

The Trans Youth Phenomenon: Critiques & Hard Questions

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Table of Contents

The Trans Youth Phenomenon: Critiques & Hard Questions.....	1
Introduction.....	4
The Inherently Illogical.....	6
Medical Science.....	7
Is Gender Dysphoria a Feature of Innate Human Biology?.....	7
Puberty Suppression.....	9
Cross-Sex Hormones.....	12
Surgical Intervention.....	13
Social Science.....	14
DSM-5 TR Diagnostic Criteria for Gender Dysphoria in Children.....	14
Suicide.....	15
Sociology & Social Contagion.....	19
What Do Practitioners Think?.....	21
Discussing Consent.....	23
What Does Informed Consent Look Like?.....	24
Is Informed Consent Enough?.....	27
Punishing Dissent.....	27
The News Media.....	29
Conclusion.....	30
About the Authors.....	32
Works Cited.....	34

Introduction

Gender dysphoria has garnered a lot of attention over the last few years. Understandably, many prefer to shy away from the uncomfortable nature of the issue out of fear of ostracization, offending, or simple indifference. However, there are lingering questions, the most peculiar of which concern minors with gender dysphoria. Over the last few years, the number of young Americans identifying as transgender has substantially increased.¹ Despite adverse experiences² and scandals,³ very few in the U.S. media have shown a willingness to subject the practice of medically transitioning adolescents with gender dysphoria to the scrutiny needed to ensure proper oversight and informed public awareness. Instead, many have disregarded caution in favor of pro-trans advocacy talking points such as “medically necessary health care” and “protecting trans youth.”⁴

We do not contend that most advocates of trans youth medical interventions are bad people. We believe these people have been deceived by a false narrative (*i.e.*, bigoted conservatives are just bullying the LGBTQ community⁵) and pseudo-science⁶ that caters to the bias of their preexisting worldview. By reflexively assigning all or most dissenting attitudes as “hate” and “transphobia,” trans advocacy groups (with the help of the media⁷) have been able to restrict debate to the detriment of the youth they claim to be helping and society as a whole.

This report is centered on understanding the questions concerning medically gender-transitioning youth. It is important to note this is inherently different from other LGBTQ issues like gay marriage, workplace protections, and housing discrimination because this debate centers on science (or the lack thereof) and a minor’s ability (or inability) to consent. Similarly, this paper does not cover issues related to socially gender-transitioning youth (*i.e.*, the use of pronouns or a style of dress associated with the opposite sex). As a society, we are asking minors as young as nine years old to make health decisions that will impact the rest of their lives in ways we (both skeptics and trans advocates) fundamentally do not understand.

Despite the popular spin, even the leading advocates of medically transitioning youth concede there are substantial research gaps and a lack of knowledge concerning long-term outcomes. The World Professional Association for Transgender Health (WPATH), the preeminent advocacy group for trans medicine, latest Standards of Care (version 8) stated the following regarding medically transitioning adolescents:

A key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary gender-affirming medical and surgical treatments ... Despite the slowly growing body of evidence supporting the effectiveness of early medical

intervention, the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible. - WPATH SOCV8 S45 & S46⁸

We will dispute this “growing body of evidence” assertion and lay out the case to reject the little evidence used as justification for medically transitioning gender non-conforming youth. However, we are highlighting WPATH’s description of the evidence to lend support to the fact that both sides (those for and against medically transitioning gender-nonconforming youth) agree that the scientific support for doing so is weak. Although it is generally understood in the medical community that these treatments are experimental, pro-trans affirmation media and politicians have been hesitant to ask hard questions.

This report seeks to ask those hard questions concerning the ideological underpinnings of medically gender-transitioning children and adolescents, the medical interventions currently being employed on minors, the ability of minors to consent, and the deficient research and advocacy used to justify increasingly intensive medical interventions. We do not address consenting adult activity, although some broader ideological questions may have applications beyond medically transitioning youth.

Terminology

We limit the use of certain terms because we believe them to be oxymoronic or inaccurate. For example, we are openly contesting if “gender-affirming care” qualifies as “care” and/or “affirmation” in the context used by trans advocacy groups.

We do not use terms like “assigned female at birth” or “assigned male at birth.” Sex is a biological feature of prenatal development; it is observed at birth, not assigned. Although it is possible for rare intersex (having both female and male anatomical features) to be missed or improperly treated, this does not change the fact that the biological features present at birth are not assigned by a doctor. For that reason, we use accurate fact-based language such as natal male or natal female to denote the sex observed at birth.

The reader should understand that this paper focuses on the treatment of natal males and females, not the intersex. Although there are controversies concerning the treatment of those with sexual development disorders, this paper does not seek to stake out a position in those debates.

There is no consensus on when childhood ends and adolescence begins. It should be assumed in this paper that we are specifically referring to people between the ages of 9 and 18, a period most commonly associated with the onset of puberty and the beginning of legal adulthood. The reader should assume that terms like children, minors, and youth are referring to the aforementioned age

group. It is important to note that some trans advocates favor socially transitioning at any age and passionately reject limiting treatments by age. However, we have very limited evidence of medical transitions before the onset of puberty and it's unclear how often it happens.⁹

The Inherently Illogical

Before diving into science and research, some core issues of logic need to be addressed. Some pro-trans advocates and their allies fervently insist that gender is a social construct, not a biological constraint.¹⁰ Although we do not endorse that view, for the sake of argument, let's say they are right.

The Merriam-Webster dictionary defines a social construct as an idea that has been created and accepted by the people in a society.¹¹ Similarly, the Cambridge dictionary has revised its definition of woman to accommodate pro-trans language use, adding "an adult who lives and identifies as female though they may have been said to have a different sex at birth" as an additional descriptor.¹² In doing so, the Cambridge dictionary used its social trust and reputable power to divorce the definition of a woman from biology.

Does redefining gender as an arbitrary set of social norms affirm trans identities?

If gender is a social construct, no one is born transgender. Social constructs are taught to us by society and are not inherently a genetic feature or biological function of humans.¹³ This creates a basis for calling into question the surgical or chemical manipulation of bodily functions to align with characteristics commonly associated with the opposite sex.

Likewise, gender as a social construct also brings into question the ethics of trans-youth medical interventions. If children and adolescents feel immense mental distress growing into their otherwise healthy natural bodies, it is because at some point, they learned this fear (there is no evidence of an innate fear of oneself).¹⁴ As rational observers, we should question how the fear of simply growing into one's own healthy body is acquired and question any attempt to reinforce this fear instead of quelling it.

We should question why anyone would subject teens and pre-teens to a lifetime of medical dependency if the basis of such is purely ideological and not imperative for physical health. Furthermore, if gender is a social construct, then children and adolescents who struggle with gender identity issues may be victims of adults who created the confusion in the first place, as social constructs are taught, not innate within us.

Medical Science

Understanding a few critical things is important to provide context to this debate. First, there is no hard evidence of a biological basis for transgender identity, and the scant evidence that does exist raises new ethical dilemmas. Puberty suppressors (also known as puberty blockers) and cross-hormone treatment are not the same things. Puberty-suppressing drugs are designed to stop an adolescent from progressing through natural puberty by lowering or blocking the levels of naturally occurring sex hormones within the body of the pre-teen or teenager. Puberty suppressors are often erroneously described as a completely reversible pause button to give pre-teens and adolescents time to think about whether they want to continue. We know such descriptions are exceptionally misleading. We contend there is no neutral way to manipulate the body's natural development. Likewise, cross-sex hormones that manipulate hormone levels to match those found in the opposite sex are not a neutral act and are also ethically questionable when considering safety and long-term outcomes. Similarly, surgical interventions performed to align a minor's physical appearance to those commonly associated with the opposite sex are far from a neutral act. These chemical and surgical interventions together are typically referred to by pro-trans interest groups as "gender-affirming care," in which a trans identity is affirmed through both psychological and medical interventions.¹⁵

Is Gender Dysphoria a Feature of Innate Human Biology?

