Medical Consensus: An Overview of the U.S. Gender-Affirming Care Industry

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by Nick D. Ulan

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This thesis has been approved by

The Honors Tutorial College and the Department of Business Administration

_____

Dr. Richard Vedder

Department of Economics

Thesis Advisor

_____

Dr. Raymond Frost

Director of Studies, Business Administration

_____

Dr. Kristina Bross

Dean, Honors Tutorial College

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Abstract

This paper explores the institutional, societal, and economic driving factors behind the rapid growth of the gender-affirming care industry in the U.S. The analysis reveals a pattern of "runaway diffusion," whereby unverified medical protocols, such as the Dutch model, were prematurely adopted and widely implemented without adequate long-term outcome data. This has led to significant diagnostic overshadowing, as mental health concerns are frequently misattributed to gender dysphoria, precluding comprehensive psychological assessment and treatment. The paper further examines the role of social contagion and maladaptive coping mechanisms, which have contributed to the unprecedented surge in transgender identification, particularly among adolescent females. The influence of peer networks, online communities, and educational institutions in propagating gender ideology is also discussed.

Alongside these social dynamics, the financial incentives driving the expansion of the gender-affirming care industry are explored, including the involvement of pharmaceutical companies, surgical providers, and technology firms. The paper highlights the potential conflicts of interest arising from these commercial relationships and their impact on research, media coverage, and patient access to comprehensive, unbiased information.

The conclusion emphasizes the need for systemic reforms to enhance professional accountability, strengthen informed consent protocols, and restructure leadership within influential medical organizations. These changes are necessary to

facilitate evidence-based decision-making and prioritize patient welfare over ideological conformity or financial interests. The paper underscores the importance of reestablishing scientific rigor and objectivity in this field to ensure ethical and effective care for individuals experiencing gender-related distress.

Prologue

The conceptualization of gender identity as currently articulated in the United States represents a culturally specific phenomenon predominantly observed within Western societies. Current Western cultures have undergone substantial sociocultural transformation in recent decades, precipitating significant alterations in normative frameworks governing social behavior and collective understanding of gender expression (The following information is from Trueman, 2022). Expressive individualism, the normative modern notion of selfhood in the West, is the concept that individuals have a unique core feeling or intuition that should be expressed if individuality is to be realized. Present western culture is one of authenticity where one is encouraged to find their way of realizing humanity as opposed to conforming to previous generation's societal or religious norms, and the modern individual is defined by achieving authenticity through acting outwardly in accordance to one's inward feelings.

The modern sexual revolution in Western civilization, which includes the promotion of LGBTQ+ activity and normalization of casual sexual encounters, does not only represent growth in routine transgressions of traditional codes or a modest

expansion of the boundaries of what's considered acceptable behavior. Instead, it is the repudiation of the existence of any codes and the subsequent, implicit requirement of others to endorse such mores. This reconceptualization has progressed to the extent where those who do not adopt such views are regarded as exemplifying moral deficiency. Private acts that define sexual orientation have pivoted into playing a central role in society in the past 100 years and are now a primary category for understanding identity. In ancient Greece, sexual desire was regarded as something humans had, but today, it is considered something vital to who human beings are. If society is defined by sexuality, then orientation must be political because rules governing sexuality are rules that govern what is and isn't considered by society as a legitimate identity.

This sexualization of politics through intellectual genealogy is primarily attributed to combining certain Marxist and Freudian elements in the 1930s. The evolution of these societal changes has precipitated outcomes such as juridical deliberations regarding school restroom policies and notable litigation, including the 2018 United States Supreme Court case, Masterpiece Cakeshop, LTD v. Colorado Civil Rights Commission, and a subsequent case adjudicated by the Colorado Supreme Court in 2024. In these cases, a baker, Jack Phillips, was requested to supply a cake for a homosexual wedding and a gender transition celebration, respectively (supremecourt.gov, 2018);(ACLU, 2024). Phillips declined the business in both instances as his religious views prevented him from contributing in particular behavior that is in contradiction with his beliefs; however, when interpreted through the

paradigm of expressive individualism, this was conceived as a personal attack on their identities. Phillips participated in an imposition of harm and discrimination through denying them support and service, so legal proceedings were initiated against him.

In his Notes on the State of Virginia, Thomas Jefferson states regarding freedom of religion, “But it does me no injury for my neighbour to say there are twenty gods, or no god. It neither picks my pocket nor breaks my leg” (docsouth.unc.edu, 2006). This represents a sense of self that is physical rather than psychologically constructed; however, within modern Western civilization, feelings have relevance on the conceptualization of harm. In contemporary society, personal beliefs on religion, ideology, and morality are of concern because disagreement insinuates one party is wrong, and advocating those views can constitute a form of oppression, marginalization, and denial of an identity's legitimacy (This and the following information is from Trueman, 2022).

The principles of expressive individualism play an underlying role in gender identity in the United States. It is accurate that there are different roles of men and women throughout varying cultures and that masculinity and femininity contain a significant element of social construction where males and females internalize behavioral expectations of the host culture. However, the suggestion that sex and gender are separable and that you may become the opposite sex is a metaphysical leap. The plausibility of this relies on the implementation of three factors into a culture. These factors include the following: inner psychology must be granted full authority in human identity, technology must advance to a point where physically altering

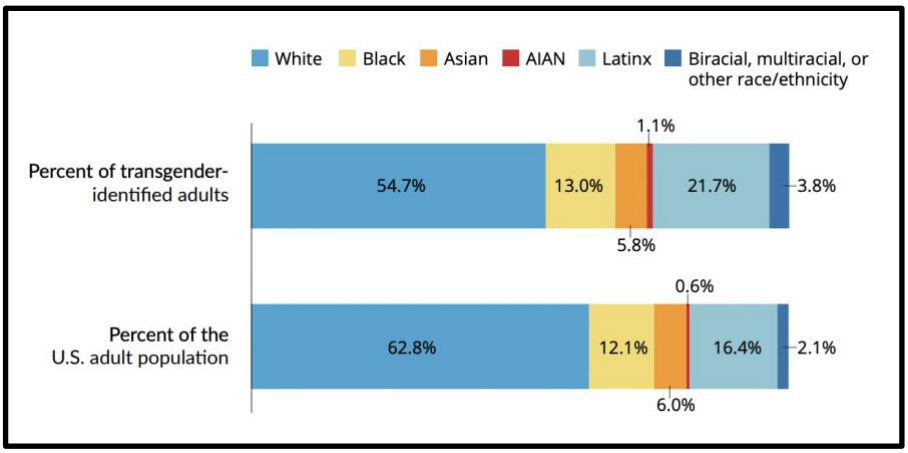
gendered features is technically possible, and the concept must become normalized through powerful lobby groups and pervasive media presence. Western civilization achieved these qualifications through expressive individualism, sex-trait modification procedures to create the perception that sex can be changed, and the implementation of transgenders into the LGB movement in conjunction with the promelgation of unsubstantiated research by prominent medical associations and the media.

Introduction

Gender-affirming care, as defined by the World Health Organization, encompasses a range of social, psychological, behavioral, and medical interventions "designed to support and affirm an individual's gender identity" when it conflicts with the gender assigned at birth (AAMC, 2022). Gender dysphoria is defined as the psychological distress one faces from being transgender (Psychiatry.org, n.d.). There are three groups of gender dysphoria classifications: early-onset, rapid-onset, and late-onset gender dysphoria (Grossman, 2023). Early-onset is defined by gender dysphoria that occurs before puberty, rapid-onset typically occurs around the time of puberty, and late-onset occurs in early-mid adulthood (Grossman, 2023). The U.S. transgender population is estimated to be 1.6 million individuals (300,000 youth) over the age of 13, consisting of an ethnic composition of predominantly Caucasian, African American, and Latino groups (Williams Institute, 2022).

Figure 1

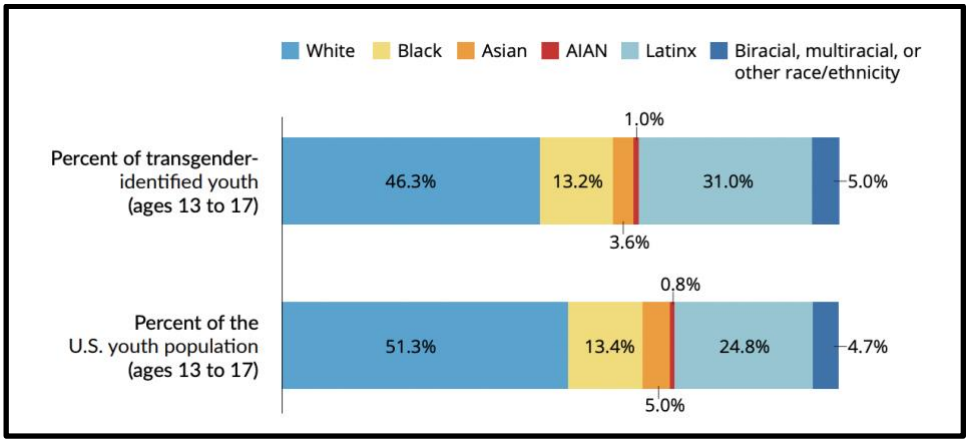
Race/ethnicity of adults who identify as transgender and of the U.S. population (ages 18 and older)



(Williams Institute, 2022).

Figure 2

Race/ethnicity of youth who identify as transgender and of the U.S. population (ages 13-17)



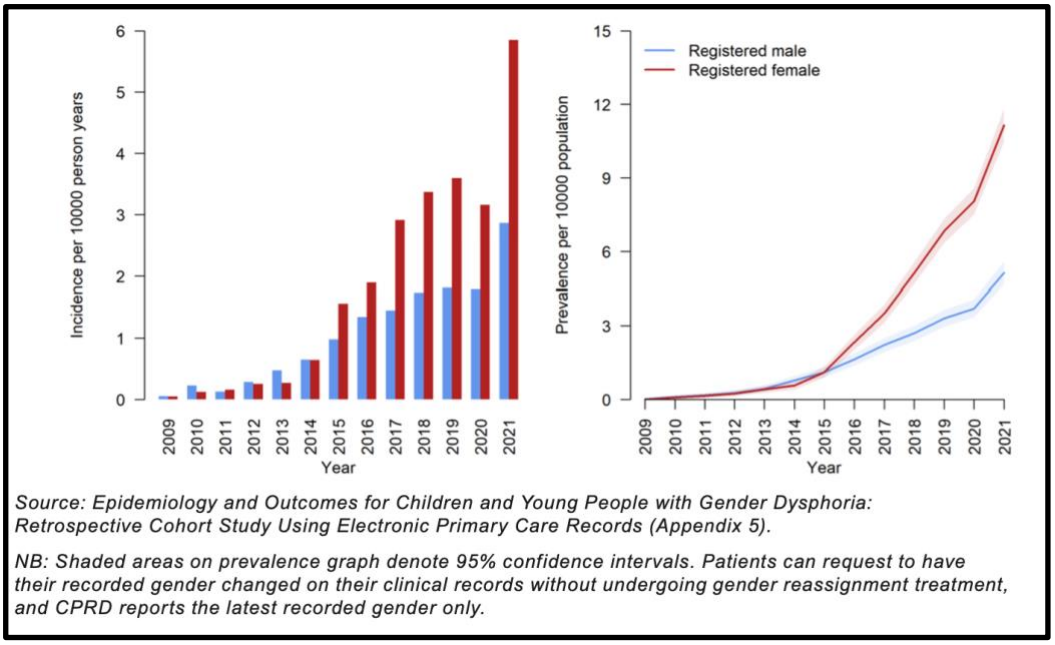
(Williams Institute, 2022)

Over the past decade, there has been an exponential increase in the number of gender clinic referrals for adolescent girls wanting to become boys. The sex ratio for referrals, which males once dominated, has since inverted (Cass, 2024). Accurate documentation of cases in the United States is challenging since the healthcare system is decentralized and lacks standardized national data collection tools that allow analysis of these trends at the state or local level (Grossman, 2023). However, it is established that the unprecedented identification of the younger generation defines the growth with an inverse relationship between increased age and transgender identification (Williams Institute, 2022).

In 2021, between 2-9 % of roughly 15 million high school students in the U.S. identified as transgender, and 8% of the 14.5 million college students identified as "gender diverse" (Reuters, 2022). Additionally, in the same year, 42,000 U.S. children and teens received a diagnosis of gender dysphoria, an increase of 70% from the previous year (Reuters, 2022). These numbers are likely undercounted since they only account for those who receive treatment covered by insurance or those with a gender dysphoria diagnosis (Reuters, 2022). The number of teens with recent onset of discomfort with their sex has increased by 4,000% since 2004 (Grossman, 2023). In 2004, there were two gender clinics worldwide for these exceedingly rare cases, which has risen to over 100 clinics in the U.S. alone (Reuters, 2022).

Figure 3

Incidence and recorded prevalence of gender dysphoria by registered gender



Source: Epidemiology and Outcomes for Children and Young People with Gender Dysphoria: Retrospective Cohort Study Using Electronic Primary Care Records (Appendix 5).

NB: Shaded areas on prevalence graph denote 95% confidence intervals. Patients can request to have their recorded gender changed on their clinical records without undergoing gender reassignment treatment, and CPRD reports the latest recorded gender only.

This influx is of interest as historically, transgenderism afflicted .01% of the population and nearly exclusively boys (Shrier, 2020). Furthermore, before 2012, there was no scientific literature on girls ages 11 to 21 ever developing gender dysphoria at all (Shrier, 2020). As gender ideology is a soft science (science that explores intangibles, behaviors, thoughts, and emotions) rather than hard science (science that explores the natural world such as biology, chemistry, physics) (Williams, n.d.), there are a plethora of components that can overlap in contribution to this increase. This paper evaluates the institutional, societal, and economic driving factors of the gender-affirming care industry within the United States.

Background

The gender-affirming care industry was established under the premise that sex-trait modification through surgery and hormones is a scientifically backed and effective protocol. Some advocates for this form of care have adamantly asserted its success in the United States since its inception. However, this assertion either highlights an ignorant or a negligent disregard for the background of the first gender clinic in the United States, which has served as a basis of procedures and ideology in the modern-day industry.

John Money and Claude Migeon established the Johns Hopkins Gender Identity Clinic in 1965, the first clinic to provide sex-change surgeries in the United States (JHU, n.d.);(The following information is from Colapinto, 2000). Money- the pioneer in the establishment of contemporary gender ideology and gender reconstructive surgeries- credited with coining the term "gender identity" in 1957, maintained unprecedented views on the concept of disjoining identity from biology. There have always historically been rare cases of transsexuals, who were almost always men believed in some way to have a disorder. However, there has never been a theory like Money's denying the role of biology in its entirety. Born in New Zealand in 1921, Money moved to the United States when he was twenty-five. He received a PHD in psychology from Harvard before joining Johns Hopkins and gaining acclaim in the specialization in sexuality and hermaphroditism.

His radical theory posits that newborns are gender-neutral and can accept a new gender if the transition occurs before the age of three, as biological sex is

detached and less influential than psychological gender. Money introduced his theory of psychosexual neutrality in 1955, stating, "We are all psychological hermaphrodites at birth with the potential of being male or female. Our identities are externally imposed, unrelated to X or Y chromosomes, genitalia, or reproductive roles" (Grossman, 2023).

Money's rejection of traditional gender norms can be traced back to his troubled childhood, marked by abuse from his father. Money wrote, "I suffered from the guilt of being male. I wore the mark of man's vile sexuality. I wondered if the world might really be a better place for women if not only farm animals but human males also were gelded at birth" (Colapinto, 2000). His theory seemingly validated his own inner psychological conflict against biology, dismissing it as insignificant in identity. His father died when he was eight years old, resulting in him being raised by his mother and aunts who held resentment towards males, and resulted in his avoidance of the role of “man of the household” (Colapinto, 2000).

To provide further context on the ideology of John Money, he was also in a sex research and academic group with several members who were disciples of Alfred Kinsey (Grossman, 2023). Kinsey is known for promoting an aversion to traditional sexual morality, suggesting in the 1940s that sexually explicit material should be used in education, and even producing this material in the attic of his house at Indiana University, filming colleagues. (Grossman, 2023). Money followed this trajectory, conceiving medical school lectures that included perverted sexual behaviors in the 1970s. Introducing them into the John Hopkins Medical School curriculum in 1971, he

“featured explicit photographs of people engaged in bestiality, urine-drinking, feces-eating, and various amputation fetishes” (This and the following information is from Colapinto, 2000).

By the mid-1970s, he was a vehement advocate for open marriages and nudism and wrote about the benefits of bisexual group sexual encounters in his book *Sexual Signatures*. Money also publicly supported pedophilia and advocated for the decriminalization of incest, expressing to *Time* magazine in 1980 that "A childhood sexual experience such as being the partner of a relative or of an older person, need not necessarily affect the child adversely". In an interview with *Paidika,* a Dutch journal of pedophilia that carries ads for pro-pedophile groups such as the North American Man-Boy Love Association, Money conveyed, “If I were to see the case of a boy aged ten or twelve who’s intensely attracted toward a man in his twenties or thirties, and the relationship is totally mutual, and the bonding is genuinely totally mutual, then I would not call it pathological in any way”, adding “It’s very important once a relationship has been established on such positive and affectionate grounds that it should not be broken up precipitously.” In 1987, Money furthered his advocacy, writing an admiring foreword in a book published in Denmark, entitled *Boys and Their Contacts with Men,* which presents positive testimonials of pedophilic relationships. The knowledge of the depravity that Money exemplifies assists in further recognizing the approach and unethical practices that are exhibited in the first documented case of sex reassignment on a child born developmentally normal- known as the John/Joan case.

