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June 21, 2023

Transparency Benefits Parents and Youth

Testimony of Dr. Andre Van Mol, MD and Dr. Michelle Cretella, MD
On behalf of parents of public school students in Smithfield, RI

Dear Smithfield School Committee Members,

Embracing a policy of transparency between schools and parents in regard to student gender identity will ultimately land Smithfield Public Schools on the right side of history. However, maintaining the current RIDE policy of surreptitiously aiding the social transition of gender dysphoric students without parental knowledge will likely result in a deluge of lawsuits by irreversibly damaged former students in the not too distant future. This is because social transition sends youth down a dangerous experimental path that often leads to permanent harm which may not be realized until ten years following the start of transition.

Science has acknowledged for decades that youth thrive best across all measures of health when nurtured into adulthood by both parents. Barring objective evidence of abuse, it is in children's best interest for health professionals and school staff to facilitate communication and act as a bridge to bolster the parent-child relationship especially when gender identity issues arise so families can pursue a comprehensive and ethical evaluation as described by at least three international mental health organizations: Gender Exploratory Therapists Association (https://genderexploratory.com), Genspect (https://genspect.com) and Thoughtful Therapists (https://thoughtfultherapists.org). In contrast, school systems and staff that usurp parental rights and aid children in a surreptitious social transition are unilaterally responsible for sending these youth down a path that leads to chemical and/or surgical sterilization, as well as a host of other permanent bodily changes, potential life-long chronic diseases and surgical complications described below. This is why mental health services to treat underlying issues and traumas are being prioritized for gender dysphoric youth by an increasing number of LGBTQ-affirming nations.

Like the state of Florida, government agencies and medical authorities in the United Kingdom,[1,2,3,4] France,[5] Sweden,[6,7,8] Finland[9] and Norway[10] issued comprehensive scientific reviews of gender affirmation in minors and reversed course as a result. These LGBQT-affirming nations which once led the charge for gender affirmation in youth are now driving an international pushback against it in favor of intensive psychological evaluation and support. This is because current science indicates gender transition procedures (GTP) may cause more harm than good. Social affirmation puts minors on a path of puberty blockers, cross-sex hormones and surgeries resulting in irreversible damage like sterility. Lawsuits filed against U.S. healthcare systems and physicians over the harms caused by transition affirming procedures in minors have begun. Schools and staff who aided minors in gender transition without parental knowledge will most certainly be included in future lawsuits.

Socially affirming cross-gender identity is not harmless. Social affirmation leads to persistence of cross-gender identification. Therefore, the American Psychological Association's *Handbook on Sexuality and Psychology* states that "Premature labeling of gender identity [premature social affirmation] should be avoided." "This approach runs the risk of neglecting individual problems the child might be experiencing …"[11] Premature social affirmation also sends these youth down a path of dangerous life-long medical and surgical gender transition procedures (GTP) including puberty blockers, cross-sex hormones and sterilizing surgeries. Contrary to popular belief, these

interventions are not proven effective, not proven safe, do not reduce suicides, and are not the standard of care for gender dysphoria.

MINORS NEED PARENTAL GUIDANCE BECAUSE THEY CANNOT GIVE TRULY INFORMED CONSENT.[12]

- Children have developing and immature brains; their minds change often; they are prone to risk taking and vulnerable to peer-pressure; and they generally do not grasp long-term consequences (this holds for social, medical and surgical transition interventions).[13,14,15,16]
- A UK High Court in Bell vs. Tavistock (2020) specified, "There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years."[17]

DESISTANCE IS THE NORM FOR MINORS WITH TRANS-IDENTIFICATION, resolving on its own for an average of 85% by adulthood, ***unless it is affirmed***.[18,19,20,21,22]

SUICIDE RISK AMONG TRANS-IDENTIFYING YOUTH IS SIMILAR TO RISK OF OTHER AT-RISK YOUTH. Oxford sociologist, Dr. Michael Biggs, calculated that being trans-identified increases suicide risk by a factor of 13. This elevated risk, while concerning, is less than or within range of the suicide risk associated with other disorders: anorexia increases suicide risk by a factor of 18; depression multiplies one's risk by a factor of 20, and autism raises suicide risk by a factor of 8. Anorexia, depression and autism also often coincide with gender dysphoria.[23]