If gender dysphoria is innate within an individual's biology, this would imply those with gender dysphoria could be subjected to medical testing to confirm or disconfirm their trans identities, a contentious issue within the pro-trans affirmation community because such testing would provide a means to exclude many who currently identify as trans. This is the case with brain scan studies that purport to show trans people have brains that align with their preferred gender identities (*i.e.*, natal males with gender dysphoria tend to have brains closer to that of natal females without gender dysphoria). Studies that grade brain scan images on the spectrum as female or male can also disconfirm trans identities. Florian et al., *Brain Sex in Transgender Women Is Shifted towards Gender Identity*, studied 24 cisgender men, 24 cisgender women, and 24 transgender women before hormone therapy and found that transgender women (natal males who identify as women) have brain structures different from typical males. However, the authors concede these brain structures are still closer to that of a non-trans natal male.¹⁶ Larger studies have reached similar conclusions.¹⁷

Brain scan studies are far from definitive. Some researchers deny there are fundamental differences between male and female brains,¹⁸ creating a clear conflict with trans-affirmation researchers seeking to use brain images to establish a biological link for gender dysphoria. In short, brain studies give rise

to more questions than answers and should not at this time be viewed as proof of anything in relation to gender identity.

Additional studies have hypothesized that hormonal imbalances, chemical exposures, and genetic mutations during gestation could provide a possible biological link to an innate trans identity.¹⁹ The Endocrine Society cited research on intersex people with diagnosable genetic abnormalities to bolster its claims that transgenderism is innate.²⁰ We believe this to be a gross mischaracterization of the science because there is little to no evidence that those who self-identify as transgender disproportionately suffer from such genetic abnormalities. For example, Endocrine cites a review entitled, “Evidence supporting the biologic nature of gender identity,” which clearly states the following within the review, “It is important to note that most transgender individuals develop a gender identity which cannot be explained by atypical sexual differentiation.”²¹ Similarly, some issues such as a hormonal imbalance during gestation and early in youth create new ethical concerns over socially and medically transitioning youth.

If a hormonal imbalance (*i.e.*, a natal male having abnormally high levels of estrogen or a natal female having an unusual presence of testosterone) is a potential cause for gender dysphoria, then intervening to bring those hormones to alignment with the pro-typical sex presentations may prove beneficial to the well-being of the child or adolescent. In other words, if a biological basis for gender dysphoria is actually established through future research, medical interventions based on improving gender congruence instead of affirming gender incongruence should be explored and may have applicability. We are currently unable to find any research that compares the efficacy or potential of medical interventions to improve gender congruence by improving hormonal alignment with pro-typical natal sex manifestation. Admittedly, such research would be decried as “conversion therapy”²² by some pro-trans advocates. We would contend there are critical differences. Conversion therapy research is scant and heavily focused on sexual orientation, not gender identity.²³ Furthermore, medically transitioning a child with no documented sex developmental disorders is indeed a conversion in and of itself. Research should be explored to ascertain if children will accept their physical bodies without distress.

Although it is unwise to dismiss biological studies that purport to affirm trans identities, it is fair to note that this research is far from providing a conclusive link at this point. Ultimately, such a search for hard biological support for gender dysphoria may prove to be as fruitless as the infamously failed search for a biological basis for same-sex attraction.²⁴ Clinicians should be open-minded and inquisitive regarding this subject matter as much is still unknown.

Puberty Suppression

The commencement of medical interventions on minors is usually a function of growth and development based on the Tanner Stages or the Sexual Maturity Rating (SMR), which are commonly used to track puberty development. The Tanner Stages are as follows:²⁵

Pubic Hair Scale (both males and females)

- Stage 1: No hair
- Stage 2: Downy hair
- Stage 3: Scant terminal hair
- Stage 4: Terminal hair that fills the entire triangle overlying the pubic region
- Stage 5: Terminal hair that extends beyond the inguinal crease onto the thigh

Female Breast Development Scale

- Stage 1: No glandular breast tissue palpable
- Stage 2: Breast bud palpable under the areola (1st pubertal sign in females)
- Stage 3: Breast tissue palpable outside areola; no areolar development
- Stage 4: Areola elevated above the contour of the breast, forming a “double scoop” appearance
- Stage 5: Areolar mound recedes into single breast contour with areolar hyperpigmentation, papillae development, and nipple protrusion

Male External Genitalia Scale

- Stage 1: Testicular volume < 4 ml or long axis < 2.5 cm
- Stage 2: 4 ml-8 ml (or 2.5 to 3.3 cm long), 1st pubertal sign in males
- Stage 3: 9 ml-12 ml (or 3.4 to 4.0 cm long)
- Stage 4: 15-20 ml (or 4.1 to 4.5 cm long)
- Stage 5: > 20 ml (or > 4.5 cm long)

Although practitioners of medically transitioning minors advocate for a personalized approach,²⁶ some have advocated suppressing puberty as early as Tanner Stage 2. WPATH does not recommend a minimum age for the application of puberty suppressors/blockers to treat gender dysphoria.²⁷

Similarly, the poor surveillance in this field makes it impossible to know how many minors and at what ages are receiving hormone suppression for gender dysphoria.

According to the Mayo Clinic, gonadotropin-releasing hormone analogs (GnRHa) refer to a range of popularly used puberty suppressors/blockers.²⁸ The drugs prevent the adolescent's body from releasing testosterone and/or estrogen. In doing so, these drugs suspend the development of what is known as secondary sex traits, such as the growth of breasts in females and the development of facial hair in males.

Similarly, medical activists have proclaimed things like puberty blockers to be safe. Puberty blockers do have a legitimate role in treating certain cancers and rare conditions like early-onset puberty. However, those limited applications have been applied to biological conditions and not psychological ailments. The use of GnRHa on gender-nonconforming children and adolescents is primarily done to prevent mental distress. This is an important differentiator between the traditional approved use of puberty-suppressing drugs to treat early onset puberty²⁹ or cancer,³⁰ and the use of GnRHa on gender-non-conforming children and adolescents. The use of these drugs for gender dysphoric youth is considered to be “off-label” and is done without approval from the U.S. Food and Drug Administration (FDA).³¹

For example, Bicalutamide is a male hormone blocker, approved to treat cancer, being used to transition natal males who identify as female. This drug promotes breast development in young males within months of use, despite not having been introduced to cross-sex hormones (estrogen).³² The prolonged use of puberty blockers during sexual development degrades the reproductive tissue and reduces overall functionality with regard to future use for reproduction or pleasure.³³ Likewise, trans-affirming surgeons warn that the prolonged use of puberty blockers can create tissue quality issues that make future sex change surgeries difficult.³⁴ This is particularly problematic in natal females because the absence of estrogen causes the vagina to become thinner, dryer, and more irritable, which can cause more painful intercourse and vaginal tearing.³⁵ Furthermore, the use of puberty blockers on pre-teens and teens has been linked to lower bone density,³⁶ stunted height,³⁷ increased risk of diabetes,³⁸ and increased cardiac risk.³⁹

Lupron is a puberty blocker that has been infamously linked to severe long-term health issues. Females who used the drug reported osteoporosis, chronic pain, degenerative disc disease, depression, anxiety, and suicidal ideations.⁴⁰ Lupron has had over 25,000 adverse events and 1,500 deaths reported to the FDA regarding its use (likely an undercount).⁴¹ The sheer number of adverse events prompted the FDA to issue additional warnings of the potential side effects of the drug.