In 1965, Janet and Ron Reimer gave birth to identical twin boys, Bruce and Brian. From the irreparable damage Bruce suffered during his circumcision at eight months old, they turned to Money after hearing of the famous professor and his philosophy on gender being more critical than anatomy on television. When the twins were twenty-two months old, they traveled from their home in Winnipeg, Canada, to Johns Hopkins in Baltimore to consult with Money in early 1967, who they believed could resolve the complications.

Money informed them that if his directions were followed, Bruce could identify as a girl and become well-adjusted and happy. They followed Money's instructions and allowed Bruce to be castrated, undertaking bottom surgery to construct female-appearing external features, and renamed him Brenda. When the Reimers agreed to this, Ron was twenty years old with an education ending in the seventh grade, and Janet was twenty-one with an education up to the ninth grade. Decades later, Janet stated, "I looked up to him like a God. I accepted whatever he said".

The twins represented an optimal experimental model for Money's research, providing a genetically identical control subject (Brian) to be juxtaposed with the experimental subject (Bruce) while simultaneously offering compliant and vulnerable parents whose desperation rendered them particularly amenable to clinical directives. Money emphasized to them that they must eradicate any doubts about the sex change, warning they were never to tell Bruce the truth and informing them that when Brenda

was older, he would need hormones to undertake female puberty and operations to construct female features.

The Reimers were in continual contact with Money about Brenda's progression for 11 years via letters and phone calls and would have yearly visits with him in Baltimore. In 1972, Money attended an annual meeting in Washington, D.C., with the American Association for the Advancement of Science when the Reimers were six. There, he revealed his twin case, portraying it as an overwhelming success, and published a book that day. The book delineates how Brenda participates in the typical norms for a girl, who is interested in dolls and kitchen work, contrasting Brian's interest in cars and tools. The astounding results of his experiment awarded Money both fame and funding for the remainder of his life.

Although Money gained widespread acclaim, he was met with dissent from the likes of voices such as long-term critic Milton Diamond, a professor of anatomy and reproductive biology at the University of Hawaii. In the 1960s, Diamond published concerns over sex reassignment for babies along with his dispute of psychosexual neutrality. Diamond's perspective was that Money prematurely reported the twin case as a success since they were only six years old (The following information is from Grossman, 2023)

Following the twin case, Money's mentality at Johns Hopkins was that sex reassignment surgery was the sole treatment for boys with underdeveloped genitalia, refusing to present any alternative. Dr. Quentin Van Meter, an endocrinologist at Johns Hopkins, recounts a situation in which Money covertly persuaded parents to

transition their child with pituitary gland issues that were suspected to resolve with testosterone treatment, recalling, "The baby goes home and comes back 6 weeks later. I went out to call the baby and family back to the clinic office, and there was the mom, but sitting on her lap was a child dressed in a pink, frilly outfit with a white bonnet on its head. I said, 'I thought you were bringing your baby boy this time,' she said, 'Oh, Dr. Money met with us before we left the hospital.' Now, we did not invite Dr. Money in to see this patient because we did not need his consultation, but he found out the child was there, grabbed the mother, sat her down, and said to the mother, 'These endocrine doctors don't know what they're doing. This protocol will not work. It has never worked. You need to go home, tell your family that you have a baby girl, change the name, dress the child as a female. You can come back, and we'll prove to those silly endocrinology doctors that they do not know what they're doing.'" Upon evaluation by Van Meter, the baby's issues were fully resolved. Although the mother adhered to Money's instructions to dress the child as a girl, she also followed the endocrinologists' call for hormone injections, and it treated the condition as expected.

The influence of Money's theory persisted for decades, becoming established doctrine across multiple disciplines, including pediatrics, child development, psychology, and sociology. During this period, his approach advocating for the surgical reassignment and female upbringing of boys with genital abnormalities was accepted as medically supported, and the adoption of this treatment continued. In 1974, in Money's book, *Sexual Signatures*, he once again states in complete certainty that the twin case was a success and that 'Brenda' was "sailing contentedly through

childhood as a genuine girl," according to *New York Times* review by Linda Wolfe (This and the following information is from Colapinto, 2000).

By 1978, the experiment still held its significance as the most credible evidence of nurture being a more significant factor than nature in gender identity. The same year, a documentary filmmaker with the British Broadcasting Corporation (BBC) visited Johns Hopkins and the Child Guidance Clinic treating Brenda. He described a sense of embarrassment towards Money and a growing worry at Johns Hopkins, communicating, “I was getting vibes from people in Baltimore being quite embarrassed by Money and the prominence of this case in the literature,” Goldwyn says. “I could tell that these people were getting increasingly worried.”

The psychiatrist supervising Brenda's case in Winnipeg, Keith Sigmundson, agreed to be interviewed by the BBC under the conditions that it would not be sold in the United States or Canada and that the Reimers and clinicians would maintain anonymity. When asked about the prognosis for Brenda's reassignment, he paused, then stated, “I don’t think all the evidence is in.” he began. “At the present time, however, she does display certain features which would make me be very suspicious that she will ever make an adjustment as a woman.” Sigmundson later described his hesitation: “I was wondering if I was really going to tell the truth or just fudge it. After all, it was still Hopkins. Money was the guru… By that time,” Sigmundson says, “there were clear doubts in my mind that this [sex reassignment] ever should have happened. At that point, I think I really wanted the world to know.”

Nineteen years later, in 1997, it became public that Brenda, at age thirty-two, is David, a man with a wife and three adopted children, and he worked as a janitor at a slaughterhouse. Contrary to Money‘s insistance, since a child, David would refuse to play with feminine toys, wear girls' clothing, or participate in typical girl activities. He was bullied incessantly, called “Cavewoman” for his boyish mannerisms. His childhood career aspirations reflected this: he wanted to become a garbage man in second grade and a car mechanic in eighth grade. He even urinated while standing up when possible.

He was subjected to the involuntary treatment of estrogen in 1977 at age 12, despite attempts to throw away ethinyl estradiol tablets. Money’s importunity and coercion for Brenda to undergo sex-trait modification surgery began in April 1973 despite his resolute opposition to ever having the surgery. Despite Money's warnings, after years of David's psychological and physical abuse, his psychiatrist urged the Reimer parents to disclose the truth. When he was fourteen in 1980, he was notified of his actual biology and immediately returned to being a boy. In 1981, a month before turning 16, David underwent surgery to construct male-appearing features. Even at extreme lengths, from creating anatomy that appears female to the socialization of the opposite gender from before the age of 2, Money's gender-neutral theory was proven incorrect. Years later, David stated, "I was relieved. Suddenly, it all made sense why I felt the way I did. I wasn't some sort of weirdo. I wasn't crazy." Janet Reimer relayed the development to Money; however, he never publicly acknowledged the revelation

and continued to endorse sex reassignment surgeries for infant boys, claiming the twin case had been lost to follow-up.

Upon learning of Money's false claims of success in his story, David was distressed by the idea that the medical protocol for other boys would be the same, so he agreed to be interviewed by Diamond and Sigmundson beginning in early 1993. In March 1997, Diamond and Sigmundson published their paper (*Sex Reassignment at Birth: A Long Term Review and Clinical Implications*), revealing the truth about the twins, which was so controversial that it took them two years to find a journal willing to publish (The following information is from Grossman, 2023).

Money never responded, only ceasing to write about or mention the case. In interviews with David and Brian, they revealed that during their annual trips to Baltimore to see Money, they were sexually abused by him until they refused to return. Brian later overdosed at age 36, and David subsequently committed suicide at age 38. The Reimer's parents blame Money for the death of their sons. In 1987, at an NIH meeting, Money was honored as a scientist funded for 25 consecutive years, along with announcing that, "Infant sexual reassignment surgery was one of his most important clinical contributions to medical science."

After Money died in 2007, a colleague wrote, "He made extraordinary contributions. Scholars are indebted to him for his brilliance, scientific contributions, and passionate commitment to research and clinical care." The Kinsey Institute, which established the John Money Collection of his Personal and Professional Papers, stated, "We are most honored to have been the fortunate recipient of his support and

exceptional collection," and praised him as an extraordinary pioneer and visionary researcher.

John Money's death was not a deterrent in advancing his ideology. Although his proof of concept was a failure, the Reimer case is not used to substantiate claims that biology has a critical role; it is rejected for the notion that identity transcends nature today. Just as John Money ignored and suppressed relevant information, the current industry does the same. This case demonstrates the inclination of academics in the medical field to accept false notions because they support a current social movement or idea.

Rapid Onset Gender Dysphoria

The rapid influx in cases of gender dysphoric patients, specifically female adolescents, is a phenomenon that breaks the historically held trends of this group, being defined by rare instances of males under the perception that they are female. The causation of such a shift has been attributed to greater acceptance of this group; however, there are overwhelming indicators that this is not the case. The minority stress model will later be reviewed to understand why this correlation is insignificant based on the demographics of this population. A more substantial theory for this occurrence is demonstrated by the idea of rapid-onset gender dysphoria (ROGD).

Coined by Dr. Lisa Littman, a Brown University physician, researcher, and academic, ROGD is defined as “the development, over a short period, of gender dysphoria in an adolescent or young adult with no significant earlier history”

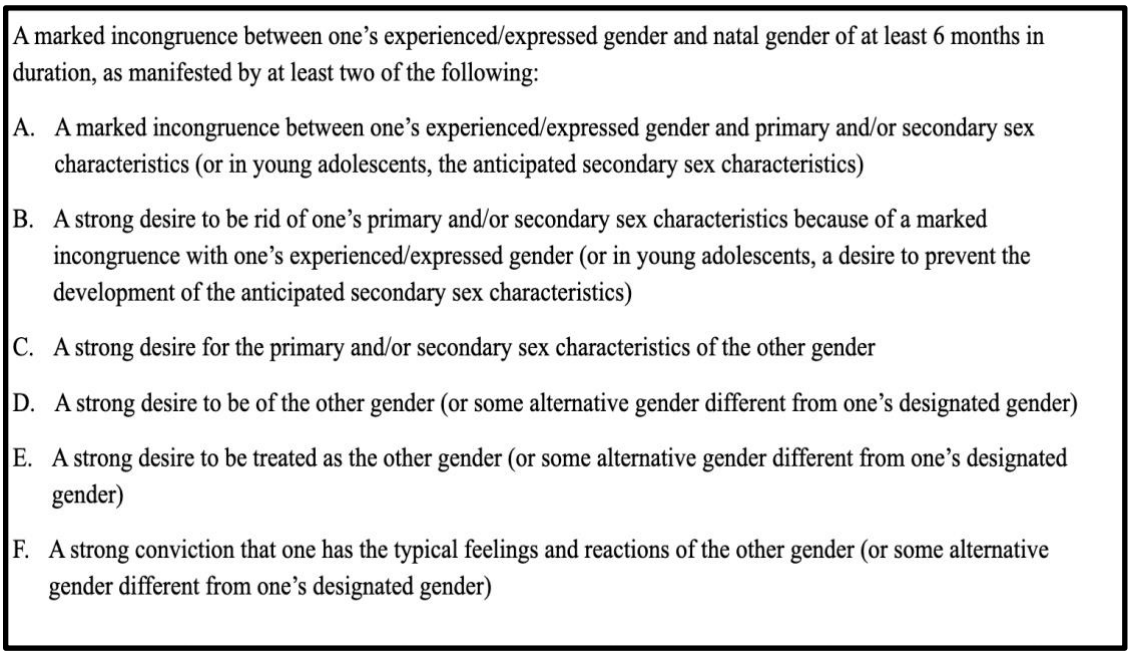
(Grossman, 2023). The onset of this group's dysphoria begins throughout or following puberty, differentiating from the precedent of early or adult-onset dysphoria being standard. A 2018 study by Littman was conducted to explore the rapid presentation of adolescent-onset gender dysphoria that is occurring in individuals who previously did not meet the criteria for gender dysphoria in childhood. Those who did not meet the requirements for ROGD were excluded from the sample (The following information is from Littman, 2018).

The study included a 90-question multiple-choice, Likert-type, and open-ended survey. The data was collected anonymously from 256 parents whose adolescent and young adult (AYA) children fit the criteria of sudden adoption of a transgender identity during or following puberty. The sample of parents was made up of 91.7% women, predominantly white (91.4%), with 88.2% believing that transgenders deserve equal rights and protections as others.

Among Littman's sample, 82.8% of the AYAs were natal females with an average age of 16.4 years old, and 41% had expressed a non-heterosexual sexual identity before coming out as transgender. The average age for the announcement of their transgender identification was 15.2 years old. 80.9% of parents responded that their announcement came "out of the blue without significant prior evidence of gender dysphoria." Respondents were requested to identify the timeline between not presenting symptoms and their announcement of their transgender identity. Nearly a third (32.4%) of parents claimed their child did not seem gender dysphoric at the time

of their announcement, and 26% stated the length of time was between less than a week and three months.

Figure 4



A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 months in duration, as manifested by at least two of the following:

A. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)

B. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)

C. A strong desire for the primary and/or secondary sex characteristics of the other gender

D. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)

E. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)

F. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

(Association AP. Diagnostic and statistical manual of mental disorders (DSM-5®).

Presented above is the diagnostic criteria for gender dysphoria from the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Based on the DSM-V guidelines released by the American Psychiatric Association (APA), not a single one of the AYA sample would have met the criteria for gender dysphoria in childhood before puberty, with 80.4% having presented zero indicators, 12.2% possessed a single indicator, 3.5% with two indicators, and 2.4% with three indicators.

The presence of comorbidities and vulnerabilities predating the onset of their gender dysphoria, including neurodevelopmental disabilities, psychiatric disorders, non-suicidal self-injury, trauma, and difficulty coping with negative emotions, is substantial within this group. 62.5% of the AYAs had at least one or more diagnoses of a psychiatric disorder or neurodevelopmental disability prior to the onset of gender dysphoria. Almost half (48.4%) of them had experienced a traumatic event preceding the onset of their dysphoria. The descriptions of trauma were categorized with "family" (including divorce, death of a parent, having a family member with a mental disorder), "sex or gender-related" (such as rape, attempted rape, sexual harassment, abusive relationship, break-up), "social" (such as bullying, social isolation), "moving" (relocation or changing schools), "psychiatric" (such as psychiatric hospitalization), and medical (such as serious illness or medical hospitalization).

45% of the children engaged in self-harm preceding the onset of their gender dysphoria. Over half (58%) were reported as having a poor or extremely poor ability to handle negative emotions productively, and 61.4% were overwhelmed by strong emotions and tried to avoid (or go to great lengths to avoid) experiencing them. Almost seventy percent (69.4%) of the respondents stated that during adolescence, their child had social anxiety, with 44.3% having difficulty in peer interactions and 43.1% having a history of being isolated.

Another cause of concern is that the trajectories of the AYAs did not follow the narrative of flourishing behavior post-adoption of their opposite sex identity. Respondents reported that following their trans-identification, their children had

exhibited a worsening of their mental health. 57.3% of respondents noted a worsened relationship with their children, and 58.1% observed they had a reduced range of interests and hobbies. Despite a small portion of AYAs experiencing improvement in mental health (12.6%), the most common result was worsened mental well-being (47.2%).

In a subset of the data, there were 30 cases in which the onset of their transgender identification occurred amid a decline in their ability to function (such as dropping out of school, taking a leave of absence from school, and/or being unable to maintain or receive employment) which reportedly was a significant variation from their typical behavior. In 43.3% of these cases, the AYAs were considered academically gifted before their functional decline. In the majority of these cases (76.7%), there was at least one psychiatric diagnosis made. 60% were diagnosed within the same year, and 16.7% were diagnosed within two years of their new transgender identity. Out of the 23 AYAs that had been diagnosed with a psychiatric condition within two years of their transgender identity, 91.3% were diagnosed with depression, 73.9% with anxiety, 26% with bipolar disorder, 17.4% with borderline personality disorder, 8.7% with psychosis, and 8.7% with an eating disorder.

More than a third (33.7%) of the 256 total AYA sample requested that they receive medical and/or surgical transition at the exact moment they announced they were transgender. 67.2% of the AYAs said to their parent that they wanted to start cross-sex hormones, 58.7% stated that they would like to go to a gender clinic or therapist, and 53.4% declared they wanted surgery for transition. The issue of suicide

was brought up by 31.2% of AYAs as a reason that they should receive treatment with parental approval.

At 55.9%, over half of them held very high expectations that transitioning would solve social, academic, occupational, or mental health issues. While 43.9% of the children expressed they were willing to work on basic mental health before gender affirming treatment, 28.1% were unwilling to improve their basic mental health before transitioning. At least two of the respondents reported that their child refused to continue psychiatric care and medications for pre-existing mental health diagnoses following their identification as transgender.

Corresponding with their sudden onset of gender dysphoria, almost seventy percent (66.8%) of the sample were in friend groups that had at least one or more members who become gender dysphoric and come out as transgender during a similar time as they did. On average, the AYAs had their first friend identify as transgender when they were 14.4 years old. Furthermore, the average number of friend group members who became transgender was 3.5 people per group. In 36.8% of friend groups, the majority of the members of the group became transgender.

