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THE DANGERS AND DUE PROCESS VIOLATIONS OF "GENDER-AFFIRMING CARE" FOR CHILDREN

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CONSTITUTION AND LIMITED GOVERNMENT

OF THE

COMMITTEE ON THE JUDICIARY
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

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THE DANGERS AND DUE PROCESS VIOLATIONS OF "GENDER-AFFIRMING CARE" FOR CHILDREN

Thursday, July 27, 2023

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON THE CONSTITUTION AND LIMITED GOVERNMENT

COMMITTEE ON THE JUDICIARY

Washington, DC

The Committee met, pursuant to notice, at 10:06 a.m., in Room 2141, Rayburn House Office Building, Hon. Mike Johnson [Chair of the Subcommittee] presiding.

Members present: Representatives Johnson, Jordan, McClintock, Roy, Kiley, Hageman, Hunt, Fry, Scanlon, Nadler, Cohen, Escobar, Jackson Lee, and Balint.

Also present: Representatives Gaetz and Greene.

Mr. JOHNSON of Louisiana. [Presiding.] The Subcommittee will come to order.

Without objection, the Chair is authorized to declare a recess at any time.

We open our proceedings here with a Pledge of Allegiance, and I will recognize the gentlelady from Georgia, Ms. Taylor Greene, to lead us for that purpose.

ALL. I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one Nation, under God, indivisible, with liberty and justice for all.

Mr. JOHNSON of Louisiana. Thank you.

We welcome everyone to today's hearing on the dangers and due process violations—

Ms. SCANLON. Point of order.

Mr. JOHNSON of Louisiana. —of gender-affirming care for children.

Ms. SCANLON. I have a point of order, Mr. Chair.

Mr. JOHNSON of Louisiana. Yes, ma'am, what's the point of order?

Ms. SCANLON. It is not the Committee's practice to allow folks who are not Members of this Committee to sit at the dais without unanimous consent, and we do not give it.

Mr. JOHNSON of Louisiana. I was going to seek that unanimous consent. The gentlelady from Georgia was here for the purpose of

merely introducing the Republican witnesses. It's common courtesy among colleagues to allow a Member the privilege of appearing for that purpose. I'm sorry that you object to that.

Ms. SCANLON. I'm sorry, too.

Mr. JOHNSON of Louisiana. You insist on the point of order?

Ms. SCANLON. I do.

Mr. JOHNSON of Louisiana. Unfortunately, it's not a debatable motion or one that is subject to a vote. So, I will provide the witness introductions after our opening statement. So, I thank our colleague for her willingness, anyway.

I will recognize myself for an opening statement and we'll get the hearing going here.

Before I provide a few opening remarks, I'm going to play a two-minute excerpt of a podcast interview with an individual named Dr. Blair Peters at the Oregon Health Science University in Portland.

He calls himself the "queer surgeon" and he boosts about the shocking, fully experimental, irreversible, and life-altering invasive procedures that he and others are performing on children to surgical modify their genitals.

I want everyone to hear this in his own words, not mine, and take special note of the frank admission that no one has published any studies on these shocking procedures, and they are, quote, as he says, "just kind of learning and figuring out what works."

Later in this video, he admits to performing, quote, "huge reconstructive surgery rearranging anatomy," and then, acknowledges that they know almost nothing about the outcomes for these children. He says, quote, "We'll know more in 5–10 years," and quote, "It will be fascinating to see how all these kids turn out." Wow!

With unanimous consent, I will enter the link to this full video in the record of our hearing because everyone should watch it. It is absolutely nightmarish and surreal to hear the description of what these people are doing to the bodies of young children.

Mr. JOHNSON of Louisiana. Please play that clip, and I will say viewer discretion is advised.

[Video played.]

Mr. JOHNSON of Louisiana. So, I'm going to speak the truth here plainly, and I think the vast majority of the American people understand and agree with what I'm going to say.

What you have just heard there is a little sample of barbarism. This is the mutilation of children, and it should be prohibited by our law.

This so-called "gender-affirming care" is anything but affirming and caring, and the language matters. This is adults deciding to permanently alter the bodies of children who do not have the capacity to make life-altering decisions on their own.

Here's some more plain truth that everybody acknowledged until about five minutes ago. It's been plainly observed and fully respected by every culture for all recorded history. Sex isn't something you are assigned at birth. It is a natural, prenatal development that occurs when every unborn child is in the mother's womb. No one can surgically free themselves from this objective and obvious fact of life or free anyone else from it.

Today, we see adults inflicting unspeakable harms on helpless children to affirm the adult's own world view: That gender is somehow fluid; that sex can be surgically altered; that there are no lasting consequences of all this madness, as a result of the sex change procedures.

What is even more alarming is that the central tenet of the transgender movement and its allies is to exclude parents as much as possible from making decisions about the health of their own children. Medical professionals and schools increasingly see parents as, quote, "transphobic bullies" who must be prevented from standing in the way of the medical sexual transition of their own kids.

We saw this in my home State of Louisiana recently, where Children's Hospital of New Orleans laughed in the face of a young girl's parents when they attempted to intervene, as doctors sought to transition their daughter without their consent.

To the left, these aren't your children, see. They are the State's children, and the State should be making the parenting decisions.

Let's also be clear about something else. Even a parent has no right to sexually transition a young child. Our American legal system recognizes the important public interest in protecting children from abuse and physical harm. No matter how liberated you may be, you still don't have the legal right to ignore seatbelt safety laws or minimum driving age laws or drinking and smoking laws for your kids. No parent has a Constitutional right to injure their children.

Of course, the reach of radical sexual identity politics isn't limited to young children alone. We see this extended to young adults, especially at the university level now. The modern left applauds men competing in women's college athletics. We see universities captured by academics advancing this ideology on students across our country.

Whether it's by scalpel or by social coercion from teachers, professors, administrators, and left-wing media, it is an aggressive attempt to transition the young people of our country. They are doing this psychologically, and now they are doing it even physically.

Something has gone terribly wrong, and deep down everybody in this country knows it. Today, we want to shed light on what this problem is, and hopefully, how we can address the problem.

Contrary to what some of my Democrat colleagues believe, the scourge of radical gender ideology is very real. The efforts to cover up what is being done to our children are extreme, and the science is on the side of what we all know deep down is morally and ethically right.

I look forward to the testimony from our witnesses, as we unravel the narratives surrounding this so-called gender-affirming care.

I now recognize the Ranking Member, the gentlewoman from Pennsylvania, Ms. Scanlon, for her opening statement.

Ms. SCANLON. Thank you, Mr. Chair.

Let's be clear. Congress has no business interfering in parents' freedom to make decisions about appropriate medical care for their children. The idea that politicians are more qualified to judge the medical value or necessity of gender-affirming care than every major medical organization is absurd.

Holding a hearing to substitute far-right ideologies for parental judgment exposes the rank hypocrisy of the party claiming to value individual freedom and small government. So, here we are before the Subcommittee on the Constitution and Limited Government.

Make no mistake; today's hearing is not about protecting children or parents' rights. It's a cynical and, frankly, dangerous political attack on transgender children and their families, driven not by science or facts, but by polling and political strategists determined to mobilize conservative voters through fear.

So, let's start by setting the record straight. Gender-affirming care is safe and effective. It is supported by every major medical association, including the American Academy of Child and Adolescent Psychiatry, the American Medical Association, and the American Academy of Pediatrics, among others, representing over 1.3 million American doctors. It's just not up for debate.

The partisans who characterize gender-affirming care as "radical gender ideology" are just repeating right-wing talking points to delegitimize critical healthcare. Access to gender-affirming care is essential to the mental health and well-being of trans youth. This care is tailored to both the mental and physical health needs of patients, as well as their developmental stage in life. The parents and guardians of these children are involved in every phase of decision-making. There's nothing radical about that.

So, when our Republican colleague allege that gender-affirming care raises particular dangers or due process issues, that is fearmongering at its worst—picking on already vulnerable kids to stir up chaos that they hope to ride to success at the ballot box, no matter how deceitful or dangerous those claims are.

As a mother of three, I certainly never found myself at my children's pediatric appointments wishing for medical advice from the House Judiciary Committee.

As a Member of Congress, I'm appalled by the weaponization of our legislative process to inject politicians into the personal medical decisions of our constituents' lives.

I strongly oppose any effort to impose ultra-conservative political or religious views on the medical decisions of American families, whether on matters of reproductive healthcare or parental decisions to seek gender-affirming care for a transgender child.

I know that Americans can be trusted to make their own healthcare decisions without politicians invading their doctors' offices, and I believe parents and doctors when they say that gender-affirming care has changed children's lives for the better, and in many cases even saved those lives.

Parents like the mother of a trans teen from Ohio who shared her family's story with the Committee, she told us that, because her 17-year-old trans daughter had access to evidence-based, medically necessary, gender-affirming care, puberty was just another phase of a normal and healthy adolescence. She said, and I quote,

> Forcing her to go through the wrong puberty and seeing the impact on her body and her mental health would have been agonizing for all of us. I don't understand why we would allow politicians to make medical decisions for our children.

She is right. Banning access to gender-affirming care would violate parents' due process rights, and the Federal Courts agree.

They agree that banning gender-affirming care for minors violates Constitutionally protected parental rights, and that politicians should stay out of those decisions.

I want to close by reminding my colleagues how much their words matter. By endorsing falsehoods and bullying tactics, Members of Congress are helping to promote a culture of discrimination that has increased violence against trans kids and their parents. Cynical political opportunists should not be allowed to use the megaphone of the House Judiciary Committee to promote cruelty and disinformation, particularly when we know that it invites discrimination and abuse of trans children and their families. I must object to this callous and reckless use of this Committee's time.

With that, I yield back.

Mr. JOHNSON of Louisiana. I now recognize the Ranking Member of the Full Committee, Mr. Nadler, for an opening statement, if he wishes.

Mr. NADLER. Mr. Chair, today's hearing is an all-time low for the Republican majority. In my three decades in Congress, I have taken part in plenty of hearings where I did not agree with the choice of topic, to say the least, but I am absolutely disgusted by the Republican majority's bullying, bigoted framing of an issue that would otherwise be worthy of serious discussion.

What we are witnessing today is nothing less than a taxpayer-funded platform for Congressional Republicans to bully transgender kids who are already some of the most vulnerable members of our community.

Things are already tough enough for these kids and their parents. A mental health survey conducted by the Trevor Project found that transgender youth experience high risk of depression, anxiety, and suicidal thoughts. It can't help that they are under siege by Republican-dominated State legislatures hellbent on passing antitrans bills.

According to the Human Rights Campaign, more than 76 of these bills have been signed into law, resulting in transgender youth losing access to lifesaving medical care, comprehensive and inclusive education, and activities, spaces, and facilities.

That is why it is so infuriating that Congressional Republicans are using their megaphone to single out transgender kids and their parents by labeling their very existence to be a social problem, practically accusing their parents of being criminals for seeking safe, lifesaving, mainstream medical treatment for their children.

The last thing trans kids and their parents need in their lives is for politicians in Washington to jump on the antitrans bandwagon, just so that they can fearmonger for their five minutes of fame.

Let me be crystal-clear. Government should not stick its nose into a parent's decision to seek gender-affirming care for their children. Indeed, it is almost comical that the Republican majority of what they have named the Subcommittee on the Constitution and Limited Government is holding a hearing, allegedly, on due process to argue that politicians, not parents, should make decisions as to what medical treatment is best for their children.

The legal theory underlying this farcical hearing is bogus, but you don't have to take my word for it. Every Federal District Court

that has considered the Constitutionality of State laws banning gender-affirming care has ruled that such bans violate parents' Constitutional rights. These decisions were issued by courts in different parts of the country and by judges from across the ideological spectrum, including three judges appointed by former President Trump.

I trust parents and medical professionals, not politicians, to make decisions about their children's health when it comes to gender-affirming care, and so does the Constitution.

That said, judging from the lineup of witnesses, it appears that there is no limit to the topics over which Republicans want to bully trans kids and their parents today. Undoubtedly, transgender youths' participation in sports will be discussed because Republicans think it is a winning political topic point. The facts do not justify the fears that Republicans and their political allies gin up over the fairness of trans girls participating in girls' athletic teams, nor the further stigma it attaches to transgender children.

What recently happened in Utah illustrates my point. Last year, Republican Governor Spencer Cox vetoed a complete categorical ban on transgender kids from participating in athletics matching their gender identity, which the Utah legislature, sadly, overruled.

In vetoing the law, Governor Cox noted in a letter explaining his decision that, of the 75,000 high school kids participating in high school sports in the State, only four—four—were transgender, but only one transgender student was playing girls' sports—one out of 75,000.

Governor Cox also noted a study that showed that 86 percent of trans youth reported suicidality and 56 percent of trans youths have attempted suicide. Let those numbers sink in for a moment. A majority of trans youth in this study reported that they had attempted to kill themselves. Out of 75,000 high school student athletes in the State, only four were transgender—an infinitesimally small minority of all high school students in Utah.

Governor Cox's letter further described a sentiment that I sincerely wish his Republican colleagues on this Subcommittee shared. The Governor wrote, quote,

> Rarely has so much fear and anger been directed at so few. I don't understand what they are going through or why they feel the way they do, but I want them to live. And all the research shows that even a little acceptance and connection can reduce suicidality significantly.

Parents of transgender kids want the same things every parent wants for their kids: To go to school without fear of bullying; to participate in extracurricular activities like sports, if they wish, and to be accepted by their peers and their community.

This hearing will only further put those things out of reach for those parents and their children. Far from protecting children, this hearing will only further stigmatize and endanger them because it sends a message that transgender kids and their parents do not deserve the law's protection.

To any transgender people or family members who may watching this hearing, I want to say that Democrats on this Committee see you; we appreciate you; we value you, and we will continue to fight for you.

This hearing is a despicable exercise and a contemptible use of the Subcommittee's time and power.

I yield back.

Mr. JOHNSON of Louisiana. The gentleman yields back.

Without objection, all other opening statements will be included in the record.

Mr. JOHNSON of Louisiana. We will now introduce today's witnesses.

Ms. Paula Scanlan is a spokeswoman and an Advisor to the Independent Women's Forum and the Independent Women's Voice. She is a former collegiate swimmer at the University of Pennsylvania, and she speaks out about what it was like for girls competing alongside and sharing a pool and locker room with a transgender woman.

Ms. Chloe Cole is an advocate and someone who has experienced gender transition procedures. After being diagnosed with gender dysphoria, she began to transition, and then, she detransitioned at age 17, and now speaks about her experiences.

Ms. Taylor Greene had wished to note today that she had the pleasure of meeting and speaking with Ms. Cole last year, when you bravely spoke out and spoke in support of her bill, the Protect Children's Innocence Act, in front of the whole Nation at a press conference. So, thank you for your courage.

Dr. Jennifer Bauwens is serving as the Director of the Center for Family Studies at the Family Research Council. Her research focuses on identifying and advancing policies that will best serve the health and well-being of families and communities.

Ms. May Mailman is a Senior Fellow at the Independent Women's Law Center. She previously served as the Deputy Solicitor General for the State of Ohio.

Mr. Shannon Minter is the Legal Director for the National Center for Lesbian Rights. The NCLR advocates for lesbian, gay, bisexual, and transgender people.

Ms. Myriam Reynolds is a Licensed Professional Counselor and an Art Therapist, and she is the mother of a transgender son and resides in the State of Texas.

We welcome all our witnesses and we thank you for your time and appearing today.

We will begin by swearing you in. So, if you would rise and raise your right hand?

Do you swear or affirm under the penalty of perjury that the testimony you are about to give is true and correct to the best of your knowledge, information, and belief, so help you God?

Thank you.

Let the record reflect the witnesses have answered in the affirmative.

You all can be seated.

Please know that your written testimony will be entered in the record in its entirety. Accordingly, we ask you to summarize that testimony in five minutes.

You have a light system there and you need to push the button to speak, so we can all hear your voice.

Ms. Scanlan, we will begin with you. You can go first.

STATEMENT OF PAULA SCANLAN

Ms. SCANLAN. Good morning. Good morning, Chair Johnson and Ranking Member Scanlon, and Members of the Subcommittee.

I am Paula Scanlan, a spokeswoman and advisor for the Independent Women's Forum, and a former NCAA athlete. I am here today to share my personal story.

I started swimming at a very young age, and by age eight, I was swimming competitively. By late middle school, I was devoting at least 20 hours per week to swimming. I gave up countless Christmas holidays, weekends, and social events to work toward my goal of swimming Division 1—a dream that came true when I began swimming for the University of Pennsylvania.

While I am not an NCAA champion, I hold the New England Independent School League record in the 400-yard freestyle relay, a record that has stood since March 2017.

In September 2021, Lia Thomas began participating as a member of the Penn women's team. Lia, formerly Will, had personal best times in every freestyle event that were faster than the women's world records.

Once the season began, Thomas was leading the country in multiple events, while only placing in the top 500 in those events on the men's team. Thomas later became an NCAA champion in the 500-yard freestyle, the first NCAA champion in our women's team history program.

While many of you already know this, what you do not know is the experiences of the women on the University of Pennsylvania swim team. My teammates and I were forced to undress in the presence of Lia, a 6′4″ tall, biological male fully intact with male genitalia 18 times per week.

Some girls opted to change in bathroom stalls and others used the family bathroom to avoid this. When we tried to voice our concerns to the athletic department, we were told that Lia's swimming and being in our locker room was a nonnegotiable and we were offered psychological services to attempt to re-educate us to become comfortable with the idea of undressing in front of a male.

To sum up the University's response, we, the women, were the problem, not the victims. We were expected to conform, to move over and shut up. Our feelings didn't matter. The University was gaslighting and fearmongering women to validate the feelings and identity of a male.

As an attempt to voice my concern about the situation we were forced into, revealing the unjust and unfair treatment, I wrote an op-ed for *The Daily Pennsylvanian*, the student-run newspaper. I approached this from a scientifically, scientific, statistical perspective where I used my engineering background to discuss how Y chromosomes cannot be changed by any surgical procedure or systemic therapy.

This biological fact lends itself to athletic advantages that cannot be mitigated by lowering testosterone levels, which are readily apparent in sports competitions and locker rooms.

The Daily Pennsylvanian published my article on the evening of February 10, 2022. Only a few hours later, my piece was retracted. I was given no notice, nor reasoning. Again, I was silenced from my

dissenting viewpoint and felt my First Amendment rights were denied by my university.

This is representative of a greater issue, the destruction of free speech. Today, any discussion maintaining the sanctity of women's spaces is labeled transphobic, bigoted, and hateful.

What's bigoted and hateful is the discrimination against women and the efforts to erase women and our equal opportunities, dignity, and safe spaces.

One might ask, why do I speak so passionately about issues that seem hypothetical, or some may perceive as only impacting a small number of women? This is not hypothetical. This is real.

I know women who have lost roster spots and spots on the podium. I know of women with sexual trauma who are adversely impacted by having biological males in their locker room without their consent.

I know this because I am one of these women. I was sexually assaulted on June 3, 2016. I was only 16 years old. I was able to forgive my attacker, but violence against women still exists.

Let us not forget the viral #MeToo movement that empowered female victims to speak up. It cast a spotlight on the widespread prevalence of sexual assault and abuse, including in scholarly and educational institutions.

Individuals on this Committee have previously stated violence against women is all too common. I am grateful for those Members who have brought awareness to the violence against women in the past, but, unfortunately, there is still much to be done.

As a sexual assault survivor, many policies pushed today completely ignore my experiences and many women like me. I ask the Members of this Committee, please consider this issue outside the lens of political affiliations and understand the true impact of ignoring the realities of womanhood. Future generations depend on us.

Thank you for the opportunity to speak here today.

[The prepared statement of Ms. Scanlan follows:]

Testimony before the House Judiciary
Subcommittee on the Constitution and Limited Government
"The Dangers and Due Process Violations of 'Gender-Affirming Care' for Children"

Paula Scanlan
Spokeswoman & Advisor
Independent Women's Forum
July 27, 2023

Good morning Chairman Johnson and Ranking Member Scanlon and members of the subcommittee. I'm Paula Scanlan, a spokeswoman and advisor for the Independent Women's Forum and a former NCAA athlete. I am here today to share my personal story.

I started swimming at a very young age, by age 8 I was swimming competitively, and by late middle school I was devoting at least 20 hours per week to swimming. I gave up countless Christmas holidays, weekends, and social events to work towards my goal of swimming Division 1. A dream that came true when I began swimming for the University of Pennsylvania. While I am not an NCAA champion, I hold the New England Independent School League Record in the 400-yard freestyle relay, a record that has stood since March of 2017.

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Independent® Women's Forum

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My teammates and I were forced to undress in the presence of Lia, a six-feet four-inch tall biological man fully-intact with male genitalia, 18 times per week. Some girls opted to change in bathroom stalls and others used the family bathroom to avoid this. When we tried to voice our concern to the Athletic Department, we were told that Lia swimming and being in our locker room was non-negotiable and we were offered psychological services to attempt to re-educate us to become comfortable with the idea of undressing in front of a male.

To sum up the university's response: we, the women, were the problem, not the victims. We were expected to conform—to move over and shut up. Our feelings didn't matter. The university was gaslighting and fear-mongering women to validate the feelings and identity of a male.

As an attempt to voice my concerns about the situation we were forced into—revealing the unfair and unjust treatment—I wrote an Op-Ed for Daily Pennsylvanian, the University of Pennsylvania student-run newspaper. I approached this from a scientific, statistical perspective where I used my engineering background to discuss how Y-chromosomes cannot be changed by any surgical procedure or systemic therapy. This biological fact lends itself to athletic advantages that cannot be mitigated by lowering testosterone levels, which are readily apparent in sports competitions and locker rooms.

The DP published my article on the evening of February 10, 2022. Only a few hours later my piece was retracted. I was given no notice, nor reasoning. Again, I was silenced for my dissenting viewpoint, and felt my First Amendment Rights were denied by my university.

This is representative of a greater issue, the destruction of free speech. Today any discussion of maintaining the sanctity of women's spaces is labeled transphobic, bigoted, and hateful.

Independent® Women's Forum

What's bigoted and hateful is the discrimination against women and the efforts to erase women and our equal opportunities, dignity, and safe spaces.

One may ask, why do I speak so passionately about issues that seem hypothetical or that some may perceive as impacting only a small number of women? This is not hypothetical, this is real. I know women who have lost roster spots and spots on the podium. I know of women with sexual trauma who are adversely impacted by having biological males in their locker room without their consent.

And I am one of these women. I was sexually assaulted on June 3, 2016, in a bathroom.

I was able to forgive my attacker, but violence against women still exists. Let us not forget the viral #MeToo movement that empowered female victims to speak up; it cast a spotlight on the widespread prevalence of sexual assault and abuse, including in scholarly and educational institutions. Individuals on this committee have stated, "Violence against women is all too common."

I am extremely grateful for those members who have brought awareness to violence against women in the past, but unfortunately, there is still much to be done. As a sexual assault survivor, many policies pushed today completely ignore my experiences and many women like me.

I ask members of this committee, please consider this issue outside the lens of political affiliations and understand the true impact of ignoring the realities of womanhood. Future generations depend on us.

Thank you for the opportunity to speak today.

Mr. JOHNSON of Louisiana. Thank you for being here and for your courage, Ms. Scanlan.

Ms. Cole, you are next, and you can begin.

STATEMENT OF CHLOE COLE

Ms. COLE. Good morning. My name is Chloe Cole, and I am a detransitioner.

Another way to put that would be I used to believe that I was born in the wrong body, and the adults in my life, whom I trusted, affirmed my belief and this caused me lifelong, irreversible harm.

I speak to you today as a victim of one of the biggest medical scandals in the history of the United States of America. I speak to you in the hope that you will have the courage to bring this scandal to an end and assure that other vulnerable teenagers, children, and young adults don't go through what I went through.

At the age of 12, I began to experience what my medical team would later diagnose as gender dysphoria. I was well into an early puberty, and I was very uncomfortable with the changes that were happening to my body. I was intimidated—I was intimidated by male attention, and when I told my parents that I felt like a boy, in retrospect, all I meant was that I hated puberty; that I wanted this newfound sexual attention to go away; that I looked up to my brothers a little bit more than I did to my sisters.

I came out as transgender in a letter I sat on the dining room table. My parents were immediately concerned. They felt like they needed to get outside help from medical professionals, but this proved to be a mistake. It immediately set our entire family down a path of ideologically motivated deceit and coercion.

The gender specialist I was taken to, taken to see, told my parents that I needed to be put on puberty-blocking drugs right away. He asked my parents a simple question: "Would you rather have a dead daughter or a living transgender son?"