Although it is unclear how many of these events were related to the treatment of gender dysphoria in children, we can confirm the drug is being used to treat minors with gender dysphoria.⁴²

Although contested, Research consistently shows once puberty blockers are administered, progression to cross-sex hormone use is extremely likely. Some research estimates show more than 95% of those who have their puberty blocked go on to use cross-sex hormones.⁴³ Pro-trans advocates often claim this as evidence of little regret and well-screened patients.

A widely publicized study of 720 patients from the Netherlands found that 98% of adolescents who started puberty blockers continued with further medical gender transitioning as they got older.⁴⁴ This study contributes to a body of work finding high rates of continuance. An alternative view of high persistence rate data is that it is just as plausible that the act of blocking puberty is not a pause to think about further treatment but a shove into a trans identity.

However, studies showing high continuance rates tend to suffer from confirmation bias and poor study design. The selection criteria is usually skewed towards including only those who did not have regrets, there usually are no control groups, and the research is conducted by clinicians who currently administer gender transition drugs and surgeries to minors.⁴⁵ Trans advocates tend to promote studies with small samples, convenience samples with no controls, and/or are not clinical in design. This does not mean such research should be ignored, but it does mean it should not be viewed as definitive.

Additionally, studies cited by WPATH in version 7 of the Standards of Care show that gender dysphoria does not persist into adulthood for most diagnosed prepubescent children.⁴⁶ Conversely, the persistence of gender dysphoria increased substantially among adolescents when given puberty blockers. Research that tracked children who were not given medical interventions found that most grow up to accept the gender identities associated with their natal sex.⁴⁷ A 2021 report found that over 86% of natal males who had gender dysphoria or were gender incongruent as children desisted by adulthood. However, the study was limited by sample size.⁴⁸ Few recent studies emulate these results because trans advocates have successfully expanded the use of puberty blockers as a first-step treatment for youth, citing flawed social science research with no clinical control groups.

Considering the aforementioned evidence, the claim that puberty blockers are a pause or neutral option is very problematic.

Cross-Sex Hormones

Cross-sex hormone treatments are considered the next phase of transitioning an adolescent after puberty suppression. These cross-sex hormone treatments introduce hormones found naturally in the opposite sex to an adolescent that otherwise would have little to no presence of the hormone. This is done to enable the adolescent to develop physical features more aligned with those commonly associated with the opposite sex.⁴⁹ Again, this is done to affirm the transitioning minor's chosen gender expression, which, as we established earlier, is arbitrary if gender is assumed to be a social construct.

However, these cross-sex hormone treatments are associated with negative drawbacks and risks. Some research shows that male-to-female transitioners have an increased risk of cardiac events and heart diseases.⁵⁰ Similarly, in female-to-male transitioners, these treatments are linked to a loss in bone density. Likewise, the use of cross-hormone treatments can render adolescents infertile⁵¹ and increase the risk of thrombosis and stroke.⁵² It can cause changes in blood lipid profiles and increase the potential for cardiovascular disease,⁵³ infertility,⁵⁴ alteration of growth and development, and the risk of some cancers.⁵⁵ Research shows that these treatments manifest in physical changes in brain structure over time.⁵⁶

In short, our sex hormones impact our outward appearances, our brain structure, and how we think and behave. Therefore, manipulating these hormones by reducing the presence of a given sex hormone in a teen or pre-teen cannot be viewed as just a “pause.” Similarly, adding sex hormones from the opposite sex also has developmental impacts that likely go beyond the desired physiological outcomes.

All people are born with a certain level of sex-specific hormones⁵⁷; these hormones fluctuate⁵⁸ through the distinct phases of human growth⁵⁹ and development. Similarly, our sex hormones have an immense impact on the way our bodies develop both physically and mentally. Scientific literature has a rich depth of research detailing the impacts of our sex hormones and gene expressions. Decades of empirical literature have built a scientific consensus that sex hormones impact our mood, cognitive function,⁶⁰ blood pressure regulation,⁶¹ motor coordination,⁶² pain sensitivity,⁶³ opioid sensitivity,⁶⁴ and brain structure.⁶⁵ Furthermore, researchers at the Weizmann Institute of Science found that 6,500 genes are shared by both male and female humans but are expressed differently in each sex.⁶⁶ Manipulating these hormones cannot be neutral and almost certainly impacts the patient's decision-making process.

Surgical Intervention

Although not generally the first step of any medical intervention in the treatment of gender dysphoria, surgeries to augment the body of an adolescent do occur in many of our nation's 100+ gender clinics. Data on how often each procedure is performed is scarce, given the low level of surveillance and reporting. However, we know that several gender clinics offer surgical interventions for minors.

Surgeries for biological males to appear more feminine include but are not limited to Adam's apple reduction (A tracheal shave), breast implants (breast augmentation), removal of the penis and scrotum (penectomy and orchiectomy), and construction of a vagina and labia (feminizing genitoplasty). Again, the scarce surveillance of these procedures makes it hard to quantify how common they are. However, research from Christine (now going by Xtine) Milrod, Ph.D., and Dan Karasic, MD, confirmed through interviews with WPATH-affiliated surgeons that vaginoplasties are being performed on minors as young as 15 years old.⁶⁷ The paper also outlines the difficulties of dealing with stunted genital development from the prolonged use of puberty blockers, which directly contradicts the idea that such use is completely reversible.

Surgeries for biological females to appear more masculine include breast reduction or mastectomy and the removal of the ovaries and uterus (oophorectomy and hysterectomy). Also, the construction of a penis and scrotum (metoidioplasty, phalloplasty, and scrotoplasty).

Physicians at the Children's Hospital of Los Angeles and the University of Southern California documented breast surgery on minors with gender dysphoria at ages as young as 13 years old.⁶⁸ Similarly, a researcher at Northwestern University and the Children's Hospital of Chicago confirmed mastectomies done on patients as young as 14 and openly advocated for expanding the practice.⁶⁹ Likewise, Boston's Children's Hospital,⁷⁰ Ann & Robert H. Lurie Children's Hospital of Chicago, and Doernbecher Children's Hospital are just a few of a growing list of hospitals confirmed to be conducting these controversial surgeries on minors. Most surgical centers profess a firm adherence to controversial and vague WPATH standards of care on their website.

Every single one of these procedures has varying risks of temporary and permanent complications.⁷¹ The risk rate and severity vary by the procedure, as is common in all surgical interventions. As with the manipulation of sex hormones, we question the ability of minors to understand the varying risks and costs.

Social Science

This section will cover the social science aspects of medical interventions for gender dysphoric children and adolescents. The core claim by practitioners administering medical interventions for gender dysphoric minors is that it is lifesaving and medically necessary. The claimed basis for chemically and surgically altering a minor's otherwise healthy body is the idea that refusing to do so will cause irreparable mental anguish that would expose the minor to unconscionable suicide risk. The aforementioned is based heavily on research that can best be defined within the scope of social sciences (*i.e.*, psychology and sociology).

Social sciences suffer from shortcomings such as the ongoing replicability crisis⁷² methodological limitations⁷³ and errors,⁷⁴ and interpretative biases.⁷⁵ Although this is not a reason to dismiss all research studies and dialogues, it is a note of caution that deserves emphasis when dealing with a vulnerable population such as children. In social science, consensus is harder to build, and demonstrating causation is far more elusive when compared to the hard science fields (technology, engineering, math, biomedical research, etc.).⁷⁶

DSM-5 TR Diagnostic Criteria for Gender Dysphoria in Children

Gender dysphoria, listed in the Diagnostic and Statistical Manual for Mental Disorders (DSM 5-TR), is a construct used to describe a psychological condition in which those suffering report a marked incongruence between their experienced gender and the gender associated with their biological sex.⁷⁷ A gender dysphoria diagnosis is commonly utilized as a justification for the use of invasive medical interventions on youth.