The respondents described a group dynamic consisting of praise and support for those identifying as transgender and ridicule for those who are not. 60.7% of the children experienced increased popularity within their friend group when coming out as transgender, and 60% of the friend groups were known to mock those who were not LGBTQ. Out of 39 respondents who provided an optional open-ended answer regarding popularity changes, 19/39 (48.7%) of them described benefits, including

positive attention, compliments, elevated status, an increase in popularity, a gain of online followers, and increased protection from ongoing bullying.

For 63.5% of the AYA sample, there was an increase in internet and social media usage leading up to their announcement of their identity. This increase is presumably attributed to their usage on online forums and platforms, where 54.2% received advice on how to tell if they were transgender, 34.7% were told the reasons they should immediately transition, 34.3% were informed that if their parents would not agree for them to begin hormones that they were "abusive" and "transphobic," 29.1% were notified they would regret if they waited to transition, 22.3% were coached on what and what not to say to doctors and therapists to receive hormones, 20.7% were instructed to use the "suicide narrative" to convince their parents to agree to hormone treatments if they are reluctant, and 17.5% were directed that it is acceptable to fabricate or withhold information about medical or psychological history from a doctor or therapist to receive hormones. 69.2% of respondents suspect their child was using language they found online while coming out as transgender, and the majority (76.5%) of surveyed parents felt that their child's belief of being transgender was incorrect. Some of the sources that parents have identified as most influential in the development of their child's transgender identity included YouTube transition videos (63.6%), Tumblr (61.7%), groups of friends they know in-person (44.5%), online communities/groups (42.9%), or a person they know in-person (41.7%).

A total of 63.8% of the respondents have been called "transphobic" or "bigoted" by their children, with the most common reason being for disagreeing with

them about their self-assessment of being transgender (51.2%). The other rationales include that the parent had recommended the child take more time to assess if their gender dysphoria will persist or go away (44.6%), expressed concern for their future if they go through hormone therapy and/or surgery (40.4%); called their child by the incorrect pronouns (37.9%); told them medical intervention would not help them (37.5%); recommended that they work through existing mental health issues first to determine its influence on the dysphoria (33.3%); called the child their birth name (33.3%); or recommended a comprehensive mental health evaluation before beginning affirming care (20.8%). Out of the sample, there were eight cases of estrangement. In six instances, the child ran away, moved out, or refused contact with the parent. Two of the cases were initiated by the parent because the AYA's outbursts were negatively impacting younger siblings or there was a threat of violence towards the parent.

Slightly over one-third (36.2%) of respondents have taken their child to a gender therapist, gender clinic, or physician intending to begin their transition. Of those respondents, 71.6% had reported that the clinician did not evaluate mental health, previous trauma, or any underlying causes of gender dysphoria. 70% reported that the clinician did not request or review any medical records; however, 23.8% of the AYAs were offered puberty blockers on their first visit. When questioned if their child completely and accurately communicated their history, 84.2% of parents were reasonably sure or positive that their child had omitted and misrepresented aspects of their history.

The following notions can be drawn about the perspective of the sample AYAs as a result of the study:

1. Non-specific symptoms (including those associated with trauma, psychiatric issues, and puberty) should be attributed to symptoms of gender dysphoria.
2. Medical transition is the sole solution and path to happiness.
3. Anyone who disagrees with a self-diagnosis of transgender identification or a plan to transition is abusive and transphobic.

The findings from Littman's study will be later referenced in subsequent sections.

(data in this section is attributed to Littman, 2018)

Runaway Diffusion

The amalgamation of the medical establishment with ideological advocacy in the name of medical consensus has permeated the gender-affirming care industry. This transformation did not occur suddenly; it resulted from activist rhetoric through outlets such as universities and select doctors beginning in the 90s (Grossman, 2023). This conversion, taking place over the past two to three decades, was exacerbated by the concealment of its occurrence through the framing of scientific substantiation. Organizations that are involved in this transformation and have issued statements to indicate their endorsement of gender affirming care for children include:

The American Academy of Child and Adolescent Psychiatry, American Academy of Dermatology, American Academy of Physician Assistants, American Nurses

Association, American, Association of Clinical Endocrinology, American Association of Geriatric Psychiatry, American College Health Association, American College of Nurse-Midwives, American College of Obstetricians and Gynecologists, American College of Physicians, American Counseling Association, American Heart Association, American Medical Student Association, American Psychiatric Association, American Society of Plastic Surgeons, American Society for Reproductive Medicine, American Urological Association, Federation of Pediatric Organizations, GLMA: Health Professionals Advancing LGBTQ Equality, The Journal of the American Medical Association, National Association of Nurse Practitioners in Women's Health, National Association of Social Workers, Ohio Children's Hospital, Pediatric Endocrine Society, Pediatrics (Journal of the American Academy of Pediatrics) and Seattle Children's Hospital, Texas Medical Association, Texas Pediatric Society, United States, Professional Association for Transgender Health (USPATH), World Health Organization (WHO), and World Medical Association (GLAAD, 2024).

Organizations whose standings enact the most consequential roles in the influence of the gender affirming care industry include the likes of the the American Psychological Association (APA), the World Professional Association for Transgender Health (WPATH), the American Academy of Pediatrics (AAP), the Endocrine Society, and the American Medical Association (AMA). These organizations have unparalleled influence on establishing procedures in their

respective fields of medicine. Their guidelines are what psychiatrists, psychologists, and pediatricians rely on for diagnosing and treating patients, signifying their expansive control of the medical field (Grossman, 2023).

American Psychological Association

The American Psychological Association (APA) is "the leading scientific and professional organization representing psychology in the United States" (APA, n.d.). One of the essential roles of the APA is the composition of the Diagnostic and Statistical Manual of Mental Disorders, otherwise known as the DSM. The DSM is the handbook utilized by healthcare professionals in the U.S. and globally as an authoritative guide to mental disorders (Psychiatry.org, n.d.). The DSM contains criteria for diagnosing mental health disorders (including symptoms and descriptions), and it establishes reliable and consistent diagnoses with related language applicable to research and communication on mental disorders. (Psychiatry.org, n.d.).

The International Classification of Disease (ICD), produced by the World Health Organization, is a global system used to classify and code diseases for health records and billing. The DSM is not only used for diagnostic and treatment purposes but also for insurance purposes, as it is compatible with the HIPAA-approved ICD-10-CM coding system and used by insurance companies (Psychiatry.org, n.d.). Essentially, the DSM is interconnected within the healthcare system as formal diagnoses in the DSM also allow the condition to receive corresponding billing codes from the ICD that are necessary for billing insurance companies.

In 1980, gender identity disorder (GID) was first added to the third variation of the DSM (DSM-III) with two qualifications specified to meet the criteria for diagnosis. The first component is a strong and persistent cross-gender identification manifested by cross-dressing, cross-sex roles in play, and preferring stereotypical activities and playmates of the other sex (Korte et al., 2008). The second element was a persistent discomfort about one's sex. (Korte et al., 2008). There also had to be evidence of clinically significant distress or impairment in critical areas of functioning (Korte et al., 2008);(The following information is from Grossman, 2023).

Beginning in the 90s, there were staunch advocates for the removal of GID from the DSM due to the implications of the use of the word "disorder." Discourse began within the APA regarding the removal of the diagnosis in 2006, with one side asserting that it should be taken out of the next DSM version (DSM-V) to push a social change that could destigmatize the group from the classification. The opposing view maintained this advocacy was purely political as there were no new studies or findings to justify this measure, and the U.S. healthcare system requires a formal diagnosis to substantiate necessary medical and psychological intervention.

By 2008, during the preliminary planning of the next DSM, a task force was assembled to determine if GID should be maintained or removed from the upcoming DSM as it was included in DSM IV, identifying transgenders as individuals with an emotional problem. An esteemed figure in LGBT matters, psychiatrist Jack Drescher, described the situation as being “difficult to find reconciling language that removes

the stigma of having a mental disorder diagnosis while maintaining access to medical care" (Drescher, 2013);(The following information is from Grossman, 2023).

In 2010, the World Professional Association for Transgender Health issued statements of influence, claiming it is a violation of human rights to believe gender confusion is a disorder, claiming, "Gender variance is not in and of itself a psychiatric disorder, and therefore the label of gender identity disorder as a mental illness or mental disorder is not appropriate. Such labeling may undermine human rights in that it undermines legitimacy of identity and creates and sustains social stigma" (Grossman, 2023). Expanding further in 2012, WPATH's position held that any attempt to align gender identity and expression with a patient's biological sex is not effective and is unethical.

The DSM Task Force administered an international survey on the GID diagnosis to facilitate their decision-making process, which was distributed to 43 groups. The survey, however, was not received by board-certified psychologists or physicians; it was instead sent to organizations that have concerns about the welfare of transgender individuals. Only 5 out of the 43 parties who received the survey are categorized as associations of medical professionals. The survey resulted in 55.8% of respondents believing that GID should be excluded from the next DSM, but the issue with removing it in its entirety from the DSM is that this would cause problems with healthcare reimbursement. The survey demonstrated a general agreement that if the diagnosis is retained, there must be a restructuring of the name, criteria, and language to destigmatize transgender individuals.

Influenced by the survey, the DSM-V included an alteration of the diagnostic criteria to no longer diagnose the internal feeling of misalignment with one's sex (Gender Identity Disorder) but rather to diagnose the distress the patients experience as a result (Gender Dysphoria). Prominent psychiatrist and author Miriam Grossman describes the revision to the DSM as, “If your son experiences his body as wrong, it's not pathology; it's not cause for concern. It's his associative distress, his dysphoria, that's of clinical significance. If a mismatch is present, free of distress, your son has no diagnosis. Insurance coverage remains. The stigma is gone. Goodbye gender identity disorder, hello gender dysphoria."

Leaders in psychiatry, Dr. Robert Spitzer and Dr. Allen Frances, were prominent figures in drafting the earlier versions of the DSM (Head of the Task Force on DSM-III and DSM-IV, respectively). During the drafting of the DSM-V, they issued a letter of condemnation, claiming that the leadership group working on the revisions of DSM-V was "sealing itself off from advice and criticism”, asserting that “DSM-V leadership has lost contact with the field by restricting the necessary free-communication of its working groups." The pair considered DSM-V to be a closed, secretive process that is offensive to other mental health professions. Following the release, Frances warned physicians to use the DSM cautiously, if at all.

In 2022, the ICD released its latest version (ICD-11), in which gender dysphoria was removed and replaced with ‘gender incongruence. Resembling DSM revisions, the basis for this change was not supported by new evidence but rather activism with the intention to depathologize gender confusion further. The latest

diagnosis, gender incongruence, is classified as a sexual health condition in the same category as pregnancy, and the change is also expected to be implemented in the next DSM in correspondence with the ICD.

World Professional Association for Transgender Health (WPATH)

The World Professional Association for Transgender Health (WPATH), founded in 1979, is an NGO that innumerable, if not the preponderance of private physicians, therapists, U.S. hospitals, and clinics follow (Grossman, 2023). Their standards of care (SOC), or their clinical protocols outlining the necessary assessment and treatment for transgenders, are promoted as the model of best practice in gender affirming care (WPATH, 2022). Despite being advertised as an objective science-based medical organization, former chairman of the International Standards of Care Committee which issued their 5th SOC, Dr. Stephen Levine, conveyed, “The Standards of Care ("SOC") is the product of an enormous effort to be balanced, but it is not a politically neutral document. WPATH aspires to be both a scientific organization and an advocacy group for the transgendered. These aspirations sometimes conflict. The limitations of the Standards of Care, however, are not primarily political. They are caused by the lack of rigorous research in the field which allows room for passionate convictions on how to care for the transgendered.” (Will-Law.org, n.d).

WPATH’s SOC 8 recommendations are heavily reliant on a single study (the Dutch Protocol; reviewed in the ensuing section), which has been refuted, contains severe methodological flaws, and is inapplicable for the majority of the current

demographic (Manhattan Institute, 2022). The SOC guidelines include the promotion of the affirmative care model (prioritization of sex-trait modification surgery and hormones over psychotherapy treatment) for trans-identified youth, endorsement of early medicalization, and a redaction of the minimum age of care from its original release (WPATH, 2022). WPATH also included the introduction of a new gender identity ("Eunuch") for males who have the inclination to be castrated, classified as, "those assigned male at birth (AMAB) and wish to eliminate masculine physical features, masculine genitals, or genital functioning." (WPATH, 2022).

A 2021 independent peer review analysis of WPATH's guidelines gave SOC 8 a quality score of 0 out of 6 and referenced the formal rejection of their guidelines in countries such as Sweden, Finland, Norway, and Britain among skepticism by medical groups in Australia, France, and New Zealand (Manhattan Institute, 2022). Despite other countries' aversion to implementing these guidelines, WPATH has substantial influence in the United States, with their guidelines effectively in use by medical organizations and even formally adopted into Medicaid programs in states such as New York and Maryland (WPATH, 2024).

In the same year (2021), Erica Anderson, former board member and the first transgender president of WPATH's American associate, USPATH, wrote an op-ed criticizing the blind embrace of affirming care for minors by the medical community in the *Washington Post* (Anderson & Edwards-Leeper, 2021). WPATH countered Anderson's concerns by issuing a joint statement with USPATH, asserting their opposition to using the "lay press" to discuss any issues (WPATH, 2021). Internally,

there was a moratorium imposed on its members from speaking to the press at USPATH, and Anderson resigned in denouncement of the industry's suppression of dissent (Davis, 2022). In one interview, Anderson confesses, "I got to a point in my concern that I felt I could no longer continue in good conscience to support the direction of USPATH, which I had led for the last two years. I resigned from the USPATH board of directors at the end of our last meeting. I have some concerns—serious concerns," which included the prevalent rate of referrals of adolescent girls to gender clinics (Davis, 2022).

Provided his 25-year tenure with the organization, Levine reinforces this notion, expressing, "WPATH claims to speak for the medical profession; however, it does not welcome skepticism and therefore, deviates from the philosophical core of medical science... Skepticism as to the benefits of SRS to patients and strong alternate views are not well tolerated in discussions within the organization. Such views have been known to be shouted down and effectively silenced by the large numbers of nonprofessional adults who attend the organization's biennial meetings" (Will-law.org, n.d).

SOC 8 has been welcomed by opposition from parties such as a group named *Beyond WPATH.* Their petition, which has collected over 2,750 signatures, proclaims, "As mental health professionals, public health scientists, and allied organizations and individuals, we have grave concerns about the damaging physical and mental health impacts of the current Standards of Care released by WPATH (the World Professional Association for Transgender Health). We hold that WPATH has discredited itself."

(Beyond WPATH, n.d.);(The following information is from Environmental Progress, 2024).

In May 2024, WPATH experienced an internal data leak of files, which included screenshots of posts in their internal messaging forum between 2021 and 2024 and an internal panel discussion. Members of WPATH are depicted as clearly acknowledging that children and adolescents cannot fully grasp the lifelong implications of gender-affirming treatments, as well as admitting that the parents of these individuals might also lack the necessary health literacy to make informed decisions.

The leaked files highlight instances where practitioners within WPATH seem to overlook the long-term consequences of medicalization despite being aware of them. The members appear to downplay concerns and dismiss the need for rigorous evaluation before proceeding with gender affirmation. Messages found in the files refer to patients with severe mental illness such as schizophrenia and dissociative identity disorder being permitted to consent to sex trait modification hormones and operations. Any concerns introduced regarding the treatment of those patients are dismissed as “gatekeeping”.

The files also reveal discussions within WPATH about surgeons performing extreme body modification procedures, such as "nullification," creating body types that do not exist in nature. These discussions point to a trend of pushing the boundaries of medical experimentation in gender medicine, raising ethical and safety

concerns. Promoting such practices has been likened to historical incidents of major medical malpractice, indicating the gravity of the situation.

Following the publication of the leaked files, Environmental Progress reached out to every named WPATH member for clarification and response to the allegations. The attempt yielded a low response rate, although those who did reply (2) confirmed the comments attributed to them were correct or did not deny the comments.

The Dutch Protocol

The foundational study accredited with the conception of the gender-affirming care model implemented in the United States came from a small study in Holland, Netherlands, entitled the Dutch Protocol. The study was intended to examine any possible correlations between the administration of sex-trait modification in adolescence and an enhanced quality of life in adulthood. Since the Netherlands' adoption of sex reassignment surgery in 1972, patients with gender dysphoria- primarily middle-aged men- experienced severe mental health issues, which prompted this research. The researchers speculated whether childhood medical intervention could produce a positive mental health outcome for patients with gender dysphoria if they physically developed to appear more masculine or feminine to align with their psychological identity (The following information is from de Vries et al., 2011; de Vries et al., 2014).

The Dutch study included 111 youth patients in their sample who underwent puberty blockers at an average of nearly 15 years old, followed by sex-trait modification hormones at roughly 17 years of age, and then breast and bottom

surgeries around 19 years old. In addition to the medical intervention, they also received continuous psychological care. The study's sample was carefully selected to include the most clinically straightforward cases who had severe lifelong gender dysphoria, and disqualified those with mental health issues.

In 2006, the interventions were published in an influential article supported financially by Ferring Pharmaceuticals, the manufacturer of the puberty-blocking agent Triptorelin. In 2014, the study's results were published, finding that puberty suppression and surgical intervention were linked with marked reduction or resolution of dysphoria, enhanced mental health, and overall functioning (The following information is from Biggs, 2022).