That choice was enough for my parents to let their guard down, and in retrospect, I can't blame them. This is the moment that we all became victims of so-called gender-affirming care.

I was fast-tracked onto puberty blockers, and then, testosterone. The resulting menopausal-like hot flashes made focusing on school impossible. I still get joint pains and weird pops in my back, but they were far worse when I was on the blockers.

A month later, when I was 13, I had my first testosterone injection. It's caused permanent changes to my body. My voice will forever be deeper; my jawline sharper; my nose longer; my bone structure permanently masculinized; my Adam's apple more prominent; my fertility unknown. I look in the mirror sometimes and I feel like a monster.

I had a double mastectomy at 15. They tested my amputated breasts for cancer, and I was cancer-free, of course. I was perfectly healthy. There was nothing wrong with my still-developing body or breasts, other than that, as an insecure teenaged girl, I felt awkward about it.

After my breasts were taken away from me, the tissue was incinerated. Before I was able to legally drive, I had part, I had a huge part of my future womanhood taken from me. I will never be able to breastfeed. I struggle to look at myself in the mirror at times.

I still struggle to this day with sexual dysfunction, and I have massive scars across my chest and skin grafts that they used, that they took from my nipples, are weeping fluid today, and they were grafted into a more masculine positioning, they said.

After surgery, my grades in school plummeted. Everything that I went through did nothing to address my underlying mental health issues that I had. My doctors with their theories on gender thought that all my problems would go away as soon as I was surgically transformed into something that vaguely resembled a boy.

Their theories were wrong. The drugs and surgeries changed my body, but they did not, and could not, change the basic reality that I am, and forever will be, a female.

When my specialists first told my parents that they could have a dead daughter or a live transgender son, I wasn't suicidal. I was a happy child who struggled because she was different. However, at 16, after my surgery, I did become suicidal. I'm doing better now, but my parents almost got the dead daughter promised to them by my doctors. My doctors had almost created the very nightmare they said they were trying to avoid.

So, what message do I want to bring to American teenagers and their families? I didn't need to be lied to. I needed compassion. I needed to be loved. I needed to be given therapy to help me work through my issues, not affirming my delusion that, by transforming into a boy, it would solve all my problems.

We need to stop telling 12-year-olds that they were born wrong; that they are right to reject their own bodies and feel uncomfortable with their own skin. We need to stop telling children that puberty is an option; that they can choose what kind of puberty they will go through, just like they can choose what clothes to wear or what music to listen to. Puberty is a rite of passage to adulthood, not a disease to be mitigated.

Today, I should be at home with my family celebrating my 19th birthday, and instead, I'm making a desperate plea to my elected, my elected Representatives: Learn the lessons from other medical scandals, like the opioid crisis; to recognize that doctors are human, too, and sometimes they are wrong.

My childhood was ruined, along with thousands of detransitioners that I know through our networks. This needs to stop. You alone can stop it. Enough children have already been victimized by this barbaric pseudoscience. Please let me be your final warning.

Thank you.

Mr. JOHNSON of Louisiana. Today is your birthday?

Ms. COLE. It is.

Mr. JOHNSON of Louisiana. You're a beautiful, brave woman. Thank you for being here.

Ms. COLE. Thank you.

Mr. JOHNSON of Louisiana. Ms. Reynolds, you're next. You may begin.

STATEMENT OF MYRIAM REYNOLDS

Ms. REYNOLDS. Good morning.

My name is Myriam Reynolds. I'm a licensed professional Counselor, a fifth-generation Texan descending from a long line of conservative Christians, and I'm the mother of a transgender son.

I am honored to be here today to give my testimony and tell you the story of my incredible child. He recently became an adult, and I will still refer to him as a child.

His name is Cameron, and he is 18 years old. He recently graduated from high school and is embarking on, embarking on adulthood with a gap year before college.

Cameron told us he was transgender when he was 11 years old. He was clearly dealing with something, but we didn't know what it was or how to help him. Then, he told us.

My husband and I had the same instinct to tell him that we love him, no matter what, and always will be there for him. We needed—we knew we needed to affirm him from our years in working with foster youth. We had no idea what to do next. We were scared. We didn't know anyone who had a trans child. We had never even heard of gender-affirming care.

I prayed that it was a phase, but already knew that it wasn't. The signs had been there all along. We just didn't understand them. We thought he was a tomboy. He refused to wear anything pink or girlie and was the only girl on the boys' football team for many years. His best friends were always boys. There were a lot of signs, looking back.

As parents, all we really want for our children is for them to be happy and healthy. Prior to receiving gender-affirming care and socially transitioning, my child was not happy and was not able to be his true self.

I didn't want him to have to face the struggles of being transgender, but I did want him to be happy and himself. At times, I grieved my little girl and felt as if she were gone. It was hard on me at first, but I was able to put my child's needs before my feelings and find him the care he needed. I could see that my child was happier and felt more and more comfortable the more he was affirmed.

We were living in Colorado at the time, and through some research, found a comprehensive program at a local hospital that provided healthcare to trans kids. We found him a counselor, immediately began trying to provide him with the best healthcare we could find.

We felt very fortunate to have access to a multidisciplinary team of professionals who could help us figure out what options we had for Cameron's healthcare. I could not imagine having to manage legal restrictions of medical care, in addition to talking to our extended family, all while learning ourselves about treatment options and caring for our child.

Later that year, we decided to move to Texas. We began researching leading programs in the field of trans healthcare and were able to find a similar program. We chose to move to a town based on proximity to the clinic. We knew we needed the support of experts. We had an appointment scheduled before we even arrived in Texas or had any idea of our health insurance coverage.

Our multidisciplinary team at the clinic consisted of physicians, nurses, social workers, psychologists, medical students, my son's counselor, the school counselor, my husband and I as parents/decisionmakers, and my son as a patient.

We filled out many, many surveys and questionnaires. Myself, Cameron, and his dad were all required to do so. We had extensive interviews with social workers and psychologists who had requested a letter from Cameron's previous provider prior to our first appointment.

The intake process was lengthy and meticulous. The process was daunting, but I was grateful that the team was so thorough. I want to make it clear that the care we received was slow, very thoughtful, provided with the utmost care and consideration. There was no rush, absolutely no coercion, lots and lots of double-checking and making sure we were all on the same page.

At the time, Cameron felt it was all moving too slowly. In retrospect, we can see clearly that it was the best thing for us to move so slowly on medical interventions, so we could properly weigh the pros and cons.

My son was asked at every appointment if he wanted to stop treatment or if he had any concerns about treatment whatsoever. Counseling was taking place the entire time. Cameron's counselor would also meet with the doctor and my husband and I, before medical interventions were decided on.

The interventions my son has had—with extreme consideration, consent, and discussion—have been counseling, first and foremost; puberty blockers, and hormone therapy. We have not even considered any kind of surgery and my child is 18. If any physician or member of the treatment team had suggested surgery to us when Cameron was a child, we would have said, "No, thank you," and immediately gotten a second or third opinion.

With the benefit of hindsight, I have no doubt that the healthcare of my son accessed was lifesaving. I am grateful that we have had access to this incredibly crucial, medically necessary healthcare for our son without the interference of our government.

Cameron is thriving now. He is doing better than he ever has. He has wonderful friends. He is dating a little. He has spoken out publicly and has the love and support of his whole family, including two grandparents who are staunch conservative, Christian Republicans.

We can all see that this is who he is. The grandparents don't fully understand what being transgender really means, but they love and accept him.

I'm asking you today to please allow parents the right to access and consent for healthcare for their children. This decision should be made with parents, the child, and the child's medical providers without government interference.

Thank you.

[The prepared statement of Ms. Reynolds follows:]

Written Testimony of Myriam Reynolds
27 July 2023

Good morning. My name is Myriam Reynolds. I'm a licensed professional counselor, a fifth generation Texan descending from a long line of conservative Christians, and I'm the proud mother of a transgender son.

I am honored to be here today to give you my testimony and tell you the story of my incredible child. He recently became an adult and I will still refer to him as my child. His name is Cameron and he is 18 years old. He recently graduated from high school and is embarking on adulthood with a gap year before college.

Cameron told us he was transgender when he was 11 years old. He was clearly dealing with something but we didn't know what it was or how to help him. But then he told us. My husband and I had the same instinct to tell him that we love him no matter what and that we will always be there for him. We knew we needed to affirm him from our years working with foster care youth. We had no idea what to do next. We were scared. We didn't know anyone who had a trans child. We had never even heard of gender affirming care. I prayed that it was a phase, but already knew that it wasn't. The signs had been there all along, we just didn't understand them. We thought he was a tomboy. He refused to wear anything pink or girlie and was the only girl on the boys football team for many years. His best friends were always boys. There were a lot of signs looking back.

As parents, all we really want is for our children to be happy and healthy. Prior to receiving gender affirming care and socially transitioning, my child was not happy and not able to be his true self. I didn't want him to have to face the struggles of being transgender, but I did want him to be happy and himself. At times, I grieved my little girl and felt as if she was gone. It was hard on me at first, but I was able to put my child's needs before my feelings and find him the care he needed. I could see that my child was happier and felt more and more comfortable the more he was affirmed.

We were living in Colorado at the time and through some research found a comprehensive program at a local hospital that provided healthcare to trans kids. We found him a counselor and immediately began trying to provide our child with the best healthcare we could find. We felt very fortunate to have had access to a multidisciplinary team of professionals who could help us figure out what options we had for Cameron's healthcare. I could not imagine having to manage legal restrictions of medical care in addition to talking to our extended family all while learning ourselves about our treatment options and caring for our child.

Later that year, we decided to move to Texas. We began researching leading programs in the field of trans healthcare and we were able to find a similar program. We chose to move to a town based on the proximity to the clinic. We knew we needed the support of experts. We had an appointment scheduled before we even arrived in Texas or had any idea of our health insurance coverage. Our multidisciplinary team at the clinic consisted of physicians, nurses, a

social worker, psychologist, medical students, my son's counselor, the school counselor, my husband and I as parents/decision makers and my son as the patient. We filled out many, many surveys and questionnaires- myself, Cameron and his dad were all required to do so. We had extensive interviews with the social worker and psychologist who had requested a letter from Cameron's previous provider prior to our first appointment. The intake process was lengthy and meticulous. The process was daunting, but I was grateful that the team was so thorough. I want to make it clear that the care we received was slow, very thoughtful, provided with the utmost care and consideration. There was no rush, absolutely no coercion, lots and lots of double checking and making sure we were all on the same page. At the time, Cameron felt it was all moving too slowly. In retrospect, we can see clearly that it was the best thing for us to move so slowly on any medical interventions so we could properly weigh the pros and cons. My son was asked at every appointment if he wanted to stop treatment or if he had any concerns about treatment whatsoever. Counseling was taking place the entire time and Cameron's counselor would also meet with the doctor and my husband and I before medical interventions were decided upon. The interventions my son has had, with extreme consideration, consent and discussion have been counseling, first and foremost, puberty blockers and hormone therapy. We have not even considered any kind of surgery and my child is 18. If any physician or member of the treatment team had suggested surgery to us when Cameron was a child, we would have said no thank you and immediately gotten a second and third opinion.

With the benefit of hindsight, I have no doubt that the healthcare my son accessed was life saving. I am grateful that we had access to this incredibly crucial, medically necessary healthcare for our son without the interference of our government. Cameron is thriving now. He is doing better than he ever has! He has wonderful friends, is dating a little, has spoken out publicly and has the love and support of the whole family including two grandparents who are staunch conservative Christian Republicans. We can all see that this is who he is. The grandparents don't fully understand what being transgender really means, but they love and accept him.

I am asking you today to please allow parents the right to access and consent to healthcare for their children. These decisions should be made with parents, the child, and the child's medical providers without government interference.

Mr. JOHNSON of Louisiana. Thank you, Ms. Reynolds.

Ms. Mailman, you're next. You may begin. Push that button for me.

STATEMENT OF MAY MAILMAN

Ms. MAILMAN. I'm May Mailman, Senior Fellow with the Independent Women's Law Center, the legal advocacy arm of Independent Women's Forum and Independent Women's Voice. I am also a mother to my eight-month-old daughter. I am testifying here today in support of her future, her freedom, and her equal opportunity.

My fellow panelists have covered the pernicious effects of gender ideology on children and their futures. I am here to address another way in which gender ideology destroys women and girls, and that is by dissolving legal protections for women in athletics.

Until recently, female student athletes might have thought that they were protected by Title 9 of the Education Amendments of 1972, and they were. That's because Title 9 is very simple. It prohibits discrimination on the basis of sex in programs run by schools that accept Federal money, and that's, basically, all of them, and those programs include sports.

Title 9 recognizes that providing equal opportunity for the sexes can mean recognizing inherent differences between the sexes. That's why the Title 9 statute explicitly allows schools to provide different living arrangements for the sexes. So, too, in sports.

In introducing Title 9, Senator Birch Bayh explained that Title 9 would not require sticking women on men's football teams. That's why Congress explicitly asked that the initial Title 9 regulations include, "reasonable provisions considering the nature of particular sports."

So, for 50 years, the Title 9 athletics regulation has explicitly permitted sex-based teams, "where selections for such teams is based on competitive skill or involves a contact sport." Importantly, the regulations also require that schools must provide equal opportunities for members of both sexes.

Unfortunately, in April of this year, the Department of Education proposed a rule that, if adopted, would flip Title 9 on its head. The proposed rule would modify the athletic regulation to let schools compete on teams consistent with their gender identity, unless a particular school can demonstrate to the satisfaction of the Department of Education that this policy would be too unfair or unsafe. In other words, women are no longer granted female sports teams as a given. We have to prove that we need it.

Of course, we do need it. Studies show that even testosterone suppression cannot eliminate the male advantage—except schools are not to be allowed to say that, as a general matter, post-pubescent biological males playing women's sports puts female athletes at risk of injury and losing playing time, medals, and privacy. No, schools are going to have to prove to Federal bureaucrats that allowing a biological male on a women's team would be unfair or unsafe in this particular sport with respect to these particular athletes.

No school is going to want to take on that litigation risk. So, schools are going to allow biological males to compete on women's

sports. This will directly and overwhelmingly harm female athletes who are far more likely to be displaced by a male athlete, than vice versa, and far more likely to face risks in private spaces like locker rooms.

Even if it were a good idea to reduce educational opportunities for women like this, the Department of Education may not do so unless this body has authorized it, but Congress has done no such thing.

The Department of Education says that the Supreme Court's decision in *Bostock* v. *Clayton County* means it can pretend that Title 9 addresses gender identity, but the Department of Education is wrong. In Bostock, the Supreme Court said that Title 7 of the Civil Rights Act prohibits employers from firing someone just because they are transgender. The decision says that an employee's sex is not relevant to the selection, evaluation, or compensation of employees.

Athletes in education, however, is governed by a different law, Title 9. When it comes to athletes, sex is not only relevant, but also often dispositive. As superstar Serena Williams said, "Men's and women's tennis are completely different sports."

We live in a Nation of laws and not bureaucratic command. That means the Department of Education must find its authorities in the laws that this legislative body has considered and passed. It may not use gender ideology to twist a simple antidiscrimination statute into a statute that reduces opportunities for women.

Thank you.

[The prepared statement of Ms. Mailman follows:]

Testimony before the U.S. House Judiciary Committee
Subcommittee on the Constitution
"The Dangers and Due Process Violations of 'Gender-Affirming Care'"

May Mailman
Senior Fellow
Independent Women's Law Center
July 27, 2023

I am May Mailman, a senior fellow with the Independent Women's Law Center, the legal advocacy arm of Independent Women's Forum (IWF) and Independent Women's Voice (IWV). IWF is a 501(c)(3) nonprofit organization founded by women to foster education and debate about liberty, personal responsibility, and the limited reach of government. IWV is a 501(c)4) organization that fights for women by expanding support for policies that enhance freedom, opportunity, and well-being.

I am, most recently, Deputy Solicitor General and Director of the Tenth Amendment Center for the State of Ohio. There, I litigated cases and drafted comment letters to oppose the unconstitutional expansion of the federal administrative state, including successfully challenging the private sector vaccine mandate in the Supreme Court. The State of Ohio has written and joined multiple comment letters explaining the Biden Administration's lack of statutory authority to eliminate protections for women, girls, and parents.

I also served as a counsel in the White House from 2019 through 2021, where I focused on health care, immigration, education, and women's issues. My responsibilities included defining the appropriate, and often limited, reach of agency authority in these areas.

Finally, I am a mother to my 8-month-old daughter. I am testifying today in support of her future, her freedom, and her equal opportunity.

1. **The aggrandizement of gender ideology over sex-based protections has claimed many victims.**

My fellow panelists have discussed the pernicious effects of gender ideology on children who have been stripped of their futures, and parents who have been torn from their sacred rights and responsibilities.

I am here to address another way in which gender ideology destroys women and girls, by dissolving legal protections for women in athletics.

2. **Women and girls should not have to seek accommodation to participate in women's sports.**

Until recently, female student-athletes may have thought they were protected by Title IX of the Education Amendments of 1972. And they were.

Title IX is simple. It prohibits discrimination *on the basis of sex*[1] in any program or activity, including athletics, run by a school that accepts federal money (which is almost all of them).

Importantly, Title IX recognizes that providing equal opportunity can require recognizing inherent differences between the sexes.[2] For example, the statute expressly permits schools to maintain "separate living facilities for the different sexes."[3] It contains express exceptions for fraternities and sororities.[4] It makes exceptions for "the Young Men's Christian Association, Young Women's Christian Association, Girl Scouts, Boy Scouts, Camp Fire Girls, and [other] voluntary youth service organizations" that "traditionally [have] been limited to persons of one sex."[5] It carves out "any program or activity of the American Legion undertaken in connection with the organization or operation of any Boys State conference, Boys Nation conference, Girls State

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[1] Specifically, Title IX states: "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance." 20 U.S.C § 1681.
[2] *See United States v. Virginia*, 518 U.S. 515, 533 (1996) (Ginsburg, J.) ("Physical differences between men and women … are enduring: '[T]he two sexes are not fungible; a community made up exclusively of one [sex] is different from a community composed of both.'") (quoting *Ballard v. United States*, 329 U.S. 187, 193 (1946)).
[3] 20 U.S.C. § 1686.
[4] *Id*. § 1681(6)(A).
[5] *Id*. § 1681(6)(B).

conference, or Girls Nation conference."[6] And it permits "father-son or mother-daughter activities" provided that if they are offered "for students of one sex" they are offered "for students of the other sex" as well.[7]

So too in sports. When introducing Title IX, Senator Birch Bayh explained that Title IX would not "mandate[ ] the desegregation of football fields."[8] In recognition of the uniqueness of women and men when it comes to sports, Congress directed that Title IX's implementing regulations must include "reasonable provisions considering the nature of particular sports."[9]

For 50 years, the Title IX athletics regulation has explicitly permitted sex-based teams "where selection for such teams is based upon competitive skill or the activity involved is a contact sport."[10] And, the school must "provide equal athletic opportunity for members of both sexes."[11]

This has benefitted the women who for so long were locked out of athletic opportunities. When Title IX was enacted, about 294,000 girls participated in high school sports each year— compared to over 3.6 million boys.[12] By 2018, over 3.4 million girls were playing high-school sports.[13]

Unfortunately, in April 2023, the Department of Education proposed a rule that, if adopted, would flip Title IX on its head. The proposed rule would modify the athletic regulation to require that schools let students compete on teams consistent with their gender identity unless a particular school can demonstrate, to the satisfaction of the Department of Education, that this

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[6] *Id.* § 1681(7)(A).
[7] *Id.* § 1681(8).
[8] 117 Cong. Rec. 30399, 30407 (1971).
[9] Education Amendments of 1974, Pub. L. 93-380, 88 Stat. 484, 612 (1974).
[10] 34 CFR § 106.41(b).
[11] 34 CFR § 106.41(c).
[12] Women's Sports Foundation, 50 Years of Title IX (2022), https://bit.ly/3V66cHW.
[13] Ibid.; *see also* Nat'l Ctr. for Educ. Stat., Fast Facts for Title IX, https://bit.ly/3npc1DR ("The girls' high school participation rate is greater than 11 times what it was when Title IX was passed, an increase of more than 1,000 percent.").

policy would be unfair or unsafe to the particular students affected on a particular team.[14]

In other words, the proposed rule upends the default position that women's sports are for biological females and establishes a new default position that women's sports are for anyone who identifies as a woman.[15] Indeed, the Department has said outright that "[u]nder the proposed regulation, schools would not be permitted to adopt or apply a one-size-fits-all policy that categorically bans transgender students from participating on teams consistent with their gender identity."

Women will therefore be forced to rely on their schools hurdling a legal bar to participate in female-only teams. One might think this hurdle is low. Studies make clear that testosterone suppression can never completely eliminate the athletic advantage of males who have experienced puberty.[16]

But that scientific fact won't be enough. The rule prohibits high schools and colleges from concluding that, in general, biological males on women's teams puts female athletes at risk of injury and losing playing time, medals, and privacy. Rather, the school would need to prove to federal bureaucrats that allowing a biological male to compete on a woman's varsity team would be unfair or unsafe in *this* specific sport and with respect to *these* particular athletes.

Because the burden of litigating the issue places a significant burden on schools with limited budgets and resources, it is likely that many schools will choose the path of least resistance and simply allow all students to compete on athletic teams consistent with their gender identity.

This, in turn, places a disproportionate burden on female students, who are far more likely to be displaced by biological males, than on male students,

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[14] The proposed rule states: "If a [school] adopts or applies sex-related criteria that would limit or deny a student's eligibility to participate on a male or female team consistent with their gender identity, such criteria must, for each sport, level of competition, and grade or education level: (i) Be substantially related to the achievement of an important educational objective; and (ii) Minimize harms to students whose opportunity to participate on a male or female team consistent with their gender identity would be limited or denied." 88 Fed. Reg. at 22891.

[15] *See* Comment of Independent Women's Law Center and Independent Women's Forum regarding implications of the Department of Education's proposed Title IX rule, *available at* https://bit.ly/450dPDg.

[16] Independent Women's Forum, *Competition, Second Ed.*, *available at* https://bit.ly/3OvkfVZ.

who have little to fear from female bodies seeking opportunities on men's teams. As related to biological uniqueness in size and strength, it is also women, not men, who face the risks in private spaces like locker rooms.

3. The Department of Education has no authority to mandate schools adopt gender-identity-based athletics.

Even if it were a good idea to reduce educational opportunities for women, the Department of Education may not do so unless Congress authorized it. Congress has done no such thing.

The Department believes that the Supreme Court's decision in *Bostock v. Clayton County*,[17] "leads to the conclusion that Title IX prohibits discrimination based on … gender identity."[18] That is false.

In *Bostock*, the Supreme Court held that Title VII of the Civil Rights Act prohibits employers from "fir[ing] someone simply for being … transgender."[19] But *Bostock* dealt only with hiring and firing in the employment context under Title VII. As the *Bostock* majority noted, "[a]n individual employee's sex is not relevant to the selection, evaluation, or compensation of employees."[20] Athletics in education, however, are governed by a different statute: Title IX. And when it comes to athletics, sex is not only relevant: it is often dispositive.

The Supreme Court has made clear that "discrimination" in the legal sense involves treating "similarly situated" people differently.[21] As Title IX recognizes, however, different treatment of the sexes is warranted when it comes to athletics because the two sexes are not similarly situated. In fact, the original athletic regulation adopted in 1975 explicitly contemplates separate athletic teams for males and females. *Bostock*'s conclusion that employment discrimination against a trans-identified person "necessarily entails discrimination based on sex" under Title VII,[22] is simply inapplicable to the

[17] 140 S. Ct. 1731 (2020).
[18] 86 Fed. Reg. 32637 (June 22, 2021).
[19] *Bostock*, 140 S. Ct. at 1753.
[20] *Id.* at 1741 (internal quotation marks omitted).
[21] *Bostock*, 140 S. Ct. at 1740.
[22] Id. at 1747.

athletics governed by Title IX, where males and females are not similarly situated.[23]

In sum, Title IX provides no basis for the Department of Education to implement a coast-to-coast policy mandating gender-identity-based sports.

Local communities can, of course, implement solutions that accommodate trans-identified students, so long as those solutions accord with Title IX. Or, schools may reject federal funds and the obligations that attach. But we live in a nation of laws and not bureaucratic command. And that means the Department of Education must find its authority in the laws this legislative body considered and passed. It may not use gender ideology to twist a simple anti-discrimination statute into a statute that reduces opportunities for women.

Thank you.

[23] *See Kleczek v. Rhode Island Interscholastic League, Inc.*, 612 A.2d 734, 738 (R.I. 1992) ("Because of innate physiological differences, boys and girls are not similarly situated as they enter athletic competition.").