THE SUICIDE REDUCTION CLAIMS OF SOCIAL/MEDICAL TRANSITION ARE MYTHS

- Bailey and Blanchard: "There is no persuasive evidence that [social/medical/surgical] gender transition reduces gender dysphoric children's likelihood of killing themselves.[24]
- A 2011 Swedish study of all their post-sex reassignment surgery adults showed a completed suicide rate 19 times that of the general population 10 years out, along with nearly 3 times the rate of psychiatric inpatient care.[25]
- A 2020 study by Bränström and Pachankis, claiming to be the first total population study of 9.7 million Swedish residents, ultimately showed neither "gender-affirming hormone treatment" nor "gender-affirming surgery" improved the mental health benchmarks.[26,27]
- There is no single reason for suicide. The U.S. CDC/MMWR "Suicide Contagion and the Reporting of Suicide" states "Suicide is never the result of a single factor or event, but rather results from a complex interaction of many factors and usually involves a history of psychosocial problems."[28]
- About 96% of US adolescents attempting suicide demonstrate at least one mental illness.[29]
- 90% of adults and adolescents who completed suicide had unresolved mental disorders .[30]

DECADES of Studies Confirm that GENDER DYSPHORIA IS ASSOCIATED WITH UNDERLYING MENTAL HEALTH PROBLEMS, ADVERSE CHILDHOOD EXPERIENCES/TRAUMAS, FAMILY ISSUES, and impressively higher rates of neurodevelopmental issues like **AUTISM SPECTRUM DISORDER**, all of which usually PRE-DATE the onset of gender dysphoria.[31,32,33,34,35,36]

- Withers 2020, "trans-identification and its associated medical treatment can constitute an attempt to evade experiences of psychological distress."[37]
- These call for mental health intervention not cross-gender affirmation

AAP, WPATH & Endocrine Society DO NOT FOLLOW THE SCIENCE ON GENDER DYSPHORIA

- The AAP (American Academy of Pediatrics) transgender policy was refuted by Dr. James Cantor in a 2019 review as "a systematic exclusion and misrepresentation of entire [scientific] literatures," misrepresenting references that actually contradicted their transition policy and advised watchful waiting, and omitting the fact of desistance over puberty being the norm for gender dysphoria in minors, among other serious flaws.[38]
- WPATH (World Professional Association for Transgender Health) is an advocacy group that purports to publish medical Standards of Care. The seventh edition of WPATH's Standards of Care (SOC 7) was evaluated and rated in a 2021 British Medical Journal (BMJ) first of its kind "systematic review and quality assessment." The researchers gave it a quality score of zero out of six because it contained no comprehensive scientific review.[39] Just calling a list of interventions "Standards of Care" does not make

them so. The latest SOC 8 version removes age restrictions for medical and surgical interventions.[40,41]
- The 2017 Endocrine Society Guidelines, the first from a medical organization, specifies this disclaimer on p. 3895: "The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care." The 2021 BMJ review gave these guidelines a quality score of one out of six.

PUBERTY BLOCKING AGENTS [PBA] chemically castrate at the level of the brain.[42]

- PBAs risk infertility by blocking the maturation of sperm and eggs.[43] Following them with cross-sex hormones assures sterility.[44,45]
- PBAs compromise bone mineral density at what should be the period of peak increase.[46]
- PBAs hinder brain development and compromise sexual function.
- The US FDA added a warning for pseudotumor cerebri (brain swelling) July 2022.[47]
- Self-harm does not improve on PBAs.[48,49]
- PBAs are not proven fully reversible, and long-term complications are known.[50]

CROSS-SEX HORMONES ARE DANGEROUS [51,52,53,54,55,56,57]

- Estrogen use in male biology strongly increases the risks of blood clots, heart attacks, strokes, breast cancer, insulin resistance and more. Risk increases with length of use.[58]
- Testosterone use in female biology strongly increases the risks heart attacks, strokes, breast and uterine cancer, hypertension, severe acne and more.
- A 2019international panel of endocrinology organizations concluded[59] "…the only evidence-based indication for testosterone therapy for women is for the treatment of HSDD [Hypoactive sexual desire disorder]." They gave no exceptions for "any other symptom or clinical condition, or for disease prevention," and observed "The safety of long-term testosterone therapy has not been established."

Automatic affirmation of social/medical and/or surgical transition is a dangerous experiment in which public schools should not participate. Schools should facilitate child – parent communication especially concerning gender identity and mental health, and then respect the right and responsibility of parents to review their options and make health decisions together with their children.

Respectfully,

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