In 2022, a Professor of Sociology at Oxford, Michael Biggs, published a comprehensive investigation into the study. Biggs detailed bias within the research, citing that two of the researchers on the experiment were elected to be on the board of directors at the Harry Benjamin International Gender Dysphoria Association, now known as WPATH. He noted the association that these researchers were serving on the board around the same time as puberty blockers, a non-FDA-approved drug, joined WPATH's standards of care in 2001. By 2000, puberty suppression (GnRHA) had only previously been administered to 7 children under the age of 16. Their 2001 standards of care at the time were based on a case study of a singular patient- the only available research at the time- as the Dutch Study was released 13 years later.

In 2007, the Dutch Protocol was adopted in the United States when Dr. Norman Spack, a Harvard-affiliated pediatric endocrinologist, co-founded the Gender

Management Service at Boston's Children's Hospital. Based on the Dutch model, this was the first clinic dedicated to gender dysphoric children in the United States, offering puberty suppression treatments with no minimum age except the requirement that the child reaches Tanner Stage 2. A psychologist was sent to Amsterdam to train staff in the facility. In 2015, Spack revealed to the New York Times that when he was in Europe 15 years prior and learned of the use of puberty suppression in adolescence, he recollected, "I was salivating… I said we had to do this" (Grossman, 2023);(The following information is from Biggs, 2022).

In 2009, The Endocrine Society endorsed puberty suppression for children as young as Tanner Stage 2 based on the recommendations of Spack and three Dutch researchers on their committee, entrusted to write their first clinical guidelines for 'transsexuals.' The Endocrine Society is an organization that self-proclaims itself as "dedicated to providing the field of endocrinology with timely, evidence-based recommendations for clinical care and practice. We continually develop new guidelines and update existing guidelines to reflect evolving clinical science and meet the needs of practicing physicians." and their position “influences a wide range of policies affecting endocrine-related research and practice." (Endocrine.org, n.d.).

Despite their claims of evidence-based recommendations, their endorsement came nearly five years before the 2014 Dutch study findings were released. The release of their guidelines precipitated the pervasive adoption of the protocol in the U.S. as doctors, clinics, hospitals, and drug companies could now point to reputable organizations such as The Endocrine Society, WPATH and, Boston Children's to

substantiate that the treatment of puberty suppression for adolescents is internationally endorsed for gender-dysphoric children (Grossman, 2023);(The following information is from Biggs, 2022).

By the mid-2010s, the Dutch Protocol was established as the standard model for transgender medicine due to the premature adoption and disregard for methodological flaws, including a key feature of medical research: replicability. In an attempt to replicate the study between 2011 and 2014, clinicians in London conducted a study with a sample of 44 teens, and their results were presented at a WPATH conference in 2016. Contrary to WPATH's position that medical intervention improves mental health, one presentation described that adolescents after one year of receiving GnRHa suppression "report an increase in internalising problems and body dissatisfaction, especially natal girls" (Carmichael et al., 2016). An additional presentation detailed adverse outcomes, reporting, "Expectations of improvement in functioning and relief of the dysphoria are not as extensive as anticipated, and psychometric indices do not always improve nor does the prevalence of measures of disturbance such as deliberate self harm improve" (Butler, 2016).

Reflective of WPATH's predisposition to suppress conflicting studies, the conference papers were never published as articles, and the outcome was never publicized in the manner the Dutch Protocol was. The findings were only published in 2021 following an extended campaign, including complaints to the ethics committee, media publicity, and a judicial review. In the replication of the Dutch study, puberty blockers did not bring measurable benefit or harm to psychological function, and their

dysphoria did not improve (Carmichael et al., 2021);(The following information is from Abbruzzese et al., 2023).

In addition to Bigg's paper, another critical evaluation of the Dutch protocol, titled *The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed* was published in 2023 by Levine and co-authors. The paper delineates the study's methodological flaws and discrediting factors, including bias, confounding variables, poor research design, and lack of a control group. The following points that invalidate the study are outlined:

1. The sample population was carefully selected to include the most stable and clinically straightforward patients.
2. 111 subjects were selected, which was reduced to 70 and then 55. The researchers excluded those who stopped treatment, declined to participate in follow-up, developed significant medical issues, or had complex personal situations. Key outcomes were only available for as few as 32 subjects.
3. One subject who was excluded was killed following vaginoplasty by necrotizing fasciitis when an intestinal graft was necessary due to the treatment.
4. Despite the high rate of psychiatric disorders and neurodivergence in the demographic, individuals with mental health issues were disqualified from the study.

5. The only subjects included in the study were those who have had lifelong, severe gender dysphoria that worsened with puberty. The current demographic (ROGD) is defined by sudden onset in adolescence.
6. Psychotherapy care was provided to all subjects, which could have benefitted their overall well-being, not the medical treatment. The industry's current stance is not only that therapy is optional but also potentially harmful.
7. Puberty blockers were assumed to be fully reversible at the time, which has been proven false.
8. Several factors were not considered for side effects of blockers, such as physical health, libido, and sexual development. There was also a lack of attention to fertility.
9. The average age at which puberty suppression began in the study was 15, while today, children as young as 8 are eligible.
10. The scale that they measured gender dysphoria with before and following treatment was problematic.
11. The study follow-up was premature as complications and regret can take years to develop.

When analyzing the outcomes of the patients who were disqualified from the study, only 22% of the patients went on to have gender surgery as adults. Of those who did not proceed with affirming care, almost 80% were content that they were not a part of the study. Levine and coauthors expanded on the overwhelming desistance

(the resolution of gender dysphoria) rates for rejected subjects, stating, "Raise the possibility that the majority of those rejected from hormonal interventions not only were unharmed by waiting but benefited from 'nontreatment' with gender reassignment in adolescence. Unlike the medically and surgically treated subjects, the 'rejects' completed uninterrupted physical and psychological development, avoided sterility, maintained their sexual function, eliminated their risk of iatrogenic harm from surgery, and avoided the need for decades of dependence on cross-sex hormones" (Abbruzzese et al., 2023).

In an additional study review, the authors discovered, "Of 30 psychological measures, there was no statistically significant improvement in nearly half of the measures, and the balance only evidenced small changes of questionable clinical relevance. Importantly, there was no improvement in anxiety, depression, and anger scores" (GETA, 2022). Aside from the study's methodological flaws, Biggs emphasized that any other experimental treatment on healthy teenagers with a fatality rate surpassing 1% would be halted (Biggs, 2022), especially considering the low diagnostic stability of the condition.

Even researchers who conducted the Dutch Protocol have voiced their discontent with the inappropriate utilization of their study to justify extensive adoption of the practice. In 2021, a primary author of the Dutch study, Thomas Steensma, highlighted, "We don't know whether studies we have done in the past can still be applied to this time. Many more children are registering, and also a different type… the rest of the world is blindly adopting our research." (Our Duty, 2021). Another lead

researcher on the study, Annelou de Vries, has expressed concern over puberty suppression being prioritized over psychotherapy, stating, "Longer term follow-up studies are needed to inform clinicians so that an individualized approach can be offered that differentiates who will benefit from medical gender affirmation and for whom additional mental health support might be more appropriate." (Grossman, 2023); (The following information is from Abbruzzese, 2023).

As a result of the comprehensive adoption of the Dutch protocol, an untold number of minors have been subjected to sex trait modification hormones and surgeries despite lacking a long-term follow-up to the study until 2022. The Dutch study's 2022 data once again does not portray any indication to justify the usage of the model. The study includes that over half of the participants in their early 30s were single (unmarried and without a partner), nearly 60% felt shame for their genital appearance, and there is a regret rate for loss of fertility in females and males, at 44% and 35%, respectively. For males, ¾ reported issues with libido, over 70% experienced pain during sex, and ⅔ had difficulty achieving orgasm. 20% of respondents had reported that their identity has changed over time. The meaning of this, although never specified, could signify a reversion to their biological sex or a nonbinary identification. Furthermore, a significant number of adverse outcomes likely went unrecorded due to the 50% response rate. Regardless, the result of this case demonstrates that even with early medical intervention and support for the most straightforward cases, the psychological belief that one belongs to the opposite gender is not immutable.

American Academy of Pediatrics (AAP)

The American Academy of Pediatrics (AAP) is "a non-profit medical professional association dedicated to attaining optimal physical, mental, and social health and wellbeing for all infants, children, adolescents, and young adults." (NORD, n.d.);(The following information is from Grossman, 2023). In 2018, the AAP endorsed gender ideology in its entirety, advocating for affirming care despite the age of the child in their guidelines, including social transition before puberty. AAP policy is widely trusted and has a substantial impact on the treatment of children. However, their policies are formulated, passed, and released by a maximum of 30 pediatricians on the board of directors and a few self-selecting committees relevant to the issue being reviewed.

The 2018 affirmation-only policy was written by a child psychologist from Brown University who had practiced transition on children for years. This draft was then edited, approved, and released by other LGBTQ activist pediatricians, including a colleague of his who also works in gender affirmation care and the AAP board of directors. The AAP has 67,000 members, none of whom have any input into the policies the entity creates. The argument that it must be a small group of experts creating policy to ensure the scientific reliability of information loses credibility when discovering their transgender policy statements directly contradict the research they cite as substantiating evidence, according to Dr. James Cantor.

Cantor, a gender dysphoria expert and psychologist, recognized the impracticality of their policy as the watchful waiting approach was primarily favored due to high desistance rates in late adolescence. The rate of childhood desistance prior to maturity ranges from 61% to 98% (Ristori & Steensma, 2016), with more recent studies depicting a rate of over 60% and 70% for males and females aged 5-24 years old, respectively (Bachmann et al., 2024). This low diagnostic stability is significant when creating guidelines that endorse the full scale of treatment for symptoms that will likely reside (The following information is from Cantor, 2018).

Cantor discovered three areas of concern when cross-referencing AAP's policies with their citations. First, AAP relied heavily on the perception that conversion therapy was being forced onto children unhappy with their sex. Cantor made a note of this being a misconception as conversion therapy only applies to sexual orientation, and the only studies that AAP cited on the subject pertained to that of sexual orientation. There was not a single citation that claimed conversion therapy was relevant for gender dysphoric patients. The second irregularity in their citations was that AAP erased 11 follow-up studies on gender dysphoric children in the psychiatric literature that demonstrated high rates of natural desistance. Lastly, numerous references that AAP cited in support of gender-affirming care categorically contradict their policy and endorse watchful waiting. Regarding these findings, Cantor asserts, "AAP is, of course, free to establish whatever policy it likes on whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false." (The following information is from Grossman, 2023).

At AAP's Annual Leadership Forum conference in 2021, Dr. Julia Mason, a pediatrician and AAP member, submitted a resolution advocating for the academy to discontinue the promotion of medical transition for minors until long-term benefit is proven. Due to COVID-19, the resolution was online, and her call to acquire adequate evidence of efficacy and safety was well-received by pediatricians. It received 4-1 positive-to-negative votes and became a top-five resolution in terms of pediatric engagement.

The resolution was submitted to a reference committee at the conference for a discussion and vote to submit it to the Annual Leadership Forum itself. It received the most considerable support for any resolution in that committee, with 80% voting yes; however, when the committee decided what resolutions to present, they had no recommendations, and the resolution disappeared. Mason, again in 2022, submitted a resolution to err on the side of caution with gender dysphoria. In response, the AAP leadership invented a rule that resolutions unsponsored by a committee or a chapter would not be reviewed. Along with Mason, four other pediatricians co-authored the resolution, but it was not permitted to receive a vote and could only be read by a select few people.

AAP's prohibition of free discourse is what prompted former AAP president Dr. Joseph Zanga and other members to leave the organization and form The American Call to Pediatricians in 2002, in which Zanga was also president. As a former president of the AAP, Zanga has personally asked their leadership to change course, though his requests were declined. He explains, "The academy of late has been

unwilling to even discuss the transgender issue. It's something that I, as a past president and a member of the past president's advisory committee, have asked the committee to consider and discuss. It, unfortunately, never gets added to our meeting agenda. I stand here and say I'm disappointed. The science says that children and adolescents are not capable of making these kinds of decisions".

The AAP not only holds the authority to construct its guidelines but also compels other associations to modify their policies to align with their position. In August 2022, AAP state government affairs analyst Jeff Hudson requested that AAP be provided an embargoed copy of WPATH's most recent clinical guidance (SOC-8) in advance of the release to be reviewed (Brock, 2024). Hudson highlighted the urgency of this review, citing implications it could have on their existing legal arguments to fight state bans on sex change for children in court (Brock, 2024).

After receiving the SOC in August 2022, emails revealed that Hudson tasked a collection of four AAP pediatricians to review how the guidance aligned with AAP policy and provide feedback (Brock, 2024). The pediatricians conducting the review were considered leaders in pediatric sex change, three of whom held positions on the leadership team of AAP's Section on LGBT Health and Wellness (archive.org, n.d.). One of the reviewers, Jason Rafferty, was the lead author of AAP's 2018 policy, which endorsed sex-trait modification hormones and surgery for minors (AAP, 2018). The guideline was subsequently reaffirmed in their 2023 policy (AAP, 2023).

On September 8, 2022, then-AAP president Moira Szilagyi wrote a letter to WPATH notifying them of concerns that they have with SOC-8, specifying their

opposition to WPATH's inclusion of age minimums for pediatric sex-trait modification surgery (Brock, 2024). In response to Szilagyi's letter, Scott Leibowitz, co-lead of the SOC-8 chapter on adolescents, orchestrated a task force to review their feedback. On September 9, 2022, Leibowitz wrote in an email, "The American Academy of Pediatrics (AAP)- a MAJOR organization in the United States that is typically very pro-transhealth/gender affirming care- voiced its opposition to the SOC8, specifically due to aspects of the Adolescent chapter. Not only did they say they would not endorse the SOC, they indicated that they would actively publicly oppose it." continuing that, "Clearly, if AAP were to publicly oppose the SOC-8, it would be a major challenge for WPATH, SOC-8, and trans youth access to care in the U.S.," (Brock, 2024).

Not only did WPATH encounter objections from the AAP for the minimum age guidelines, but also from the transgender former U.S. Assistant Secretary for Health, Admiral Rachel Levine. According to Cantor's expert report, "Sarah Boateng, who is Adm. Levine's chief of staff [said the] biggest concern is the section below in the Adolescent Chapter that lists specific minimum ages for treatment, *she is confident, based on the rhetoric she is hearing in DC, and from what we have already seen, that these specific listings of ages, under 18, will result in devastating legislation for trans care. She wonders if the specific ages can be taken out* and perhaps an adjunct document could be created that is published or distributed in a way that is less visible than the SOC8, is the way to go." (Cantor, 2024). As a result of pressure from the state and AAP's ultimatum of withholding endorsement of SOC-8 if the age

minimum was not removed, WPATH acquiesced to the demands and removed the age minimum from SOC-8 (Cantor, 2024).

American Medical Association (AMA) & Endocrine Society

In June 2023, the AMA passed a resolution drafted by the Endocrine Society in support of children receiving gender affirming care, declaring that "it is the responsibility of the medical community to speak out in support of evidence-based care. Medical decisions should be made by patients, their relatives and health care providers, not politicians." (GLAAD, 2024). The cosponsors of this resolution include: The American Academy of Pediatrics, The American College of Obstetricians and Gynecologists, The American Urological Association, The American Society for Reproductive Medicine, The American College of Physicians, The American Association of Clinical Endocrinology, GLMA: Health Professionals Advancing LGBTQ+ Equality, and the AMA's Medical Student Section (GLAAD, 2024).

Among the AMA's policy statements include the announcement that sex should be removed as a legal designation on birth certificates, alleging that "Designating sex on birth certificates as male or female, and making that information available on the public portion, perpetuates a view that sex designation is permanent and fails to recognize the medical spectrum of gender identity. This type of categorization system also risks stifling an individual's self-expression and self-identification and contributes to marginalization and minoritization," (AMA, 2021) ; (The following information is from Grossman, 2023)

Dr. William Malone, endocrinologist and co-founder of the Society for Evidence Based Medicine, depicted the presentation of the Endocrine Society's 2017 guidelines describing, "They rolled out a set of guidelines for gender dysphoric adolescents and children that had really no evidence base, and essentially said that: 'Okay, your job as endocrinologists now is to medically affirm children'; well, i.e, healthy adolescents with puberty blockers and cross sex hormones. There was no discussion at all. It was difficult even to submit questions after they presented the guidelines. It was done under an atmosphere of 'This is how it's going to be, and if you ask questions, you're a bigot.'" Their guidelines support the usage of sex-trait modification hormones on adolescents (Endocrine Society, 2017), amassing a score of 1 out of 6 in a peer-reviewed systematic review of their guidelines (Manhattan Institute, 2022).

In 2020, Van Meter, the pediatric endocrinologist mentioned describing Money's conduct, proposed a debate to be held on the treatment of transgender youth at the Endocrine Society's annual meeting, offering to orchestrate it in its entirety if permitted to allow open dialogue. Informed that he missed the deadline, he attempted to organize it the following two years but did not receive a response from the organization.

Runaway diffusion is described as "a problematic but not uncommon phenomenon whereby the medical community mistakes a small innovative experiment as a proven practice, and a potentially non-beneficial or harmful practice 'escapes the lab,' rapidly spreading to general practice settings." (SEGM, 2023). This principle

represents the expeditious introduction of the Dutch protocol into general clinical practice worldwide without adequate research to verify the hypothesized benefits or evidence that benefits are significant enough to outweigh the burdens of lifelong medical dependence. Despite the establishment's collective insistence on a medical consensus, the only consensus was their solidarity in adopting unsubstantiated guidelines that contradicted long-term research (The following information is from The Economist, 2024).