Mr. JOHNSON of Louisiana. Thank you, Ms. Mailman.
Mr. Minter, now you may begin.

STATEMENT OF SHANNON MINTER

Mr. MINTER. Thank you.

My name is Shannon Minter. I am the Legal Director of NCLR. It's a legal organization that represents LGBTQ people.

In my 30 years with NCLR, 20 years as its Legal Director, I've represented many transgender young people in cases involving discrimination and harassment in schools, in the child welfare system, the healthcare system, other areas. Recently, I've been involved in Federal challenges to State laws that ban medical care for transgender younger people and completely banned them from school's sports.

I *really* appreciate the opportunity to address this Committee.

Parents should have the freedom to make healthcare decisions for their transgender children. Parents want what's best for their children. Americans differ about a lot of things, but there is one point on which we strongly agree, and that is that parents, not the government, are best situated to make medical decisions for their own children.

There's a lot of misinformation about transgender children, youth, and adolescents. Gender dysphoria is very rare, less than one percent of the population. Most people in this country don't know a transgender person, much less have they met parents with transgender children.

For most people and most legislators, this seems like a new issue, but medical care for transgender adolescents has been available for more than 20 years. The very same medications being prescribed for transgender youth have been prescribed for other young people for other conditions for more than 40 years.

There is a substantial body of research that shows these treatments work; they improve mental health outcomes, quality of life, social relationships, and family relationships. They dramatically reduce suicidality. One Federal judge, after a full trial, said there is now extensive clinical evidence showing excellent results for these treatments.

The medical standards for these treatments, as has been noted, have been endorsed by every major medical association in this country: The American Medical Association, the American Academy of Pediatrics, the American Psychological Association, and many more.

These standards, they're evidence based. They require a rigorous, multidisciplinary assessment before diagnosing the child with gender dysphoria. They take a conservative approach to treatment.

Those standards have been in place for a long time. They are not new. What is new is this recent massive overreach by State lawmakers to ban medical care for transgender youth. These laws, these recently passed State laws, they prevent doctors from doing their job. They prevent parents from getting the medical care that their children need.

That is why every Federal District Court, all six of them, after hearing all the evidence, have concluded these bans violate parents'

rights. They violate equal protection. The claims they put forward to justify, justify the bans have no basis.

These decisions, as has been noted, have been issued by a wide range of judges: Arkansas, Alabama, Florida, Indiana, Kentucky, and Tennessee. In every case, the State officials supporting these bans had every opportunity to back up their false claims with actual evidence. In each case, they have failed.

These bans pose a serious threat to the health and safety of transgender young people across the country, and I urge the Members of this Committee to reject any Federal attempts to replicate that harm.

As a transgender person myself, I have benefited from decades of access to healthcare, legal equality, support. I've been able to marry, have a family, pursue a career, participate in my local church, and community.

It is very disheartening to see the protections that have given me and other transgender people so many opportunities to thrive and to succeed now just being needlessly taken away from young people.

Healthcare bans conflict with medical expertise. They rob parents of their right to make decisions for their children. They have devastating consequences for young people's lives.

Decisions about children's medical care should be made by the parents who love them, not by politicians who know nothing about a child's life or history or circumstances, and who won't be the ones having to watch a young person they love suffer the devastating consequences of going without needed medical care.

Thank you.

[The prepared statement of Mr. Minter follows:]

United States House of Representatives

Committee on the Judiciary

Subcommittee on the Constitution and Limited Government

"The Dangers and Due Process Violations of 'Gender-Affirming Care' for Children"

July 27, 2023

Testimony of Shannon Minter, Legal Director of the National Center for Lesbian Rights

My name is Shannon Minter. I am the Legal Director of the National Center for Lesbian Rights (NCLR), a legal organization that represents LGBTQ people and their families across the country. Since 1977, NCLR has sought to advance the civil and human rights of LGBTQ people through litigation, policy, and public and community education. Throughout its history, NCLR has played a leading role in advocating for the equality, humanity, and dignity of transgender people. During my 30 years with NCLR and over 20 as its legal director, I have represented many transgender young people in cases involving discrimination and harassment in schools, the child welfare system, the healthcare system, and other areas. Recently, I have been involved in federal challenges to state laws that prevent transgender adolescents from receiving essential medical care and participating in school sports. Thank you for the opportunity to submit testimony to the Committee on Judiciary, Subcommittee on the Constitution and Limited Government.

This Committee should ensure that parents of transgender youth have the continued freedom to make responsible healthcare decisions for their children. Any parent whose child is in

need wants to be able to seek expert medical advice—and act on that advice if it will enable their child to thrive. Americans may have differing views on many issues, but there is one point on which we strongly agree: parents, not the government, are best situated to make medical decisions for their children.

There is a lot of misinformation about transgender youth and adolescents. Gender dysphoria is rare,[1] so it's not surprising that many people in this country do not know a transgender person or the parents of a transgender child. For most people and most legislators, this appears to be a new issue. But it is not a new issue for parents of transgender youth or for the medical community.

Evidence-based medical care for transgender adolescents has been available for more than twenty years.[2] The same medications prescribed for transgender youth have been prescribed for non-transgender youth for a variety of other medical conditions for even longer—more than forty years.[3] There is a substantial body of medical research demonstrating that these medications are safe and effective. This includes longitudinal studies showing that transgender adolescents who receive the care they need have the same mental health outcomes as their non-

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[1] The DSM-5 estimates that less than 1 % of children and adolescents have gender dysphoria. *Diagnostic and Statistical Manual of Mental Disorders* 5. American Psychiatric Association. 2013. p. 454. ISBN 978-0-89042-555-8.

[2] Carswell, Jeremi M., Ximena Lopez, and Stephen M. Rosenthal. "The Evolution of Adolescent Gender-Affirming Care: An Historical Perspective." *Hormone Research in Paediatrics* 95.6 (2022): 649-656; Coleman, Eli, Asa E. Radix, Walter P. Bouman, George R. Brown, Annelou LC De Vries, Madeine B. Deutsch, R. Ettner, et al. "Standards of Care for the Health of Transgender and Gender Diverse People, version 8." *International Journal of Transgender Health* 23, no. sup1 (2022): S1-S259.

[3] *See Ecknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1145 (2022) ("[The record shows that medical providers have used transitioning medications for decades to treat medical conditions other than gender dysphoria, such as central precocious puberty, a condition in which a child enters puberty at a young age. Doctors have also long used hormone therapies for patients whose natural hormone levels are below normal.").

transgender peers.[4] In contrast, when left untreated, gender dysphoria puts transgender young people at risk of very serious harms, including depression, anxiety, and suicidality.[5]

The medical community has spoken with one voice following decades of research and clinical care. All of our country's major medical associations agree about the approach to care, which emphasizes personalized treatment and is based on medical standards of care developed by the Endocrine Society, the leading professional association of endocrinologists, and the World Professional Association for Transgender Health.[6] These standards have been endorsed by every

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[4] *See, e.g.*, Olson, Kristina R., Lily Durwood, Madeleine DeMeules, and Katie A. McLaughlin. "Mental health of transgender children who are supported in their identities." *Pediatrics* 137, no. 3 (2016); Achille, Christal, Tenille Taggart, Nicholas R. Eaton, Jennifer Osipoff, Kimberly Tafuri, Andrew Lane, and Thomas A. Wilson. "Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results." *International Journal of Pediatric Endocrinology* 2020, no. 1 (2020): 1-5; Chen, Diane, Johnny Berona, Yee-Ming Chan, Diane Ehrensaft, Robert Garofalo, Marco A. Hidalgo, Stephen M. Rosenthal, Amy C. Tishelman, and Johanna Olson-Kennedy. "Psychosocial functioning in transgender youth after 2 years of hormones." *New England Journal of Medicine* 388, no. 3 (2023): 240-250.

[5] *See, e.g.*, Turban, Jack L., Dana King, Jeremi M. Carswell, and Alex S. Keuroghlian. "Pubertal suppression for transgender youth and risk of suicidal ideation." *Pediatrics* 145, no. 2 (2020) (finding that transgender people who received puberty blockers as adolescents have a lower risk of suicidal thoughts as adults than those who wanted them but were unable to receive them); Kuper, Laura E., Sunita Stewart, Stephanie Preston, May Lau, and Ximena Lopez. "Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy." *Pediatrics* 145, no. 4 (2020) (finding that transgender adolescents who received hormone therapy had improved mental health measures); Tordoff, Diana M., Jonathon W. Wanta, Arin Collin, Cesalie Stepney, David J. Inwards-Breland, and Kym Ahrens. "Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care." *JAMA Network Open* 5, no. 2 (2022): e220978-e220978 (finding that treatment with puberty blockers or hormones was associated with 60% less moderate to severe depression and 73% less suicidal ideation, compared to youth not treated).

[6] *See* Hembree, Wylie C., Peggy T. Cohen-Kettenis, Louis Gooren, Sabine E. Hannema, Walter J. Meyer, M. Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha, and Guy G. T'Sjoen. "Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline." *The Journal of Clinical Endocrinology & Metabolism* 102, no. 11 (2017): 3869-3903, (Endocrine Society Guidelines); Coleman, *supra* n. 2 (WPATH Guidelines).

major medical association in the country, including the American Medical Association, the American Academy of Pediatrics, the American Psychological Association, and many others.[7]

These standards reflect the best available scientific research. They require a rigorous multidisciplinary assessment before diagnosing a child with gender dysphoria and take a conservative approach to treatment. As one federal court noted, "minors and their parents undergo a thorough screening process and give informed consent before any treatment begins."[8]

This medical standard has been in place for a long time. It is not new. What is new is recent, massive overreach by state lawmakers to ban essential medical care for transgender youth. These recently passed state laws prevent parents from getting their children the medical care they need. They stand in the way of doctors being able to use evidence-based standards to treat their patients.

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[7] *See Ecknes-Tucker*, 603 F. Supp. At 1139 ("The American Medical Association, the American Pediatric Society, the American Psychiatric Association, the Association of American Medical Colleges, and at least eighteen additional major medical associations endorse these guidelines as evidence-based methods for treating gender dysphoria in minors."). *See also* American Medical Association. (2021, April 26). Letter to National Governor's Association, *available at:* https://searchlfamaassn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf; American Academy of Pediatrics, *Policy Statement: Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents* (2018), *available at*: https ://pediatrics.aappublications.org/content/142/4/e20182162; American Psychological Association, *APA Resolution on Gender Identity Change Efforts* (2021), *available at*: https ://www.apa.org/about/policy/resolution-gender-identitychange-efforts.pdf; American College of Obstetricians and Gynecologists, *Committee Opinion No. 823: Health Care for Transgender and Gender Diverse Individuals* (2021), *available at*: https ://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-carefor-transgender-and-gender-diverse-individuals; American Academy of Family Physicians. (2020). Care for the Transgender and Nonbinary Patient. Available at: www.aafp.org/about/policies/all/transgender-nonbinary.html.

[8] *See Ecknes-Tucker*, 603 F. Supp. at 1142.

That is why six federal district courts, after hearing all the evidence, have concluded that these bans violate fundamental constitutional guarantees of due process and equal protection, and that the claims put forward to justify them have no factual basis. Court decisions have been issued by a wide range of judges, including three judges appointed by President Trump, in states including Arkansas, Alabama, Florida, Indiana, Kentucky, and Tennessee. In each case, the state officials promoting these bans have had every opportunity to back up their false claims with actual evidence, and in each case, they have failed. And in each case, courts have found that transgender youth are benefitting from receiving care and that banning it would cause them serious, irreparable harm. As one court found: "If allowed to take effect, [Kentucky's ban] would eliminate treatments that have already significantly benefited [the minor plaintiffs] and prevent other transgender children from accessing these beneficial treatments in the future."[9]

These state medical bans pose a grave threat to the health and safety of transgender youth across this country. I urge the members of this committee to reject any federal attempt to replicate this harm. Decisions about children's medical care should be made by the parents who love them—not elected officials who know nothing about a child's life or history and who will not have to live with the consequences of watching a young person they love suffer the devastating consequences of going without needed medical care.

As a transgender person myself, I have benefitted from decades of access to healthcare, growing legal equality, and support. Because of that progress, I have been able to marry, have a family, pursue a career, and participate in my local church and community. It is disheartening to see the protections that have allowed me to thrive being needlessly taken away from youth. Bans on healthcare for transgender youth conflict with medical expertise, undermine parents' abilities to make responsible medical decisions for their children, and have devasting consequences for young people's lives.

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[9] *Doe 1 v. Thornbury*, No. 3:23-CV-230-DJH, 2023 WL 4230481, at *6 (W.D. Ky. June 28, 2023).

Mr. JOHNSON of Louisiana. Thank you, Mr. Minter.
Dr. Bauwens, last, but not least, you may begin.

STATEMENT OF JENNIFER BAUWENS

Ms. BAUWENS. Chair Johnson, Ranking Member Scanlon, Members of the Subcommittee, thank you for the opportunity to speak with you today.

My name is Dr. Jennifer Bauwens, and I'm a licensed therapist, clinical researcher, currently serving as the Director of the Center for Family Studies at Family Research Council.

Based on over 25 years of experience as a clinician providing trauma therapy to children, and as a researcher investigating the psychological effects of trauma stress, I'm here to express my concern about what has been termed gender-affirming care.

I've considered it a privilege to practice, research, and train future clinicians, and be a part of a discipline aimed at protecting and bringing healing to the most vulnerable in our society, which are children. When it comes to gender transition procedures, my field is not operating as a helping profession. Instead, it is actively causing harm.

Historically, children have been treated as a special and vulnerable class in the psychological and research fields. Caution has been applied to children, in light of the fact that they do not have the neurological capacity to understand lifelong decisions.

Professional and research ethics tell us that we should proceed very cautiously with regards to interventions for children when empirical evidence is weak or the research methods are in the early phase, as with this case. We should avoid interventions that pose unnecessary risks, particularly when the symptoms are known to change with maturation.

Risk avoidance is not what's happening with gender transition procedures. Instead, we have too many cases like Mike. Mike was nine years old when he first saw a gender therapist. I was deeply saddened when I read his gender therapist's case notes, where it was reported that Mike couldn't distinguish between fantasy and reality.

Instead of investigating these symptoms, the therapist wrote in the treatment plan, which included puberty blockers, guidance on social transition, and education for future hormonal and surgical procedures. This treatment plan was enacted without regard for this child's known diagnoses of autism, possible OCD, and possible parental diagnoses which were reported in the case notes.

Mike is just one example of how so-called gender-affirming care is in direct opposition of knowledge, of our knowledge regarding development and our understanding of good research and treatment. There are many reasons why I have concerns, but I will just share a few with you:

(1) These interventions are being endorsed based on consensus, not evidence. In the case of gender-affirming care, the term "evidence-based" does not mean that this practice is standing on the merits of solid research findings addressing gender dysphoria. Instead, it refers to a vote by those who are ideological supporters of the practice. Compared to other psychological disorders found in the DSM–5–TR, gender dysphoria is currently being treated with

the most invasive, invasive interventions connected to a psychological issue with the lowest quality of evidence to support that practice.

(2) The success rates of nonintervention for gender dysphoria for children already exceed what most psychological interventions have. In most cases, 85 percent or more of those experiencing gender dysphoria will desist if they are left alone. This is a higher rate than most well-established and researched psychological interventions. With success rates this high, it is actually unethical to intervene.

(3) The research and practice around this issue does not properly account for competing diagnoses and variables. So, in one example, a report from the UCLA Williams Institute found that 45 percent of transgender-identifying people reported childhood sexual abuse.

As a trauma clinician, I can tell you that, when someone experiences sexual trauma, it is not uncommon for that person to hate parts of their body or want to get rid of those aspects of themselves that made them vulnerable to abuse.

(4) It is often claimed that a failure to provide these interventions increases the risk for suicide. This approach is actually unethical and it's a clear departure from the practice of empowerment and self-management, which are important goals of mental health practice.

This claim is, also, not supported by the literature. Despite years of empirical study, there is no definitive understanding of the etiology in the suicide literature.

(5) After review of the literature, other countries have actually backed away from gender transition procedures, and the list now includes the United Kingdom, France, Finland, Norway, Australia, and Sweden.

(6) Gender-affirming care has created a monopoly on treatment options, as it demands that it is the only way to treat gender dysphoria. By comparison, we can look at Cochrane Collaboration, for example. There are 245 meta-analytic reviews of varied treatment options for depression. Yet, when it comes to gender dysphoria, there is only one path currently prescribed to help someone, and that's to become someone else.

Researchers and clinicians should be innovating solutions to heal the stress, not coercing kids onto a path that tells them that they need to remove or change physical parts of who they are to be whole. This is why I'm calling on you to act on behalf of children.

Thank you.

[The prepared statement of Ms. Bauwens follows:]

July 2023

Testimony on the Dangers of Gender-Affirming Care

Jennifer Bauwens, Ph.D.
Center for Family Studies at Family Research Council

Chairman Johnson, Ranking Member Scanlon, and members of the Sub-committee:

Thank you for the opportunity to speak with you today. My name is Dr. Jennifer Bauwens. I am a licensed therapist and clinical researcher currently serving as Director of the Center for Family Studies at Family Research Council. Based on over 25 years of experience as a clinician providing trauma therapy to children and as a researcher investigating the psychological effects of traumatic stress, I am here to express my concern about what has been termed "gender-affirming care" for children.

I have considered it a privilege to practice, research, and train future clinicians and be a part of a discipline aimed at protecting and bringing healing to the most vulnerable in our society—children. But when it comes to gender transition procedures, my field is not operating as a helping profession. Instead, it is actively causing harm.

Historically, children have been treated as a special and vulnerable class in the psychological and research fields. This followed a series of highly unethical and dangerous medical studies that came into public view (*e.g.*, Tuskegee). The need for ethical research standards culminated with the passage of the National Research Act of 1974 and the subsequent Belmont Report of 1979. The Belmont Report gave guidance for ensuring that research practices were nonexploitative. For this reason, children, as well as

those with intellectual disabilities and other groups of people who could be targeted with coercive treatment and research protocols, were to be afforded extra precautions. Of course, greater caution was applied to children in light of the fact that they do not have the developmental capacity to understand life-long decisions. How many of you wish you could change something you did in elementary or high school?

Even if natural observation wasn't enough to confirm the need for extra precautions for children, neurological science tells us why this is the case. A large-scale study of 20,000 brain scans funded by the National Institutes of Health found that the brain continues to develop into a person's mid-twenties.[1] 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 is still undergoing major change. Importantly, this structure is known to play a role in many mental disorders. It also takes the longest to reach structural norms. Again, most people do not reach these norms until their twenties. Hence, the reason why the psychological, medical, and research fields have instituted ethical safeguards to move conservatively with regard to interventions, particularly when the evidence is weak, or the research methods and agenda are in the early phases (which is the case in transgender research).

Sadly enough, some in my profession have set aside this basic understanding of child neurological, emotional, and cognitive development. Instead, they have embraced what has been referred to as "gender-affirming care," which permanently alters the human psyche and physiology through puberty blockers, cross-sex hormones, and surgical procedures to remove healthy body parts.

Incidentally, compared to other psychological disorders found in the DSM V-TR, gender-affirming care is the most invasive and unnecessary physiological intervention connected to a psychological issue. Gender-affirming care is also in direct opposition to the basic practices of good mental health treatment.

1) As I already mentioned, this experimental practice has been administered to children despite our understanding of a child's developmental capacity to truly give **informed consent** for social and physiological interventions that have life-long consequences.

2) The state of the scientific literature is based on consensus, not evidence. This means that people who have an interest in transgenderism joined a committee on the topic and voted on the use of gender-affirming care rather than promoting it based on the merits of the research findings addressing gender dysphoria, which are quite poor.

In fact, based on the research methods alone, never mind the topic of inquiry (*i.e.*, cross-sectional, self-selected samples, no RCTs, missing significant variables), gender-affirming practices should never have been allowed on anyone, particularly a child.

3) Therefore, it is no surprise that the benefits do not outweigh the risks. If I told you that 85 percent of research participants no longer had anxiety, posttraumatic stress, etc., after going through my treatment program, I'd be the next multimillion-dollar grant recipient of NIH funds, and suddenly you'd see clinics everywhere adopting my new treatment. This success rate is already true for gender dysphoric children.[2] If we provide basic supportive therapy or simply leave children alone, they will desist. Given this, gender-affirming care is not only unnecessary but potentially interrupts a natural developmental process.

4) Good mental health assessment and research accounts for competing diagnoses (variables in the research context). This one-size fits all approach to gender dysphoria emphasizes the source of psychological distress as related to an issue of acceptance. This is done at the expense of a thorough understanding of other psychological phenomena that may play a significant role with gender dysphonia (*i.e.*, neurodevelopmental and other mental disorders, substance use, self-harm, and trauma-based responses). The problem with this premise is that it explains away other sources of distress, not giving proper weight to other issues known to be prominent in the trans-identifying person may experience.[3] Without including these known factors, the clinician and the researcher will almost always have an incomplete picture of the problem.

For example, gender-affirming practice and research do not account for the high rates of early childhood trauma (ACEs) found in the transgender-identifying population.

The UCLA Williams Institute, an LGBTQIA+ advocacy group, found that:

- **45 percent** of transgender-identifying people reported childhood sexual abuse.
- **44 percent** of transgender-identifying people reported childhood physical abuse.
- **75 percent** of transgender-identifying people reported childhood emotional abuse.[4]

As a trauma clinician, I can tell you that when someone has endured a traumatic event, particularly one sexual in nature, it is not uncommon for a person to hate the parts of their body or want to get rid of those aspects of themselves that made them vulnerable.

For the trauma survivor, an ideology that suggests a child can be born in the wrong body, unfortunately, fits hand-in-glove with the mentality of a person who self-harms and wants to dissociate from any aspect of their being or body that highlights vulnerability. Yet, despite this knowledge, clinical settings and research studies promoting transgenderism have not properly accounted for this significant variable and how it relates to gender dysphoria.

5) Empowerment and self-management are aspects of good mental health practices. We often hear that suicide will be the result if someone struggling to embrace their biological sex isn't offered transgender physiological procedures. It is entirely inappropriate and unethical for anyone in my profession to plant the idea that an inevitable outcome will be suicide (even in the absence of expressed suicidal ideation) if the clinician's counsel for gender-affirming care is not followed. This is blatantly manipulative and has no part in promoting psychological or relational health.

Scientifically, based on the research methods alone, it is impossible to establish a causal relationship between the absence of gender-affirmative procedures and suicide. A recent meta-analysis from the suicide literature, which has been around a lot longer than research addressing gender dysphoria, notes a number of risk factors for a completed suicide, which curiously happen to be the same risk factors that

are prominent in the trans-identifying community. This literature frequently reports that although we have identified risks, it is unclear which combination will ultimately lead someone to suicide.[5]

In the practice setting, using the threat of suicide to motivate a client or family member to engage in an intervention would be considered egregious when dealing with any other issue. I worked on a suicide hotline early in my career. We know someone who gambles often can be at risk for suicide, especially after a big loss. As a clinician, it would be bad practice for me to tell someone who gambles that if they don't get more money to gamble, they will probably commit suicide. Yet, this threat is given every day in settings all over where gender dysphoria is the focal point.

Taken together, the onus should be on the transgender theorists and researchers to tell us (with overwhelming results from RCTs, clinical practice reports, and long-term studies that report on five to seven years after the procedures) that this practice significantly benefits children and far outweighs the harms. Instead, this research body leaves many unanswered questions on the mental health front. Contrary to some political opinions, this matter is far from settled. Here are a few of the countless unanswered questions:

1. What factors are responsible for the new cohort of biological females presenting as gender dysphoric rather than the historic numbers who were primarily biological males?
2. Are there comorbidities that affect the outcome?
3. Do biological males and females have different outcomes as a response to gender affirmation and different responses to components of these interventions?
4. Is there an aspect of gender-affirming care that affects a quantifiable rate of those with gender dysphoria?
5. Who will fare best after surgery, cross-sex hormones, or puberty blockers?
6. **No common program evaluation questions have been answered.** For example, what effect does attending treatment alone have on mental health outcomes (without gender-affirming care)?
7. Who are the people who regret each one of these unique interventions (*i.e.*, puberty blockers, hormones, and surgeries)?

8. What effect do transgender physiological procedures have on trauma symptoms, the desire to self-harm, or other mental distresses?
9. Who is most likely to benefit or be harmed by these procedures?

Instead of answers to these questions, we've plowed ahead with practices that break ethical research and practice boundaries. Gender-affirming care creates an illusion that there is only one choice for children and their families to experience relief from their distress, and that is to become someone else.

