called gender affirming care, if it could even be called care, at 21 I have had to watch as my body has wasted away before my very eyes,

I deal with constant joint pain, my breasts are gone, my vocal chords ache, I've watched as parts of me have atrophied away and I don't know if I'll ever be able to carry a child some day. I will deal with these consequences for possibly the rest of my life, never knowing if they'll go away and feeling abandoned by the medical professionals who did this to me.

My parents were baited with the threat of me committing suicide if they didn't go along with everything, despite the fact I have always maintained I was never suicidal, they were told would you rather have a dead daughter or a living son. These are not the words of a medical professional, but of an activist.

I was just a teenager who needed actual help, not surgery. I needed that chance to grow up safe and whole, but it was taken away from me in the name of gender affirming care. I will have to live with this forever, and so will the many others like me who are stepping forward as being harmed by these practices. Children cannot consent to being a lifelong medical patient, puberty and growing up aren't diseases that need to be fixed with surgery and medicine. Children deserve to know that their body isn't something needing to be fixed."

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• Blaze Media/News

Biden's transsexual assistant secretary of health suggests America will soon embrace 'gender-affirming' mutilation of children: 'Wheels will turn on this'

JOSEPH MACKINNON
March 17, 2023

Assistant Secretary for Health Rachel Levine told a crowd of pediatric health care providers last month that he is "optimistic" that genital mutilation and chemical transmogrification of children — euphemistically referred to as "gender-affirming care" — will soon be fully embraced.

The Biden nominee spoke at a "Pediatric Grand Rounds" session hosted in February by Connecticut Children's, an expansive health system catering to kids. Levine, the highest-ranking transsexual official in U.S. history, discussed "gender-affirming care," the long-term impact of the COVID-19 pandemic, and mental health problems suffered by American youths.

"By proactively engaging with the social and environmental world that defines our patients' lives, we can help them in terms of preventative care, acute

care, chronic care, and other very impactful issues that affect our children and their families," said Levine.
Levine intimated that the failure by "the social and environmental world" to fully embrace the transsexual agenda has resulted in mentally ill youths attempting suicide.
A Pew Research Center national survey published in June found that 46% of U.S. adults polled favored making it illegal for health care professionals to "help" someone under the age of 18 with medical care for gender transition. 72% of Republican or Republican-leaning respondents supported the statement. 58% of all respondents agreed that transsexual athletes should have to compete on sports teams that match their biological sex.

"Lesbian, gay, bisexual, transgender, queer, and intersex Americans, especially our youth, are very challenged at this time and are attempting suicide at an alarming rate," claimed the health secretary.

"Gender-affirming care is medical care. Gender-affirming care is mental health care. And literally, gender-affirming care is suicide prevention care," said the health secretary.
Dr. Stanley Goldfarb of the anti-woke medical group Do No Harm told Fox News Digital that contrary to Levine's claims, there is "no good evidence that children treated

with gender-altering hormones or puberty blockers improved mental health assessments."

"Levine's appearance at Connecticut Children's Hospital praising 'gender-affirming care' for minors and claiming it will be fully embraced is wrong and must be countered," added Goldfarb. "A recent study from the University of Washington showed that there was absolutely no change in the psychological well-being of children with gender dysphoria treated with these medications. ...There can be irrevocable harm being done to children by those pushing for these radical, ideologically driven treatments."

TheBlaze previously reported on a study published September 19 in the Journal of Sex and Marital Therapy that explained how the puberty blockers foisted on children as part of the "gender-affirming care" regimen are also known as luteinizing hormone-releasing hormone agonists or GnRHa drugs. These drugs, used also to "chemically castrate men," are not just creating sexless adults, but depleting victims' bone density, hampering their cognitive development, and producing a myriad of harmful emotional effects.

The American College of Pediatricians reportedly indicated that GnRHa drugs "arrest bone growth, decrease bone accretion, prevent the sex-steroid dependent organization and maturation of the adolescent brain, and inhibit fertility by preventing the

development of gonadal tissue and mature gametes for the duration of treatment."

Per Goldfarb's suggestion that irrevocable damage is being done to minors, a host of so-called de-transitioners such as Chloe Cole and Michelle Zacchigna have recently begun speaking out about how "gender-affirming care" inevitably amounts to irreversible damage.

Levine told Connecticut Children's that the Biden administration will "try everything we can legally" to circumnavigate the democratic will of Americans in states that have enacted prohibitions on the mutilation of children.

After all, said Levine, transsexual medical procedures on minors have the Biden administration's "highest support."