While WPATH claims to have the most accurate guidelines based on thorough systematic reviews, court documents released in the discovery process of an Alabama court case (*Boe v. Marshall*) involving youth gender medicine demonstrate that WPATH leadership has interfered with the production of systematic reviews. In 2018, the Johns Hopkins University Evidence-Based Practice Center (EPC) was commissioned by WPATH to conduct systematic reviews with the intention of controlling the results of their findings.

During early contract negotiations between the parties in December 2017, WPATH executive director Donna Kelly informed EPC director Karen Robinson that the board felt the researchers "cannot publish their findings independently", stating weeks earlier that "the [WPATH] board wants it to be clear that the data cannot be used without WPATH approval". According to John Ionnidis of Stanford University, a co-author of guidelines on systematic reviews, if sponsors interfere or have the ability to veto results, it can produce biased summaries or suppress unfavorable results. When Robinson recognized the attempt to exert undue influence over an independent

process, she objected, alerting Kelly of concerns- “In general, my understanding is that the university will not sign off on a contract that allows a sponsor to stop an academic publication.”

After WPATH relented, Robinson signed a contract in May 2018 permitting WPATH authority to review and offer feedback on produced work, although withholding the ability to alter work substantively. This agreement posed issues in July 2020 when WPATH leaders saw two manuscripts submitted for review that they deemed problematic. In the following month, the WPATH executive committee informed Robinson of the implementation of a new policy granting WPATH the power to influence the output of the EPC, including authority to reject research on the basis of their conclusion as a result of the “many concerns” of the two papers.

Robinson challenged that this policy violates principles of objective scientific inquiry and contradicted the nature of their contract. Later, released in court documents, it was revealed that WPATH provided a checklist to confirm that someone from WPATH would be involved in “the design, drafting of the article and final approval of [that] article”. Documents also revealed that WPATH instituted a publication proposal mechanism that required approval via a voting process to prevent unfavorable research from becoming a publishable manuscript and mandated that the authors request permission to submit the final manuscript to a peer-review publication. Subsequently, the authors were also required to include a statement asserting the researchers’ independence from WPATH to deny any indication of interference with the checklist incorporating, “the author(s) have acknowledged that the authors are

solely responsible for the content of the manuscript, and the manuscript does not necessarily reflect the view of WPATH in the publication" (Alabama AG, 2024). In an October 2020 email, WPATH leadership, including then-incoming president Walter Bouman, demanded to the working group on guidelines that research must be "thoroughly scrutinised and reviewed to ensure that publication does not negatively affect the provision of transgender health care in the broadest sense" (The Economist, 2024).

The consequences of this ideological movement and the concomitant suppression of dissenting perspectives have resulted in diminished financial support for research initiatives that present contradictory findings: "Only certain kinds of research are prioritized for funding, given ethical approval, and subsequently allowed to be published. For a paper that manages to survive this first set of censors, despite being 'controversial,' once activists get wind of its publication, it will either be removed or have a correction issued while being publicly discredited" (Soh, 2020). An open letter signed by 54 academics across diverse fields of study supports this assertion. The letter expresses their concerns and their inability to conduct research or proper academic analysis on the transgender community without encountering censorship or harassment (The Guardian, 2018). Mason summarizes the state of the industry, proclaiming, "When we hear that 22 professional organizations support affirmation, this is not the voice of the average pediatrician. It's the position of a few activists that have captured key committees at these medical societies and are using

the bureaucracy to ensure the voice of regular pediatricians isn't heard." (Grossman, 2023).

The institutional adoption of gender affirming care is defined through the runaway diffusion of the medical establishment. However, the continued suppression of contrary research and conclusions are indicative of intent to advance a social justice agenda and protect the standing of the ideology to which they have sanctioned. Whether the intention is out of compassion for this group or driven by other motivations, this field has submitted to activist appeal in the normalization of gender confusion.

With the diagnostic depathologization of gender identity disorder to gender incongruence and the pervasive adoption of guidelines with intolerance to dissent, the enthusiasm of the medical field to adopt ideas in support of a social movement is evident. No longer are these organizations defined by objective and critical research, but rather are oriented on producing outcomes that are advantageous in justifying their guidelines.

Diagnostic Overshadowing

The establishment of gender identity clinics in the United States was substantially influenced by international medical practices. Examining the operational frameworks of leading centers offers essential perspectives on the broader implementation of gender-affirming care nationwide. These prominent clinics often

demonstrated concerning patterns in their practices, which were fundamentally based on the affirmative care approach advocated by influential professional organizations.

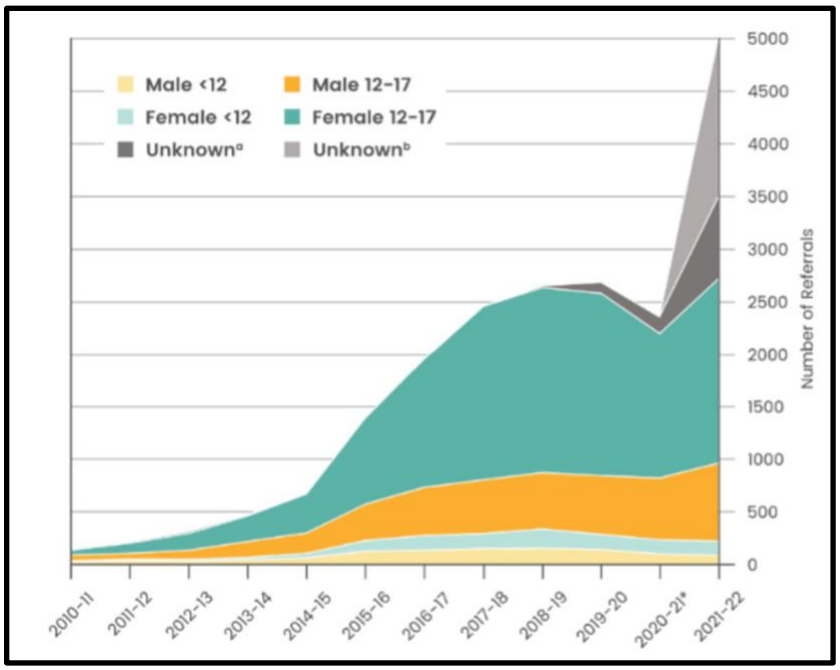
Major institutions with extensive gender-affirming care services in the United States include the Mayo Clinic, Cleveland Clinic, and Planned Parenthood. In fifteen years, gender-affirming clinics treating minors in the United States have increased dramatically, growing from none to over 100 (Reuters, 2022). The total number of facilities providing sex-trait modification hormones to minors is estimated to exceed 300 (SEGM, 2021). This analysis primarily concentrates on larger operations where more comprehensive data is available.

Tavistock Gender Identity Development Service (GIDS)

Established in 1989 in London, England, the Tavistock Gender Identity Development Service (GIDS) had evolved into the world's largest gender clinic (Cass, 2024). From 2000 to 2005, the service saw merely 18 patients. The patient population experienced a dramatic surge, escalating from 72 to 1,807 between 2009-2010 and 2016-2017 (Times Magazine, 2022), representing an exponential increase of nearly 2,500%. The growth continued, reaching 3,585 patients in 2021-2022 - representing a staggering 4,555% increase over a decade (Grossman, 2023). Notably, this figure only represented the current patients, excluding the 2021 waitlist that exceeded 5,300 individuals (Grossman, 2023).

Figure 5

Child and Adolescent Referrals for Gender Dysphoria (UK, GIDS), 2010/11 to 2021/22

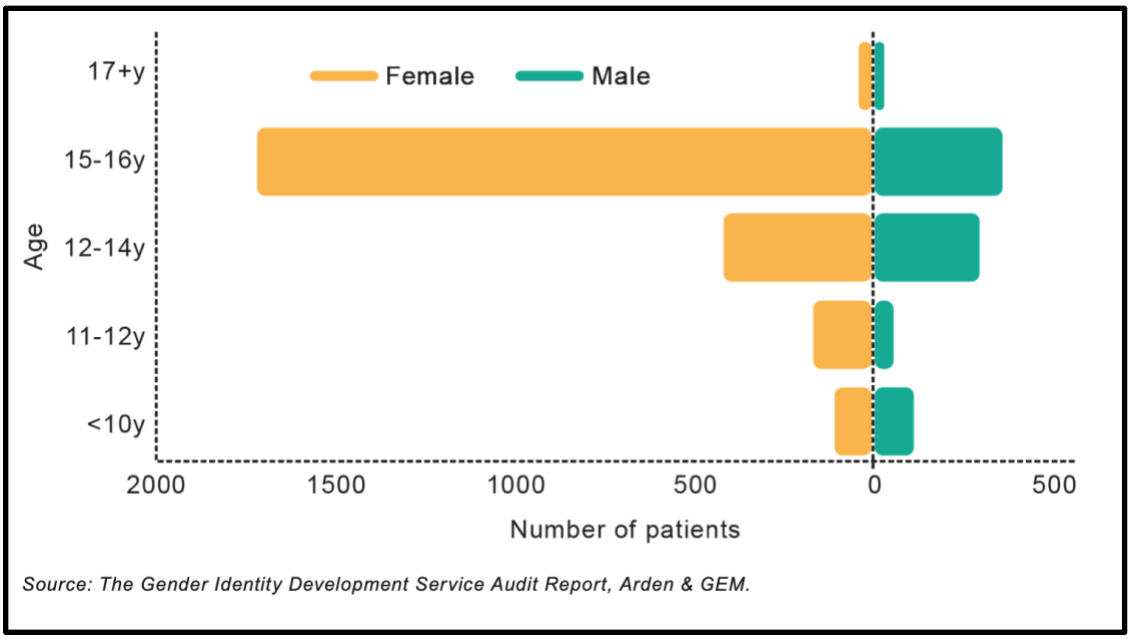


(Cass, 2024)

The patient growth figures evolved through two distinct phases: a moderate growth period from 2009 to 2014, succeeded by a more dramatic acceleration beginning in 2015 (Cass, 2024). During this second phase, the increase was notably more pronounced among patients registered as female (Cass, 2024). Female patients, once a minority, had now made up 70% of the patients, a 5,000% increase in only 7 years (Times Magazine, 2022), signifying the prevalence of ROGD (The following information is from Times Magazine, 2022).

Figure 6

Distribution of patient's age on referral and birth-registered gender on referral to GIDS, 1 April 2018 to 31 December 2022



Tavistock originated specializing in watchful waiting through the 90s, with their patient demographics consisting of 75% female-presenting boys, with most cases resolving themselves. Following the Dutch protocol, Susie Green, eventually the CEO of a transgender children's charity named Mermaids, campaigned for puberty blockers to be provided by GIDS. In the early 2000s, lobby groups such as the Gender Identity Research and Education Society (GIRES) and the government-funded organization Mermaid became increasingly influential at GIDS. As a result, in 2011, Dr Polly Carmichael, the new GIDS director, began a "trial" of puberty blockers. However, she made it widely available due to high demand before any research was concluded.

In 2014, GIDS lowered the minimum age from 16 to 11. In a 2017 interview, GIDS associate director Bernadette Wren was asked if she had any concerns about the hormone blocker Leuprolide. She responded, "Do you think I don't worry about blockers? We all worry. Of course, we worry." At GIDS, even the Dutch Protocol was being violated, prescribing puberty blockers to neurodiverse or mentally ill patients without receiving proper therapy. In 2018, 10 clinicians at GIDS, concerned by the unethical practices, went to the staff governor at Tavistock, Dr. David Bell, who was unaware of the malpractice. He retired three years after his report on the clinicians' concerns with GIDS was suppressed.

By 2019, the Associate Clinical Director of Adult and Adolescent Service, Marcus Evans, resigned and wrote the 2020 article, *Why I Resigned from Tavistock: Trans-Identified Children Need Therapy, Not Just 'Affirmation' and Drugs*. He describes GIDS as a de facto regime that harms children, fast-tracking them through affirming care without psychological evaluation (Evans, 2020). ⅕ of GIDS staff members have detailed serious ethical concerns, including the failure to withstand pressure from trans-activists (Evans, 2020). Evans details that the officials at GIDS have convoluted views about the outcomes of their patients, stating, "'First do no harm,' should be the least we expect from those who treat our children yet in 2019, it was revealed that the GIDS program at Tavistock Clinic had lowered the age at which it offers children puberty blockers based on a study that—it later was revealed—concluded that 'after a year of treatment, a significant increase was found in patients who had been born female self-reporting to staff that they 'deliberately try to hurt or

kill myself.' The fact that Tavistock officials ignored such evidence suggests they have bought into the idea that transition is a goal unto itself, separate from the wellbeing of individual children, who now are being used as pawns in an ideological campaign." (Evans, 2020).

The absence of comprehensive psychological assessment protocols at GIDS had resulted in inadequate identification and treatment of pre-existing mental health conditions, with patients proceeding under the presumption that gender transition interventions would sufficiently address their psychological distress. Evans postulates that when such medical interventions fail to ameliorate underlying mental health concerns, patients may experience heightened risk for self-injurious behaviors. He states, "When doctors always give patients what they want (or *think* they want), the fallout can be disastrous, as we have seen with the opioid crisis. And there is every possibility that the inappropriate medical treatment of children with gender dysphoria may follow a similar path." (Evans, 2020).

At the time of Evan's resignation, thirty-five other psychologists had left for the same reason (Grossman, 2023). This conduct also got the attention of Lord Moonie, physician and member of the British government, who sponsored an event examining GIDS entitled *First Do No Harm: the Ethics of Transgender Healthcare*, in the House of Lords. A day before the event, Lord Moonie resigned from the Labour Party after an investigation was launched in response to complaints of alleged transphobia (Transgender Trend, 2019); (The following information is from Nottingham, 2021).

Shortly after, the United Kingdom's High Court was petitioned to evaluate the capacity of minors diagnosed with gender dysphoria to provide informed consent for puberty suppression interventions. This judicial review was initiated by Kiera Bell, a former patient of GIDS, who had commenced puberty suppression therapy at age 16 and subsequently underwent bilateral mastectomy at age 20. Upon examination of the evidence, the judicial panel concluded that puberty suppression interventions for this demographic constitute experimental treatment and establish a treatment trajectory that almost invariably progresses to cross-sex hormone administration, resulting in irreversible physiological consequences. Consequently, the court determined that the essential criteria for informed consent could not be satisfied by individuals below 16 years of age, as they lack sufficient capacity to comprehend and evaluate the long-term implications and consequences of such medical interventions.

Dr. Hilary Cass, Former President of the Royal College of Pediatrics and Child Health, was appointed to conduct an independent review of GIDS. Her findings (the Cass Review) included severe deficiencies in the provision of services, including diagnostic overshadowing and failure to gather evidence on comorbidities or long-term outcomes (Cass, 2024). Diagnostic overshadowing is defined as "the misattribution of symptoms of one illness to an already diagnosed comorbidity, leads to compromised patient care and likely contributes to increased mortality experienced by individuals with mental illness" (Hallyburton, 2019). The review’s findings conclude that:

1. Affirmation-only models of care are not evidence-based
2. Puberty blockers, instead of acting as a pause button, appear to solidify their future of medicalized treatment
3. There is not enough evidence to make recommendations on hormone treatment
4. The best way to support gender-dysphoric minors has not been determined

Following her comprehensive investigation, Cass concluded that the clinical practices at GIDS had exposed young patients to significant risk of mental health complications and that these interventions were predicated upon an inadequate evidentiary foundation. In response to these findings, the National Health Service (NHS) announced the closure of GIDS with plans to establish regional centers characterized by a more circumspect and comprehensive approach to care. The final cessation of GIDS operations occurred on March 31, 2024, representing a delay from the initially proposed closure date in 2023 (SEGM, 2024). Cass was appointed to the House of Lords in August 2024 (Wilson, 2024);(The following information is from Grossman, 2023).

Gender Identity Service at Toronto's Centre for Addiction and Mental Health

Dr. Kenneth Zucker, among the most frequently referenced authorities in gender dysphoria literature, exemplifies the constraints imposed upon academic discourse within this domain. As the founder of the Gender Identity Service at Toronto's Centre for Addiction and Mental Health—one of the earliest such institutions globally—Zucker implemented a conservative therapeutic framework

designed to facilitate patients' comfort with their natal sex rather than immediately affirming cross-gender identification, especially when treating very young children (as young as three years of age). This approach was substantiated by empirical evidence regarding the high probability of natural symptom resolution during adolescence and the potential adverse consequences associated with premature medical or social interventions. Despite the scientific validity of his methodology, Zucker was subsequently accused of engaging in conversion therapy practices due to his clinical perspective. In 2015, Zucker was removed from his position, and the clinic was disbanded. An investigation later exonerated Zucker and found that activists advocated for his removal, and he was awarded substantial damages and a public apology.

Washington University Pediatric Transgender Center at St. Louis Children's Hospital

The Washington University Pediatric Transgender Center at St. Louis Children's Hospital demonstrated operational deficiencies comparable to those observed at GIDS, characterized by an absence of standardized treatment protocols alongside significant ethical concerns. Established in 2017, the center's problematic practices eventually attracted scrutiny from the Missouri Attorney General's Office during its brief operational period. Jamie Reed assumed a case management position at the center in 2018 (Reed, 2023). Throughout her tenure from 2018 to 2022, Reed's responsibilities encompassed patient meetings occurring two to three days weekly, as well as intake procedures and supervisory functions (this information and subsequent details are attributed to ago.mo.gov, 2023).