Please look at www.cochrane.org, the website of the healthcare information organization the Cochrane Collaboration, and type in the name of any mental disorder (*i.e.*, depression). You will see a multitude of treatments that have been researched to help children through depression.[6] When it comes to gender dysphoria, there's only one path.[7] That is, to make yourself look like someone else. These kids deserve better. We should be innovating solutions to heal their distress, not coercing them onto a path that tells them they need to remove or change parts of who they are in order to be whole.

I'm calling on you to please act on behalf of children. Please see Appendices A-C for more information on this issue.

Jennifer Bauwens is Director of the Center for Family Studies at Family Research Council.

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[1] Ajay Nadig et al., "Morphological integration of the human brain across adolescence and adulthood," *Proceedings of the National Academy of Sciences of the United States of America* 118, no. 14 (2021): e2023860118, https://www.pnas.org/content/118/14/e2023860118.

[2] Jiska Ristori and Thomas D Steensma, "Gender dysphoria in childhood," *International Review of Psychiatry* 28, no. 1 (2016): 13-20, https://doi.org/10.3109/09540261.2015.1115754; Devita Singh et al., "A Follow-Up Study of Boys With Gender Identity Disorder," *Front Psychiatry* 12 (2021): 632784, https://doi.org/10.3389/fpsyt.2021.632784.

[3] Chris Rowe et al., "Prevalence and correlates of substance use among trans female youth ages 16–24 years in the San Francisco Bay Area," *Drug and Alcohol Dependence* 147 (2015): 160–66, https://doi.org/10.1016/j.drugalcdep.2014.11.023.

[4] Ilan H. Meyer et al., "LGBTQ People in the US: Select Findings from the Generations and TransPop Studies," UCLA School of Law – Williams Institute, June 2021, https://williamsinstitute.law.ucla.edu/wp-content/uploads/Generations-TransPop-Toplines-Jun-2021.pdf.

[5] Christine B. Cha et al., "Annual Research Review: Suicide among youth - epidemiology, (potential) etiology, and treatment," *Journal of Child Psychology and Psychiatry* 59, no. 4 (2018): 460-82, https://doi.org/10.1111/jcpp.12831.

[6] "Site search: Depression," The Cochrane Collaboration, accessed January 23, 2023, https://www.cochrane.org/search/site/depression.

[7] "Site search: Gender dysphoria," The Cochrane Collaboration, accessed January 23, 2023, https://www.cochrane.org/search/site/gender%20dysphoria.

Appendix A

The following will address the problematic research used to promote physiological procedures (*i.e.*, puberty blockers, cross-sex hormones, and surgery), often referred to as "gender-affirming care." These procedures have been promoted as an intervention to treat psychological distress defined by the Diagnostic and Statistical Manual of Mental Disorders Edition 5-TR (DSM 5-TR) as gender dysphoria (GD). This testimony speaks to the current state of the scientific literature and raises significant concerns about the quality of the evidence used to support gender-affirming care, which is the most invasive practice(s) for treating any psychological condition conceptualized in the DSM 5-TR. The studies referenced in this testimony raise concern that no clear and long-term path has been established to demonstrate that gender-affirming practices successfully reduce the psychological distress characteristic of GD. Lastly, this testimony will highlight ideological rather than scientific evidence that has been used to support the use of gender-affirming practices.

What Transgender Advocates Themselves Are Saying

Before looking at the studies, it is important to note what the primary transgender advocacy group has said about the current practices for treating gender dysphoria. The World Professional Association for Transgender Health (WPATH), formerly the Harry Benjamin International gender dysphoria Association, is a key promoter of using surgical procedures and off-label drugs to treat the psychological distress associated with GD. WPATH "publishes the leading clinical guidance on gender dysphoria treatment," guidance that some medical groups claim is a "robust body of scientific evidence" and use to administer puberty blockers, cross-sex hormones, and surgical procedures.[1] However, as the U.S. Courts of Appeal for the First and Fifth Circuits have recognized, WPATH's guidelines "reflect not consensus, but merely one side in a sharply contested medical debate."[2]

A few of WPATH's own leaders have publicly agreed with the First and Fifth Circuits' explanation of the group's practice guidelines:

Dr. Stephen Levine, who helped author an early version of WPATH's guidelines, said "that later versions of WPATH were driven by political considerations rather than medical judgment." Dr.

Levine said that the guidelines are not "politically neutral" because WPATH is "an advocacy group for the transgendered"—which means that its positions "sometimes conflict" with "scientific" evidence and that the group does not "tolerate" "[s]kepticism and strong alternate views." Dr. Levine added that the field generally is characterized by a "lack of rigorous research" about "the long-term effects of sex reassignment surgery and other gender dysphoria treatments."[3]

Dr. Marci Bowers, who has conducted more than 2,000 gender transition surgeries, known as vaginoplasties, noted that in formulating the guidelines, WPATH "tr[ied] to keep out anyone who doesn't absolutely buy the party line that everything should be affirming," leaving "no room for dissent." And Bowers lamented that many clinics like Planned Parenthood would start giving adolescents cross-sex hormones after just "one visit."[4]

Drs. Levine and Bowers are not the only medical and mental health professionals commenting on the credibility of the scientific evidence used to undergird gender-affirming practices.

The State of the Scientific Literature: Consensus Is Not Evidence

In 2012, the American Psychiatric Association (APA) Task Force reported on the treatment of Gender Identity Disorder (now gender dysphoria). The report concluded that the "quality of evidence pertaining to most aspects of treatment in all subgroups was determined to be low; however, areas of broad clinical consensus were identified and were deemed sufficient to support recommendations for treatment in all subgroups."[5] Note the use of the phrase "clinical consensus" rather than the term "evidence-based." Although this statement is from 2012, there has been very little change in the literature since the APA made this statement.

A study conducted in 2021 assessed the relationship between gender-affirming practices and mental- health outcomes. This study referred back to the APA's earlier conclusion that "the quality of evidence for treatment of gender dysphoria is low, and consequently, recommendations regarding gender-affirming care have been driven by clinical consensus where empirical evidence is lacking. This [their] study offers new data that substantiate the current clinical consensus by

expanding the evidence base in support of gender-affirming surgical care." That is, the researchers who published this comment in 2021 recognized more studies are needed to claim robust empirical support for gender-affirming care that goes beyond clinical consensus.

These concerns certainly apply to WPATH's guidelines, too, which are not true standards of care. They cannot be true standards of care because the evidence to support these practices does not exist. In short, these guidelines are "suggestions or recommendations," not "authoritative, unbiased consensus positions designed to produce optimal outcomes."[6] Worse, they are suggestions based on an ideological construct, not solid empirical data. This is also the case in the latest iteration of the WPATH guidelines (version 8), which note that the standards are based on the "best available evidence." Ultimately, these guidelines were constructed and then voted on by those who adhere to transgender ideology and not on the basis of studies with solid research methods and certainly not by any neutral research entities.

Given the use of highly physiologically invasive practices associated with "gender-affirming care," the nature of these practices should necessitate the highest standard of evidence from studies that employ a wide range of research methods (*e.g.*, sampling, design). These studies should stand up against the most rigorous scrutiny, and any data used to support these practices should be available for secondary analysis. Instead, any efforts to question the methods of these studies are met with attempts to suppress legitimate scientific debate (*e.g.*, Washington State[7]). Further, many of the studies used to support these practices are from cross-sectional investigations, are missing key variables that are known to present in the transgender-identifying community (*e.g.*, ACES), and contain poorly defined constructs (*e.g.*, Turban study[8] 2,3). Still, these studies are touted as proof that transgender physiological procedures have a positive and unquestionable effect on mental health. Some have even claimed this effect on mental health is settled, which is quite a remarkable statement that cannot be said about any other psychological issue outlined in the DSM 5-TR. Based on the research methods alone, these studies are limited in their ability to evaluate the impact of major life-altering pharmaceuticals and surgeries, particularly on minors. Therefore, if the scientific method is adhered to, any claims to calling these procedures a settled science cannot be supported with any measure of professional integrity.

Reports on Puberty Blockers

These drugs have been portrayed as well-known and that their "effects are reversible."[9] Yet the effects cannot be accurately depicted as reversible because a child blocked from development can never get those years back. There is also evidence that these drugs could have long-term negative effects. At a minimum, as the U.K. High Court explained, "there is real uncertainty over the short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it is seeking to achieve."[10]

Likewise, Britain's recent National Institute for Health and Care Excellence (NICE) review concluded that no "reliable comparative studies" exist about "the effectiveness and safety of [puberty blockers] for children and adolescents."[11] In 2022, the Cass Review was conducted at the commissioning of the U.K.'s National Health Service (NHS). After a review of the data and engagement with a wide range of stakeholders, the interim report expressed concern over the use of puberty blockers and hormones for children and adolescents.[12]

Advocacy groups like the American Academy of Pediatrics (AAP) also say that puberty blockers may have "long-term risks, particularly in terms of bone metabolism and fertility" that cannot currently be assessed by the "limited" research available.[13]

In terms of mental health, puberty blockers in adolescents can lead to depression and other emotional disturbances. Some evidence shows "that after a year on [puberty blockers,] children reported greater self-harm, and that girls experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body."[14]

Lupron, the most widely prescribed puberty blocker for females in America, may block hormones that contribute to neurological development, "suppressing peak IQ" levels.[15] As endocrinologist Dr. William Malone has explained, puberty cannot necessarily be "restart[ed]" later: once "the system 'goes to sleep,'" "it may not wake up."[16] Finally, the use of puberty blockers may worsen gender dysphoria by "solidif[ying] the feeling of cross-gender identification."[17]

For these reasons, including the known physiological harms that come through these medical interventions (see attached paper), the U.K High Court found that "the consequences of the treatment are highly complex and potentially lifelong and life changing in the most fundamental way imaginable."[18] "The treatment goes to the heart of an individual's identity, and is thus, quite possibly, unique as a medical treatment."[19] Additionally, Britain's NICE review concluded the "limited evidence for the effectiveness and safety of gender-affirming hormones in children and adolescents with gender dysphoria" consists entirely of studies that are "uncontrolled," "observational," or have "outcomes of very low certainty."[20]

The Scientific Evidence Used to Support Transgender Medical Procedures Is Weak

Despite the learning from other countries, medical interest groups in the United States continue to claim that "research has linked gender-affirming care to a significantly lowered risk of depression, anxiety, and other negative mental health outcomes."[21] For support, medical groups have cited "a study of 50 transgender youth undergoing puberty suppression treatment [that] found that the treatment was associated with decreased depression and improved quality of life over time."[22]

That study—contrary to the medical group's claims of "robust" evidence—acknowledged that "there are few data concerning the impact of endocrine intervention on psychological function in transgender youth."[23] And the study's results are weak at best. Of 116 participants who entered the study, less than 50 percent completed it. Forty-seven participants were given drugs, and three participants were not.

Many participants were older than age 18—as old as 25.[24] A non-randomized control group (*i.e.*, participants given no drugs) of three participants is deficient, and the study makes no attempt to compare outcomes between the groups. Because the study makes little effort to control for other relevant variables, the study could not show any causal relationship between gender transition treatments and outcomes. Finally, according to the study itself, "most predictors did not reach statistical significance."[25] No entity concerned with evidence-based medicine would rely so heavily on this study.

Medical groups in support of transgender procedures have also referenced "[a] systemic analysis of 25 years of peer-reviewed articles found a robust consensus that gender-affirming treatments, including treatments such as hormone therapy, improve the overall wellbeing of transgender individuals."[26] This analysis only confirms the lack of any "robust" evidence here. The analysis says nothing about this issue—gender transition drugs and surgeries for children—and it concedes that even as to adults, available evidence is "limited" and seldom involves "prospective studies or randomized control trials."[27]

Likewise, groups advocating gender-affirming practices cite "multiple studies have revealed long-term positive outcomes for transgender people who have undergone puberty suppression."[28] But the study by Anna Van der Miesen et al. explicitly rejected these groups' proposition, stating that it does "not provide evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes."[29] According to the study, "Conclusions about long-term benefits of puberty suppression should thus be made with extreme caution needing prospective long-term follow-up studies with a repeated measure design with individuals being followed over time."[30] Yet, scientific groups acting in good faith would not say that a study "reveal[s] long-term positive outcomes"[31] when it expressly repudiates that reading.[32]

Regarding the claim of "long-term positive outcomes," medical groups cite a 2014 study by de Vries et al.[33] The study looked at a mere 55 people, drawn with self-selection problems from an initial group of nearly 200.[34] The study acknowledged that the self-selected group was "different from the transgender youth in community samples."[35] ("[A] selection bias could exist.") No control group existed. And the study found that gender dysphoria and "body image difficulties persisted through puberty suppression"; in fact, these problems were worse after puberty suppression drugs were used than before.[36] This study also found only a "small amount of scientific evidence of the medical safety and efficacy and the psychological efficacy" of treatments that have been featured as "robust" evidence.[37]

As for the commonly cited high risk for suicide, particularly among minors who identify as transgender, groups have repeatedly cited a study by Turban et al. that used responses from an online survey drawn from trans-affirming websites as "data." The problem with this study is that

it "excluded those who underwent medical intervention and then subsequently stopped identifying as transgender" and, of course, "those who actually committed suicide."[38] "73% of respondents who reported having taken puberty blockers" "said they started on them after the age of 18 years"—which is even not when puberty blockers are prescribed.[39] The study itself concedes that it "does not allow for determination of causation."[40]

Admission of Harm Is Rising

On the other hand, a growing body of evidence shows gender transition drugs and surgeries harm children (see the attached paper). Specifically, these interventions are risky and unnecessary as there is also evidence that up to 94 percent of children experiencing gender dysphoria no longer suffer from it by adulthood. This finding has been supported by WPATH's guidelines, which report that 73 to 94 percent of children referred for GD have conditions that do not "continue into adulthood."[41] And the medical group's own study says that "predicting individual persistence at a young age will always remain difficult."[42] Other studies confirm that most children desist.[43]

However, if a child is introduced to puberty blockers to prevent normal development, once they are used, they almost always lead to the use of cross-sex hormones that permanently alter the child's body. For this reason, many countries—including the United Kingdom, Sweden, and Finland—are moving away from these experimental interventions. Specifically, a number of countries have conducted their own reviews of physiological gender-affirming care and have all warned against these procedures:

- **Britain's National Health Service**'s systematic review found a lack of evidence to support the use of puberty blockers and cross-sex hormones.[44]
- **France's National Academy of Medicine** warned about the deleterious long-term side effects of puberty blockers and cross-sex hormones in children and adolescents. They further noted that there is no solid predictive measure to ascertain the persistent or transient nature of gender dysphoria.[45]

- **The Finnish Health Authority**'s systematic review determined that GD should first be treated as a psychological condition rather than introducing physiological procedures or drugs.[46]
- **The Royal Australian and New Zealand College of Psychiatrists** released a statement noting a need for better evidence and assessments for treating GD in children and adolescents. They also determined that the current evidence for gender-affirming care is weak.[47]
- **The Swedish National Board of Health and Welfare** in 2022 found that the risks of these physiological hormones and procedures were greater than the benefits. This followed the Children's Hospital at the Karolinska Institute's decision to halt physiological affirming care based on their findings that the use of puberty blockers and hormones carried irreversible and negative consequences.[48]

A New Cohort, but an Old and Untested Method

The protocols for gender affirmation procedures were designed 15 years ago and have no application to the patient population now presenting with gender dysphoria—overwhelmingly, adolescent females.

Since 2008, the share of biological female college students identifying as transgender has increased 100-fold.[49] Twice as many girls as boys struggle with gender dysphoria, when the opposite was true just a few years ago.[50] At the same time, "the number of gender clinics in the U.S. has grown from one in 2007 to hundreds today."[51] Medical professionals have called this rise in female GD a "clinical phenomenon" with "uncertain diagnostic significance making up a substantial proportion."[52] Many attribute this change to the rise of "rapid onset gender dysphoria."[53] (The professor who coined the phrase was promptly relieved of her position.[54])

The lead author of the Dutch study recently cautioned practitioners about using the Dutch Protocol to treat the more recent wave of girls who present as adolescents with gender dysphoria, calling this a "new developmental pathway … involving youth with postpuberty adolescent-onset transgender histories."[55] "According to the original Dutch protocol," she noted, "one of the

criteria to start puberty suppression was a presence of gender dysphoria from early childhood," while now "the older presenting youth simply experienced gender history events at older ages."[56]

Another of the original Dutch protocol researchers agrees. Thomas Steensma, a researcher at the Center of Expertise on gender dysphoria, explained that it is unknown "whether studies we have done in the past can still be applied to this time. Many more children are registering, and [are] also a different type."[57] Youth "with post puberty adolescent-onset transgender histories" were not studied in the earlier evaluations.[58] Steensma criticized American physicians for "blindly adopting [the Dutch] research" without accounting for the change in the population of GD patients.[59]

Particularly given this new population, it is reasonable and responsible to put a hold on experimental treatments on unstudied patient groups. As one leading gender transition doctor—a WPATH board member—cautioned, "we're going to have more young adults who will regret having gone through this process" thanks to doctors "[r]ushing people through the medicalization'" and failing "to evaluate the mental health of someone historically in current time, and to prepare them for making such a life-changing decision."[60]

Regret: An Understudied Reality

There are also growing reports from those referred to as detransitioners. Many who are coerced into experimental medical interventions later regret that irreversible decision. One recent study, although limited in design, found that 60 percent of those who detransitioned "bec[ame] more comfortable identifying as their natal sex," and most "felt that they did not receive an adequate evaluation from a doctor" "before starting transition."[61]

In this study, participants recognized that there were other root causes for gender dysphoria that were not addressed, and the transitioning process prevented them from addressing the true source of distress:

- **58 percent** said the GD was caused by trauma or a mental health condition,
- **51 percent** reported the process of transitioning delayed or prevented them from dealing with or being treated for trauma or a mental health condition, and
- **41 percent** said what they thought were feelings of being transgender were the result of a mental health condition.

In sum, there is a lack of scientific evidence to support the claim that gender-affirming practices account for any sustained reduction in gender dysphoria. There is evidence that puberty blockers, cross-sex hormones, and surgical procedures can cause permanent physiological damage and cause psychological harm. There is also a growing awareness of those who are unhappy with their gender-affirming care and have decided to detransition. Further investigation is needed to understand this population's experiences and those who did not fare well following these medically based practices.

I'm calling on you to please act on behalf of children.

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[2] *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019); see also *Kosilek v. Spencer*, 774 F.3d 63, 78–79 (1st Cir. 2014) (discussing debate within the medical community).

[3] Amicus Brief, *Brandt v. Rutledge*, at 22.

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[5] William Byne et al., "Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder," *Archives of Sexual Behavior* 41, no. 4 (2012): 759–96, https://pubmed.ncbi.nlm.nih.gov/22736225/.

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[11] "Evidence review: gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria," National Institute for Health and Care Excellence, March 11, 2021, 40, https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_GnRH-analogues_For-upload_Final.pdf.

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[14] Michael Briggs, "Tavistock's Experimentation with Puberty Blockers: Scrutinizing the Evidence," Transgender Trend, March 5, 2019, accessed January 27, 2022, https://www.transgendertrend.com/tavistock-experiment-puberty-blockers/.

[15] Amicus Brief, *Brandt v. Rutledge*.

[16] Id.

[17] Tavistock ¶ 76; see Amicus Brief, *Brandt v. Rutledge*.

[18] Tavistock ¶ 134; see Amicus Brief, *Brandt v. Rutledge*.

[19] Id.

[20] "Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria," National Institute for Health and Care Excellence, March 11, 2021, 50, https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_Gender-affirming-hormones_For-upload_Final.pdf.

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[23] Christal Achille et al., "Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results," *International Journal of Pediatric Endocrinology*, 8 (2020), https://ijpeonline.biomedcentral.com/articles/10.1186/s13633-020-00078-2.

[24] Ibid., Tbl. 1; see also Tbl. 2 (apparently noting that 24 participants were only given cross-sex hormones).

[25] Ibid.

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[29] Anna I. R. van der Miesen et al., "Psychological Functioning in Transgender Adolescents Before and After Gender- Affirmative Care Compared With Cisgender General Population Peers," *Journal of Adolescent Health* 66, no. 6 (2020): 669, 703, https://www.sciencedirect.com/science/article/abs/pii/S1054139X20300276.

[30] Ibid.

[31] Amicus Brief, *Brandt v. Rutledge*, at 19.

[32] Ibid. It is also worth noting that the study controls for few variables and relies on self-reported data rather than "a diagnosis of any mental health condition made by clinical assessment."

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[35] Id.

[36] Id, at 19-20.

[37] Annelou L.C. de Vries et al., "Young adult psychological outcome after puberty suppression and gender reassignment," *Pediatrics* 134, no. 4 (2014), https://pubmed.ncbi.nlm.nih.gov/25201798/.

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[50] Amicus Brief, *Brandt v. Rutledge*, at 12.

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[52] Id.

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Appendix B

Issue Brief
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Diagnosing Gender Dysphoria in Children: An Explainer

by Jennifer Bauwens, Ph.D.

"Gender dysphoria" is a diagnostic category listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM).[1] It was first included as a psychological diagnosis in the DSM-5, which came out in 2013. The DSM-5 has since gone through revisions and was re-released this year.

There has been debate over whether gender dysphoria should be included in the DSM. Some argue that creating a diagnostic category pathologizes those who identify as transgender, and the diagnosis is only necessary in American culture for the purposes of insurance reimbursement for transgender physiological procedures.[2] In this explainer, the gender dysphoria diagnosis will be described along with the problems with diagnosis and treatment, specifically in children.

Definition of Terms

- *Gender* "refers to the psychological and cultural characteristics associated with biological sex. It is a psychological concept and sociological term, not a biological one."[3]
- *Dysphoria* is defined in the dictionary as "a state of dissatisfaction, anxiety, restlessness, or fidgeting."[4]

- *Gender dysphoria (GD)* is a clinical term used in the DSM to describe children and adults who experience a psychological condition marked by an incongruence between their experienced gender and the gender associated with their biological sex. They often express the belief that they are the opposite sex.[5]

Diagnostic Criteria for Gender Dysphoria

- The gender dysphoria criteria stipulate that a diagnosis can be made after an observation period of just six months.[6]
- Oddly, the observation period for a gender dysphoria diagnosis is the same for both children and adults.
- Once the feelings of incongruence between a child's biological sex and their experience of another gender have been expressed, a diagnosis is made by marking at least six other criteria.
- Strangely enough, a significant portion of these criteria resemble many Western stereotypes and traditional sex roles. For example:
    - **Criteria 3.** A strong preference for cross-gender roles in make-believe play or fantasy play
    - **Criteria 4.** A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender
    - **Criteria 5.** A strong preference for playmates of the other gender[7] (A complete listing of the DSM criteria is cited here.[8])

Determining Diagnosis for Gender Dysphoria

- There are no physiological tests (*i.e.*, lab work, imaging) to determine the extent of dysphoric symptoms.[9]

- There are no psychological tests to predict who will *regret* transgender procedures.
- There are no psychological tests to predict *how long* gender dysphoria will last.
- There are no psychological tests to predict who will supposedly *benefit* or be *harmed* by transgender procedures.
- There are no standardized measures to assess *etiology* or different root causes of gender dysphoria.
- There are no tests to detect the differences between the mostly biological males who showed up for treatment with gender dysphoria decades ago and the current cohort of mostly biological women presenting with symptoms.
- There are no psychological tests to differentiate between all the *categories* of transgender experiences (*e.g.*, non-binary, trans-man, trans-woman) and all the aforementioned psychological and physiological tests.
- The only outcome that can be predicted for gender dysphoria is that, in many cases, it will resolve in children if left alone.
- The number of children who *grow out of* their gender dysphoria, the "desistance" rates, range from 70 percent to 97.8 percent in biological males and 50 percent to 88 percent in biological females.[10]

Comparing Gender Dysphoria to Other DSM Diagnoses That Account for Maturation

- Accounting for a child's maturation process is generally recognized and upheld in other DSM-5 diagnoses that involve observing a stable pattern of behavior, emotion, and thought over time.[11]

- When making these diagnoses, the criteria require that the symptoms be present longer in children than for adults. Diagnosis is recommended after 18 years of age.[12]
- In rare instances in which diagnosis occurs before 18, symptoms must be observed for one year to determine a stable pattern (unlike gender dysphoria at six months).[13]
- The waiting period for these disorders is related to the widely accepted fact that the brain continues to develop into a person's mid-twenties.[14]
- The limbic system in the brain, also known as the seat of our emotions, relates to emotional processing, learning, and memory.
- The limbic system plays a significant role in a person's mental health and takes the longest to reach structural norms. Many people do not reach maturation norms until they are in their twenties.[15]

A Good Diagnostic Assessment Involves Ruling Out Other Causes for Gender Dysphoria

- Good practitioners take the time and thoroughly interview a child and primary caregiver(s) to rule out other diagnoses and factors that could contribute to the presenting problem. For example:
    - It has been well documented that those presenting with gender dysphoria may also experience some of the following issues:
        - Childhood physical, sexual, and emotional abuse and neglect[16] [17]
        - Autism[18]
        - Influenced by peers and social media sites[19]

Treatment Recommendations from the Medical and Psychological Establishment

- When it comes to other diagnoses listed in the DSM, researchers and theorists are encouraged to develop treatment options. Clinicians are encouraged to make their clients aware of the different treatments available and what they themselves can provide, given their training and expertise. For example, if you go for treatment following a traumatic event, you can find a therapist who can offer you cognitive therapy, medication, EMDR, exposure therapy, etc.
- When it comes to the gender dysphoria diagnosis, multiple treatment options are not available to reduce symptoms.
- The only treatment option you will be offered for gender dysphoria is to socially and medically transition.
- This option leads to physiological procedures that will alter and/or remove healthy organs and bodily systems to treat a psychological condition.
- The use of puberty-blocking drugs can lead to a range of health problems in children, including sterilization, reduced bone density, cognitive problems, increased body fat percentage and body mass index, decreased lean body mass, and arterial hypertension.[20] [21] [22]
- Transgender procedures are the most invasive physiological practices known to treat a psychological condition.
- These procedures have the least amount of scientific evidence to support their use.
- Transgender physiological procedures have been offered with disregard for the six-month observation period noted in the gender dysphoria diagnostic criteria.
- Groups like Planned Parenthood distribute cross-sex hormones at the initial visit, without mental health assessment or parental consent.[23]
- There are no federal gatekeeping mechanisms to hold practitioners or providers accountable for misdiagnosis and wrongful distribution of puberty blockers and cross-sex hormones and the

performance of surgical procedures on minors (unless a state has pursued legislation to limit procedures on minors[24]).