There are a few important aspects of these diagnostic criteria to bear in mind.

First, it is important to state that the psychological pain associated with gender dysphoria is real. However, the formulation of the diagnosis has been a source of debate. It has been widely critiqued, particularly in countries that perceive it as an American phenomenon needed to garner insurance reimbursement for gender transition procedures.⁷⁸ However, handing out a diagnosis for the purposes of an insurance claim is only one questionable aspect. Another often overlooked aspect of the gender dysphoria diagnosis is its questionably short observation period of six months. This brief window of time is at odds with other diagnoses for youth for conditions that characterize a pervasive, long-term pattern of thought and behavior.

When it comes to other enduring mental health conditions listed in the DSM V-TR, youth are diagnosed with greater caution than adults because symptoms have been known to change during

the maturation process.⁷⁹ Well-established research shows that some of the greatest developmental strides occur within complex neurological structures during adolescence. The limbic system, also known as the seat of our emotions, relates to emotional processing, learning, and memory and plays a significant role in a person's mental health.⁸⁰ Structures like the limbic system take the longest to reach structural norms. Many people do not reach these structural norms until their twenties.

This neurological reality has been acknowledged in the DSM V-TR in another cluster of disorders referred to as personality disorders. These disorders are marked by an “enduring pattern of thinking, feeling, and behaving that is relatively stable over time.”⁸¹ When diagnosing a personality disorder, the criteria require that the symptoms be present longer in children than what is required for adults:

[Personality disorder categories] may be applied with children or adolescents in those **relatively unusual instances** in which the individual's particular maladaptive personality traits appear to be pervasive, persistent, and **unlikely to be limited to a particular developmental stage** or another mental disorder. It should be recognized that the traits of a personality disorder that appear in childhood will often not persist unchanged unto adult life. **For a personality disorder to be diagnosed in an individual younger than 18 years, the features must have been present for at least 1 year.**⁸²

By the standards set in the DSM V-TR, diagnosing personality disorders in children should be rare, and symptoms should be observed for a lengthy period. Yet, the interventions for treating personality disorders in children are not physiologically invasive, nor do they involve the potential for altering or removing healthy organs. A robust body of literature suggests that, in most cases, maturation will win the day with gender dysphoria symptoms, and the distress will resolve by adulthood (see page 9).

Given the life-altering nature of the interventions currently attached to gender dysphoria, one would expect a longer waiting period, at a minimum. Unfortunately, a gender dysphoria diagnosis is not made with the same caution as other disorders.

A gender dysphoria diagnosis is only one of the ways youth are fast-tracked onto a path of life-long medical interventions. Expressions of suicidal ideation are often pointed to as justification for shorter clinical observation periods and initiating irreversible interventions.

Suicide

The most potent talking point advanced by advocates of trans youth medical interventions is the supposed suicide risk. To be clear, some studies show that LGBTQ youth, particularly those with gender dysphoria, report suicidal thoughts at higher rates.⁸³ Similarly, there's also evidence that trans

adults commit suicide at higher rates than the general population. This is the primary justification cited for the use of incredibly aggressive medical interventions for youth with gender dysphoria. Practitioners and advocates of these medical interventions refer to this as “lifesaving” and “medically necessary” care, but there are a few issues with the claims.

For context, suicidal thoughts, attempts, and completed suicides are not the same. It’s safe to assume that all those who purposely commit suicide had suicidal thoughts, but that does not mean everyone who thinks of suicide will actually follow through. Likewise, even attempted suicides vary in severity of self-harm.⁸⁴ Research tends to confirm a wide gap between those who report having suicidal thoughts, those who attempt suicide, and those who end up dead from a completed suicide. Everyone who reports suicidal thoughts does not necessarily go on to attempt and complete the act. Some studies suggest that over two-thirds of those who report suicidal thoughts do not attempt suicide within the following two years. Another study showed that only 7% of those reporting suicidal thoughts follow through with it.⁸⁵ This should not be interpreted to mean suicidal ideations can be dismissed but clinicians have to be clear about the limitations of research that heavily depends on self-reported suicidal ideations when consulting patients and caregivers, especially when children are involved.

Some reports put trans suicidal attempts as low as 20%⁸⁶ and as high as 56%.⁸⁷ Although this research has methodological limitations (as is common with all research), it should not be disregarded outright. Widely cited research⁸⁸ commonly utilizes self-reported feelings⁸⁹ of depression and suicidal thoughts and attempts to support the premise that medical interventions for gender dysphoric youth are “lifesaving” in effect. As stated previously, suicidal thoughts through self-reporting are not a perfect proxy for suicidal attempts and completions; this is particularly true with adolescents.⁹⁰ Non-suicidal self-injury exists and can be conflated as a suicidal attempt despite never reaching such a level of severity.⁹¹ This can make it difficult to understand the true risk of suicide within a population. Similarly, varying survey methods and respondent recruitment produce widely different calculations concerning suicidal thoughts and attempts.

A real-world review of data from England’s Tavistock youth gender clinic (now shuttered) found that “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,” after analyzing 30,000 cases (including over 15,000 waitlisted) over a nearly 10 year period.⁹² Suicide risk among gender dysphoric youth is notably higher than their heteronormative peers but still extremely rare and exceptionally lower than reported suicidal ideation.

The few studies on completed suicides among the trans adult population lend no support to the idea that medical transitions reduce suicide risk when tracking actual suicides after transitioning. For example, a longitudinal study done in Sweden from 1979 to 2003 found that medically transitioning was associated with higher levels of suicide.⁹³ However, this research was not focused on early medical interventions for minors.

Those who support the idea that chemically and surgically transitioning adolescents is necessary to “save” them are at odds with the youth suicide surveillance data. According to Reuters, over the last 15 years, the number of pediatric gender clinics went from 0 to 100, with some estimates as high as 300.⁹⁴ This means almost no specialized clinics provided these controversial medical inventions for minors before the year 2000. America was able to substantially decrease reported youth suicidal ideation to lower levels with virtually no access to these supposed life-saving medical interventions.⁹⁵