During this period, the practitioner observed significant areas of concern, notably referrals from psychiatric inpatient facilities and emergency departments for individuals diagnosed with serious mental health conditions, including schizophrenia, post-traumatic stress disorder, and bipolar disorder.

While the GIDS received international media attention, Reed perceived a professional and ethical imperative to take action in the spring of 2020. Following her expression of concerns through workplace discussions and electronic correspondence, she was subject to negative performance evaluations in 2021 and was cited for "responding poorly to direction from management with defensiveness and hostility" (Reed, 2023). Moreover, she faced allegations of transphobia despite her marital relationship with a transgender man and identifying politically left of Bernie Sanders (The following information is from Reed, 2023).

In the summer of 2022, the management scheduled a half-day retreat where she and other colleagues who had concerns were told they must stop questioning the medicine, science, and their authority. After internally raising concerns for years and being told, "Get on board, or get out," Reed left the Center and accepted a new job in November 2022. Reed decided to take action externally after the transgender U.S. Assistant Secretary for Health, Dr. Rachel Levine, claimed, "clinics are proceeding carefully and that no American children are receiving drugs or hormones for gender dysphoria who shouldn't." (Reed, 2023). On January 26, 2023, Reed wrote a letter to the Missouri Attorney General, Andrew Bailey. An affidavit ensued (The following information is from ago.mo.gov, 2023).

In the affidavit, she detailed the full extent of the unethical practices the St. Louis clinic engaged in, claiming witness to the center's healthcare providers' dishonesty regarding treatment, lack of psychological care, and lying about effects of treatment to both the public and to parents of patients. She spoke about the administration of puberty-blocking and cross-sex drugs to children without fully informed parental consent and proper assessment, which had led to an injury that went unreported.

The Center claims to practice endocrinology, adolescent medicine, psychiatry, and psychology. However, the Center placed strict limitations on psychiatric and psychological care, making it nearly inaccessible apart from the event of writing a letter of support for medical transition. Instead, children would be sent to Endocrinology for puberty blockers and cross-sex hormones and then to adolescent medicine, which was for children after puberty.

Some members at the Center did consider patient histories and comorbidities and attempted to raise concerns about transitions; nonetheless, those members were told to stop questioning the treatment. The patients and their parents were never informed that there was no consensus regarding their treatment. The treatment at the St. Louis center, like GIDS, was based on the Dutch model, which claimed to exclude patients with underlying mental health issues. According to Reed, "Nearly all children who came to the Center here presented with very serious mental health problems. Despite claiming to be a place where children could receive multidisciplinary care, the Center would not treat these mental health issues. Instead, children were automatically

given puberty blockers or cross-sex hormones even though the Dutch study excluded persons experiencing mental health issues", continuing that, "Most children who come into the Center were assigned female at birth. Nearly all of them have serious comorbidities, including autism, ADHD, depression, anxiety, PTSD, trauma histories, OCD, and serious eating disorders. Rather than treat these conditions, the doctors prescribe puberty blockers or cross-sex hormones."

Reed furthermore discusses how a large number of patients had depression or anxiety before beginning hormones. However, it was only after starting the drugs that it worsened to the extent of requiring mental health medication. Many patients were also suspected of having autism but were never formally assessed for the condition before starting hormones.

As purported by other clinics and large organizations, patients were also falsely informed that puberty blockers are fully reversible, ignoring risks and the rate of persistence if puberty suppression is initiated. Publically, the Center claims surgery is not an option for those under 18. However, Reed claims they routinely refer minors to surgeons, claiming it is for 'educational purposes' for when they turn 18, but these patients have obtained surgeries as minors. Reed had also named Dr. Allison Snyder-Warwick as one surgeon who performed a gender transition surgery in-house on at least one instance in the previous years.

Between 2020 and 2022, the Center initiated the medical transition for over 600 children at the Center, 74% of whom were biological females. Most of the procedures were paid for by private insurance; however, there were indications that

the Center also billed the costs to federal and state-funded insurance programs. Reed recollects, "I have personally witnessed staff say they were uncomfortable with how the Center has told them they have to code bills sent to publicly funded insurance programs. I have witnessed staff directly ask the providers for clarification on billing questions and have providers dismiss the concerns and work to have the patients have this care covered as the priority."

She additionally reports that staff knew the incorrect insurance codes were entered to register puberty blockers for the treatment of precocious puberty (the medically justified use of puberty blockers) instead of for gender transition. She continues, "Based on my observation that the Center has prescribed puberty blockers or cross-sex hormones hundreds of times where they should not have, the Center is billing private and public insurance for unnecessary procedures. Even when it is clear that the cross-sex hormones or puberty blockers are harming the child, the Center continues that treatment and continues billing public and private insurance.".

Another approach utilized at the Center was to gain parental consent through coercion. Reed states, "A common tactic was for doctors to tell the parent of a child assigned female at birth, ‘You can either have a living son or a dead daughter.’ The clinicians would tell parents of a child assigned male at birth, ‘You can either have a living daughter or dead son.’ The clinicians would say this to parents in front of their children. That introduced the idea of suicide to the children. The suicide assertion was also based on false statistics. The clinicians would also malign any parent who was not

on board with medicalizing their children. They would speak disparaging of those parents. I was present during the visits with many parents when this happened."

The earliest documented use of the living daughter or dead son innuendo was in a 2011 ABC News article in which a leading researcher in the field described how she often asks parents that question while referencing suicide rates (Soh, 2020). Since then, it has been widely adopted by media coverage and doctors alike. The common statistic used is that 41% of transgender youth attempt suicide, which is nearly 6 times more likely than non-LGBTQ youth (Grossman, 2023). This figure, however, is misquoted as it is from a 2014 study that found 41% of adults who identify as transgender have attempted suicide at some point in their life, not specifically adolescence (Tanis, 2016). Additionally, the researchers of the studies acknowledged their limitations, which included that they did not ask respondents about comorbidities such as other mental health conditions or if they even identified as transgender at the time of the suicide attempt (Tanis, 2016). Biggs reported that over 11 years and among 15,000 patients at GIDS, including the waitlist, there were four suicides (Biggs, 2022). Two of the suicides were individuals on the waiting list. The remaining two were patients being affirmed and likely receiving hormone treatments (Biggs, 2022), signifying a higher rate of suicide in those treated than untreated from this sample.

The morally bankrupt, emotional blackmailing of parents not only results in invalid parental consent through instilling fear of losing their child, but it also implants the idea of suicidality in a vulnerable class. Doctors at the St. Louis center would also accuse parents who were in favor of psychotherapy of abuse if they would not

chemically affirm their child (ago.mo.gov, 2023). Furthermore, the doctors would not inform parents of severe side effects such as sterility despite knowing that many patients have detransitioned (This and the following information is from ago.mo.gov, 2023).

Any attempt by Reed to implement increased safety protocols for patients was terminated. She states, "Because I was concerned that the doctors were giving cross-sex hormones and puberty blockers to children who should not be on them, I created a 'red flag' list of children where other staff and I had concerns. The doctors told me I had to stop raising these concerns. I was not allowed to maintain the red flag list after that. During the time I was creating the red flag list, noting my concern that these children were not good candidates for permanent, irreversible medication treatment, the doctors would simply send these children to our in-house therapists. Those therapists would inevitably provide letters to the doctors, and then the doctors would say there can't be any concern over these children because another therapist was fine with prescribing puberty blockers or cross-sex hormones." Reed elaborated on the lack of protocol, asserting, "The Center also refuses to track complications and adverse events among its patients. There is no standard protocol for tracking patients who have received treatment. And the Center actively avoids trying to learn about these adverse events. On my own initiative, I have tracked some patients on a case-by-case basis, but the Center discouraged me from doing so. I wanted to track the number of our patients who detransition. I wanted to track the number of our patients who have attempted suicide or committed suicide. The Center would not make either of these tracking

systems a priority. It is my belief that the Center does not track these outcomes because they do not want to have to report them to new patients and because they do not want to discontinue cross-sex hormone prescriptions. The Center never discontinues cross-sex hormones, no matter the outcome." As a result of Reed's efforts and testimony, the Missouri Save Adolescents from Experimentation (SAFE) Act was passed in 2023, prohibiting sex trait modification surgery as well as the initiation of hormone treatment for minors (senate.mo.gov, 2023).

The glaring parallels between clinics and professional organizations' intention for adverse outcomes and iatrogenic harm to go unreported is a defining attribute of this industry. The aversion to monitoring patient outcomes in conjunction with the dysfunctionality in accurate reporting signifies the systematic malfeasance present in this industry; furthermore, it demonstrates intent to suppress significant and relevant information from being considered in the patient's medical decision.

Informed Consent

The gender-affirming care industry is plagued by systemic accountability failures that saturate multiple levels of medical practice. From prestigious scientific organizations to individual clinics, there exists a troubling pattern of professional negligence. Unverified research is routinely promoted and widely accepted, while diagnostic overshadowing increasingly transforms patients into prolonged medical subjects in place of treatment that could improve or resolve symptoms. This approach not only serves the financial interests of medical providers but also occurs with a

striking absence of professional consequences for those who facilitate potentially uninformed medical interventions.

Informed consent is the "process in which patients are given important information about a medical procedure or treatment, genetic testing, or a clinical trial, including possible risks and benefits. This is to help them decide if they want to be treated, tested, or participate in the trial. Patients are also given any new information that might affect their decision to continue, called the consent process" (National Cancer Institute, n.d). For informed consent to be legally and ethically valid, it must be given voluntarily, without any form of intimidation, pressure, or external coercion (Grossman, 2023); (the following information is from Levine, 2018).

The informed consent model that is used in gender-affirming care deviates from the normative approach as it entails an emphasis on patient autonomy. The 2011 revision of WPATH's Standards of Care endorsed a model of informed consent that asserts that patient autonomy is the singular ethical consideration for consent as the patient knows what they are required to be happy. Predating this revision, professionals were "required to assent to medical or surgical intervention after a thorough psychiatric evaluation, with or without continuing psychotherapy. Mental health professionals functioned as gatekeepers who made recommendations, by individuals or committees, about a patient's eligibility and readiness for social transition, hormone administration, or gender-conforming surgeries". The updated standards of care have significantly undermined mental health professionals' diagnostic capabilities when evaluating patients with gender dysphoria. By attributing

psychiatric challenges exclusively to minority stress and dismissing potential pathological considerations, these standards have severely restricted clinicians' ability to comprehensively assess a patient's readiness for medical transition.

The four central questions relevant to determining the informed consent of the patient are as follows:

1. What benefits do you expect this identity, gender transition, hormones, or surgery to provide?
2. How do you understand the transition's social, educational, vocational, and psychological risks?
3. What do you understand about the short-term and long-term common and rare health risks of hormone and surgical intervention?
4. What have you considered regarding your life in 10 to 20 years?

Regarding the comprehension of these questions, Levine asserts, "Although the mental health professional would seem to be the professional who is best equipped to answer the question of whether the patient is in a psychological state that can tolerate being informed about the risks, no physician is exempt from making this determination. This question is no less paternalistic than the assumption that competence in this arena is characterized by the commitment to advocacy. This widely promulgated idea is based upon the idea that science has already established what is best, ignoring facts to the contrary. The resolution of the existing tensions rests upon

the professional obligation to introduce the relevant risks at various nodal points during health care. Respect for patient autonomy enables patients to make decisions; nonmaleficence requires that the professional discuss these risks." (Levine, 2018). The risks of gender-affirming treatment, including puberty blockers, hormone therapy, and surgery, include biological, social, and psychological risks. These risks include but are not limited to, infertility, impairment in sexual capacity, shortened life expectancy, emotional distancing and isolation, replacement of existing friends, a significantly reduced pool of individuals willing to sustain an intimate physical relationship, social discrimination, deflection from personal developmental challenges, and demoralization (the following information is from Grossman, 2023).

Iatrogenic Harm

Most long-term data on iatrogenic harm of cross-sex hormones come from the treatment of adults because long-term follow-up for children has not been reported. Specifically in males, cross-sex hormone therapy can result in decreased muscle mass and strength, decreased sexual desire, reduced sperm production, voice change, decreased testicular volume, erectile dysfunction, deep vein blood clots, stroke, coronary artery disease, and cerebral vascular disease. In comparison to the untreated male population, those on hormones are 46 times more likely to get breast cancer, 2 times more likely to have a stroke, 16 times more likely to be diagnosed with deep vein clots, and two times more likely than women to have a heart attack.

For women on testosterone, risks include hair loss, elimination of menstruation, deepening of voice, severe acne, high blood pressure, high cholesterol,

an increased risk of type 2 diabetes, erythrocytosis (which includes symptoms of blurred vision, headaches, confusion, high blood pressure, nose bleeds, itching, weakness, and tiredness), cerebrovascular disease, hypertension, pelvic pain, and uterine cancer. In this group, pap smears to detect cervical cancer have a 3 times increased likelihood of being unsatisfactory, meaning unable to detect cervical cancer.

A systematic review of 76 studies demonstrated that while females on testosterone develop breast cancer less frequently, it occurs twenty years earlier than expected despite having mastectomies prior to the diagnosis (Di Lisa et al., 2024). Additionally, there are reports of intracranial hypertension, which causes severe headaches that can result in visual loss from damage to the optic nerve (Grossman, 2023). Compared to women not on testosterone, women who are are almost 4 times as likely to have a heart attack (Grossman, 2023). In comparison to men, they are 4 times more likely to have a stroke (Grossman, 2023). The chance of developing clots in the vein, which can cause life-threatening pulmonary embolism, is 5 times greater in women treated with testosterone (Grossman, 2023);(the following information is from Levine, 2018).

Informed consent for minors consists of two elements: the child's agreement (assent) and the parent's permission. For the multitude of risks, there are varying degrees for comprehension of the implications, corresponding with the patient's age. Children and adolescents often demonstrate a limited understanding of long-term medical risks, such as potential infertility. The gender-affirming approach to medical intervention recommends puberty suppression at the initial stages of pubertal

development, which renders infertility when combined with subsequent cross-sex hormone treatments, as evidence indicates that the maturation and reproductive viability of gametes critically depend on the natural hormonal surges of testosterone and estrogen during puberty (Grossman, 2023).

While older adolescents may appear more receptive to such risks, many minimize or dismiss these concerns, either claiming disinterest in future parenthood or citing selective anecdotal examples (Levine, 2018). This passionate yet superficial certainty is a barrier to meaningful informed consent, as patients fail to critically evaluate the comprehensive potential consequences of their medical decisions (Levine, 2018). The University of California San Francisco's Gender Affirming Health Program states, "The issue of infertility is often far more problematic for parents and family members than for youth" (Grossman, 2023).

Despite the Endocrine Society's approval of hormone administration to adolescents, a 2019 study from the organization explicitly states the opposite. Their conclusion found the only evidence-based usage of testosterone in women is for treatment of hypoactive sexual desire disorder, submitting that "There are insufficient data to support the use of testosterone for the treatment of any other symptom or clinical condition, or for disease prevention.", expanding with, "The safety of long-term testosterone therapy has not been established." (Davis et al., 2019).

In a study of almost 490 female patients, 72% reported pelvic cramping after receiving testosterone (Zwickl et al., 2023). In severe cases, hysterectomies were prescribed to treat the iatrogenic pain experienced, which also entails possible

complications such as injury to the bladder, urinary tract infections, overactive bladder, increased risk of stroke, and increased risk of heart attack. (Zwickl et al., 2023)

Like hormones, sex-trait modification surgeries commonly result in severe adverse effects. A comprehensive 2022 systematic review and meta-analysis of phalloplasty procedures exposed alarming surgical outcomes. Analyzing 1,731 patients, the exhaustive study revealed a staggering complication rate affecting 76.5% of subjects (Wang et al., 2022). Specifically, close to 1/3 of patients experienced urethral fistula, and 1/4 suffered from urethral stricture (Wang et al., 2022). The study's authors ultimately concluded that the evidence supporting patients receiving their anticipated surgical outcomes remains critically weak.

A 2021 study reviewing metoidioplasty surgeries found that 56.8% suffered from urethral complications and approximately 50% required corrective surgery (Waterschoot et al., 2021), while a study on both phalloplasty and metoidioplasty reaffirms the high complication rates, with 73% of patients requiring revision surgery (Veerman et al., 2020).

According to a 2024 study, transgender surgical interventions result in urogenital complications developing in 66-75% of cases, over half requiring reoperation, and surgical outcomes frequently remaining unsatisfactory (Bayraktar, 2024). These interventions potentially shorten lifespans by 25-28 years when accounting for suicides, surgical complications, reoperations, and hormone-related diseases (Bayraktar, 2024). The study also found that psychological problems persist

or intensify post-surgery, contrary to patients' expectations of relief (Bayraktar, 2024). A significant number of individuals ultimately detransition, reporting regret about their medical and surgical transitions, as medical evaluations frequently lack depth, with superficial psychiatric assessments preceding potentially life-altering treatments (Bayraktar, 2024).

The gender-affirming care industry claims a low transition regret rate of approximately 1%, but this figure stems from significant methodological limitations. Inadequate long-term follow-up studies and incomplete data collection render the true rate of transition regret essentially unknown. A 2021 letter to the editor addressing research examining regret states, "Data in this field are often of low quality because of ‘lack of controlled studies, incomplete follow-up, and lack of valid assessment measures… The majority of included studies ranged between ‘poor’ and ‘fair’ quality: only five studies—representing just 3% (174) of total participants—received higher quality ratings. However, even these had a loss to follow-up rates ranging from 28% to more than 40%, including loss through death from complications or suicide, negative outcomes potentially associated with regret’." (Expósito-Campos and D'Angelo, 2021). These studies also likely underestimate the actual rate of transition regret due to methodological limitations, including overly restrictive definitions of regret that demand formal legal gender status reversal, exceptionally high participant dropout rates ranging from 22-63%, and an unexamined correlation between regret and the elevated suicide rates observed post-transition (Expósito-Campos and D'Angelo, 2021).