- Treatment should characterize:
    - At minimum, a detailed evaluation of the child and their caregiver's psychological histories should be conducted.
    - The evaluation should describe how the clinician ruled out other known factors (*e.g.*, trauma, autism, social contagion) that may be responsible for expressions of gender dysphoria.
    - These other factors should be addressed in the treatment plan.
    - Researchers and clinicians should be unshackled from the transgender ideology that demands only one treatment option.

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Appendix C

Issue Analysis
July 2021 | No. IS20J04

Do Not Sterilize Children

Why Physiological Gender Transition Procedures for Minors Should Be Prohibited

Edited by Jennifer Bauwens, Ph.D.

Key Points

Radical physiological treatments to treat the psychological condition of gender dysphoria have serious negative side effects, up to and including permanent sterilization. None of these procedures have been shown to improve the patient's mental health.

When left to themselves, most children with such conditions outgrow them and do not identify as "transgender" adults.

These physiological procedures violate the most fundamental principle of medical ethics: "First, do no harm."

Summary

It has long been known that some children suffer from "gender incongruity" (a disconnect between one's psychological, self-perceived "gender identity" and one's biological sex) or "gender dysphoria" (distress about such incongruity). Studies have shown that, when left to themselves, most children with such conditions outgrow them and do not identify as "transgender" adults. However, such conditions and identities are increasingly being embraced and actively affirmed, not only through "social transition" (changing one's public expression of gender identity) but also through radical physiological interventions. These include the use of drugs to block normal puberty, cross-sex hormones, and gender reassignment surgery.

Each of these procedures has serious negative side effects—up to and including permanent

sterilization. Despite claims to the contrary, these procedures are often not reversible, and they are not evidence-based. Research has not shown that these procedures are effective in accomplishing their purpose, which is to improve the patient's mental health. They violate the most fundamental principle of medical ethics: "First, do no harm."

These facts fully justify—in fact, they demand—state and federal legislation to prohibit such procedures from being performed upon minors. The rights of parents who affirm their child's transgender identity are not of a higher value than the public interest in protecting children from physical harm. Economic blackmail should not dissuade legislators from acting on this issue.

Introduction: The James Younger Case

In 2019, the case of James Younger, a boy caught up in a tragic custody battle between his parents, highlighted the dangers "gender transition" poses to children. Many Americans were alarmed that James' mother wanted him to wear girl's clothes, have a girl's name, and eventually take puberty-blocking hormones—even though James' father insisted that he is a perfectly happy 7-year-old boy.[1] Custody of James was eventually awarded to both parents by a Texas judge after a national outcry.[2]

Understanding the Issue

"Sex" vs. "Gender"

The transgender issue has been depicted primarily as one of "discrimination" against a particular group of people because of "who they are." The primary dispute is a philosophical one over what it means to be "male" or "female."[3] For most of human history, it was regarded as self-evident that these terms referred to an individual's biological sex, as defined by their reproductive capacity. The American Psychiatric Association (APA), which is supportive of transgender identities, continues to define the word "sex" in biological terms. Here is the definition that appeared in the most recent (2013) edition of the APA's *Diagnostic and Statistical Manual of Mental Disorders*, or *DSM-5*:

Sex Biological indication of male and female (understood in the context of reproductive capacity), such as sex chromosomes, gonads, sex hormones, and nonambiguous internal and external genitalia.[4]

By these definitions, "sex" is a biological characteristic that is evident at (or, with ultrasound, even before) birth, and one's identity as "male" or "female" is an objective physical reality that is innate and immutable. Family Research Council (FRC) holds firmly to these definitions and this view of "sex."

However, some have sought to undermine it—in part linguistically, by substituting the word "gender" for "sex." Sometimes, "gender" is used as essentially a *synonym* for "sex"—such as when expectant parents have a "gender reveal" party. At other times, however, "gender" is defined in psychological terms (in *contrast* to biological "sex"), based upon a person's subjective self-perception or self-identification as "male" or "female." The core principle of what is called "gender ideology" is that this subjective, psychological self-perception is a *more fundamental and more accurate* determinant of who is "male" or "female" (or something else) than a person's objective, biological sex.[5]

These beliefs are at the heart of the transgender movement. It is virtually impossible to discuss that movement without using "gender" and its derivative terms in this way, so this paper will do so (and without quotation marks). The reader should bear in mind that such usage should not be taken as representing the author's affirmation of that theoretical construct, however.

What Is Gender Incongruence/Gender Dysphoria?

The American College of Pediatricians explains these terms this way:

- *Gender* is a term that refers to the psychological and cultural characteristics associated with biological sex. It is a psychological concept and sociological term, not a biological one.
- *Gender identity* refers to an individual's awareness of being male or female and is sometimes referred to as an individual's "experienced gender."

- *Gender dysphoria (GD)* in children describes a psychological condition in which they experience marked incongruence between their experienced gender and the gender associated with their biological sex. They often express the belief that they are the opposite sex.[6]
- The term *transgender* "refers to the broad spectrum of individuals who identify with a gender other than that associated with their birth sex."[7]

DSM-5 Diagnostic Criteria for Gender Dysphoria in Children

There are a few noteworthy points to make about the gender dysphoria (GD) diagnosis. For one, it should be noted that the formulation of the GD diagnosis has been critiqued as an explication of a cultural phenomenon, most relevant to the United States, to garner insurance reimbursement for transgender medical treatments.[8] The current diagnostic criteria itself was greatly debated for five years leading up to the release of the *DSM-5*, and for good reason. In particular, the criteria comprising the GD diagnosis show a questionable departure from other considerations that are apparent in the *DSM-5* while diagnosing mental health issues for children.

First, GD has been conceptualized as applicable to both children and adults. When diagnosing a child or an adult, the symptoms should be present for six months. Interestingly, the observation period is the same for both children and adults. This is suspect because it is well documented that the brain continues to develop into a persons' mid-twenties.[9] Some of the greatest developmental strides are known to occur within complex neurological structures during adolescence. Specifically, the limbic system, also known as the seat of our emotions, relates to emotional processing, learning, and memory. This important structure plays a significant role in a person's mental health. Structures like the limbic system take the longest to reach structural norms. Many people do not reach these structural norms until they are in their twenties.

This maturation process is generally recognized and upheld in other *DSM-5* diagnoses that are thought to reflect a stable and observable pattern over time. For example, the *DSM-5* contains a cluster of disorders referred to as *personality disorders*. These disorders are characterized by an "enduring pattern of thinking, feeling, and behaving that is relatively stable over time."[10] When diagnosing a personality

disorder, the criteria requires that the symptoms be present longer in children than what is required for adults. Here is the guidance offered in the *DSM-5* in regard to making a diagnosis for children:

> *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…. 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.[11]

In contrast, the criteria for GD in children includes an observation of six criteria for a six-month duration. Further, the *DSM-5* tells us that the GD diagnosis requires that one of the six criteria must include a "marked incongruence between one's experienced/expressed gender and assigned gender." The person should also experience "[t]he condition [as] associated with clinically significant distress or impairment in social, school, or other important areas of functioning."[12]

The remaining five criteria necessary for a GD diagnosis arguably give a lot of room for interpretation. Here's an example of some of the criteria used to determine GD:

> Criteria 3. A strong preference for cross-gender roles in make-believe play or fantasy play
> Criteria 4. A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender
> Criteria 5. A strong preference for playmates of the other gender[13]

By the standards set in the *DSM-5*, diagnosing personality disorders in children should be rare and observed for a lengthy period. Yet, the interventions for treating personality disorders in children are not as physiologically invasive, nor do they involve the potential for altering or removing healthy organs. However, the interventions outlined throughout the remainder of this paper are potentially life-altering and, if diagnosed, are preceded by only a six-month awareness of gender dysphoria symptoms. In this way, the gender dysphoria diagnosis in children is not made with the same caution as personality disorders, which are considered indicative of a stable psychological and behavioral pattern.

What Percentage of Children with Gender Dysphoria Go On to Identify As Transgender Adults?

According to the *DSM-5:*

> Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%.[14]

Those "persistence" rates are the percentages that *continue* to have gender dysphoria. That means that the number who *grow out of* their gender dysphoria, the "desistance" rates, range from 70 percent to 97.8 percent in biological males and 50 percent to 88 percent in biological females.

In a separate analysis combining the results from 10 studies, two scholars reported in 2016 that "for the majority of the children (85.2%; 270 out of 317) the gender dysphoric feelings remitted around or after puberty,"[15] meaning that only 14.8 percent continued to experience such feelings.

No Objective Test for a "True Transgender" Child

As a group of physicians warned in a letter to a medical journal in 2018, "There are no laboratory, imaging, or other objective tests to diagnose a 'true transgender' child." In other words, "There is currently no way to predict who will desist and who will remain dysphoric."[16]

Given the evidence that the majority of children with gender dysphoria do not identify as transgender adults if left to themselves, and the inability to know which will "persist" and which will "desist," it is simply irresponsible for those trained to provide medical care to perform physical interventions, some effects of which are irreversible, that almost always put a child on a path toward a transgender identity.

Invasive Physiological Procedures

Gender Transition

Gender transition is the process whereby a person experiencing gender incongruity changes his or her appearance and self-presentation from being consistent with the individual's biological sex at birth to being more consistent with the individual's preferred psychological gender identity. The first step in such a transition is usually "social" transition, which involves changing one's name, clothing, hairstyle, and public self-identification (as male, female, or something else) and requesting that others affirm this new public identity. Social transition may occur before or in the absence of any interventions that require the aid of people with pharmacological or medical training, such as the use of hormones or surgery.

For the most part, this paper does not address the question of "social" transition—although there are significant concerns about it. Instead, this paper focuses on procedures designed to alter the body's physiology, such as hormones and surgery. When we use the term "gender transition procedures," it will be in reference to these more invasive physiological interventions.

What Physiological Procedures Are Performed on Children/Minors with Gender Dysphoria?

Since at least the 1950s, invasive physiological procedures have been offered to adults wishing to change the appearance of their bodies as part of a gender transition. These include the use of cross-sex hormones (testosterone for females identifying as male, and estrogen for males identifying as female) and gender reassignment surgery. However, only in the last 20 years or so have such interventions begun being offered to minors for this purpose.

One set of scholars described these treatments, first devised in the Netherlands and referred to as "the Dutch protocol," in a 2010 journal article:

> Since the mid-1990s, one model of therapeutic care, developed by Dutch clinicians and researchers, has been to initiate the biomedical aspects of sex-reassignment in early- to mid-adolescence rather than to wait for the legal age of adulthood (18 years in many countries) or even later. After careful psychologic evaluation, adolescents deemed appropriate for such treatment are prescribed hormonal medication to delay or suppress somatic puberty (prior to the age of 16 years). If the gender dysphoria persists, then cross-sex hormonal therapy is offered at the age of 16 and, if the adolescent so desires, surgical sex change procedures are then offered at a lower bound age of 18.[17]

Puberty Blockers

"Puberty blockers" is a colloquial term for a class of hormones that can prevent a pre-adolescent child from undergoing the physical changes associated with puberty. Originally developed and approved to treat a medical condition known as "precocious puberty," they are now being used as part of a gender transition in some children.

"Central Precocious Puberty"

Some children begin to develop the physical signs of puberty at unusually early ages. If, for example, a girl's breasts begin to develop at the age of six, or a boy begins to grow pubic hair at the age of seven, these may be considered signs of a medical disorder known as "central precocious puberty." Websites on the disorder describe the physiological process:

> The brain starts the process [of puberty] with the production of a hormone called gonadotropin-releasing hormone (GnRH).
>
> When this hormone reaches the pituitary gland — a small bean-shaped gland at the base of your brain — it leads to the production of more hormones in the ovaries for females (estrogen) and the testicles for males (testosterone).

. . .

> Most commonly, especially in girls, precocious puberty is due to the brain sending signals earlier than it should.[18]

This condition can adversely affect children both physically[19] and emotionally.[20]

In the 1980s, scientists realized that children experiencing precocious puberty could be treated with a class of drugs that effectively neutralize the puberty-stimulating effect of the GnRH. These are known as GnRH analogs or GnRH agonists (GnRHa) but are referred to more colloquially as puberty-blocking hormones, puberty-blocking drugs, or simply "puberty blockers." These drugs can essentially pause the physical changes associated with puberty until the child reaches an age where his or her peers are typically experiencing them. Then the treatment is withdrawn, and normal pubertal development resumes within about a year.[21]

Use of Puberty Blockers for Gender Transition

However, some health care providers are turning the usual (and FDA-approved) use of puberty blockers on its head. Instead of using these drugs to stop *premature* puberty and then withdrawing them at the normal age for puberty to allow normal development to resume, they are using them to *prevent* children who have gender dysphoria from going through puberty at the *normal* age. In other words, instead of *preventing* an abnormal condition in order to *facilitate* normal development, doctors in gender clinics are *creating* an abnormal condition in order to *prevent* normal development.

One journal article explains the rationale for this approach:

> . . . [T]he suspension provides adolescents with GD "time and rest before making definite decisions on gender reassignment without the distress of developing secondary sex characteristics."[22]

However, puberty blockers "have potentially serious physical side effects."[23] An article in the journal *Nature* said that "some scientists worry that putting off puberty in older children may disrupt bone and brain development, reducing bone density and leading to cognitive problems."[24] A 2018 article in *Pediatrics* (the official journal of the American Academy of Pediatrics) noted other concerns:

- GnRHas significantly increased both body fat percentage and BMI [body mass index] while decreasing lean body mass . . .
- [P]otential adverse effects such as arterial hypertension . . . [were] reported in a recent case series in association with GnRHas.[25]

This is not to mention the more obvious fact that puberty blockers "inhibit fertility by preventing the development of gonadal tissue and mature gametes for the duration of treatment."[26]

No Evidence Puberty Blockers Improve Mental Health

As with all gender transition procedures, the goal is not to improve the patient's physical health but to improve his or her mental health, and especially to ease gender dysphoria (the distress associated with "gender incongruence") itself. However, it is not even clear that the use of puberty blockers achieves this goal, which would be absolutely necessary to justify such a radical and unnatural physical intervention.

One early (2010) study of puberty suppression for gender transition reported, "Gender dysphoria did not resolve as a result of puberty suppression."[27] A more recent (2018) study reported that "our psychometric data suggest that . . . the impact [of puberty blockers] on reducing psychological difficulties is limited."[28]

Are Puberty Blockers "Fully Reversible?"

Critics of the use of puberty blockers for gender transition have warned, "Children and adolescents generally lack the emotional and cognitive maturity needed to consent to a treatment that will have lifelong consequences."[29] Supporters of puberty suppression acknowledge that children and young adolescents are immature but deny that its consequences are necessarily lifelong, claiming, "Puberty suppression is fully reversible and can be discontinued should the adolescent decide not to pursue GR" (gender reassignment).[30]

The claim of reversibility, however, is based on the use of these drugs in treating central precocious puberty—not gender dysphoria. In a letter to a British medical journal in 2019, three experts noted, "It is surely presumptuous to extrapolate observations from an intervention that suppresses pathologically premature puberty to one that suppresses normal puberty."[31] A group of German scholars noted in 2008 that the claim of reversibility "is true, however, only with respect to its physical effects, not with respect to the irreversible damage it does to the process of psychosexual development."[32] The three British experts (Richards, et al.) said that the use of puberty blockers "leaves a young person in developmental limbo without the benefit of pubertal hormones or secondary sexual characteristics, which would tend to consolidate gender identity."[33]

There is no record in the academic literature documenting what happens to a child who goes on puberty blockers at the age of 11 and then discontinues them at 16 or 18. In a key early study of "the first 70 eligible candidates who received puberty suppression between 2000 and 2008" at a pioneering gender identity clinic in Amsterdam, "No adolescent withdrew from puberty suppression, and all started cross-sex hormone treatment, the first step of actual gender reassignment."[34]

The dramatic contrast between the 85 percent *desistance* rate in prepubertal children with gender dysphoria[35] and the reported 100 percent *persistence* rate in those placed on puberty blockers at the onset of puberty[36] strongly suggests that, like "gender social transition of prepubertal children," puberty blockers "will increase dramatically the rate of gender dysphoria persistence."[37] Richards, et al. note,

"Our concern is that the use of puberty blockers may prevent some young people with GD from finally becoming comfortable with the birth sex."[38]

This is being done despite the lack of any long-term longitudinal studies evaluating the risks and benefits of using these drugs to treat gender dysphoria and gender transition.[39]

Cross-Sex Hormones

A second step in the invasive physiological gender transition of minors (for those who first took puberty blockers), or a first step for those who have already entered their natural (biological) puberty, is the administration of cross-sex hormones. For example, biological females who wish to present themselves as males are given the male hormone testosterone in order to give them more masculine physical characteristics (such as facial and body hair and deepening of the voice). Meanwhile, biological males who wish to present themselves as female are given the female hormone estrogen in order to give them more feminine characteristics (such as enlarged breasts).[40]

In those who have previously taken puberty blockers, cross-sex hormones may be used as a tool to, in effect, initiate an artificial puberty corresponding to the desired gender identity. In this situation, there may be pressure to start cross-sex hormones at even younger ages so that the child does not remain in an artificial pre-pubescent state while his or her peers are continuing to develop more adult sexual characteristics. Endocrinologist Michael Laidlaw has sharply criticized this approach, however, saying, "There is no such thing as 'trans puberty.' What happens is that [an] abnormal, pathologic state . . . is induced . . ."[41]

Risks of Cross-Sex Hormones

The use of cross-sex hormones is associated with a likely or potential increased risk of several serious physical health conditions. Even the pro-transgender World Professional Association for Transgender Health acknowledges this in their "Standards of Care."

Biological males using feminizing hormones (estrogen) are at increased risk for:

- Blood clots
- High triglycerides
- Cardiovascular disease
- High blood pressure
- Diabetes

Biological females using masculinizing hormones (testosterone) are at increased risk for:

- High red blood cells
- High cholesterol
- Cardiovascular disease
- High blood pressure
- Diabetes
- Destabilization of certain psychiatric disorders[42]

Other side effects have also been reported in recent journal articles. One in *Pediatrics* stated, "Testosterone significantly increased both body fat and BMI" [body mass index].[43] Another cautioned that "reduction of [natural] sex hormone production in mid-adolescence to late adolescence may well have effects on reducing energy and psychological well-being," and "Alterations in mood, including the development of irritability and anxiety, are risks of this treatment."[44]

Gender Reassignment Surgery

Gender reassignment surgery (GRS)[1] is the least likely of the invasive physiological gender transition procedures to be performed on minors—but unfortunately, the practice is not unheard of.
There are two types of gender reassignment surgery, colloquially referred to as "top" surgery (either removing or fabricating breasts) and "bottom" surgery (either removing or fabricating genitalia).

"Top" (Chest) Surgery

Biological females who have undergone normal puberty but identify as male may experience "chest dysphoria"—distress about having breasts. In a 2018 study, nearly half of the females who had their breasts surgically removed (33 of 68) were under the age of 18, nearly a quarter (16) were under 16, and two were only 13 years old.[45]

"Bottom" (Genital) Surgery

Genital or "bottom" surgery is the least likely procedure to be performed on minors, but even that has sometimes happened. In 2014, a Beverly Hills plastic surgeon (ironically named Gary Alter) boasted in a press release about performing male-to-female gender reassignment surgery on a 16-year-old. However, "the creation of a vagina and clitoris" was complicated by the fact that, thanks to the hormones, the patient "never . . . developed normal penis and scrotum size."[46] A more recent journal

[1] Terminology for the surgery that some transgender people undergo to alter their anatomy has changed rapidly through the years. What used to be called "sex change surgery" became "sex reassignment surgery," then "gender reassignment surgery," and more recently "gender affirmation" or "confirmation" surgery. It is preferable not to use the term "sex" or "sex change," because sex is an innate biological condition which cannot be changed. On the other hand, "affirmation" or "confirmation" are used to imply that the transgender identity is the patient's "real" or innate identity, which is being belatedly "affirmed" or "confirmed" by the doctor. This is an ideological construct which FRC does not share. Therefore, "gender reassignment surgery" or "GRS" is being used to indicate that what is changing in a "gender transition" is not a person's (biological) sex, but his or her (social and psychological) "gender" or "gender identity," which is indeed being consciously and deliberately "reassigned" by a surgeon, rather than "affirmed" or "confirmed."

article verified this problem, saying, "Concern now exists that the early blockade of puberty may result in insufficient genital skin being available for this procedure."[47]

Perhaps the most famous transgender teenager is reality TV star Jazz Jennings, who underwent genital surgery to turn his penis into an artificial vagina at the age of 17. Jennings was candid about the challenges involved, acknowledging that after taking puberty blockers followed by cross-sex hormones,

> I say it's going to be like a patchwork vagina, Franken-vagina . . . There was just an unfortunate event and setback where things did come apart, and there was a complication. I had to come back in for another procedure . . .[48]

Neither the 2014 case touted by press release, nor the celebrity case of Jazz Jennings is extraordinary anymore. A 2017 study (titled "Age is Just a Number") found that a majority of the surgeons surveyed who perform vaginoplasty (11 of 20) acknowledged they have done the procedure on minors.[49]

Even apart from the problems created by a lack of genital tissue in patients who have taken puberty blockers, genital gender reassignment surgery is "associated with important complication rates"[50] and "a great number of adverse events."[51] "Transsexuals have an increased risk for the development of micturition [urination] disorders after sex reassignment surgery,"[52] according to a 2017 article, including urinary problems such as "incontinence, overactive bladder, urinary tract infections and decreased urinary stream."[53]

Sterilizing Children

One side effect of physiological gender transition procedures is, in a way, obvious, yet in another way easily overlooked. Since such procedures involve deliberately disrupting sex-related functions involved in reproduction, infertility—the inability to conceive and/or bear biological children—is an obvious side effect of those procedures in many cases.

Effect of Cross-Sex Hormones on Fertility

Young people who have already undergone natural puberty before beginning a gender transition will generally be rendered infertile, at least temporarily, by administering cross-sex hormones, which inhibit ovulation in biological females and the production of sperm in biological males. To preserve fertility, individuals may gather sperm or eggs before beginning hormone treatments, and these can be frozen and then used later in artificial reproductive procedures. (Gathering eggs is a much more difficult, invasive, and expensive procedure than gathering sperm.[54])

Alternatively, transgender individuals on hormone therapy can stop taking hormones when they decide to have children, and after a period of time, their fertility may return—although experts warn that "thresholds for amount and duration of exogenous [cross-sex] hormone exposure causing permanent negative effects on fertility have not been established."[55] However, a transgender person adopting this route must be willing to forgo for a period of time the feminizing or masculinizing effects that were sought from hormones in the first place.

