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PLEASE OPPOSE GENDER TRANSITION PROCEDURES FOR MINORS
Testimony of Dr. Andre Van Mol, MD
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Gender transition procedures (GTP) imperil already at-risk gender dysphoric youth with experimental and unproven hormonal and surgical gender procedures, which medicalize prematurely and permanently. Transition procedures are not proven effective, not proven safe, do not reduce suicides, and are not the standard of care for gender dysphoria. Comprehensive literature reviews are driving an international pushback against GTP in favor of intensive psychological evaluation and support, and the lawsuits over the harms of transition affirming interventions have begun. GTPs are out of step with evidence-based care for gender dysphoric youth.

THE GOVERNMENTS AND MEDICAL/ACADEMIC INSTITUTIONS OF THE UK,[1] [2] [3] [4] SWEDEN,[5] [6] [7] FINLAND,[8] and NORWAY[9] HAVE REJECTED prioritizing gender transition in favor of emphasizing extended mental health evaluation and support.

- The UK closed the world's largest pediatric gender clinic, NHS's Tavistock Gender Identity Development Service,[10] per findings of the Cass Review.[11]
- Comprehensive literature reviews done in the UK,[12] [13] [14] Sweden,[15] [16] and Finland,[17] show GTPs are out of step with the evidence base for gender dysphoric youth.

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] Why permanently medicalize a child for a condition that usually goes away?[23] [24] [25]

DECADES of Studies Confirm that GENDER DYSPHORIA CARRIES THE OVERWHELMING LIKELIHOOD OF 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 PREDATE the onset of gender dysphoria.[26] [27] [28] [29] [30] [31]

- Withers 2020, "trans-identification and its associated medical treatment can constitute an attempt to evade experiences of psychological distress."[32]
- These call for mental health intervention, not gender transition procedures.

THE MEDICAL LITERATURE IS CLEAR: DO NOT PREMATURELY AFFIRM.

- *APA Handbook on Sexuality and Psychology*: "Premature labeling of gender identity should be avoided."[33] "This approach runs the risk of neglecting individual problems the child might be experiencing …"[34]
- 2020 Nordic J of Psychiatry: "An adolescent's gender identity concerns must not become a reason for failure to address all her/his other relevant problems in the usual way." [35]

Gender Transition Procedures (GTPs) Are Not the "Standard of Care" for Gender Dysphoria.

- So-called gender affirming care guidelines ultimately derive from non-scientific, non-medical activist groups like WPATH (World Professional Association for Transgender Health) whose SOC 7 was rated by a 2021 BMJ first of its kind "systematic review and quality assessment" with a quality score of zero out of six. [36] It contains no comprehensive literature review. Just calling them "Standards of Care" does not make them so. The latest SOC 8 version removes age restrictions for medical and surgical interventions.[37] [38]
- 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. GTPs are not the standard of care.
- The American Academy of Pediatrics' policy was discredited by Dr. James Cantor in a 2019 review as "a systematic exclusion and misrepresentation of entire 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.[39]

MINORS CANNOT GIVE TRULY INFORMED CONSENT.[40]

- Children have developing and immature brains; their minds change often; they are prone to risk taking and vulnerable to peer-pressure; and they don't grasp long-term consequences.[41] [42] [43] [44]
- 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."[45]

PUBERTY BLOCKING AGENTS [PBA] chemically castrate at the level of the brain.[46]

- PBAs risk infertility by blocking the maturation of sperm and eggs.[47] Following them with cross-sex hormones assures sterility.[48] [49]
- PBAs compromise bone mineral density at what should be the period of peak increase.[50]
- PBAs hinder brain development and compromise sexual function.
- The US FDA added a warning for pseudotumor cerebri (idiopathic intracranial hypertension) July 2022.[51]
- Self-harm does not improve on PBAs.[52] [53]
- PBAs are not proven fully reversible, and long-term complications are known.[54]

AS FOR CROSS-SEX HORMONES [55] [56] [57] [58] [59] [60] [61]

- 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.[62]
- Testosterone use in female biology strongly increases the risks heart attacks, strokes, breast and uterine cancer, hypertension, severe acne and more.
- A 2019 international panel of endocrinology organizations concluded[63] "…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."

MANY REGRET TRANSITION. Many claim their **consent lacked information on transition procedures' known risks and available alternatives**.[64]

- Studies downplaying rates of regret consistently show high rates of loss to follow up (20-60%) and set unreasonably strict definitions for regret. (D'Angelo, 2018)…"[65]

- Regret rates comes from gender clinics, precisely where regretters say they avoid.[66]

PRO-TRANSITION STUDIES COMMONLY SHARE THE SAME FATAL FLAWS.
“Limitations of the existing transgender literature include general lack of randomized prospective trial design, small sample size, recruitment bias, short study duration, high subject dropout rates, and reliance on “expert” opinion.” Pediatric endocrinologist and academic Paul Hruz, MD.[67]

THE SUICIDE REDUCTION CLAIMS OF TRANSITION ARE MYTHS, used as emotional blackmail.

- Many parents of gender confused youth report being frightened by mental health and medical officials with shock questions like, “Do you want a live son or a dead daughter?” or “Would you rather be planning a transition or a funeral?”
- But GTPs are not proven to reduce suicides. In fact, the best studies show worsening of long term mental health for many.
- Bailey and Blanchard: “There is no persuasive evidence that gender transition reduces gender dysphoric children’s likelihood of killing themselves.[68]
- 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 year out, along with nearly 3 times the rate of psychiatric inpatient care.[69]
- 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.[70] [71]
- A 2021 comprehensive data review of all 3,754 trans-identified adolescents in US military families over 8.5 years showed that gender hormone treatment lead to increased use of mental health services and psychiatric medications, and increased suicidal ideation/attempted suicide.[72]
- There is no one reason for suicide. The U.S. CDC/MMWR “Suicide Contagion and the Reporting of Suicide” warned against “Presenting simplistic representations of suicide. 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.”[73]
- About 96% of US adolescents attempting suicide demonstrate at least one mental illness.[74]
- 90% of adults and adolescents who completed suicide had unresolved mental disorders .[75]

Non-Discriminatory. Refusing to provide gender transition procedures is actually non-discriminatory and appropriate both professionally and scientifically.

- GTPs have not been proven safe, effective, or of more benefit than harm.
- Physicians take an oath to do no harm, and GTPs are documented to lead to much harm.
- Withholding unproven interventions is non-discriminatory.
- There are mental health alternatives to GTPs which are at least as effective and without the harms of hormonal and surgical interventions.

The chemical sterilization and surgical mutilation of otherwise healthy young bodies is not health care. [76] [77] [78] **Gender transition procedures are being rejected by nations formerly leading them. GTPs are unproven child experimentation masquerading as better, and refusing GTPs is non-discriminatory. Minors should be protected from them.**

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