One of the studies used to substantiate the low regret rate is from the Center for Transyouth Health and Development at Children's Hospital Los Angeles. The 2018 study on mastectomies conducted by Dr. Johanna Olson-Kennedy claims that only one patient experienced occasional feelings of regret (Olson-Kennedy, 2018). However, 30% of the patients could not be contacted or declined to participate in follow-up (Olson-Kennedy, 2018). The majority of patients in Olson-Kennedy's study were surveyed less than 2 years following their surgeries, even though medical complications and regret appear to take an average of 8- 8.5 years to develop and admit regret (Expósito-Campos & D'Angelo, 2021). Olson-Kennedy told the New York Times, "There's very few things in the world that have a 0% regret rate and chest surgery, clinically, I've experienced that." (Grossman, 2023). Ironically, in 2024, a lawsuit was filed against Olson-Kennedy by a former patient, around 8 years after beginning puberty suppression, for medical negligence, fast-tracking transition, and ignoring trauma and mental health issues. (Zimmerman, 2025).

Despite significant documented complications and the absence of comprehensive long-term studies, surgeons are able to justify performing gender affirming surgeries as they follow WPATH’s standards of care. The medical establishment and affirming clinics persistently advocate for these measures, asserting substantial patient benefits while simultaneously, media outlets maintain an uncritical narrative resulting in a general perception that the practices are medically supported.

Beyond the broader misrepresentation that influences patient perception of the procedures, a fundamental requirement for valid consent is the patient's demonstrated

mental capacity to make rational, comprehensively evaluated medical decisions (Levine, 2018). Regardless of the age at which the rejection of one's biological sex begins, it does not occur in an entirely rational, conscious process (Levine, 2018). Returning to Littman's research, 55.9% of participants viewed transition as a comprehensive solution to their social, academic, occupational, or mental health challenges (Littman, 2018), suggesting an increased susceptibility to assume greater medical risks to alleviate other stressors. Moreover, 28.1% of the study population demonstrated an unwillingness to address basic mental health concerns before transitioning (Littman, 2018), conveying a singular, potentially myopic perspective that indicates vulnerability rather than a nuanced, objective decision-making process.

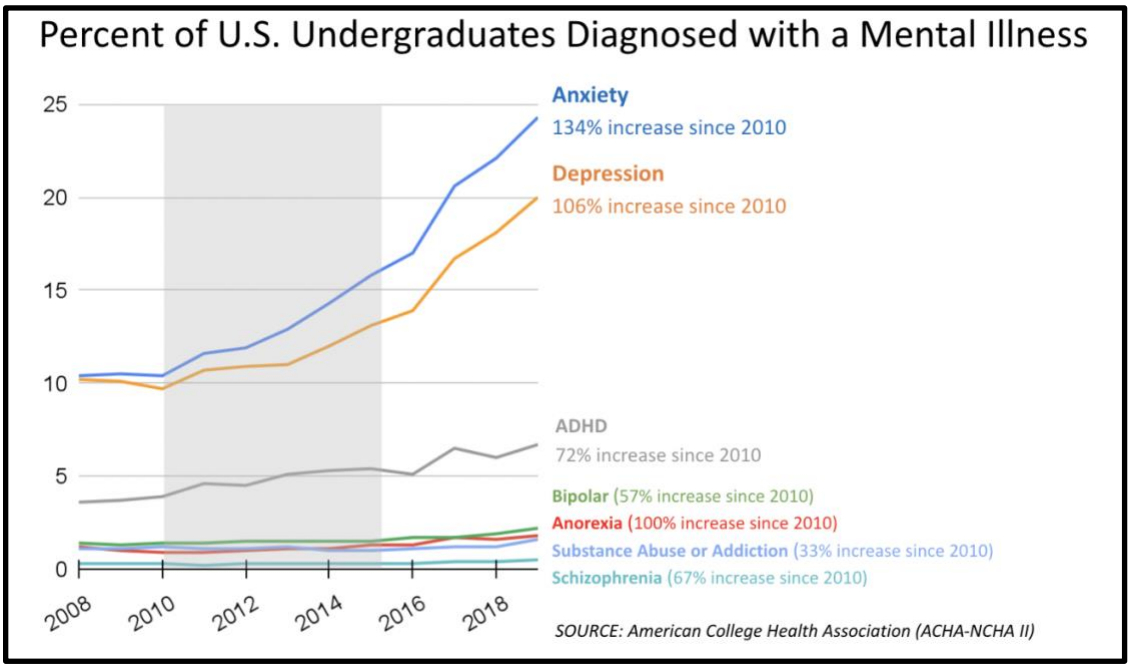
While clinicians are traditionally instructed to rely on prestigious organizations like the AAP for clinical guidance, the erosion of these organizations' credibility critically destabilizes standard treatment protocols. This raises profound ethical questions: When an authoritative organization like the AAP dismisses peer-reviewed research highlighting transition risks, does this effectively absolve clinicians of their ethical obligation to disclose that information to acquire valid informed consent? Consequently, the very notion of informed consent becomes compromised when the medical establishment selectively embraces favorable research while deliberately marginalizing critical scientific findings to establish a selective narrative.

Maladaptive Coping

In Western society, teenagers are currently experiencing what psychologist Jonathan Haidt deems a mental health crisis, with record levels of anxiety and depression in America, Britain, and Canada. From 2009 to 2017, the number of high schoolers contemplating suicide increased by 25%, while teen clinical depression diagnoses rose by 37% between 2005 and 2014. These statistics are particularly alarming for females, with teenage girls experiencing depression at a rate three times higher than boys (Soh, 2020). The sudden increase in mental health issues is unfortunately not indicative of an increase in willingness to report issues but rather coincides with the increase in behaviors such as self-harm and suicide (Haidt, 2024).

Among teenage girls, the average rate of self-harm has increased by 62% from 2009-2020 (Soh, 2020), and in girls aged 10-14, the rates of self-harm have risen 189% between 2010-2020 (Soh, 2020). Between 2004 and 2023, the percentage of U.S youths with a major depressive episode has nearly doubled in males from 5% to 9.4% and more than doubled in females from 13.1% to 27.3% in 2023 (Statista, 2024). The undergraduate demographic also demonstrates these trends with an alarming exacerbation in mental illness diagnoses (Johnathan Haidt, 2024).

Figure 7



Given the high prevalence of suicidal thoughts (81%), suicide attempts (over 40%), and non-suicidal self-injury (56%) among U.S. adults identifying as transgender (William's Institute, 2023), it is accurate to depict this group as suffering from considerable mental health issues. Proponents of affirming care argue that the transgender population experiences higher rates of suicidal ideation due to societal rejection, though they simultaneously contend that the growing transgender population results from increased social acceptance and visibility.

A transgender suicide rate study, which has been cited by prominent U.S. news sources, including CNN, provides an illustrative example of this approach, asserting, "Between 1980 and 2021, an increasing prevalence of transgender individuals was observed, which is in accordance with clinical reports and systematic reviews. This trend has been linked to a stronger presence of transgender role models in the media, destigmatization, and increased societal openness toward gender identity issues"

(Erlangsen et al., 2023). They subsequently undermine this rationale by asserting, "Transgender individuals may be exposed to systemic negativity regarding their trans identity in the form of bullying, discrimination, exclusion, and prejudice, which in turn may result in alienation and internalized stigma, mental health problems, and, ultimately, suicidal behavior." (Erlangsen et al., 2023). The argument reveals a familiar logical fallacy: proponents attribute the rising visibility of transgender individuals to reduced stigma while simultaneously citing ongoing societal discrimination as a primary source of their mental health challenges.

Suicide rates among transgender persons correlate more strongly with the rates for underlying mental health conditions than with social marginalization. A study from the American Journal of Psychiatry indicated that 61% of patients with gender dysphoria have another psychiatric disorder (Soh, 2020). Littman's study concurs with this figure, finding one or more diagnoses in 62.5% of patients (Littman, 2018). Out of the 61%, 75% of those patients' gender dysphoria was determined to be a symptom of another mental illness, such as a mood, personality, or psychotic disorder (Soh, 2020). Some of the comorbidities recognized in transgender patients include but are not limited to depression, anxiety, bipolar disorder, borderline personality disorder, psychosis, and eating disorders (Littman, 2018). According to data of children and adolescents referred to gender services, anxiety and depression were both prevalent, each affecting 38% of the referred youth (Taylor et al., 2022).. Nearly half (48%) experienced both anxiety and depression simultaneously (Taylor et al., 2022)..

Regarding eating disorders, 5.2% had a formal diagnosis, while 15.5% exhibited symptoms of an eating disorder without a formal diagnosis (Taylor et al., 2022).

Reviewing the suicide attempt rates of patients across various mental health conditions provides adjacent data to compare: 31% of individuals with major depressive disorder (depression) have attempted suicide (Dong et al., 2018); those with bipolar disorder show attempt rates between 25%-60% (Novick et al., 2015); 24.7% of people experiencing psychosis have made suicide attempts (Yates et al., 2018); and among adolescents with psychotic experiences attempt rates span from 12.4% to 72% (Barbeito, 2021). Individuals with body dysmorphic disorder show suicide attempt rates of 35.2% (Rautio et al., 2024), which shares similar characteristics to gender dysphoria, as both conditions involve a fixation on perceived physical flaws that others cannot detect (Soh, 2020).

Borderline personality disorder, which frequently co-occurs with gender dysphoria, is characterized by an unstable and rapidly shifting self-perception, suicidal behavior, self-harm, impulsivity, and stress-induced paranoia that can lead to disconnection from reality (Mayo Clinic, 2024). A number of these traits are personified by Littman's AYA sample, given the rapid adoption of their identity, attempt to immediately medically transition, refusal to work on basic mental health issues, and threats of self-harm or suicide if they do not transition. Borderline personality disorder typically appears during early adulthood (Mayo Clinic, 2024), aligning with the timeline for ROGD, and has a prevalence rate in the transgender population between 15% and 80%, according to various studies (Meybodi & Jolfaei,

2022). An estimated 73% of those who have this disorder will have approximately three suicide attempts in their lifetime (Yen et al., 2020).

If the high rates of suicidality were attributed to bullying, discrimination, and transphobia, with an absence of mental health issues, as cited by proponents of affirming care, one would expect the figure to have a more significant correlation to rates such as the 10.9% attempted suicides of bully-victims (Hasan et al., 2021). Although not all Americans believe in the gender ideology of transgenders, only 10% of Americans said that they would oppose legislation granting protections to them from discrimination (Pew, 2022).

To contextualize this, American views on homosexuality in 1994 consisted of 49% believing homosexuality should be discouraged, 61% viewing the gay rights movement unfavorably, and in 1999, only having the support of 17% of the public (Pew, 2010). Given the 'discrimination, exclusion, and prejudice' that the homosexual population endured, one might expect a suicide attempt rate that is parallel to that of the 40% of the current transgender population today; however, at this time where this group's sexuality was not affirmed, suicide attempts in gay and bisexual men were at 11.9% (Paul et al., 2002).

Consider the correlation between several concerning trends: Mental illness rates are rising across Western nations, with half of all cases emerging before age 14 (Psychiatry.org, 2022); simultaneously, there's an unprecedented surge in historically rare gender dysphoria diagnoses among the same age with documented high rates of psychiatric comorbidities. These patterns suggest a possible hypothesis: the increase in

ROGD among adolescents—many of whom displayed no childhood gender dysphoria symptoms according to DSM criteria—may represent instances where gender-related distress manifests as a symptom of underlying mental health conditions, particularly given the alignment between typical mental illness onset and the timing of these gender identity concerns (the following information is from Littman, 2018).

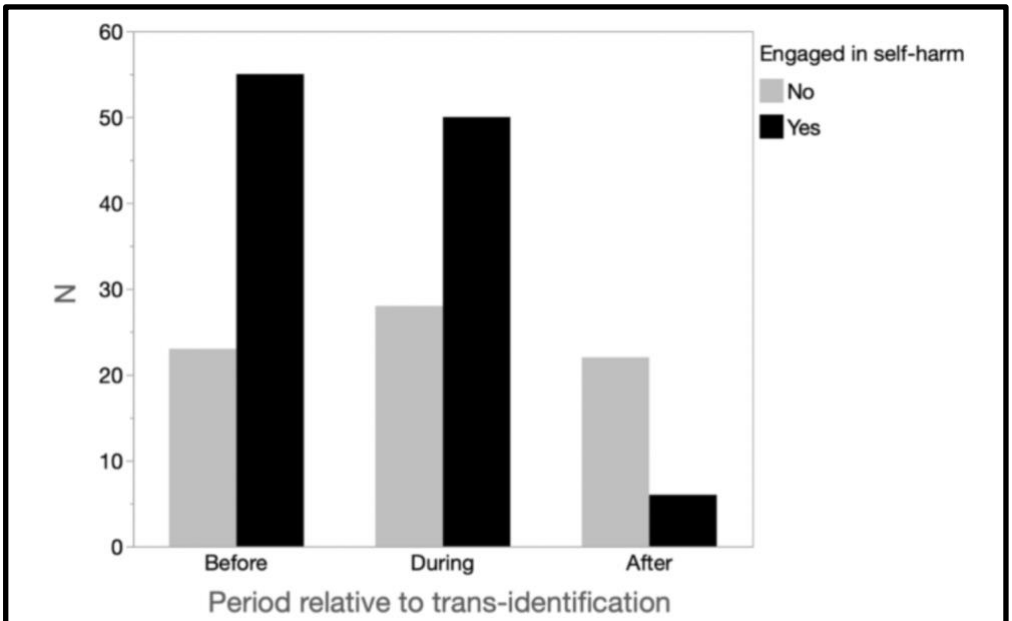
A maladaptive coping mechanism is "a response to a stressor that might relieve the symptoms temporarily but does not address the cause of the problem and may cause additional negative outcomes". Returning to Littman's data, her findings signify strong evidence that transition, in some cases, is being utilized as a maladaptive coping mechanism for dealing with legitimate stressors. With the findings exhibiting high rates of mental health issues, poor ability to deal with emotions, beliefs that transition would solve their issues, an unwillingness to work on prior issues before transition, and lack of evaluation of these issues, the notion that transition might be utilized to avoid dealing with mental health issues is rational.

Since maladaptive coping mechanisms do not address the root causes of distress, the adverse mental health outcomes found post-transition are also consistent with this hypothesis. Littman concluded that ROGD used as a maladaptive coping mechanism may be harmful as it can lead to non-treatment or delayed treatment for trauma and mental health issues, alienation from crucial support systems such as parents, isolation from mainstream, non-transgender society, and medical and surgical risks of transition without benefit.

The high rates of suicidality in this population in comparison with other victimized groups may be reflective of the results of non-treatment of underlying comorbidities due to maladaptive coping. Due to the high rates of self-harm before transgender identification in the surveyed group, Littman also notes the possibility that this atypical strain of gender dysphoria, with the drive to transition, might itself constitute a form of intentional self-harm. The self-harm rates in this population appear to support this theory as, according to the sample in a 2023 detransitioner study, self-harm decreases or desists when individuals revert to their biological sex (Littman, 2023).

Detransition

Figure 8



Frequency distributions of self-harm for all participants for the periods before, during, and after trans-identification

(Littman, 2023)

A 2022 detransition demographics survey conducted on Reddit revealed that 82% of detransitioners, "Realized gender dysphoria was related to other issues, including mental health," along with slightly over 40% of natal females and 32% of natal males agreeing with the statement, "I discovered that my gender dysphoria was caused by something specific; For example, trauma, abuse, mental health condition" (Genspect, 2022).

A 2021 study by Littman, comprising 69% natal females and 31% natal males who have detransitioned, revealed significant insights. 71% of participants believed transition was their only option to feel better, with 65% expecting it to eliminate gender dysphoria and 63% expecting it to decrease dysphoria (Littman, 2021). The study found that 58% of participants' gender dysphoria was linked to specific causes

like trauma or mental health conditions (Littman, 2021). Notably, 51.2% felt transitioning prevented or delayed treatment for mental health conditions or trauma, while 23% voluntarily reported experiencing internalized homophobia and difficulties accepting themselves as lesbian, gay, or bisexual (Littman, 2021). A separate 2021 study reinforced these findings, with 70% of detransitioners recognizing their gender dysphoria was related to other issues and 50% reporting that transition did not decrease or alleviate their dysphoria (Vandenbussche, 2021).

Despite the likes of those such as Olson-Kennedy, who insist that there is no regret in medically transitioning, on Reddit alone, the "detrans" community has over 56,000 members who share their severe difficulties and complications as a result of their withdrawn transgender identity (Reddit, 2025). These individuals face additional stressors such as abandonment and criticism from the community, and their statistics are unaccounted for due to the prevalent argument that "No transgenders desist because if you desist, you were never truly transgender," an argument which also skews criteria in transgender studies (Grossman, 2023).