Effect of Puberty Blockers Followed by Cross-Sex Hormones on Fertility

However, a young person who has taken puberty blockers will have prevented the development of the reproductive system to the point where viable sperm or eggs are produced in the first place. Therefore, *a course of puberty blockers followed by cross-sex hormones is highly likely to result in permanent sterility* and make the preservation of fertility impossible.

As noted above, claims that either puberty blockers or cross-sex hormones alone are "fully reversible" are questionable. The application of both amounts to what some have called "chemical castration."[56] But the impact of genital gender reassignment surgery is indisputable—even the Endocrine Society, in their pro-transgender Guidelines, concedes, "Surgery that affects fertility is irreversible."[57]

Sterilization of Children Is Unethical

Infertility should be viewed as a serious medical problem. As one survey of the topic summarized:

> Research demonstrates a negative psychosocial impact of infertility among otherwise healthy adults, and distress among adolescents facing the prospect of future infertility due to various medical conditions and treatments that impair reproductive health.[58]

Any procedure causing infertility in *minors* should be viewed as a serious ethical problem as well, as noted by Kelsey Hayes in the *Online Journal of Health Ethics*:

> Sterilization of humans without medically acceptable and sound justification, is ethically and morally wrong. When an individual is sterilized, even as a secondary outcome of therapy, lacking full, free, and informed consent, it is a violation of international law.[59]

Experimenting on Children: The Myth of "Evidence-Based" Care

One of the arguments raised by opponents is that these procedures should not be restricted because they represent a standard of care that is "evidence-based."[60] "Evidence-based" is something of a buzzword in medicine, indicating that medical practices should not just be based on opinion (even "expert" opinion), but on sound scientific research.

The Quality of the Evidence Is Low

But just how good is the "evidence" cited in support of gender transition procedures—especially for minors?

One of the most recent and influential sets of guidelines for procedures to be offered to transgender people was published in 2017 by the Endocrine Society.[61] This document explicitly sought to adopt an "evidence-based" approach.[62]

The key question is—what is the *quality* of the evidence in support of the Endocrine Society's guidelines? They set forth three types of guidelines:

- an "Ungraded Good Practice Statement"—essentially supported by *no* evidence (beginning "We advise . . .");
- a "weak recommendation" (beginning "We suggest . . ."); and
- a "strong recommendation" (beginning "We recommend . . .").

Only with the *strong* recommendations does the task force express "confidence that persons who receive care according to [them] . . . will derive, on average, more benefit than harm."

Then, for each of the "recommendations" (weak or strong), they give a rating of the "quality of the evidence" in support of that recommendation on a four-point scale: very low, low, moderate, or high.

There are 24 guidelines that are generally relevant to the procedures at issue in Vulnerable Child Protection Acts—puberty blockers, hormones for adolescents, and surgery.

Of these 24 guidelines:

- Five are ungraded good practice statements (*no* evidence);
- Two are weak recommendations with *very* low evidence; and
- Nine are weak recommendations with low evidence.

That means only eight of the 24 "guidelines" are even "strong" recommendations—one-third of the total. Of those:

- Two are supported by *very low* evidence;
- Five are supported by *low* evidence;
- *Only one* is supported by even "moderate" evidence;
- *None* are supported by "high quality" evidence.

In summary, the claim that these treatments are "evidence-based" is misleading because the quality of the evidence in this field (even for the Endocrine Society's "strong" recommendations) is low.

Without higher-quality evidence of both their efficacy and their safety, gender transition procedures must be considered *experimental* procedures at best.[63]

No FDA Approval

The U.S. Food and Drug Administration (FDA) is the federal agency charged with certifying that medications are safe and effective for their intended use. Given the sweeping claims that puberty blockers and cross-sex hormones represent a well-established "standard of care," and the claims (misleading, as we have seen) that these treatments are "evidence-based," it might surprise some readers to learn that the FDA has *never* approved puberty blockers and cross-sex hormones for the purpose of gender transition.

Off-label use of drugs is not illegal—in fact, it is fairly common.[64] However, the "off-label" use of a drug means that it has not been scientifically proven to be safe and effective for that particular condition.[65]

Indeed, if you look closely, advocates of gender transition procedures do not even try to deny this. A 2018 article in the journal *Transgender Health* reiterated that "there are no medications or other treatments that are FDA-approved for the purpose of gender affirmation."[66] And the American Medical Association's Council on Science and Public Health reported that "steroidal hormones,"

"GnRH analogs" (puberty blockers), and "antiandrogens" are all used "off-label" for "gender re-affirming therapy"—because their use "lacks scientific evidence."[67]

Carl Heneghan, Professor of Evidence-Based Medicine at the University of Oxford and Editor in Chief of the *British Medical Journal*'s Evidence-Based Medicine, concluded in 2019 that:

> treatments for under 18 gender dysphoric children and adolescents remain largely experimental. There are a large number of unanswered questions that include the age at start, reversibility; adverse events, long term effects on mental health, quality of life, bone mineral density, osteoporosis in later life and cognition. We wonder whether off label use is appropriate and justified for drugs such as spironolactone [an antiandrogen drug used with estrogen[68]] which can cause substantial harms and even death. We are also ignorant of the long-term safety profiles of the different GAH [Gender Affirming Hormone] regimens. The current evidence base does not support informed decision making and safe practice in children.[69]

Do Gender Transition Procedures Prevent Suicide?

Transgender activists often argue that minors must be allowed to undergo gender transition procedures because they will be at higher risk of suicide if they do not undergo them. Author Sahar Sadjadi described this narrative in an article in the *Journal of Medical Humanities*:

> [A] core argument for puberty suppression is frequently repeated by numerous clinicians and advocates of the treatment: preventing the body from developing unwanted secondary sex characteristics saves children from violence, suicide, self-harm, and mental illness at the onset of puberty . . . and from violence and discrimination (and in some accounts, unemployment, drug use, prostitution, suicide) which besets . . . transgender adulthood.[70]

There is some evidence that people who identify as transgender, including youth, are more likely to engage in suicidal behaviors than those who do not identify as transgender. One example is the 2015

U.S. Transgender Survey published by the National Center for Transgender Equality. It reported that among the transgender population:

- 40 percent have attempted suicide *in their lifetime*—nearly nine times the rate in the U.S. population (4.6 percent).
- Seven percent attempted suicide *in the past year*—nearly 12 times the rate in the U.S. population (0.6 percent).[71]

Data like that from the U.S. National Transgender Survey are based on a "convenience sample," meaning people who volunteer online to participate. This method does not necessarily produce a representative sample of the population under study. Hacsi Horvath, an epidemiologist who "detransitioned" (that is, reclaimed his biological identity after having identified as transgender), points to the California Health Interview Survey, which used more scientific methods. This survey of adolescents did not explicitly ask respondents whether they identified as transgender, but it did identify a population who were "highly gender non-conforming," which may be taken as a proxy for transgender status. Within this population, only three percent of girls and two percent of boys reported having attempted suicide.[72]

Nonetheless, experts on suicide in general report, "Untreated mental illness (including depression, bipolar disorder, schizophrenia, and others) is the cause for the vast majority of suicides," noting, "Over 90 percent of people who die by suicide have a mental illness at the time of their death."[73] Further, in both national and international studies, substance abuse and mood disorders continually have the largest associations with completed suicides.[74] [75] 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 percent for adults, with increased rates of suicidality among the adolescent population who had experienced traumatic event(s).[76] Additionally, comorbidities (*e.g.*, depression, substance abuse) are common among those who experienced traumatic events and subsequently suffer from posttraumatic stress disorder.

Importantly, despite the years of empirical study, there is no clear understanding of etiology in the suicide literature. In other words, there is no clear understanding of the individual and combined risks that cause a person to commit suicide.[77] When trying to understand the increased suicide rates in the transgender identifying population, which is a fairly new subject of scientific inquiry, "discrimination" is repeatedly and curiously given as the primary cause for elevated suicide rates. It is essential to note the other increased risk factors for suicide that have been cited in the transgender identifying population, namely a significantly greater incidence of adverse childhood experiences (ACEs).[78] A recent study showed 45 percent of transgender identifying people reported childhood sexual abuse.[79] There are also reports of higher rates of substance abuse than those in the general population.[80] These are just a few examples of known risk factors in the suicide literature, which might better account for the elevated suicide rate in the transgender identifying population. Undoubtedly more research is needed to understand both etiology and suicide among the GD population.

Analyzing Key Suicide Studies

Another problem with the reports on transgender suicide rates is that the statistics are cited as though they provide evidence that gender transition procedures are the *solution* to the problem of transgender suicide. However, these studies often do not indicate *when* the suicidal thoughts or actions occurred—before or after gender transition.

For example, a 2020 article in the journal *Pediatrics* examined the link between taking puberty-blocking hormones and nine different mental health outcomes.[81] Only one finding received most of the media attention because it was the only one that reached the technical benchmark of "statistical significance." This was a finding that those who received puberty blockers had lower "lifetime suicidal ideation" (that is, thoughts about suicide) than those who wanted them but did not receive them. But it was impossible to conclude that the administration of puberty blockers *caused* a reduction in suicidal thoughts. And another finding was more dramatic (though not "statistically significant"). In the study, those who received puberty blockers were *twice as likely to have had a suicide attempt resulting in inpatient care (i.e., hospitalization) in the last 12 months* as those who did not (45.5 percent vs. 22.8 percent).[82]

Perhaps the most dramatic evidence undermining the theory that gender transition reduces suicide comes from a Swedish study published in 2011. The authors examined the medical records of *every* person in Sweden who underwent gender reassignment surgery over a 30-year period. The study found a number of physical and mental health problems were elevated among this population. Most shocking of all, however, was the rate of completed suicides—which was over *19 times higher* than in the general Swedish population.[83]

A comprehensive review of the literature on the subject by the U.S. Centers for Medicare & Medicaid Services declared about the Swedish study that "we cannot exclude therapeutic interventions as a cause of the observed excess morbidity and mortality."[84] In other words, not only does gender reassignment surgery (and other "therapeutic interventions" such as hormone therapy) not demonstrably benefit those who identify as transgender (including by reducing their risk of suicide)—*it may actively harm them* and increase their risk of suicide.

Legislative Response

Because of concerns like those described in this paper, bills to prohibit gender transition procedures on minors have been introduced in a number of states, with the first one becoming law in Arkansas in 2021.[85]

Although transgender activists who support invasive physiological gender transition procedures for minors will obviously oppose such legislation, two issues have been raised in an effort to persuade even conservatives that they should be wary of these bills. These are described below.

Parental Rights

Some critics have raised the question of whether restricting gender transition procedures for minors would not violate another principle usually endorsed by the pro-family movement—that of "parental

rights" to control the upbringing and care of their children. These bills would indeed prohibit these procedures, even if the child's parents consent to them. However, *the law has never recognized "parental rights" as a justification for actions that endanger a child's physical health and safety.*

The most obvious example is laws that prohibit child abuse. If a parent or any other person commits physical acts upon a child that inflict such harm that the child requires medical care, we normally consider that a crime. Indeed, many concerned observers, including the American College of Pediatricians,[86] have declared that gender transition for minors is a form of "child abuse."

However, there are less dramatic areas in which we also impose health and safety protections for children which may override "parental rights." Parents may not choose to transport their young children in an automobile without using a car seat or seat belts. We do not permit parents to supply their young children with alcohol, cigarettes, or illicit drugs.

The proposed bills are actually quite modest in scope. They do not interfere with parents' right to control the *moral* or *social* upbringing of their children. Parents of a child with gender dysphoria would remain completely free to change the child's name, wardrobe, hairstyle, and other forms of "gender expression" if they believe that is in the child's best interest—even though others may vigorously disagree. They remain free to request that schools and other institutions recognize the child in his or her preferred "gender identity" rather than biological sex.[87]

These laws limit only *physical* interventions which disrupt or interfere with normal physical development and/or that radically alter the child's natural anatomy.[88] As noted above, such uses of drugs have *not* been approved by the Food and Drug Administration, and such surgeries have *not* been proven by high-quality scientific evidence to be safe and effective even for their intended purpose (to relieve gender dysphoria), let alone to justify such radical interference with nature.

Restricting such dangerous procedures is fully within the legitimate power of each state to regulate the practice of medicine.

Claims of Economic Harm

Economic blackmail has been increasingly used, rather than persuasion on the merits, to get state and local legislators to bow to their will on public policy issues. This tactic was used in South Dakota to resist H.B. 1057, which would have protected vulnerable children from the severe physical damage caused by certain "gender transition" procedures.[89] California banned official state travel to Iowa after that state passed modest legislation in 2019 prohibiting Medicaid coverage of gender transition procedures.[90]

A classic example of the use of this tactic, however, was the attacks upon North Carolina after the passage of HB 2, the so-called "bathroom privacy bill," in March of 2016. This bill merely required that in state-owned buildings, sex-separated restrooms and changing facilities (such as school locker rooms and showers) should be used by people whose biological sex corresponds to the designation on the restroom or facility.[91]

Dire warnings were given of economic calamity for the state, and they succeeded in coercing some large sports entities such as the National Basketball Association (NBA)[92] and the National Collegiate Athletic Association (NCAA)[93] to withdraw or refrain from placing some specific events at North Carolina venues. In addition, some corporations such as PayPal and Deutsche Bank announced (or claimed) that they were calling off planned expansions in the state.[94]

Such pressure led North Carolina to repeal the original version of HB 2 a year after it was enacted, in March 2017, replacing it with a "compromise."[95]

However, *even during the year that the original HB 2 was in effect*, the economic impact on North Carolina was minimal. A study reported in April 2017 found, "The loss of business, concerts and sporting events represented just 6/100ths of 1 percent of the state's nearly $500 billion annual economy." John Connaughton, professor of financial economics at the University of North Carolina-Charlotte, said the figure was so negligible as to amount to a "rounding error."[96]

In fact, in February 2017—when the original HB 2 had been in effect for almost a year—the biggest economic issue facing state officials was what to do with a $552 million budget *surplus*.[97]

When one business group gave Texas warnings of economic doom if they adopted similar legislation, even *Politifact* did an analysis and found the claims "Mostly False."[98]

Conclusion

Family Research Council has grave concerns about even a social gender transition for minors. Kenneth Zucker, perhaps the world's leading expert on gender identity in children, has said:

> I would argue that parents who support, implement, or encourage a gender social transition (and clinicians who recommend one) are implementing a psychosocial treatment that will increase the odds of long-term persistence.[99]

Proposed legislation like that described above is actually modest in scope, in that it would place no restrictions upon the ability of minors who are supported by their parents to undertake a social transition or request that others recognize and affirm such a transition. (Of course, the response of other institutions, such as schools, to such a request must take into account not only the wishes of the transgender-identified child but the well-being of other students as well.)

However, the implementation of invasive physiological gender transition procedures—puberty blockers, cross-sex hormones, and/or gender reassignment surgery—upon minors raises additional grave concerns. The interference with natural biological functions, the serious potential side effects, and the often-irreversible nature of the physical changes made mean that a high bar would have to be reached to justify them.

There is no convincing evidence that these procedures improve mental health in the long run, which means that bar has not been met. And minors are certainly not capable of the kind of long-term evaluation of risks and benefits that would allow them to give "informed consent" for such procedures.

Invasive physiological gender transition procedures for minors should be prohibited by law.

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Mr. JOHNSON of Louisiana. Thank you.

I'm sorry for that buzzer background noise. It didn't rattle you at all.

We will now proceed under the five-minute rule with questions, and the Chair recognizes, first, the gentlewoman from Wyoming for five minutes.

Ms. HAGEMAN. First, I want to say thank you for being here. You are four incredibly brave women and you're my heroes.

You have been willing to put yourselves out there to address something that many people want you to stop talking. They want to prevent you from talking. Don't listen to them. Make sure that you continue to use your voice to educate us, to educate the American people, because these children are worth saving.

Dr. Bauwens, I want to thank you for being here.

In your testimony, you reference what I think is one of the more important points in this debate, in that children are treated as special and a vulnerable class in the psychological and research fields. You reference the experience at Tuskegee. To me, the important takeaway here is that controversial so-called healthcare practices, treatments, and experience have not always withstood the test of time.

Outside of your reference, I think of how lobotomy was once a form of care we wouldn't even consider today and, in fact, has been banned in countries throughout the world.

In this debate, I have wanted to replace the misleading terminology "gender-affirming care," especially as it relates to children.

(1) It replaces the biological reality of sex, and

(2) It falsely suggests that, using term "affirming," that there is anything good going on here.

There are only two sexes. Boys are girls—or boys are boys and girls are girls, and one cannot become the other.

In fact, and especially when it comes to children, it seems to me that gender-affirming care is better described as "sexual lobotomy." It is treatment that is fundamentally and permanently—that fundamentally and permanently alters the sexuality and medical and psychological well-being of these patients. It causes irreversible sterilization and serious long-term medical complications and long-term reliance on pharmaceuticals.

These treatments and surgeries are controversial medical practices that seek to change a person in a manner which is not actually achievable, and they will not withstand the test of time.

Dr. Bauwens, are there medical professionals in the United States and abroad already rejecting these surgeries as any form of serious medical care?

Ms. BAUWENS. Yes. Thank you for your question—or your question.

We are seeing an increase of medical professionals speaking out. Just this past week, there were 21 doctors that came out and said, "We are very concerned about this."

The AAP, American Academy of Pediatrics, was referenced earlier. Eighty percent of their membership has been asking for a review of the literature, and they've been denied that review by the upper echelon. So, there are—and I've listed many other coun-

tries—there are people who are standing up because they're seeing the harms done to these kids like Chloe Cole.

Ms. HAGEMAN. Can you discuss why referring to these treatments as lifesaving treatment is so extremely misleading?

Ms. BAUWENS. Yes. It's misleading for a number of reasons. Because, for one, the whole impetus of the scientific method is that we're discovering things. We're supposed to be in a process of, "Isn't this the right approach, or not?"

This whole discussion about saying that it's lifesaving automatically says there's no room for discussion; there's no room for scientific inquiry because the science is settled, which it's an amazing statement because the suicide literature has been around far longer than the transgender literature, and the suicide literature is not conclusive.

So, we have where the right hand doesn't know what the left hand is doing in this case.

Ms. HAGEMAN. It seems to me what we've been living through for the last couple of years is a government that wants to suppress any type of speech that it disagrees with. We're seeing that with the industrial censorship complex that we've been talking about.

It seems—it appears that's exactly what's going on here. They want to stop the debate because they know that they can't win it.

Dr. Bauwens, my last question is, what is the success rate of sex change operations?

Ms. BAUWENS. Well, we have—it's hard to find longer-term data with children. What the data that we do have, which is probably the most reliable data point available, is from the Swedish study. It looked at over 10 years, which is really important because regret doesn't just happen a year after some sort of transition. What you see is a suicide rate that's associated with 19 times higher than the general population.

Ms. HAGEMAN. Well, actually, there is a zero percent—there's a 100 percent failure rate for sex change operations, isn't there, because it's not possible to change your sex?

Ms. BAUWENS. That's right.

Ms. HAGEMAN. A hundred percent failure rate for these procedures?

Ms. BAUWENS. That's right, you can't change your sex.

Ms. HAGEMAN. Thank you, and I yield back.

Mr. JOHNSON of Louisiana. Thank you.

The gentlelady yields back.

The Chair recognized the gentleman from New York for five minutes.

Mr. NADLER. Thank you, Mr. Chair.

Mr. Minter, a Federal court has stated that, quote,

> Under the WPATH standards of care and Endocrine Society guidelines, before puberty, treatments focused on support for the child and family. Some prepubertal children may socially transition. No medical interventions are indicated or provided for the treatment of gender dysphoria in prepubertal children.

Do you understand this to be a correct statement?

Mr. MINTER. Yes.

Mr. NADLER. Talk to the mic. Yes.

Mr. JOHNSON of Louisiana. It's actually not—is the button red? Sorry.

Mr. MINTER. OK, there you go. My apologies.

Yes, sir, that is 100 percent correct. Before puberty, there are no type of medical or medication interventions whatsoever. We're talking about transgender adolescents who's hit puberty and who would be eligible to be considered, when it's medically appropriate.

Mr. NADLER. Thank you.

What does the Federal court mean in saying that, quote, "No medical interventions are indicated or provided for the treatment of gender dysphoria in prepubertal,"—actually, you just answered that.

What does the Federal court mean in saying that, "Some prepubertal children may socially transition."?

Mr. MINTER. Yes, the only type of medical support or support offered to a transgender youth before puberty is to just let them be who they are. I can't stress enough; this isn't about kids becoming someone they're not. This is about kids being who they are. So, just allowing them to live with a name, clothing, et cetera, that reflects who they really are.

It's remarkable; they found that when—research has found that, when children are supported in that way, they are indistinguishable in terms of their mental health outcomes from nontransgender kids. They're just as healthy and really thrive when they get the support, that simple support that they need.

Mr. NADLER. Thank you.

Mr. Minter, what have courts said about laws that restrict transgender individuals' access to medically necessary care?

Mr. MINTER. That they severely burden parents' fundamental rights to make medical decisions for their own children, and that they're blatantly discriminatory; that they violate the guarantee of equal protection, because they do something that has just never been done before in this country, which is single out a particular group of people, transgender young people to deny them medical care.

Mr. NADLER. Thank you.

Mr. Minder, a Federal court has stated that, quote,

> The risks of gender-affirming medical care are not categorically different than the type of risks that other types of pediatric healthcare pose. For many adolescents, the benefits of treatment greatly outweigh the risks.

Do you agree with this statement?

Mr. MINTER. Absolutely.

Mr. NADLER. What are the benefits of receiving gender-affirming care?

Mr. MINTER. They're enormous. They produce positive mental health outcomes for these young people. They dramatically improve their quality of life. They do better in school. They develop positive social relationships. We heard that with Ms. Reynolds' testimony. Their relationship with their family improves. Their gender dysphoria is alleviated, and any depression, anxiety, suicidality is dramatically reduced. There's a study from 2022 that found a 73 percent reduction in suicidality among kids who had received this treatment.

Mr. NADLER. Ms. Reynolds, thank you very much for being here today.

Is there anything about you, your son, and other families like yours that you think this Subcommittee and the American people should know?

Ms. REYNOLDS. I would like to just add one thing, if I could. That is, with the sports debate, I just want to share my son's process was with that.

So, as I mentioned, he was the only girl on the boys' team for many, many years when he was a child. When he transitioned, he completely dropped out of playing sports altogether. So, that left a big hole in his life. That's nothing that he did anymore, and it was because he felt the pressure from all this kind of political discussion around this, and dropped out completely. I think that story is probably way more common than the isolated cases.

Mr. NADLER. Thank you.

Mr. Minter, what would you say about what we heard from Ms. Cole about her experience with gender care and her unfortunate experience?

Mr. MINTER. I thank her for sharing that story.

How I'd respond, the most important thing to understand, that story is the exception, not the rule. The vast majority of young people who receive these treatments are getting them after careful assessment and because they really need them.

This has actually been studied. We know that 98 percent of young people who receive these treatments continue to receive them into adulthood. What that reflects is the care behind these standards of care and the assessment process, and the care with which gender specialty clinics in this country are providing this care.

Mr. NADLER. So, she is part of the two-percent?

Mr. MINTER. Apparently so.

Mr. NADLER. Thank you.

My time is expired. I yield back.

Mr. JOHNSON of Louisiana. The gentleman is out of time. Thank you.

The Chair recognizes the gentleman from California for five minutes.

Mr. MCCLINTOCK. I wonder, first, if Ms. Cole would like to respond to that.

Ms. COLE. I didn't see a trans-identifying child who had a positive outcome with their transition.

The reason why most children who are affirmed continue on in transition, either as adolescents or as adults, is because, once you've either socially transitioned or gone on blockers, or started the other interventions, like surgery or hormones, it's incredibly difficult to go back. The social ramifications are—

Mr. MCCLINTOCK. So, it's irreversible and they have no choice at that point, is what you're saying?

Ms. COLE. In every single way.

Mr. MCCLINTOCK. There are two aspects to the question. Let me dispose of the first one involving sports, the fairness of allowing biological males to compete against females in sports. The second is

a more complicated one, whether children should be subjected to irreversible transgender surgical or chemical procedures at all.

Ms. Scanlan, can you tell me if a female claiming to be a male has ever dominated in men's sports?

Ms. SCANLAN. No. Actually in my league, there isn't two instances where the female athlete transitioned to the men's side.

Mr. MCCLINTOCK. So, this is very much a one-way street.

Ms. SCANLAN. Yes.