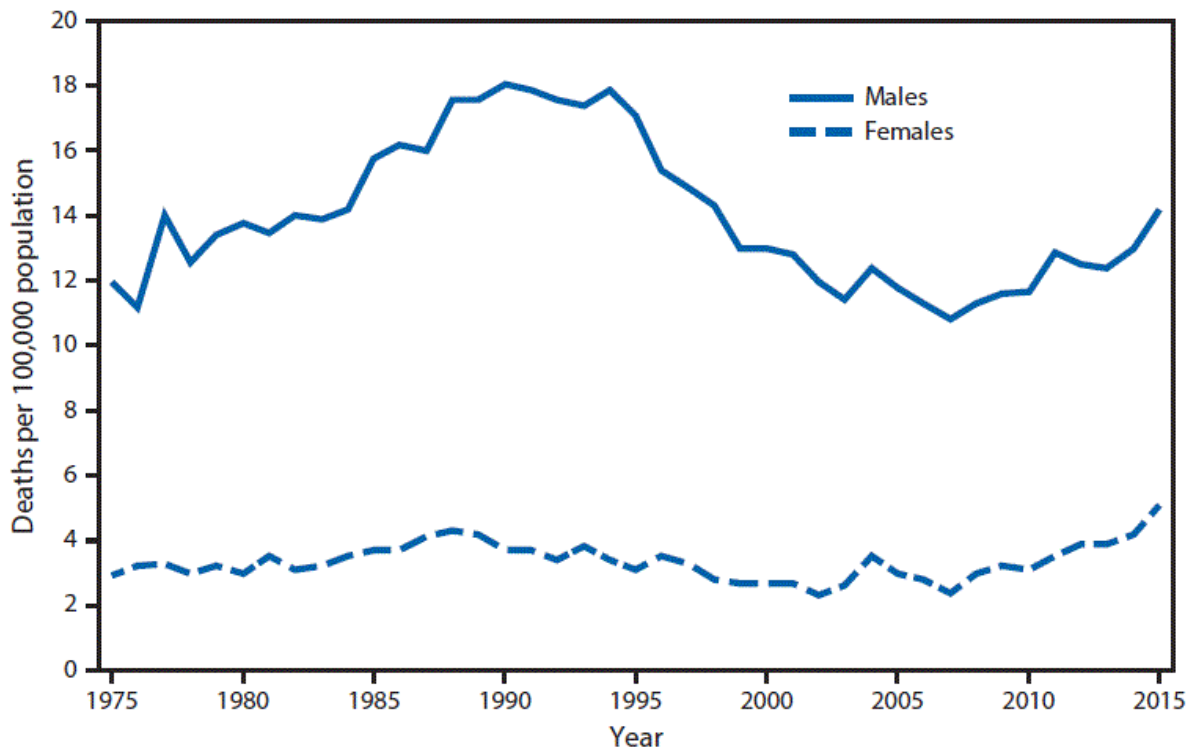


Figure 1 CD Quick Stats: Suicide Rates for Teens Aged 15–19 Years, by Sex – United States, 1975–2015

If transgender identity is innate, as claimed by the Endocrine Society, why did suicidal thoughts among youth decrease throughout the 1990s only to spike with the proliferation of so-called trans-affirming medical interventions? If this medicine is lifesaving and LGBTQ youth are disproportionately suicidal, shouldn't we expect to see a decline in overall teen suicidality as availability has increased over time? The CDC data above shows the exact opposite has happened.

Research consistently shows that our youth are experiencing a massive increase in suicidal ideation relative to previous (and notably less “affirming”) generations and periods.

To be clear, this does not mean youth gender clinics are causing suicidality among youth to rise. However, it does call into question the idea that we are seeing a massive improvement in the mental health of pre-teens and adolescents because of access to trans-affirming medical interventions. In short, there’s no macro-level data to suggest that these early medical interventions save lives.

Admittedly, there’s limited research of varying quality that shows these controversial treatments do improve the mental health of gender-nonconforming youth.⁹⁶ However, there is a lack of high-quality research to confirm whether this is true at all⁹⁷ and if it is accomplished by drugs, social support,⁹⁸ or a combination of the two.⁹⁹ Furthermore, there’s little evidence that children and adolescents commit suicide as a result of being denied medications. A retrospective study published in 2021 of over 900 trans individuals who received hormone therapy (before the age of 18) to transition found no significant change in mental health when compared to those who did not receive the drugs.¹⁰⁰

One of the more popular studies by Stanford Researcher Jack Turban, *Access to Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, found that early transition was associated with lower odds of lifetime suicidal ideation.¹⁰¹ However, this oft-cited study is far from conclusive. It uses convenience sampling, a sampling method that cannot be used to draw conclusions about the entire trans population. It suffers from the same previously noted limitations of self-reported feelings. Furthermore, secondary analysis data revealed the study’s conclusion is not supported by the data utilized in the study itself.¹⁰²

The trans youth suicide issue is further complicated by the fact that gender dysphoria is commonly associated with comorbidities.¹⁰³ Research consistently shows that those who identify as trans generally have other diagnosed mental health conditions at rates substantially higher than the general population. It is difficult to establish causality between comorbidities and gender dysphoria¹⁰⁴ in regard to suicidal ideation.

Despite the challenges to establishing a causal effect regarding suicidal ideation and gender dysphoria, we can understand much about this phenomenon by looking at the known risk factors for suicide. Evidence consistently shows that “untreated mental illness (including depression, bipolar disorder, schizophrenia, and others) is the cause for the vast majority of suicides.”¹⁰⁵ In national and international studies, substance abuse and mood disorders continually have the largest association with completed suicides.¹⁰⁶ Trauma-related experiences have also been found to be significant risk

factors for suicide. A systematic review of the suicide literature showed estimates of suicidality around 20% for adults, with increased rates of suicidality among the adolescent population who had experienced traumatic event(s).¹⁰⁷ It's worth noting that some of the same comorbidities found in the transgender-identifying population are also those known to be common among those who experienced traumatic events and subsequently suffer from post-traumatic stress disorder (*e.g.*, depression, or substance abuse).

Nonetheless, despite this long-standing body of research, there is still no clear understanding of etiology in suicide literature. In other words, there is no clear understanding of the individual and combined risks that cause a person to commit suicide.¹⁰⁸

Remarkably, the same known risk factors for suicide cited in the general population seem to be elevated in the transgender-identifying population, namely a significantly greater incidence of adverse childhood experiences (ACEs).¹⁰⁹ A recent survey showed 45% of transgender-identifying people reported childhood sexual abuse.¹¹⁰

These are just a few examples of widely known risk factors from suicide literature, which are found at a high rate among those with gender dysphoria. Research into these risk factors might better account for the elevated rates of suicidal thoughts and behavior in the transgender-identifying population. Notably, none of these risks for suicide directly pertain to access to gender transition procedures.

As is the norm with this particular topic, the research in this area is nascent and should not be viewed as definitive. Undoubtedly, more research is needed to understand both etiology and suicide among the gender dysphoric population. To be clear, we are not arguing the suicide rate should be ignored in any population. We are simply calling into question the idea that this suicide risk research can be used to support the premise that it is “medically necessary” to administer experimental treatments and invasive procedures to minors.

Sociology & Social Contagion

The social contagion effect is noted as a phenomenon that takes place when multiple people within the same sphere of influence display the same behaviors or ideas.¹¹¹ Social contagion has been documented in eating disorders,¹¹² self-injury,¹¹³ and mindset.¹¹⁴ It is not unique to transgenderism or gender dysphoric youth.

Social contagion in the context of gender dysphoric youth is based on the idea that certain social elements could influence an individual's decision to identify as transgender. Somewhat

oxymoronically, pro-trans groups and activists dismiss the concept of social contagion despite some openly pushing the view that gender itself is a social concept.

With regard to gender dysphoric youth, social contagion is referred to as Rapid Onset Gender Dysphoria (ROGD). This phenomenon was first hypothesized in a paper by Dr. Lisa Littman, which used reports from parents to document a peer effect amongst trans youth.¹¹⁵ The study faced immense backlash and was re-published with changes. However, the re-published version did not involve any changes to the methodology or the final results.¹¹⁶ This context is provided because the fact that there were changes to the paper is erroneously cited by some trans activists to claim the paper and the social contagion theory have been debunked and thoroughly refuted. This is false.