In an interview Monday with "The Daily Show," President Joe Biden singled out Florida's laws barring chemical and surgical transsexual "treatment" for kids, suggesting they are "cruel."

Biden's comments, further evidence of the "highest support" Levine mentioned in Connecticut, took on a quasi-religious dimension: "What's going on in Florida, as my mother would say, is close to sinful. It's just terrible what they're doing," said Biden.

Levine suggested that the Biden's administration's support will soon become the norm.

"I think that it's not going to be politically advantageous. It wasn't particularly in 2022. And so I think that as we look to all the different elections in 2024, I think the next two years are going to be challenging," said the health secretary. "But I'm a positive and optimistic person, and I choose to be positive, optimistic. And I think that the wheels will turn on this."

Levine claimed that criticism of the "gender-affirming care" he intends to help normalize tends to be "ideologically and politically motivated" and is "unconscionable," reported the New York Post.

In April 2022, Levine told NPR that for some critics, "these issues of gender identity are beyond their experience. They don't understand it, and so they fear it, and that fear can lead to negative feelings and emotions."

Levine had also claimed that "there is no argument among medical professionals – pediatricians, pediatric endocrinologists, adolescent medicine physicians, adolescent psychiatrists, psychologists, etc. – about the value and the importance of gender-affirming care."

Rep. Andy Harris, a member of the House Doctors Caucus and co-chair of the Pro-Life Caucus, told Fox News Digital that it was "reprehensible for a government official — let alone the Assistant U.S. Secretary of HHS — to promote the genital mutilation of minors as becoming a standard practice."

"Many pediatricians, particularly pediatric endocrinologists, have expressed serious concerns about the use of puberty blockers, hormone blockers, and sex transition surgeries in minors," said Harris. "These doctors know that these medications and procedures can impact children's bone growth, fertility, and risk of breast and prostate cancer. Meanwhile, HHS has pressured providers to provide this care or else face discrimination lawsuits. We must protect our children."

Neither Safe Nor Reversible" Says Canadian Doctor Who Helped Pioneered Puberty Blocker Drugs

By Brian Lupo Mar. 15, 2023

Dr. Susan Bradley, who helped pioneer "gender affirming care" in Canada, has now spoken against the popular model of "gender affirming care" by placing children on puberty blockers, according to an interview with the **Daily Caller**.

Dr. Bradley founded the Child and Adolescent Gender Identity clinic in Toronto, Canada in 1975 began to issue puberty blockers to children around the early 2000s. Prior to the medication, she used more traditional forms of therapy such as talking with her patients. In her interview with the Daily Caller, Dr. Bradley stated in regards to the puberty blocker medication:

"We were wrong. They're not as reversible as we always thought, and they have longer term effects on kids' growth and development, including making them sterile and quite a number of things affecting their bone growth.

We thought that it was relatively safe, and endocrinologists said they're reversible, and that we didn't have to worry about it. I had this skepticism in the back of my mind all the time that maybe we were actually colluding and not helping them. And I think that's proven correct in that, once these kids get started at any age on puberty blockers, nearly all of them continue to want to go to cross sex hormones."

Despite the recent push to "affirm" children's gender identity by use of puberty blockers, the safety of such drugs is

relatively unknown. According to the **Doernbecher Children's Hospital**:

The U.S. Food and Drug Administration approved puberty blockers in 1993. They were originally approved to temporarily stop puberty in children who were going through it too early.

Researchers have not finished studying how safe puberty blockers are in the long term. So, there might be some risks that doctors do not yet know about.
Dr. Bradley participated in the "**largest sample to date of boys clinic-referred for gender dysphoria with regard to gender identity and sexual orientation**" with the most recent follow-up in March 2021. The study found that 87% of male participants assessed at a mean age of 20.58 years were deemed "desisters."

A **parallel study** of girls showed similar results: only 3 out of the 25 participants were judged to have gender-dysphoria at the mean age of 23.24 years.

In the interview, Dr. Bradley conceded: "These kids are not fairing well with the current affirmative approach. I don't know that any kids actually could, given the capacity of a 10 or 12, or even 14 or 15 yar old to understand the complexity of the decision that they're making on their long term sexual and life function. It just doesn't make sense."