Mr. MCCLINTOCK. It is biological males competing against women dominate those sports. There is not a case of a biological female going transgender and dominating a male sport. Am I correct?

Ms. SCANLAN. Yes, you're correct. It's obvious that would be the case because—

Mr. MCCLINTOCK. In this case, it is simply—this is an attack on the integrity of women's sports. I wonder why my Democratic colleagues who often posture as feminists can't see this plain truth.

Ms. Scanlan, what would be wrong with simply allowing transgender men and women to compete in their own sports competition while we preserve the fairness of women's sports?

Ms. SCANLAN. Yes, I believe all individuals should have a right to play sports. I think sex-based categories make the most sense.

Mr. MCCLINTOCK. So, transgender males should be allowed to compete with other transgender males in their own sports category. Nobody's got a problem with that, I think.

Ms. SCANLAN. Yes. If that's what governing bodies decide is a fair solution, then I'm for that. I believe that female sports should be protected, and female sports teams should be—

Mr. MCCLINTOCK. Now, the more weighty question is who should make the decision to subject a child to such a procedure on behalf of that child?

Ms. SCANLAN. Nobody.

Mr. MCCLINTOCK. Well, long before governments existed, there were mothers and fathers who had children. So, the family is the most fundamental governing unit. It's established by nature itself. So, I think it therefore follows that parents have a fundamental natural right to raise their children according to their own best judgment.

It can't be absolute, of course. You can't kill them. You have to feed them and clothe them and shelter them. Society has a role to play in being sure that you do. It is intrusions into the decisions of parents over the raising of their children. That needs to be very cautious, very limited, and very humble.

Now, the Ranking Member, in her opening statement, makes this point, once you strip all of the partisan rhetoric. It seems to me there are two issues here. The first is the effort in States like California to bypass parent's judgment and subject their children to transgender procedures against the parent's judgment or even to hide this from the parents. That is going on in California right.

So, I want to be sure I understood the Subcommittee's Ranking Member correctly. It sounded like she, too, opposes government replacing parent's judgment over the decision on transgender procedures for their children. Am I correct on that? Am I correct on that? I yield to the gentlelady to answer.

Ms. SCANLON. I'm sorry. I was—

Mr. MCCLINTOCK. It sounded like you opposed government replacing parent's judgment over the decision of transgender procedures on their children. Am I correct on that?

Ms. SCANLON. What I said was that parents have the ultimate right to make the decisions concerning appropriate medical care for their children.

Mr. MCCLINTOCK. Then I think we're in agreement. We can take that off the table. Both parties oppose the government, any government, making decisions over whether a child will be subjected to transgender procedures contrary to the wishes of the parents. Do I understand that correctly?

Ms. SCANLON. I believe that is generally the legal standard, yes—

Mr. MCCLINTOCK. OK. That's great. Then we need to take it—

Ms. SCANLON. —over what is appropriate apparently.

Mr. MCCLINTOCK. If both parties support a law that forbids performing these transgender procedures on a minor without the full and informed consent of the parents, then Mr. Chair, I believe we should advance such a bill right away. I think that would address the fears that I hear from a lot of parents that their desire to protect their child is at risk from various State governments like California who are trying to usurp that decision. We have complete agreement on that.

Ms. SCANLON. I think you are mischaracterizing the complete agreement.

Mr. MCCLINTOCK. Well, I thought we had just arrived at that agreement until it comes down to actually doing it and then you seem to have a change of heart. Mr. Chair, let's put that to the test. I see I'm out of time. I think the sooner we move on that the better.

Mr. JOHNSON of Louisiana. A very keen observation. The Chair now recognizes Ms. Balint, the gentlelady from Vermont.

Ms. BALINT. Thank you, Mr. Chair. I want to start by saying these issues are typical for most Americans to talk about. I want to bring us back to the basic dignity and humanity of all Americans full stop.

Ms. Reynolds, I really appreciate you being here today. I, too, am a parent. I know that I would do anything that I could to get my children the care that they need. Implied in what you've said is that journey was not always easy for you.

I'm wondering if we could bring it back to the experience of real parents, real Americans right now who are trying to wrestle with these issues. Just tell us a little bit more, if you could, about your experience of trying desperately to get your child to support that you felt like they needed, and you didn't always know what that was.

Ms. REYNOLDS. So, when my child came out as transgender there was not sort of the hysteria that there is now about this. So, there was not a lot of information. We didn't know anyone. We didn't know other parents. We didn't know other kids.

So, if you can imagine late nights on the internet trying to find any information. Lots and lots of tears, lots and lots of discussions with my husband, what are we going to do? How are we going to

support our child. Then we sort of put to the test the social transition. Then we spoke with experts, right?

We took our time, and we learned, and we grew. As our child matured, that sort of changed things, too. It was painful. I don't want to—I sort of don't want to focus on the negative of all this, but it was extremely painful for us. It wasn't an easy choice. It wasn't anything that we took lightly. We took this extremely seriously. We were trying to get it right.

Ms. BALINT. So, is it fair to say that you tried to put the needs of your child at the center of all the decisions that you were making, difficult decisions in the face of a lot of stigma, and a lot of misunderstanding, and you said recently, the hysteria around this. Does the added stigma make it more difficult for parents in this situation to have the courage to stand up for their children? Like what is that when you feel like you are trying desperately to do the right thing, and you're hearing all these voices that you are not being a good parent?

Ms. REYNOLDS. It's absolutely heartbreaking actually. I've spent my entire career trying to help people, particularly children. That is what I do. To sort of be looked at as a child abuser or an indoctrinator or something like that, it's extremely painful and just adds a whole other layer to this. It feels very hateful and divisive.

Ms. BALINT. I really appreciate you saying that because I think there are a lot of parents across the country right now that are trying their level best to do right by their children. This kind of heightened hysteria around this issue is making it very difficult for them to do that. So, I wanted to bring this hearing back to basic humanity and dignity because I feel like we have gone astray. That's the first thing I want to say. So, thank you for being here.

For Ms. Cole, I also want to thank you for being here. I am very sorry you feel like you didn't get the care that you needed and deserved.

Ms. COLE. Thank you.

Ms. BALINT. You're welcome. Mr. Minter, if you could talk to us about gender-affirming care, what does that look like for young kids? What are we talking about when we talk about gender-affirming care for young children?

Mr. MINTER. For young children, we are simply talking about parental love and support, not trying to change the child, recognizing that the child is transgender, and allowing them to be who they are, and encouraging others, family members, to do the same. It's really just loving and supporting a child.

Ms. BALINT. I really appreciate that. Again, let's get back to the basic humanity and dignity of all. The last thing I want to say, in his opening statement, the Chair said, "there is no such thing as gender assigned at birth."

I just want to be on the record here as standing up for the 5.6 million Americans who are in intersex. Actually, that is exactly what the experience that they had was they were having their gender assigned at birth, and they are Americans, too. They are trying to navigate this.

There are atypical chromosome patterns, gonads and genitals, that do not fit typical binary notions of male and female. That does

not make them less American or less legitimate or less worthy of dignity and respect. I yield back.

Mr. JOHNSON of Louisiana. The gentlelady yields back. The Chair now recognizes the gentleman from Texas, Mr. Hunt.

Mr. HUNT. Thank you, Mr. Chair, and thank you brave ladies for being here today. I greatly appreciate it, and I admire your bravery in these times. Many of my colleagues on the left like to discuss gender-affirming care and claim that puberty blockers and hormone therapy and sex reassignment surgery are the only ways to treat gender dysphoria.

Once a child expresses a feeling of gender dysphoria, instead of questioning the root cause of that feeling, that child will more likely than not be on a fast track to gender reassignment surgery, or otherwise known as genital mutilation.

I want you to imagine something. What if we affirmed every thought that our children have? I would like to show you a food pyramid. Now, I know what you are thinking. This is not the FDA's approved food pyramid although many of you probably wish it was.

This is the food pyramid according to my four-year-old and my two-year-old daughters. By the way, in the Hunt house, we don't do Ben and Jerry's. It's Blue Bell only. If my children had their way, they would have ice cream for breakfast, lunch, and dinner, and for every single meal in between. Oh, the wisdom of children.

In the same country, we know that children are mature enough to make adult decisions that will impact the rest of their lives. That is why we have parents. Children cry for ice cream, but as parents, we have the wisdom to know that ice cream is not in their best interest, particularly their long-term interest.

I want to thank my parents, Willie and Diane Hunt. They had three children. All of us three went to West Point. All three of us served our country. All three of us earned multiple master's degrees from Ivy League schools. Do you know why? Because my parents did not give in to the thoughts of an adolescent Wesley Hunt.

I am a United States Congressman because my parents didn't listen to me when I was eight years old. They raised us. They cared for us. They taught the ways of being successful people.

As an adult, you can do whatever you want with your body and with your own money. You are mature. You are fully grown. You can make adult decisions.

I am a combat veteran. I fought for the right for you as an adult to make your own decisions. In my opinion, children are a different story. It is our obligation to protect them.

When it comes to gender dysphoria in children, many in the American medical establishment have absolutely lost their minds. A child will tell their parent they have thoughts of gender dysphoria, and the parent may take that child to a doctor. The doctor, instead of questioning the root cause of the dysphoria, will instead affirm the child's thoughts and proceed with gender-affirming care.

Is many of my colleagues on the left want you to believe, there isn't widespread agreement on how to treat gender dysphoria. I can assure you that child mutilation is not the answer. In fact, Finland, Sweden, France, and the UK, are reversing course and asking questions. In the UK, their only national gender clinic for children

shut down last year by court order, what do their doctors know that our doctors don't?

I am sorry we are here right now. I am sorry, Ms. Cole. We failed you. Ms. Scanlan, my daughters are going to watch this because you have become their new hero. I can assure you that my four-year-old and my two-year-old daughters will not change in front of biological men. This is ridiculous.

I don't care what party you are a part of. If you think that we are all equal and the same biologically, you have literally lost your mind. When my two daughters work hard in a sport, work hard in their craft to be the best that they can be among other women, they will compete against other women. I owe Victoria and Olivia and every other young lady in this country that.

If you think I am wrong, I am not the problem. I can assure you. We have an opportunity in this country to get this right in 2024, so we can stop all this foolishness. I cannot thank you ladies enough for bringing this up. I apologize that we live in America when this is happening. Thank God for the American spirit fire and thank God for brave women like you, because it's brave women like you that are going to turn the tide so that future women won't have to suffer in the same way that you have. God bless you.

Thank you so much for being here. I yield back the rest of my time.

Mr. JOHNSON of Louisiana. Thank you. The gentlemen yields back. The Chair next recognizes the gentleman from Tennessee, Mr. Cohen.

Mr. COHEN. Thank you, Mr. Chair. First, I would like to quote Judge Moody from Arkansas, a Federal judge. He said,

> The diagnosis of gender dysphoria is made by a clinician who assesses whether a patient meets criteria based on a clinical interview, the clinician's observations of the patient, and the reports of the minor's parents.

This is how diagnosis of other mental health conditions are generally made.

Gender dysphoria is a serious condition that if left untreated can result in other psychological conditions including depression, anxiety, self-harm, suicidal behavior, and impairment of functioning.

So, these things need to be discussed and determined in a scientific manner and a logical manner, not emotion, not behavior and attitudes that appeal only to voters in trying to gain votes at the ballot box. This should be done responsibly.

Transgender people have been around for a long time. They have rights, and they need to be respected. I read Ms. Scanlan's testimony. I wasn't here to hear it, and I think Penn didn't deal with your situation like they could have and should have in putting up some type of different barriers in the women's area of the locker room, but that's another issue. Things should be dealt with in a different way.

This is an easy way for people to try to get points. Pick on a minority group that is the most minority and least understood in our country. It's gone on for centuries. A hundred years ago, it was African Americans. Later it was Hispanics, then it was gay people, and now transgender people. Find a group that is not understood and is easy to use to gain political power. If it is bad for politics, it is bad for people, you should use science.

Parents have rights in raising their children. Athletes have rights. There is a connection. We need to figure out the right answer. To get the right answer, we need to ask the medical association and the psychiatric association to choose the people that come before us to testify and give us their opinions on the right way to deal with this issue. Not each group picking people that are favorable to them to put out divergent issues, but people who are experts based on the AMA, the American Psychiatric Association, and maybe another association similar where they pick the witnesses and send them to us to talk about the issue and to suggest a response that would be both fair to the transgender's parent, the transgender child, and the society at large.

The Republicans didn't want vaccines and face masks, and they argued that parental rights were sacrosanct then, and parents had a right to direct healthcare decisions for children. Well, a lot of people died, tens and hundreds of thousands of people died because they didn't get vaccinated.

Gender-affirming surgery, the Republicans think the government should make these sensitive decisions. It's not necessarily the case.

They also believe Americans only have access to healthcare if their healthcare match Republican radical beliefs. Republicans fought against the Affordable Care Act. They fought and refused to expand Medicaid in States leaving millions without healthcare coverage, 120,000 in my State, Tennessee not getting healthcare coverage when the Federal Government would have funded.

They passed countless abortion bans depriving women of safe reproductive healthcare. They spread misinformation to try to undercut medical experts during the COVID pandemic, particularly in Florida. Now, they are trying to limit gender-affirming care for transgender youth. Limiting access to healthcare, wedging the right-wing ideology into the exam room, and substituting their personal beliefs for the professional judgment of doctors, they are causing needless suffering.

In the past two Congresses, I Chaired this Subcommittee. When the Republicans took control, they changed the name, which used to be the Constitution, Civil Rights and Civil Liberties Subcommittee. They changed it to Constitution, I imagine with a small c, and limited government. Civil rights and civil liberties were out the window.

I was disappointed, not totally surprised, that civil rights and civil liberties were removed. What I didn't understand, is how this has anything to do with limited government. This does not have to do with a limited government. There is nothing limited about asserting the preferences and beliefs of Federal legislatures into individual healthcare decisions about young people. It is intrusive, and it is dangerous. I yield back the balance of my time.

Mr. JOHNSON of Louisiana. The gentleman yields back. The Chair now recognizes the gentleman from South Carolina. First, seeking unanimous consent to allow the gentleman from Florida, a Member of the Full Committee, to participate and have the time waived to him for the Subcommittee proceeding.

Mr. NADLER. Mr. Chair, I object. I withdraw the objection.

Mr. JOHNSON of Louisiana. Thank you. Thank you. The Chair recognizes the gentleman from South Carolina, Mr. Fry.

Mr. FRY. Mr. Chair, I would like to yield my five minutes to the gentleman from Florida, Mr. Matt Gaetz.

Mr. GAETZ. I thank the gentleman for yielding. Ms. Scanlan, we just heard my Democratic colleague, Mr. Cohen, say that your circumstance could have been fully resolved if we would have just had some barriers up in the women's showers. Do you think that this is a sufficient way to resolve what we are dealing with here?

Ms. SCANLAN. I think by Representative Cohen admitting that we need barriers acknowledges there are biological differences between men and women. By acknowledging that we need to have private spaces that are separate from each other, why can't we just use the locker rooms that we have always used, the men's and the women's locker rooms? If you are acknowledging that we need protection and privacy from these men, then you are acknowledging that the locker rooms we have always used are the correct ones.

Mr. GAETZ. My next question is for Shannon Minter. Are you familiar with the changes in law recently in Washington State regarding transgender youth?

Mr. MINTER. Yes.

Mr. GAETZ. As I understand it, it used to be the case in Washington State that if a youth showed up at an emergency shelter, there was a legal requirement to notify the parent within 72 hours in the absence of some abuse or neglect. Is that your understanding of what the law was then?

Mr. MINTER. I believe that is correct.

Mr. GAETZ. Then the law changed where now in Washington State if someone shows up to one of these shelters who is a minor and says that their parents don't agree with them changing their gender that the shelter no longer has to notify the parents within 72 hours and can instead notify a government authority. Do I have that right?

Mr. MINTER. The parents will be notified. There is no question about that. This simply allows for a delay to allow them to investigate to make sure this child is going to be safe. There is no question that the parents will be notified.

Mr. GAETZ. How long should parents have to wait not knowing where their child is, while a government process is playing out to make a gender determination?

Mr. MINTER. There is no reason to treat these situations with transgender young people who may be in danger or at risk of abuse at home any differently than we would treat any other child where we would have reasonable basis to worry about that and to investigate that.

Mr. GAETZ. It does treat them—

Mr. MINTER. A short delay to protect the safety of young people is always—

Mr. GAETZ. Hold on. How long is the delay? How long do you want a parent not knowing where their kid is, because the kid says they want to change their gender? Just tell me how long a delay you think is appropriate?

Mr. MINTER. I want authorities to treat these kids with the same care they treat all other children.

Mr. GAETZ. That's—

Mr. MINTER. It will be a short delay, and the parents will be notified.

Mr. GAETZ. Hold on now because—well, you won't tell us how long a delay. So, if you are watching this, just imagine you are that parent, and you don't know where your child is. The law now says there is a 72-hour period where the shelter has to notify you. That 72-hour period for any child of any gender or any circumstance is a period to investigate whether there is abuse in the home. Beyond that, beyond 72 hours, you have got to tell the parent.

So, it is really important to understand here what the proponents of radical gender ideology want. They want to stand between a parent and a child on these important decisions. I don't think it is abuse if a parent says, I am not going to get my child gender blockers.

It is odd to hear you advocate for the law because just moments ago, in testimony, you said, and I wrote it down, "parents have a fundamental right to make healthcare decisions regarding their children."

If in Washington State today, the parent makes the decision that they are not going to provide that gender affirming care, what it does it unlocks for the government a window of time to keep the child away from the parent and to not tell the parent where the kid is.

PARTICIPANT. Murderer.

Mr. GAETZ. Oh, please. Get over yourself. What's terrible is when you have this incongruent desire of the government to restrain the ability of parents to parent. I can only imagine the terror that a parent must go through not knowing where their child is. So, I think that is really challenging.

We have also seen in the State of Alaska, Title IX, which was established for girls' sports to be used as a justification to socially transition a child against their wishes. Ms. Scanlan, as a beneficiary of Title IX, as a female athlete, do you think Title IX should be used in that way?

Ms. SCANLAN. Absolutely not. Swimming did a lot of really good things for my life. I am a sexual assault survivor, and swimming was the only things that I had to keep me going when I was struggling with that. To think about young girls that are not going to be given those same opportunities because Title IX is being reworked and rewritten for these new people that have different definitions of what a woman is.

Mr. GAETZ. Yes. I am against transitioning children against the will of their parents, and I am against transitioning Title IX away from an asset for women's sports through this strange social justice cause that is deeply misguided. Thank you, Mr. Chair, I yield back.

Ms. SCANLON. Mr. Chair, I seek unanimous consent to introduce into the record an article entitled, "No, Washington Did Not Just Pass a Law Allowing the State to Kidnap and Transgenderify Children."

Mr. JOHNSON of Louisiana. Without objection.

Ms. SCANLON. Thank you.

Mr. JOHNSON of Louisiana. The Chair now recognizes the gentlelady from Texas, Ms. Escobar.

Ms. ESCOBAR. Thank you, Mr. Chair. Before I begin my questioning, I have to say this has been so deeply disturbing on a number of levels. What we have seen today is what we have been seeing this entire Congress, which is an effort by my Republican colleagues, and indeed some of the more extreme voices in the Republican party, to keep Americans on a treadmill of rage. Whatever the latest issue is that they want people to be angry about, they do their best to keep Americans on a treadmill of rage.

They get their *Fox* or *Newsmax* or whatever right-wing media outlet of the moment is, they get their viewers. They get a clip from this hearing that gets displayed, it gets put on Twitter, and they make money. That's what all this is all about, unfortunately.

I would like unanimous consent to enter into the record a couple of articles. The first is, "Gender Affirming Surgeon Speaks at Jacobs School Event," dated June 9, 2023.

Mr. JOHNSON of Louisiana. Without objection.

Ms. ESCOBAR. That article, we saw a clip earlier of Dr. Blair Peters. Had Dr. Peters actually been here, he could have helped dispel some myths. In fact, in the article you will find Dr. Peters saying very explicitly transgender kids do not get surgery, Dr. Peters said, "directly refuting a key talking point for those trafficking in antitrans rhetoric."

The other article I would like to enter—I would like unanimous consent, Mr. Chair, to enter into the record, is an article entitled, "I Don't Want to Live in this State of Terror Anymore. Some Families with Trans Children are Leaving Texas." If I could have unanimous consent to enter that into the record.

Mr. JOHNSON of Louisiana. Without objection.

Ms. ESCOBAR. Thank you. Mr. Minter and Ms. Reynolds, thank you for being here to dispel some of these myths and to fight back against this effort to keep Americans on this treadmill of anger and rage.

I would also—Ms. Reynolds, I want to apologize to you. One of my Republican colleagues made some really demeaning and belittling comments meant to humiliate and minimize the parents of trans children by comparing the very difficult, painful journey, and conversation with children about transitioning to allowing kids to eat ice cream all day every day. So, I want to apologize on behalf of what happened. I want to congratulate you for your courage to speak on behalf of your child and other children.

I would like to ask you, Ms. Reynolds, I entered into the record this article about Texas. Texas has been a very hostile State to vulnerable populations. Can you tell me—and I listened very carefully to your journey. Can you tell us what happens when the government marshals all its energy and resources to harm families like yours?

Ms. REYNOLDS. It is absolutely terrorizing is what it does. It is very—it creates another level of stress. I really can't even underState that, overState that. It is terrorizing. It really is.

It is extremely stressful. It is extremely distracting. It produces all kinds of fear. I would have left Texas already if that were something that was financially feasible for my family, and it is not. My career is in Texas. My children are established there. They have their friends. They have their schools. They are there. We are here.

Because of this, I would have been a political refugee to another State if I could afford to do that. So, we have no choice but to try to at least tell our story and see if anybody can hear sort of something a little more rational, something a little more like what families like mine are experiencing.

Ms. ESCOBAR. Thank you so much, Ms. Reynolds. I would be remiss if I didn't say, if Congress really wanted to protect children, my colleagues on the other side of the aisle would have joined with us in passing robust comprehensive gun violence prevention legislation. That would truly protect children. Thank you, Mr. Chair. I yield back.

Mr. JOHNSON of Louisiana. The gentlelady yields back. The Chair recognizes the gentleman from California, Mr. Kiley.

Mr. KILEY. I yield back to the Chair.

Mr. JOHNSON of Louisiana. Thank you for yielding the time. Dr. Bauwens, can you define what gender dysmorphia is?

Ms. BAUWENS. Dysmorphia or dysphoria?

Mr. JOHNSON of Louisiana. Well, there are two different terms?

Ms. BAUWENS. Yes. So, gender dysphoria is a diagnosis in the DSM, which is what we are talking about, I think.

Mr. JOHNSON of Louisiana. Yes. So, is it increasing among our children now, this gender dysphoria?

Ms. BAUWENS. Yes, yes. The diagnosis has increased. I believe even from 2021 to current, there was like a 40 percent increase. The other thing is that we have also had a proliferation of gender clinics. So, 10 years ago, there was just maybe a few. Now, all of a sudden there are tons of gender clinics with a really steep curve of surgical markets expected to increase.

Mr. JOHNSON of Louisiana. So, do you think social media has any role in this increase in gender dysphoria?

Ms. BAUWENS. Absolutely. We know that kids are being influenced. I have a list of—there are 40,000 subscribers to a detransitioning site. I have a list of people who are willing to testify, not to mention those who are silent. I'm sorry. What was the question again?

Mr. JOHNSON of Louisiana. Well, just about the role of social media and the influences there.

Ms. BAUWENS. Social media, yes. So, social media, especially with this age cohort has a very important role. The unfortunate thing, and which is actually the compassionate thing, would be if we were to begin to research why is there such an increase in diagnoses of gender dysphoria, and not just our pat answer of more people feel comfortable coming out.

Why has the demographic flipped from mostly biological males experiencing gender dysphoria to biological females? So, we don't have answers to those questions, and yet we are plowing ahead with these procedures anyway.

Mr. JOHNSON of Louisiana. Well, the evidence seems to show that there is sort of a rush to force gender transition or sex change procedures on children. Are we imagining that, or do you think that's actually happening?

Ms. BAUWENS. No, I don't think we are imagining that. I wish that some of the experiences that we have heard reported today were accurate for the population as a whole, but that is not what

we are seeing. You can go on Planned Parenthood's website and see that if you want a testosterone or estrogen prescription, you can go there and get it in an hour. You you don't have to go through a rigorous assessment.

I think if we had those markers in place, then you would see kids not running toward this kind of transition because I think the number is around 78 percent come to a clinical setting with at least three other—or at least some kind of diagnosis other than gender dysphoria.