In this vein, a 2022 study¹¹⁷ published in the prestigious journal *Pediatrics* by physicians who advocate for medically transitioning children and adolescents with gender dysphoria was widely circulated in popular media¹¹⁸ as a definitive refutation of the “Rapid Onset Gender Dysphoria” (ROGD) concept. The study does indeed provide evidence that challenges some assumptions of the theory, but it is by no means a definitive refutation of social contagion. The study does not attempt to measure the peer group effect or social desirability within the surveyed population. The study also counters the idea that natal females are more likely to experience gender dysphoria. However, simply noting that natal males and females experience gender dysphoria at similar rates, does not disprove the possibility that there is a social contagion impact. Furthermore, one of the paper’s claims, that the trans youth population is declining, is contrary to many other sources that found the exact opposite.¹¹⁹

A 2023 study authored by Suzanna Diaz and J. Michael Bailey and published in the *Archives of Sexual Behavior*, relied on parental reports of more than 1600 cases of ROGD. The study found that these kids often had pre-existing mental health issues and that parents often felt pressured by clinicians to affirm their minors’ new gender and support their transition. Similarly, the researchers found that 60% of female and 38% of male adolescents had at least one friend who declared a transgender identity around the same time. Parents estimated that their children spent about 4.5 hours per day on the Internet and social media (a possible medium for social contagion) before the onset of gender dysphoria, with heavier internet use among male adolescents (5.6 hours for males versus 4.1 hours for females).¹²⁰ Although this is not a definitive summation of the key findings, there’s more than enough here to conclude that the social contagion theory warrants further study. The study was retracted by the *Archives of Sexual Behavior* because of issues regarding consent but this is heavily disputed by the authors and is unrelated to the central findings and methods used.¹²¹

To be clear, it would be inaccurate to characterize the research on potential social contagion as conclusive evidence that gender dysphoria is a fad. In reality, the research in this area is emerging just like most other aspects of gender dysphoric youth research. Only recently has research broached a hypothesis that there could be more factors other than the minority stress framework that has been used to explain the reportedly high levels of LGB-identifying youth who express suicidal ideation. Although this research didn't specifically focus on gender dysphoric youth, the findings suggest that some distressed youth may have been socialized to use suicidal ideation as a means for expressing their pain.¹²² Clinicians should be aware of these nuances, particularly when exploring care options for children who are presenting as gender incongruent or gender dysphoric.

What Do Practitioners Think?

Several medical associations have come out in favor of providing gender transition hormones and surgeries to minors. The American Academy of Pediatrics (AAP),¹²³ American Academy of Family Physicians,¹²⁴ American Medical Association (AMA),¹²⁵ and Endocrine Society¹²⁶ are some of the more noteworthy organizations endorsing intensive medical interventions for minors with gender dysphoria. The support of these associations is often cited by the media to imply there is a consensus among experts.

However, the premise of such a consensus is highly questionable. The AMA represents less than 25% of practicing physicians.¹²⁷ Similarly, the AAP adopted its current guidance by a board vote and blocked a full membership vote on the subject. AAP also refused to allow dissenting voices at their annual meeting.¹²⁸ It is unclear if there was a full membership vote with other medical organizations. Most organizations cited the same weak research to justify their support of medical interventions due to the absence of longitudinal studies with clinical controls. The Endocrine Society openly concedes it is unconvinced that its current contested¹²⁹ guidelines are the least harmful treatment regime.

There are gaps in knowledge that are necessary to address in order to optimize care. Comparative effectiveness research in hormone regimens is needed to determine: the best endocrine and surgical protocols, as it is not yet known if certain regimens are safer or more effective than others; the degree of improvement as a result of the intervention (*e.g.*, decrease in mental health diagnoses); the need for training of health care providers and the most effective training methods; and to build the body of evidence pertaining to cardiovascular, malignancy, or other long-term risks from hormone interventions, particularly as the transgender individual ages.¹³⁰

In December 2022, the Florida Board of Medicine moved to ban experimental chemical and surgical treatments to gender transition minors, a move condemned by trans activists.¹³¹ Most American media were intent on characterizing the Board as acting against the evidence to appeal to the political sensitivities of the American right. However, the Board conducted a full literature review and is not alone in questioning the core claims being made to justify medical gender interventions for minors and adolescents.

In Norway, the use of puberty blockers and hormone therapy for minors experiencing gender dysphoria was restricted in 2020. The decision to restrict these treatments followed a review of the medical guidelines for the treatment of gender dysphoria by the Norwegian Directorate of Health. The review was prompted by concerns about the long-term effects of puberty blockers and hormone therapy on minors, as well as concerns about the lack of evidence and safety supporting these treatments for this population. The use of these treatments must be made on a case-by-case basis and require informed consent from the individual and their parents or guardians. It also directed the creation of a national database to track medical interventions for minors. Likewise, all gender care is now defined as experimental.¹³²

The Swedish National Board of Health and Welfare has made significant policy changes regarding healthcare for transgender minors. They have decided to prioritize mental health therapy over hormones for gender-dysphoric youth. Sweden has also imposed new restrictions on the prescribing of puberty-blocking hormones. Previously, the Swedish healthcare system prioritized the use of hormones over therapy for gender-dysphoric youth. The new policy aims to prioritize therapy, with the hope that it will allow young people to better understand their gender identity and make informed decisions about their healthcare. The second policy change relates to the prescription of puberty-blocking hormones, which are often used to delay the onset of puberty in transgender youth. Under the new restrictions, the prescribing of these hormones will be far more limited.¹³³

The Finnish Health Authority has deviated from the WPATH guidelines on gender dysphoria treatment for minors. The Finnish government has announced that it will prioritize psychotherapy over medical interventions such as hormone therapy and surgery for minors with gender dysphoria, although hormone therapy is still allowed.¹³⁴

The United Kingdom's (UK) National Health Service (NHS) has made changes to its guidelines for gender dysphoria treatment, specifically for children and young people. The new guidelines state that young people under the age of 16 should not be prescribed puberty blockers, and that those aged 16-17 should be subject to additional safeguards before being prescribed these treatments.¹³⁵

The NHS has found that there was a lack of evidence regarding the long-term effects of these treatments on children and young people.¹³⁶

The caution coming from European medical authorities is of particular note because Norway, Sweden, the UK, and Finland have stern hate speech laws that generally prevent harsh criticism of the LGBTQ community.¹³⁷ These laws go as far as to mandate preferred pronoun use. In Norway, a lesbian filmmaker is currently facing criminal charges for publicly insisting a transwoman (a natal male) cannot be a lesbian.¹³⁸ Similarly, in the UK, people are regularly arrested and investigated for posting anti-trans speech.¹³⁹ It would require an incredible stretch to assert that European health officials acted out of political malice towards the LGBTQ community.

This giant gap between the actions of European authorities and American medical groups is evidence of a few critical facts. There is no real consensus amongst medical practitioners on the sensitive subject of medical gender transitions for minors. The standard of care guidelines cited by American interest groups and journalists are not universally accepted and are currently being contested by medical experts around the world. Most importantly, the “evidence” used to justify medical gender interventions for minors is far too weak.

Currently, there’s scant polling of medical professionals available, but that is likely to change as the academic environment in American society is extraordinarily hostile to dissent, and many American medical schools¹⁴⁰ have adopted left-of-center social policies as a core part of their identity.¹⁴¹ It is more likely than not that most American doctors will adopt the WPATH treatment model as new doctors are trained and senior physicians stay quiet out of fear of retribution.

One particular reason for the divergence between American and European health officials could be the profit motive. Although we are not endorsing socialized medicine or objecting to private hospitals generating profits, the ethical risk of putting profits over principle should be constantly scrutinized. For example, Vanderbilt University Medical Center’s Clinic for Transgender Health physician Dr. Shayne Taylor is on video bragging about “getting into the gender-transition game.” The doctor emphasized that gender transition is a “big moneymaker” in the video. “They make money,” she adds of the transgender surgeries. “They make money for the hospital.” She went on to note the immense billing potential for the required follow-up.¹⁴²

Discussing Consent

Although the use of puberty blockers is often described as a pause button, this view should be strongly challenged. As we have stated previously, the removal and addition of sex hormones to and

from the body is not a neutral act. This creates well-documented cognitive-behavioral and physical changes in the human body. Similarly, children who are prepubescent and early in puberty are not knowledgeable enough nor disciplined enough to understand the long-term ramifications of such a drastic intervention. Practicing physicians on both sides of this issue concede the long-term ramifications are not well known. However, advocates of medically transitioning children and adolescents dismiss these concerns by claiming patients and parents are counseled on these risks. Once one considers the state of the research, more issues arise.

What Does Informed Consent Look Like?