"Blocking the sexual development of children is a highly authoritarian intervention. Children are asexual, and so they can't understand the impact of impaired sexual function. We

are roughly 10 years into this large-scale experiment and already we have reports on issues with cognitive development, bone mineral density, and fertility. **All the up-to-date evidence shows that puberty blockers are neither safe nor reversible.**"

Despite Dr. Bradley's long term study suggesting that children eventually grow out of their gender dysphoria, there is still a widespread push to start children on puberty blockers at a young age. In the case of social media influencer Chloe Cole, 18, she was told that "gender dysphoria would never resolve itself" by doctors. **The Gateway Pundit reported** on a lawsuit filed by Harmeet Dhillon's Dhillon Law Group and the Center for American Liberty on Cole's behalf.

Wolf, Sheldon

From: Lee, Judy E.
Sent: Tuesday, March 28, 2023 10:14 PM
To: -Grp-NDLA Senate Human Services; Wolf, Sheldon; Lahr, Pat; NDLA, Intern 02 - Pouliot, Lindsey
Subject: Fwd: message from Dr. Casas

FYI -
Should we discuss this before the bill is presented next week?l

Senator Judy Lee

From: Casas,Luis <Luis.Casas@SanfordHealth.org>
Sent: Tuesday, March 28, 2023 9:05 PM
To: Lee, Judy E. <jlee@ndlegis.gov>
Subject: Re: [EXTERNAL] RE:

Good evening, Senator Lee

I listened in today to your committee meeting and would like to add some important information to the discussion.

Senator Roen stated that the rationale for extending the pubertal blockers and blocking the use of cross hormones was so that "the 80 plus percent of the adolescents who will not go on to be transgender will not have irreversible treatment." I think she miss understood the data that I and others have thrown around. Seventy percent of children (pre pubertal) who experience gender dysphoria will go on to not have gender dysphoria or be transgender in adolescent or adulthood - we don't' treat them. However, 99% of adolescents who start puberty will continue to have gender dysphoria if not treated and go on to be transgender. There is NO data that 80+ percent of pubertal adolescents will not go on be transgender.

While I appreciate the amendment that would not criminalize physicians for using pubertal blockers, treating them until 18 years is not medically recommended. It is one thing to treat a 3-year-old for 7 years (until they are 10) for early puberty because doing so only restores their normal prepubertal state. Suppressing puberty in an adolescent for 7 years (from 11 to 18 years) is simply not advisable and risks causing poor bone quality and bone density. Treating an adolescent for 2-3 years is fine, but not for 5 or more years. Also, waiting 12 months after starting puberty for psychiatric evaluations is simply arbitrary, follows no standards of care and defeats the point of "pausing puberty" - because after 12 months, puberty is halfway complete. Senator Roen even admitted that 12 months was an arbitrary number and not based on data, science or standards of care.

I find it frustrating that the physicians who spent years training, who are entrusted to care for all children in North Dakota are going to be told what we can't do and also what we should be doing. I respect that Senator Roen has some medical background, but the amendment she proposes is dangerous, follows no standards of care, is arbitrary and does not address the underlying issue of treating the gender dysphoria.

I would gladly sit with you, the committee members or anyone else who cares to hear more and answer your questions honestly and based on medical facts and science. I would love to invite you to my clinic and visit with some of my transgender adolescents and their families so you can understand that for most, this is not a "phase". For all the kids we

evaluate, there are many who we don't treat. It seems like those who support this bill believe that we are treating every adolescent that states they have gender dysphoria - We are not! I've been treating gender dysphoria in North Dakota for 10 years. Have you heard of any young adult or adolescent who has come back and expressed regrets for their treatment? That should tell you that we are doing this right and with the interest of the patient in mind.

Thank you again for your time.

Respectfully,

Luis Casas, MD
Pediatric Endocrinologist

From: Lee, Judy E. <jlee@ndlegis.gov>
Sent: Wednesday, March 15, 2023 9:43 PM
To: Casas,Luis <Luis.Casas@SanfordHealth.org>
Subject: [EXTERNAL] RE:

We do want to get it right. I have diverse opinions in my committee, but most are very thoughtful. I'm more concerned about convincing some of the new, far-right Senators who came with personal agendas and don't pay much attention to committee recommendations.
We will do our best!

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
Home phone: 701-282-6512
Email: jlee@ndlegis.gov

From: Casas,Luis <Luis.Casas@SanfordHealth.org>
Sent: Wednesday, March 15, 2023 9:24 PM
To: Lee, Judy E. <jlee@ndlegis.gov>
Subject:

Dear Senator Lee

I want to thank you for today. I had lost all faith in our political system after the house committee meeting last month. Today, I felt heard and that you and your committee members were genuinely interested in our testimony and that you want to get this right.

Thank you again,

Luis Casas
Endocrinologist

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