Mr. JOHNSON of Louisiana. I think it is an obvious fact that there are some industries that stand to benefit financially from all these procedures and all this experimentation. Are you aware of European nations putting a pause on gender transition procedures for minors?

Ms. BAUWENS. Yes. I think that is the issue that we are asking for. This is the compassionate issue. Let's review the literature.

Mr. JOHNSON of Louisiana. Yes.

Ms. BAUWENS. Let's review, what does the science actually say? Not just from people who are supporters, either way, but what does the science say? Then what we are seeing is where countries, like the UK that shut down the Tavistock Clinic, you are seeing other countries like Finland, Norway, et cetera, that once they actually look at the science that is used to support these procedures, they back away from it because the evidence is actually very weak.

Mr. JOHNSON of Louisiana. There are no reliable studies on long-term effects. We don't know.

Ms. BAUWENS. The longest one we have is Sweden because it goes 10 years. The reality is that a lot of people don't experience regret until like five–seven years after they have gone through these procedures.

Mr. JOHNSON of Louisiana. I will have more time for questions for the panel. I know Ms. Cole is about to hit that button. I am coming back to you because I will have more time.

I just want to note that on May 13, 2021, a Subcommittee Member here on the Judiciary, our colleague, Ms. Sheila Jackson Lee who walked in the room, I am going to quote because you said, I think it is up on the screen there, in essence, "the brain doesn't fully mature until at least 25 years old." Does that tell us about high school students, middle schoolers and, yes, young people who make rash or irreverent or spontaneous decisions? Should that be their life? Now, admittedly she was saying this in the context of a criminal Subcommittee hearing. I think that is a truism. I think she stated an obvious fact that everybody should acknowledge.

Unfortunately, I am out of time. I will have some more in a bit. The Chair now recognizes Ms. Jackson Lee. How about that introduction?

Ms. JACKSON LEE. Mr. Johnson, thank you for giving me that gift. You are absolutely right. That hearing, if I might quote it specifically as the Chair of the Committee, it was made during a Committee hearing entitled, "The Juvenile Justice Pipeline and the Road Back to Integration."

The idea, Ms. Reynolds and Mr. Minter, was to save lives from young people being incarcerated for life. It was the individual

young person making rash actions that would draw themselves into criminal life or criminal acts should that be the rest of their life.

So, let me not step away from the idea that we want to save lives in many instances. Let me get to the point of this hearing since that was not relevant to this hearing, and it was on a completely different topic. Let me get to this point. Let me apologize for a hearing that frightens me.

I have dealt with this issue for decades. I dealt with a young man named David Ritcheson, who was a gay young man, a young, young, young man, who in the place he lived, Texas, his life was not affirmed. He lived in a skin of concern and fear and, ultimately, he was sodomized. We introduced legislation of the David Ritcheson Anti-Hate Legislation because as a gay young man who lived life differently, he was not affirmed. Ultimately, even though he got past this case, he ultimately committed suicide.

So, let me, as I begin my questioning, tell you how fearful I am that the intervention of this Committee on issues of private healthcare determination frighteningly label the trans community in a way that someone is being intimidated in fear and concern for their life or their personal thinking is that they are not worthy. They are not entitled to good healthcare and that their life is not worth it.

I insist on pronouncing today, your life is worth it. Your son's life is worth it. Your daughter's life is worth it however they are transitioning and as they live their life. I plead and beg for those who might be listening know that we do not believe that this is a question for this Committee. It is a question for healthcare, for your parent or loved one or guardian and as well your personal determination.

I will not pretend to be a scriptured person. I am not ordained. I am not in any leading religious organization as a religious leader, but I have spoken to persons who lead. They have given me no evidence that this issue speaks to anyone's religion.

Again, I don't pretend to know every aspect of everyone's faith. In this country, you practice as you desire. I will not sit here and allow the trans community to be abused or in essence to be rejected. For someone somewhere, let me say your life is worthwhile.

Mr. Minter, let me provide you with a question very quickly. My time is short. The due process clause of the 14th Amendment forbids States to deprive any person of life, liberty, or property. The Supreme Court has stated this clause includes a substantive component that provides heightened protection against government interference. What does this mean to the interests of parents in the care and custody and control of their children is important. Please give what this means to you as you lead out in this community.

Ms. Reynolds, please let us know what this meant to you for your son, for his coming together and how you needed the support of your community, your surroundings, and how important this is for the trans.

Let me go to Mr. Minter, please. I would ask the Chair for his indulgence as I had to respond to his commentary. Yes, Mr. Minter.

Mr. MINTER. Thank you so much for your statement of support for this community. Kids need to hear that. Yes, these State bans are an unthinkable intrusion on the traditional, deeply rooted au-

thority of parents to make medical decisions for their own children, who are talking about obtaining established care through parents who know there is an effective treatment. They see their child suffering. To have the government come in and say, no, you cannot obtain this healthcare for your children is a shocking violation of parent's rights.

Ms. JACKSON LEE. Psychologically, Ms. Reynolds, if you can just bring it home to us what it really means and to somebody who is not in this room that might be seeing what's going on here.

Ms. REYNOLDS. I just want to highlight how incredibly difficult all this was. This was, again, nothing that we arrived on easily. There was nothing, nothing impulsive about any of this decision. It was made collaboratively with a team of trained professionals.

There was a ridiculous amount of assessment that happened prior to that. This is not just some kind of fly by night, my kid said this one day, and this whole thing launched. That is not how this went down. It was very, very, very careful.

Ms. JACKSON LEE. Are others impacted by listening to this—

Mr. JOHNSON of Louisiana. The gentlelady is out of time.

Ms. JACKSON LEE. —quickly, can you just say what impact hearing that they are not affirmed?

Ms. REYNOLDS. It is devastating.

Mr. JOHNSON of Louisiana. The gentlelady is out of time.

Ms. JACKSON LEE. I yield back. Thank you.

Mr. JOHNSON of Louisiana. Thank you. The Chair yields next to the gentleman from Texas, Mr. Roy.

Mr. ROY. Thank you, Chair. I thank the witnesses for being here. Ms. Scanlan, is Lia Thomas a man or a woman?

Ms. SCANLAN. Lia Thomas is biologically male.

Mr. ROY. Did the University of Pennsylvania attempt to silence or sensor you or any of your teammates when the news broke about a member of the team, the swim team, would be joining your female swim team?

Ms. SCANLAN. We had already known at this point that Thomas would be joining our team. The university advised us to seek counseling if we objected.

Mr. ROY. Did they try to silence you all in terms of voicing your opinions?

Ms. SCANLAN. Yes. In fact, I wrote an opinion piece for the school newspaper that was quickly retracted because it was too offensive to be written and published.

Mr. ROY. Offensive that you were concerned about a biological male competing against you and undressing in a locker room with you and others? That would be "offensive"?

Ms. SCANLAN. Yes.

Mr. ROY. What steps did the University of Pennsylvania take to platform Lia Thomas over you and your female teammates?

Ms. SCANLAN. The University of Pennsylvania nominated Lia Thomas for NCAA Woman of the Year. In fact, I found this to be very offensive because there are plenty of other female athletes at the University of Pennsylvania that are very strong and very worthy of that nomination.

Mr. ROY. Are you familiar with the International Swimming Federation?

Ms. SCANLAN. Yes.

Mr. ROY. Do you consider it to be some bastion of right-wing conspiracy or somehow a conservative right-wing organization?

Ms. SCANLAN. No.

Mr. ROY. Did the International Swimming Federation ban Lia Thomas from competing at the 2024 Paris Olympics?

Ms. SCANLAN. Yes. The governing body of swimming put in laws to say that individuals that have gone through male puberty are not permitted to compete in women's competitions.

Mr. ROY. So, a question for you, Ms. Cole, and first, thank you for being here. I have heard some of my colleagues on the other side of the aisle use words like this frightens me, this hearing. They are frightened by us having a hearing, in which, you are able to speak to the world about what you have gone through.

I have heard colleagues on the other side of the aisle say life is worth it in the context of pushing a particular world view and saying life is worth it. I would just ask to say that I just want to make sure that you know, like from our standpoint, that your life is worth it. That the people that have gone through this, that your lives are worth it.

I have wondered if you would like to comment on the worth of your life, the social pressures, and the pressure placed on you to pursue a path that you now believe was not the correct path.

Ms. COLE. I think we are on the same page here, that everybody's life, the right to happiness, is worthy. That is what we are all fighting for even if we don't necessarily agree on what that means.

If I may ask, would I be able to address another witness?

Mr. ROY. Through the Chair, you may. So, you may speak to me and reference any other testimony you wish to.

Ms. COLE. OK. Well, Ms. Reynolds—

Mr. ROY. You can direct it to me and say that what Ms. Reynolds talked about, you want to respond to and go ahead.

Ms. COLE. Well, I understood that Ms. Reynolds is scared for her child. I just want to set the record straight that I don't hate her. I don't think anybody in this room hates her. In fact, I see my own mother and my own father in her. That clearly, she really loves her child, and she is doing the best with what she has been given, and unfortunately it is not much. For that I am sorry. I mean, I think every parent deserves the utmost grace and guidance with how to help their child.

With that being said, I don't wish for her child to have the same result as I did. I don't wish for anybody to regret transition or detransition because it is incredibly difficult. It comes with its own difficulties, and it is not easy. I hope that her child gets to have a happy and fulfilling adulthood, however that may look like.

Mr. ROY. Well, thank you for that, Ms. Cole. I think that was heartfelt. I know that a number of us share your view.

One last question as my time is winding down, do you believe that the American healthcare system failed you?

Ms. COLE. On every single level.

Mr. ROY. Thank you.

Ms. COLE. My doctors and systemically.

Mr. ROY. Thank you for being here. I yield back.

Mr. JOHNSON of Louisiana. Thank you. The gentleman yields back.

Ms. BALINT. Mr. Chair, I ask unanimous consent to enter into the record two articles, first, "Social Contagion Isn't Causing More Youth to be Transgender," that is *NBC News*, August 2, 2022, and, "Study finds No Evidence of Social Contagion Among Transgender Youth," August 3, 2022, *American Academy of Pediatrics*.

Mr. JOHNSON of Louisiana. Without objection. Another?

Ms. JACKSON LEE. Yes, Mr. Chair. Thank you. "Human Rights Watch Attacks on Gender Affirming Care by State," but I just want to show this map and just indicate how personal I think these decisions are. Ms. Cole has indicated how personal it is, and you have, too, Ms. Reynolds, thank you. Unanimous consent.

Also, "A Hole in Our Heart. Family and Friends Mourn Murder Victim Chyna Gibson", another unanimous consent. "Chyna Gibson is the fifth transgender woman killed in 2017." This is related, and I am introducing the "Chyna Gibson Stop Murdering Trans Today and Planned Parenthood, Texas Affiliates and PPFA Move for Decision in Baseless Medicaid False Claims Act," particularly, attacked because of their work in trans affirming healthcare. I ask for unanimous consent for those to be placed into the record, Mr. Chair.

Mr. JOHNSON of Louisiana. Without objection.

The Chair now recognizes the Ranking Member, Ms. Scanlon, for five minutes.

Ms. SCANLON. Thank you. Thank you to our witnesses. We appreciate you being here to share your experiences and help everybody understand both the very personal stories that are implicated in this issue as well as some of the political agendas that are being pushed.

It is remarkable that our majority colleagues were not able to find any medical professionals to back their claims in today's hearing other than an edited video of someone who actually has refuted their conclusions. Much of what we have heard today really is playing to and from some of the furthest extremes of right-wing ideology and fearmongering.

Mr. Minter, our colleagues and witnesses have expressed concern about the participation of transgender students on athletic teams aligning with their gender identities even while conceding several times now that to the extent this is a concern in competitive athletics, the athletic governing bodies are addressing this issue for competitive athletes. Can you further comment?

Mr. MINTER. Yes. Transgender students, transgender girls and women have been playing on sports teams for a long time now. Only recently has this become weaponized as a political issue.

Sports associations, high school athletic associations, governing sports bodies, and local school districts have long been able to deal with this issue as they should by looking at relevant factors like age, sport, level of competition, and individual circumstances.

This is a classic solution in search of a problem. The real problem, if there is one, is the one Ms. Reynolds identified, which is still so difficult for transgender kids to participate at all or to receive any encouragement and support.

Ms. SCANLON. Right. That has been one of the primary concerns that we have been hearing from families as they have kids who

just want to be kids and participate in sports and because of the weaponization of this issue, it has become a problem. So, thank you for that.

We have also heard conservative lawmakers and activists argue that bans on gender-affirming care are necessary to protect minors with many labeling gender-affirming treatments experimental. As we have seen here today repeatedly deliberately confusing gender-affirming care with gender transition surgery. Can you speak to that issue?

Mr. MINTER. Again, surgery is an adult treatment. That is not what we are talking about with children and youth. There have been now six court cases, including two complete full trials, where these States have had the opportunity to substantiate the claim that this treatment is experimental. They have no evidence of that.

Again, courts across a wide of variety of judges have concluded that this is not experimental care. It is well-established. It is well-founded. There is extensive clinical research showing the benefits. This is just what ordinarily happens in our healthcare system, which is parents with their children and their healthcare providers making reasonable medical decisions to help their own children.

Ms. SCANLON. Thank you. If you had about 30 seconds to address any additional concerns, what would you say?

Mr. MINTER. The UK still provides healthcare to transgender young people. They shut down the one clinic that used to provide all the care to open up multiple regional clinics to serve more children.

The Swedish study has been referred to here, a number of times today. It is so important. That study lends zero credence to the notion that these treatments are not effective. The author of that study has repeatedly expressed great distress at the way her study has been misrepresented. She strongly opposes bans on healthcare for transgender youth.

Ms. SCANLON. Thank you. We have heard a lot of misinformation probably firmly held personal beliefs, but that may be at odds with the facts. So, I want to correct some of that for the record, Mr. Chair.

I would seek unanimous consent to enter the following items into the record. A letter from leading medical organizations to Congress opposing efforts to ban gender affirming care.

A letter from the Leadership Conference on Civil and Human Rights in support of laws and policies that promote transgender, nonbinary, and intersex people from discrimination.

An Opinion by the U.S. District Court in Arkansas which was later affirmed by the 8th Circuit Court, which has a very complete assessment of the legal and factual basis for this discussion. It found a statewide ban on gender-affirming care to be in violation of the 14th Amendment.

A human rights campaign FAQ on gender-affirming care for anyone who has questions about what is actually going on.

A policy paper from Women's Sports Foundation entitled, "Participation of Transgender Athletes in Women's Sports." I'm almost done.

A *The New York Times* article entitled, "How a Campaign Against Transgender Rights Mobilized Conservatives."

Mr. JOHNSON of Louisiana. Without objection.

Ms. SCANLON. Thank you. I yield back.

Mr. JOHNSON of Louisiana. Thank you. The gentlelady yields back. The Chair recognizes the Chairman of the Full Committee, Mr. Jordan.

Chair JORDAN. Thank you, Mr. Chair. Ms. Scanlan, the Ranking Member just said this is simply about letting kids compete and that the sport's governing bodies are addressing this.

So, I would just ask you two questions. Is Lia Thomas a kid?

Ms. SCANLAN. No.

Chair JORDAN. Is the NCAA appropriately and in the right way in your judgment addressing the situation?

Ms. SCANLAN. They did not during our season. They said that Olympians deserve protections, but collegiate level athletes, grassroot level athletes, middle schoolers, and high schoolers did not deserve those same protections.

Chair JORDAN. So, in your judgment, the Chair calling this hearing is not waste of time as the Ranking Member said. We are trying to get to the bottom of a real concern that is impacting all kinds of young ladies who participate in collegiate athletics.

Ms. SCANLAN. Yes. I would like to say that while there has been a lot of notions that this is such a minority group of people, this one transgender athlete, Lia Thomas, affected hundreds of girls.

There were hundreds of girls at the NCAA championship that were in tears over the situation, whether it be getting bumped out of their spots in competition, failing to qualify for the meet or having to change in the locker room next to a 6′4″ biological male. This not a minority group that is being affected by this.

Chair JORDAN. Well, I thank our witnesses for being here today, and I thank the Chair for his work. I yield to the Chair.

Mr. JOHNSON of Louisiana. Thank you for yielding. A quick question for Mr. Minter. You, yourself, transitioned at age 35 and not as a child, correct?

Mr. MINTER. That is correct. I wish I had been able to do so earlier.

Mr. JOHNSON of Louisiana. All right. Ms. Cole, I want to thank you again for being here today and for sharing your powerful testimony, especially on your 19th birthday. That has been very helpful to us.

Ms. COLE. Thank you, sir.

Mr. JOHNSON of Louisiana. I want to acknowledge what you said earlier, tearfully, as appropriate. Everyone here, as you said, our hearts go out to everybody, the families, everybody affected. We are trying to strike the right balance. We do believe Congress has a role here. I appreciate your testimony for providing evidence of that.

I wanted to ask you first about your parent's involvement in your transition process, and then ask you about some of the hormone treatments you underwent because I think all that is important.

First, were you or your parents informed of the long-term effects of the procedures and hormones that you were subjected to?

Ms. COLE. We had consent forms with a list of some of the side effects. We did do consultations where we did speak about some of them. It was in very vague terms. As a child, it was a lot for me

to process because I was perfectly healthy. Children tend to think that they are invincible, that nothing can get them. With all these things being listed, it was hard to know which of these things I would experience.

Most of the side effects that I experienced, most of the ones I am experiencing today actually, were not even listed on this form, so I had no idea. Children just don't know what permanence is because they have only been in the world for so many years.

Mr. JOHNSON of Louisiana. It is an important legal principle that we have informed consent, fully informed consent, for life altering medical procedures. Are you then suggesting that it was not really fully informed consent?

Ms. COLE. No matter how much information they would have given me as a child, I just would not have been able to consent to this. My parents were required to sign off on these. It was under duress. I don't think there was really consent. It was coercion. They were told—they were given the false dichotomy of either your child transitions or she dies, but transitioning almost killed me.

Mr. JOHNSON of Louisiana. The evidence suggests that this is a common practice, regardless of what has been said here today. There are some other things that are very disturbing. One aspect of the current child movement about this sex change movement that is particularly pernicious is the so-called off-label medications. One that is well-known is leuprolide acetate, which is commonly known as Lupron, to chemically altering boys and girls, not by surgery, but chemically—

Ms. COLE. Yes.

Mr. JOHNSON of Louisiana. —it is the same thing. There is a long list of pharmaceutical drugs that medical personnel across the country are using to, for example, shut off the testosterone production in young boys to make them more feminine looking or to shut off the estrogen production in young girls to make the more masculine looking. So, I am going to say for the record, post-hearing, we have five days I will enter some of the articles that detail a list of these chemical drugs being used on children for purposes that are not approved by the FDA.

Ms. Cole, was one of those puberty blockers that you prescribed Lupron?

Ms. COLE. Yes, I was put on Lupron.

Mr. JOHNSON of Louisiana. What was the purpose of that in your hormone treatment?

Ms. COLE. Just to stop the natural production of my hormones to make way for the exogenous testosterone.

Mr. JOHNSON of Louisiana. Does it concern you as it does us that some pharmaceuticals are being used to chemically mutilate some children today that were never explicitly approved for that purpose by the FDA?

Ms. COLE. Incredibly so.

Mr. JOHNSON of Louisiana. To my knowledge, there is currently no effort underway by the FDA to explicitly approve these pharmaceuticals for a child for these purposes.

Ms. COLE. They shouldn't.

Mr. JOHNSON of Louisiana. They shouldn't. The time has expired for the time that was yielded to me. I thank the Chair. Now, I rec-

ognize myself for my five minutes finally. So, I will keep going here.

The last time I checked, it was still illegal under Federal law to use FDA approved pharmaceuticals for an underapproved, or off label use and yet we are seeing that very commonly in this field.

Ms. Cole, do you find it concerning that medications that were used on you or on countless other children across the country for a reason contrary to the original purpose they were approved for—you said that is something that concerns you, disturbs you, shouldn't be allowed, right?

Ms. COLE. Very much so.

Mr. JOHNSON of Louisiana. Ms. Mailman, let me go to you. There has been a lot of talk here in the recent few minutes about legal precedents, et cetera. I saw you sort of biting your lip as some of that was presented. I will give you a moment here to refute any of that or to respond to it if you will.

Ms. MAILMAN. Right. Well, we have heard a lot about the parent's rights to put drugs into their kids, which the 6th Circuit has just very recently said that there is no Supreme Court case that extends this idea of parental rights to a general right to receive new or experimental drug treatments.

In general, this idea of substantive due process would strip people, would strip parents, would strip voters, and would strip doctors of a say and push all those decisions into our courts, which are not medical experts.

So, as the 6th Circuit also recently said,

> Life tenured Federal judges should be wary of removing a vexing and novel topic of medical debate from the ebbs and flows of democracy by construing a largely unamendable Federal constitution to occupy the field.

So, that is what people are asking for. They are asking for judges to create medical law rather than voters informed by medical science.

Mr. JOHNSON of Louisiana. That's right. I think you have touched on a really important issue here, and it is one that has been discussed a little bit today, and that is, as Mr. McClintock said eloquently, "we are conservatives. We are limited government conservatives," right?

We obviously recognize that parents have a natural and fundamental right to the upbringing of their children, to make decisions with regards to their care, custody, and control. At the same time, our legal system in this country, our law, does not allow a parent to physically or mentally abuse or harm a child, right?

So, what we are all trying to do here in a very reasoned way is to strike the balance, to make sure that we are not doing life-altering harm to young people who are not prepared for that.

In some of the States, like in California, Mr. McClintock's home State, they are pushing the parents out of the room. They are doing this without their consent. That is alarming, and it should be obviously unlawful.

Let me switch the subject here. If doctors are using chemical castration drugs in an off-label fashion that is for a purpose other than what they were approved for by the FDA, should doctors face legal consequences? What do you think about that?

Ms. MAILMAN. So, that is subject to medical malpractice charges. Also, States regulate the practice of medicine. So, States are perfectly entitled to regulate what drugs that people can access themselves. If you can regulate what people can access themselves, obviously that would confer to the child as well. Unfortunately, I think you are seeing this movement that States should not be able to regulate the practice of medicine and somehow Federal judges should.

Absolutely, medical practice suits should be available here. Unfortunately, you've seen the politicization of medical associations creating standards that are then informing doctors. So, I think that what this body could and should do is make sure that there is research, that there is science that are informing States so that their medical boards can make better decisions.

Mr. JOHNSON of Louisiana. That's well said. Early in my legal career, I did medical malpractice defense was one of the areas. The medical standard was a big thing. We had medical review panels in the State of Louisiana, as most States do, and they would look to the medical standard. If the standard itself is not fully informed by studies that back it up, we have a broadscale concern here.

Can you define quickly, changing subjects, what a sanctuary is in the context of gender transition procedures for children?

Ms. MAILMAN. So, California has bragged that it is a sanctuary State as far as gender transition for minors. It has SB–107. There a copycat bill being introduced in other States, and it has two main provisions.

First, is that if a child goes to California to have a gender procedure, the California courts will take over the custody proceedings. So, one parent can take a child away from the other parent and then the California court can assert jurisdiction. That's one provision.

The second provision is that in California, they will not give over any medical information if it relates to another State's transgender procedure laws. So, California is priding itself on ripping families apart when you would think that if they have 170,000 homeless people living in the State that they would focus on the benefits and improving the lives of Californians.

Mr. JOHNSON of Louisiana. That is very well said. In seven seconds, I can't do any justice to any of you asking another question. I want to thank you all sincerely. This is an important hearing. It was not an easy one for anybody, but it is a really important issue that we have to wrestle with on both sides of the aisle and in every State across the country. Many legislatures are doing that right now. In my view, some are doing some really important work.

So, we have to determine what we are going to do at this level. So, your testimony, all of you, your testimony today was valuable for that purpose.

This concludes—

Ms. SCANLON. I have one—

Mr. JOHNSON of Louisiana. One more, one more.

Ms. SCANLON. I have one more UC. Thank you. An article entitled, "California Bill on Youth Mental Health Services Has Been Distorted on Social Media," discussing the fact that California law does not authorize gender-affirming surgeries without parental consent.

Mr. JOHNSON of Louisiana. I am going to defer to the wisdom of my witness, but without objection, we'll admit that for the record.

This concludes today's hearing. We thank our witnesses for appearing today. Without objection, all Members will have five legislative days to submit additional written questions for the witnesses or additional materials for the record. Without objection, this hearing is adjourned.

[Whereupon, at 12:17 p.m., the Subcommittee was adjourned.]

All materials submitted for the record by Members of the Subcommittee on the Constitution and Limited Government can be found at: *https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=116284*.

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