In contemporary medical practice, obtaining informed consent for medical interventions is an essential ethical duty for physicians. Informed consent is grounded in professionalism, honesty, and respecting patients' dignity and autonomy in the decision-making process.¹⁴³ Noting the role that sex hormones play in the development of the human brain and its functioning, it is wise to wonder if a minor's underdeveloped brain that is being chemically manipulated can provide consent and reaffirm it throughout this process if the process itself has immense potential to change the cognitive abilities of the minor. In short, even if we accept the argument that few grow up to regret transitioning, this alone would not prove that the original decision to administer the treatments during early pubertal development was ethical or correct.

After years of medically muting the natal sex hormones, introducing cross-sex hormones, and psychological counseling to affirm a trans identity, using regret as a litmus test is arguably dubious. One could just as easily argue that low regret rates are nothing more than evidence that the intense years-long chemical and mental manipulation of vulnerable youth populations will have lasting lifelong impacts on an individual's gender expression.

Thus, a new question arises: Are advocates and practitioners of medically transitioning children and adolescents protecting trans kids or making kids trans? It is impossible to answer this question without rigorous longitudinal control studies or a definitive medical means of testing for innate biological markers.

We also have to understand that many of the clinicians who are directly involved in medical gender transitions of gender dysphoric youth generally subscribe to "affirmation only" techniques. Affirmation only means that once a child or adolescent has self-diagnosed as being transgender, this position should be "affirmed," not challenged, by medical professionals. Some states and jurisdictions legally require affirmation. This means other potential causes for body dissatisfaction

and identity issues are not explored, and attempting to do so is condemned and sometimes (ironically) outlawed as conversion therapy.

Furthermore, the purported counseling provided is sure to emphasize (perhaps even exaggerate) the risk of self-harm and suicide, possibly leading both patients and parents to believe that failing to consent to the medical interventions would be a death sentence. Despite the evidence supporting youth medical gender interventions as a suicide prevention method being exceptionally weak¹⁴⁴ and there being no consensus in the literature on the actual risk of suicide, any questioning of an “affirmation only” approach is widely condemned by activists. This is particularly problematic when considering the well-documented presentation of gender dysphoria with comorbidities.

The act of manipulating hormones causes the brain and body to behave in drastically different ways. Consider also that the counseling given to both the patient and legal guardian is based on highly contested research and strongly biased towards the care as “lifesaving” despite the extraordinarily weak evidence base for such a claim. Therefore, we doubt the oft-cited informed consent process is balanced and fair enough to provide families with an accurate representation of the state of the medicine.

Parental Rights & Consent

Regarding parental rights, we contend that there are no unlimited rights. A right to self-defense is not a right to hurt anyone under any context. A right to education does not entitle everyone to admission into Harvard University. Similarly, the right to free speech does not protect a liar from the repercussions of libel and slander. Likewise, parental rights are not unlimited.

Parental rights are a contentious issue within and outside of medical care. Every single state has laws and administrative procedures in place for removing children and adolescents from legal guardians who abuse minors or are seriously negligent in providing for them. A society has to balance the interests of the minor and legal guardians in an objective way that ensures the best possible outcomes for children and adolescents.

This is particularly true with the experimental nature of medically gender-transitioning children and adolescents. Under the affirmation-only framework, care professionals of a minor experiencing gender dysphoria are to accept and encourage the minor’s chosen gender expressions and encourage the legal guardians to do the same. This sounds like heartwarming unconditional love, but it can be exceptionally problematic in practice.

Affirmation-only is not a neutral approach. Operating under the assumption that gender is indeed a social construct, children or adolescents will inevitably experience some confusion about traditional gender roles and adjust to changing social attitudes. As previously noted in the social science section, this confusion can resolve itself without medical interventions, with most children and adolescents settling on traditional gender expressions. Given the current state of science, parents and medical practitioners may have no idea if they are affirming a child's innate identity or pushing a child towards adopting a particular gender expression the minor would not otherwise permanently adopt.¹⁴⁵ The "affirmation only" approach could be nudging children into a permanent expression of gender that they were previously only exploring.

The problematic state of the research noted in previous sections should prompt us to be cautious. How can parents be expected to make choices that will have profound long-term ramifications on the future of their children when the medical professionals themselves openly concede so much is yet to be known about long-term health outcomes? These ethical issues are only compounded by the fact that those who administer medical interventions often have a strong ideological bias towards the treatment and a financial incentive to pursue it. Considering these nuanced issues related to informed consent, it is reasonable to ask if parents themselves can consent on their children's behalf.

We also contend that pro-trans advocates deploying the language of parental rights should be viewed with suspicion. In 2022, California passed Senate Bill 107, enabling minors from out of state to receive gender-transition medical interventions in California during custody disputes. The law, called the Trans Youth Healthcare Access Act, was signed by Governor Gavin Newsom in September 2022 and went into effect immediately.¹⁴⁶ Washington State has enacted a measure that allows for a minor to pursue gender transition medical interventions without parental consent.¹⁴⁷ Trans advocates vocally supported these measures despite the egregious erosion of parental rights.

According to WPATH's latest Statement of Care (SOCv8) Guidelines, parental consent is only required when not deemed to be harmful.

Parent(s)/ caregiver(s) may be too rejecting of their adolescent child and their child's gender needs to be part of the clinical evaluation process. In these situations, youth may require the engagement of larger systems of advocacy and support to move forward with the necessary support and care.¹⁴⁸

This vague guidance is very problematic. Would a parent rejecting medical intervention for a minor's gender dysphoria be deemed harmful and thus be ignored? According to trans advocates, the answer is yes. WPATH's SOC calls for clinicians to move forward without parental consent if parents refuse. Although some may find this disturbing, it is consistent with their claims that interventions are

medically necessary. However, this guidance is wholly inconsistent with any appeal to parental rights.

Is Informed Consent Enough?

We do not deny a minor can provide assent (express a willingness to participate), but we contend that this alone does not substantiate consent. A rational observer would be hard-pressed to ignore the immense ethical pitfalls of assuming that minors (with or without parental consent) can consent to the loss of reproductive ability and sexual function and changing their brain and body structure well before natural maturation. New questions arise from the informed consent defense of medically gender-transitioning minors.¹⁴⁹

Should a 10-year-old be able to consent to a vasectomy? If children and adolescents can truly understand what it means to permanently augment their sexual function, what rational basis do we have to prevent children from consenting to sexual relationships if all that is needed to do so is informative counseling? Furthermore, if simply informing a minor of the risk is sufficient to gain their consent, what is the basis for restricting the bodily autonomy of minors relative to adults in any context?

Although one may be able to answer these questions in a multitude of ways, it is impossible to know to what extent permitting these extreme medical interventions will be used as a basis to challenge other legal restrictions on minors. We simply believe it is naïve to assume that the informed consent model currently used as a basis to obtain support for experimental medical procedures for minors will not be applied elsewhere.

Punishing Dissent

In the rush to affirm trans ideologies, medical practitioners have been fired for refusing to affirm an intellectually deficient ideology. We must consider the extent to which professional practitioners or researchers who are unconvinced are free to challenge these assertions and dissent. In short, people should view pro-trans research in the context of the environment it was produced. These studies are often lacking in quality and conducted by researchers with a fervent desire to confirm a certain view of the issue.¹⁵⁰ Those who question the medical affirmation-only view subject themselves to harsh criticism and professional exile. Perhaps the extent to which such professionals have been extensively rooted out of leadership positions has caused others to remain silent out of fear of being targeted for retribution.

This is not an unfounded conspiracy theory.

Valerie Kloosterman, a pediatric physician assistant with 17 years of experience, was fired for refusing to refer children and adolescents for trans medical interventions.¹⁵¹ Valerie regularly received exemplary reviews, and supervisors called her “professional,” “very ethical,” and a “pleasure to work with.” Kloosterman alleges in the summer of 2021, after a mandatory “diversity and inclusion” training, she asked for a religious accommodation because she could not affirm statements about gender identity that violated her deeply held Christian beliefs. With total disregard for her exemplary record, a corporate representative with no medical training defamed Valerie as “evil” and a “liar” and even blamed her for gender dysphoria-related suicides. She was fired within a month.¹⁵²

Dr. Kenneth Zucker, a researcher with an extensive list of publications, is the former head of the Centre for Addiction and Mental Health. The esteemed psychologist had led the Child Youth and Family Gender Identity Clinic in Toronto, Canada, for more than 30 years. Dr. Zucker correctly noted the total lack of evidence for the affirmation-only approach as well as the difficulties of dealing with comorbidities associated with treating youth presenting with gender dysphoria. “I think that conflation with politics has made it very difficult for many people in the field to say what they really think,” he said. “And I think that’s really sad, that in a field where there are so many important issues to discuss and work on, that really bright people feel intimidated.” Unsurprisingly, Dr. Zucker was effectively canceled for refusing to endorse and employ an affirmation-only approach.¹⁵³

Jamie Reed, a former case manager at The Washington University Transgender Center at St. Louis Children’s Hospital, blew the whistle on barbaric practices in a gender clinic. Her testimony and internal email leaks have led to an investigation of clinic practices.¹⁵⁴ Reed identifies as queer and, for all intents and purposes, can be characterized as pro-LGBTQ. Despite that, she has been harshly criticized and attacked for calling for caution concerning trans youth care.

Vanderbilt University Medical Center’s Chair of Pediatrics, Dr. Ellen Clayton, is also on video addressing hospital staff on the money-making potential of medical gender transitioning for minors. Dr. Clayton went as far as to tell staffers who may have reservations about the practice to find a new job.¹⁵⁵ She made it exceptionally clear that dissent would not be tolerated.

A Catholic healthcare system in Northern California is currently in a years-long lawsuit for refusing to provide gender transition surgeries. Evan Minton sued Mercy San Juan Medical Center near Sacramento for refusing to allow a doctor to perform a hysterectomy on Minton as part of an attempted gender transition from female to male. Minton said the treatment denial was a violation of California law that bars discrimination.¹⁵⁶ The hospital said it does not discriminate against transgender patients but does not allow its facilities to be used for abortion, sterilization, and euthanasia, which are contrary to Catholic teachings.¹⁵⁷

The hospital called the procedure, which surgically removes the uterus, "elective sterilization" and said that it conflicts with its ethical and religious beliefs. It also said requiring physicians to perform such procedures violates the Constitution's free exercise clause.

A trial court sided with the Catholic hospital, saying the three-day delay in the procedure was not a denial of full and equal access to health care under state law. An appeals court reversed that decision, rejecting the hospital's defense and the U.S. Supreme Court declined to hear the case.¹⁵⁸

This is not an all-inclusive list of incidents concerning trans-identity conflicts. There is a significant risk to questioning the prevailing orthodoxy on this issue; resistance to the trans youth agenda could be a very devastating career move that could subject professionals to ostracization and expensive litigation. This creates an environment that is hostile to scientific inquiry and common sense.

The News Media

The news media plays a big role in shaping our perception of events and policy. Unfortunately, the American press has not only failed to give the issue of medical gender transitions for minors proper scrutiny, but they may also be actively misleading the public. News outlets like CNN, CBS, and NBC frequently employ biased pro-trans activist language when covering these issues. The utilization of terms such as "evidence-based," "medically necessary," and "lifesaving" to describe policies and practices that result in the chemical and physical castration of minors are deployed regularly in written works. Likewise, terms like "anti-LGBTQ," "transphobic," and "hate" are applied to describe laws that seek to prevent the chemical and physical castration of adolescents.

For example, in the spring of 2022, a scandal with Boston's Children's Hospital brought the practice of surgical interventions for gender dysphoric youth to the forefront. The hospital's guidelines stated on its website that it offers breast removal for those as young as 15, and bottom surgery as early as 17 years old.¹⁵⁹ After the discovery caused an uproar and backlash, the hospital quickly deleted the guidelines and removed videos from its website and YouTube channel that advocated for surgical interventions.¹⁶⁰ As the scandal gained more media attention due to reported bomb threats, misleading "fact-checkers" omitted this crucial context when erroneously declaring that surgical interventions on minors at the hospital were not happening. Yet, as these media fact-checkers were running interference, doctors from the hospital were bragging about the procedures in medical journals.¹⁶¹

An uproar over these controversial surgeries was decried by many in the media as anti-LGBTQ hate and right-wing extremism,¹⁶² with some prominent news organizations arguably misleading some readers into believing no surgeries are taking place by denying a specific procedure was performed.¹⁶³

In another case of the media abandoning objectivity and factual reporting, a group of nearly 1000 contributors¹⁶⁴ and 34,000 media professionals and subscribers signed an open letter objecting to *New York Times* coverage of issues related to transgender youth.¹⁶⁵ The letter accused the newspaper of promoting anti-transgender views and perpetuating harmful stereotypes.¹⁶⁶ Signatories demanded the *Times* pivot to pro-trans talking points to reinforce the falsehood that gender-transitioning medical interventions for youth are sound and settled science. Although the letter is written as an appeal for more “accuracy,” it is little more than thought policing and an attempt to declare the debate over despite a great deal of evidence that conflicts with the preferred narrative of media ‘professionals’ and transgender activists that promoted the letter.

The fact that thousands of media personalities have unquestioningly adopted the view that the case for widescale gender-transitioning medical interventions for youth is settled science is a testament to the careless complicity of the American press.

The New York Times is not an anti-trans propaganda mill. The vast majority of their coverage has been affirmative and lends legitimacy to the trans community. However, simple attempts to be somewhat impartial on the issue are viewed by pro-trans advocates as “hateful” and “bigoted.” WPATH openly concedes there is insufficient longitudinal data and a lack of high-quality studies concerning trans youth. Yet, many journalists (who are generally further to the left than most Americans¹⁶⁷) insist on abandoning impartiality.¹⁶⁸

A large share of the American media is openly seeking to push the public towards accepting these radical medical interventions as evidence-based, expert-approved, and lifesaving medicine while ignoring credible calls for caution every step of the way. This has undoubtedly contributed to a hostile and politically charged environment around topics related to gender dysphoric youth.

Conclusion

This report should by no means be interpreted as an attack on consenting adults, regardless of how they choose to live their lives. Although we are skeptical of the trans movement as a whole, our cause for alarm relates to the pressure placed on our nation’s youth. Children and adolescents are malleable and impressionable¹⁶⁹; this is well documented throughout academic literature and reinforced through our collective lived experiences.

While we explore the varying causes for concern, we admit some of the research used in this report is far from definitive. Citing and finding research that confirms your bias can only settle an issue once other views have been thoroughly discredited and debunked. A lot more research is needed

regardless of one's position on this issue. However, we present our narrative review to push back against the erroneous idea that medically transitioning minors is a settled science.

Too many advocates of trans-youth gender transitions have produced and promoted weak research to justify the chemical castration and physical mutilation of adolescents. Their ideological worldview has often been informed by activist clinicians and other like-minded advocates who shield them from information and viewpoints that do not comport with their preferred narratives. The human tendency to over-emphasize research, ideas, and concepts that fit our preconceived worldview and deemphasize what does not may be clouding the judgment of otherwise competent clinicians.

We do not seek to demonize professionals who truly believe they are acting in the best interest of children. We simply believe medical experimentation on children deserves far more scrutiny. The guidelines for treating them should be developed through a process that employs strict scientific examination and must not be compromised by surrendering to the demands of ideological zealots.

About the Authors

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