A single longitudinal study from Sweden serves as the only available high-quality long-term study that follows the outcome of gender surgeries. Sweden's centralized national health registries track complete medical and mental health histories, including all instances of suicide, for the 13.8 million individuals in their healthcare system from birth to death. This offers significantly more reliable outcome measures than data from the United States, where the decentralized healthcare system creates challenges in tracking patient outcomes. The comprehensive nature of the

Swedish data eliminates confounding variables, resulting in more objective outcome measurements for patients who undergo gender surgeries.

The study examined long-term suicide risk among women who received testosterone treatment and surgical interventions compared to women of matching age and demographic characteristics. While the study, published in 2011, has limitations, it nonetheless offers the most reliable statistical data currently available. The study found that 10 years following sex reassignment, women who transitioned to men had increased mortality from several causes, especially suicide (Dhejne et al., 2011). Women who transitioned were 40% more likely to die from suicide than women matched for age and other demographics in the general population (Dhejne et al., 2011). The study concluded that surgery and hormonal medical transition are "apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons." and that "Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism" (Dhejne et al., 2011);(the following information is from Bränström & Pachankis, 2019).

Another long-term study from Sweden, exemplifying the misrepresentation of studies by proponents of gender-affirming care, claimed evidence of improved mental health; however, their data demonstrated the opposite. An October 2019 publication concluded that although gender-affirming hormones do not lead to improvements in health, surgeries such as mastectomies do. Their study measured three parameters of men and women following surgeries, including visits for mood or anxiety disorder,

prescriptions for anti-anxiety or antidepressant medication, and hospitalizations after suicide attempts.

They discovered that "Compared with the general population, individuals with a gender incongruence diagnosis were about six times as likely to have had a mood and anxiety disorder health care visit, more than three times as likely to have received prescriptions for antidepressants and anxiolytics, and more than six times as likely to have been hospitalized after a suicide attempt". They subsequently concluded there is no evidence in support of gender affirming surgeries because the number of appointments, prescriptions, and hospitalizations had decreased over time. Their study included severe methodological flaws such as a one-year time frame, no control subjects, a retrospective design, loss to follow-up, and not including psychiatric hospitalization figures for reasons other than suicide attempts. Although the study's goal was to perceive mental health outcomes, the study even omitted actual suicides even though that data is readily accessible in the Swedish database.

Due to researchers and scientists notifying the American Journal of Psychiatry of the methodological flaws that undermine the study's conclusions, a statistical reviewer conducted a reanalysis of the data (SEGM, 2020). Despite the editor-in-chief receiving seven letters from groups of esteemed researchers regarding the statistical analysis and conclusion, it took 10 months for the authors and the American Journal of Psychiatry to respond publicly and issue the significant correction (Grossman, 2023) which stated, "The results [of the reanalysis] demonstrated no advantage of surgery in

relation to subsequent mood or anxiety disorder-related health care visits or prescriptions or hospitalizations following suicide attempts" (SEGM, 2020).

Although the correction was published in August of 2020, the incorrect conclusion from 2019 was already heavily publicized with headlines such as "Transgender surgery linked with better long-term mental health, study shows" from ABC News, "Sex-reassignment surgery yields long-term mental health benefits, study finds." from NBC News, and "Study Finds Long-Term Mental Health Benefits of Gender-Affirming Surgery for Transgender Individuals." from the APA (Johnston, 2019). A popular news site for physicians, WebMD, also published "Study Finds Long-Term Mental Health Benefits of Gender-Affirming Surgery for Transgender Individuals," as well as Yale, declaring, "Mental Health Outcomes Improve for Transgender Individuals After Surgery, Study Finds" (Grossman, 2023).

While it is accurate that the study itself was eventually corrected, this occurred nearly a year after extensive publication and acceptance by the general public. This is an example of the underlying unethical theme of presenting erroneous research with unsubstantiated conclusions and pursuing aggressive publicity of the study, resulting in substantial acceptance by the public and allowing the gender affirmation lobby to declare that there is a medical consensus that the science backs gender-affirming care.

The inclination to transition is entirely comprehensible when considering what this industry offers. Their product is a "scientifically backed" method of improving mental health issues for those suffering from symptoms of mood, personality, and psychotic disorders that present a barrier that impedes them from achieving happiness.

This narrative is the cause of the high percentage of individuals who believe transitioning will resolve other issues. Meanwhile, the attempt by activists and proponents of gender-affirming care to conceal studies indicating the risks, mental health implications, and regret rate of these procedures is an utter injustice to these vulnerable individuals.

Adverse Childhood Experiences

Another notable figure in the population is the amount of trauma that this group of individuals has endured. Although there are relatively few studies that report on adverse childhood experiences, a systematic review revealed that the available studies demonstrate high rates of trauma among children referred to gender clinics. The types of adverse childhood experiences included rates of between 11%-67% who have experienced neglect or abuse (across four studies; 15%-20% physical, 5%-19% sexual, 14% emotional), 8% and 19% who have experienced a death or permanent hospitalization of a parent (across two studies), 23% and 25% who had exposure to domestic violence (across two studies), and high rates of mental illness or substance abuse in parents (across two studies, mothers: 53% and 49%, fathers: 38%) (Taylor et al., 2022).

While these percentages reported in the systematic review are concerningly high, it is impossible to determine the variation of these figures over time as minimal studies have been conducted to document adverse childhood experiences, indicating a need for additional research. However, a review of the first 124 patients seen at GIDS discovered that 42% of children had experienced the loss of one or both parents,

primarily through separation, 38% had family physical health problems, 38% had family mental health issues, and physical abuse was documented in 15% of cases (Di Ceglie et al., 2002). This further demonstrates the need to address issues within the family when assessing children with gender dysphoria to reduce diagnostic overshadowing as a result of maladaptive coping.

Neurodevelopmental Disorders

The presence of neurodevelopmental disorders such as attention-deficit/ hyperactivity disorder (ADHD) and Autism Spectrum Disorder (autism) is also a prominent factor in the transgender demographic. The prevalence of ADHD in children with gender dysphoria, according to two separate studies, is 11% and 15.8%, and those with ADHD are 6.64 times more likely to express a "wish to be the other gender repeatedly" (Teddy G Goetz & Noah Adams, 2025). Studies on the prevalence of ADHD in transgender adults range from 4.1% to 10% (Teddy G Goetz & Noah Adams, 2025).

The combined estimate of children referred to gender clinics who have autism is 9%, though one study demonstrated a higher rate of 13.8% in 2012, which increased to 15.1% by 2015 (Taylor et al., 2022). Some studies suggest that transgender individuals are between 3 and 6 times more likely to be autistic than cisgenders (Warrier et al., 2020). Motivation to transition for those on the autism spectrum may be attributed to rigid ideas of gender roles; i.e., if a child dislikes dresses, she may interpret that as if she should really be a boy (Soh, 2020). Highly focused and intense interest is one of the characteristics of being on the autism spectrum, and transitioning

can also be attributed to a form of such (Soh, 2020). Susan Bradley, former Psychiatrist-In-Chief at Toronto's Hospital for Sick Children and international expert on gender dysphoria in children, states, "When I start identifying these traits in these adolescents who present with gender dysphoria, I really want to be clear whether they've had a previous history of having what we call repetitive and obsessive interest in certain things. Because once some of these kids fix on an idea, they can become really, quite obsessed by it." (Soh, 2020).

Co-Rumination

Social contagion is defined as the swift spread of activities, behaviors, or even emotions through a network (APA, 2018). Based on relevant studies such as the original ROGD sample and the subsequent substantiating studies, it is reasonable to conclude that although it is unlikely that friends and the internet can make people transgender, it can be "initiated, magnified, spread, and maintained via the mechanisms of social and peer contagion." (Littman, 2018).

Resembling the manner in which affirming care advocates cite the minority stress model (theoretical framework aiming to explain minority health disparities through stressors such as discrimination) as a reason for mental health detriments, they also do so in response to the hypothesis that social contagion plays a significant role in the unprecedented population of transgender-identified youth. Again, proponents of affirming care assert that the number of transgenders people is perpetual and innate, so the increase in AYAs is solely attributed to a society-wide increase in trans-visibility

and reduction of transphobia and prejudice, allowing those with gender dysphoria to express themselves.

If this perspective were accurate, one would expect this to translate to a similar number of adults in their 30s, 40s, 50s, and 60s who could finally express 'their truth.' However, this is not the case. While it is challenging to determine the exact number of minors identifying as transgender, a 2022 U.S. demographic dataset highlights a trend in transgender identification across age groups, supporting the notion that this development is primarily concentrated among younger individuals.

The figures delineate a decreasing prevalence of transgender identification as age increases, with 1.43% of 13-17-year-olds, 1.31% of 18-24-year-olds, a sharp decline to 0.45% among 25-64-year-olds, and just 0.32% of the 65+ population identifying as transgender (Williams Institute, 2022). Another 2022 survey posits that 2% of 18-29-year-olds are transgender, followed by 0.3% prevalence in 30-49-year-olds and 0.2% in those 50+ (Pew Research, 2022). Although exact prevalence figures are challenging to obtain, the available demographics concur that a younger generation distinguishes this movement. Mirroring the declining rate of transgender-identifying individuals with age, the prevalence of severe mental illness in the United States follows a similar pattern. Mental illness is observed in 11.6% of 18-25-year-olds, 7.6% of 26-49-year-olds, and only 3% of individuals aged 50 (NIH, 2024).

Another factor that challenges the validity of the minority stress model as an explanation for the growing transgender population is the inversion of the sex ratio among AYAs. Between 2018 and 2022, 73% of referrals to GIDS were natal females

in comparison to the minority 27% of natal males (Cass, 2024). Once again, if the minority stress model were correct and increased trans-visibility and acceptance were provided as the variable for the influx in transgender identity, then one would expect the figures also to reflect exponential growth in prevalence for both sexes, not an inversion of the once male-dominated condition. This phenomenon is especially pertinent as, prior to 2012, there was no scientific literature on females aged 11-21 ever having developed gender dysphoria at all (Shrier, 2020).

Social transition, also known as social affirmation, is defined as the public adoption of a new gender identity that includes some or all of the following: A new name and pronouns, altering outward presentation (clothing, hairstyle, makeup), and the usage of opposite sex facilities such as bathrooms and locker rooms. (Grossman, 2023). In the United States, the proportion of those with gender dysphoria who socially transition (77%) is greater in comparison with most other countries (59%) (Taylor et al., 2022).

A 2023 large-sample study on AYAs with gender dysphoria (75% natal female) with a mean age of onset of 14.6 years old has found an average age of social transition of 15.4 years old and found greater prevalence in AYA females with gender dysphoria (65.7%) in comparison to males (28.6%) that socially transition (Bailey & Diaz, 2023). 55.4% of respondents stated that the AYAs were friends with others who announced a transgender identity around the same time (60.9% of natal females and 38.7% of natal males) (Bailey & Diaz, 2023). The average number of transgender

friends for those who had friends come out around the same time was 2.4 people (Bailey & Diaz, 2023).

The figures demonstrate a significant association between those who have friends who announce a transgender identity contemporaneously and the likelihood of social transition. 73.3% of natal females with transgender friends have taken steps towards social transition, as opposed to 54% that social transition without such friends. The influence of that variable for natal males increases their likelihood of social transition by nearly double, with 39.5% undergoing a social transition with contemporaneous transgender friends, compared to 21.7% who socially transitioned and do not have transgender friends (Bailey & Diaz, 2023). Although data on the relationship between social transition and the persistence of gender dysphoria is not available for the ROGD demographic, a 2022 study has indicated that children who underwent social affirmation between the ages of six and seven years exhibited a 97.5% persistence rate of gender dysphoria five years post-transition, establishing a general association between social transitioning and persistence (Olson et al., 2022).

A 2023 study with a sample of detransitioners (71% natal female) was conducted by Littman and colleagues, where 60.3% of respondents belonged to a friendship group where one or more members became transgender-identified around the same time, with 24.4% referring to offline friendship groups, 14.1% referring to online friendship groups, and 21.8% referring to both (Littman et al., 2024). More than a third of the study participants indicated the majority of their offline friends became transgender (34.6%) as well as online (38.5%) and that their offline and online

friendship groups mocked people who were not transgender-identified (42.3% and 41%, respectively) (Littman et al., 2024).

This data corresponds with Littman's 2018 study, where the influence of social contagion on individuals with ROGD becomes evident when comparing the expected prevalence of AYAs at the time (0.7%) to the localized increase observed within friend groups analyzed in her research (Littman, 2018). The friend groups examined in the study had an increase of 70 times the expected rate, as over ⅓ of the friend groups had 50% or more members of the group identify as transgender over a brief period (Littman, 2018). The highly concentrated and localized increase observed within these friend groups can not be attributed to the expected prevalence of gender dysphoria in the general AYA population, suggesting the presence of alternative factors.

A potential counterargument posits that observed clustering of transgender identification within peer networks may reflect homophily principles rather than emergent group dynamics influencing concurrent identity development. While homophilic selection might account for minor variance, it fails to adequately explain the synchronized emergence of transgender identification timelines documented within pre-existing friend groups, as the studies denote.

Peer Contagion

Peer contagion is a "mutual influence process that occurs between an individual and a peer and includes behaviors and emotions that potentially undermine one's own development or cause harm to others" (Dishion & Tipsord, 2012). Internalization of symptoms such as depression can be spread through co-rumination,

which involves repetitive discussion of issues, excessive reassurance-seeking, and negative feedback (Littman, 2018). Deviancy training is "the process whereby attitudes and behaviors associated with problem behaviors are promoted with positive reinforcement by peers" (This and the following information is from Littman, 2018).

Insights into the correlation between peer contagion and other forms of mental illness such as eating disorders and anorexia nervosa, can be applied to comprehend further the co-rumination and deviancy training that exist within these issues. Within the literature on eating disorders and anorexia, it is established that the internalization of symptoms and behaviors have been shared and spread through peer influence. This phenomenon parallels the dissemination of transgender identities within friend groups, as described by Littman. Just as peer groups may share preoccupations with body image, weight, and weight-loss methods, they may also develop shared concerns about body image, gender identity, and transitioning methods.

There are significant similarities pertaining to deviancy training within the dynamics of these two groups, with pro-anorexia groups praising the thinnest individuals and ridiculing those recovering from anorexia, while pro-transgender friend groups praise and validate those who are transgender-identified and mock those who are not. This resemblance also extends to the pervasive online communities of the respective groups, which provide positive reinforcement, share tips (on weight loss or transition), and spread information on how to deceive parents and doctors. Aside from offline friends, online environments provide an additional platform for co-rumination,

including excessive reassurance-seeking, positive and negative feedback, and deviancy training from those who endorse their unhealthy and self-harming behavior.

Amanda Rose, Professor of Psychology at the University of Missouri and researcher, conducted a study on co-rumination that found, "It is noteworthy that the effects of co-rumination on depression and anxiety held only for girls. This finding suggests that friendships may play an ironic role in the development of girls' internalizing problems. Girls' intentions when co-ruminating may be to give and seek positive support. However, these conversations appear to contribute to increased depression and anxiety." (Rose et al., 2012). In general, interactions within girls' friendships often involve mutual validation and reassurance, which can inadvertently foster the reinforcement and affirmation of behaviors that may be detrimental to their well-being. In an excerpt from Abigail Shrier's *Irreversible Damage: The Transgender Craze Seducing Our Daughters,* Rose told Shrier, "When we listen to girls versus boys talk to each other, girls are much more likely to reply with statements that are validating and supportive than questioning. They're willing to suspend reality to get into their friends' worlds more. For this reason, adolescent girls are more likely to take on, for instance, the depression their friends are going through and become depressed themselves." (Shrier, 2020). Co-rumination, being predominantly observed among female populations, potentially indicates a correlative relationship between the demographic sex distribution inversion and the presence of co-ruminative behavioral patterns. This may be recognized as a variable in the disproportionate growth of the female transgender population in comparison to males.

The marked discrepancy between baseline population prevalence rates of transgender identification among AYAs (particularly female), and the amplified rates observed within certain social clusters – particularly those characterized by rapid-onset presentations, peer influence dynamics, and intensive co-rumination patterns – positions social transmission mechanisms as the most empirically supported explanation for prevalence spikes exceeding 70-fold population expectations.

The presence of the internet facilitates the rapid spread of ideas and ideologies that might not otherwise be adopted or sustained, largely due to the advocacy and amplification that occur on these platforms. Online co-rumination and deviance training are a significant factor in accessing a seeming consensus of positive reinforcement and encouragement for individuals researching if their symptoms are a result of being transgender.

Another detransitioner study by Littman (69% natal female), released in 2020, corroborates the pervasiveness of online influence in transgender identification that's found in the 2018 ROGD study. The respondents cited sources of encouragement to transition as YouTube transition videos (48%), blogs (48%), Tumblr (45%), and online communities (43%) (Littman, 2020). Symptoms that are frequently attached as possible indications or symptoms of gender dysphoria online include continual difficulty with getting through the day, a sense of misalignment, disconnect, or estrangement from your own emotions, a feeling of just going through the motions in everyday life, a seeming pointlessness to your life, and knowing you are somehow different from everyone else and wishing you could be regular like them (Grossman,

2023). With these vague symptoms that could be attributed to any number of factors, it is plausible that such content may encourage vulnerable individuals to attribute nonspecific symptoms and ambiguous feelings to be interpreted as stemming from gender dysphoria (Littman, 2018).

School Policy

One of the most common settings for AYAs to adopt a new gender identity is school, where social transition is most frequently initiated (Grossman, 2023). Similar to prominent medical organizations and clinics, educational associations are another segment of institutional acquisition by the proponents of transgender care. Notable organizations such as the National Association of School Psychologists, The National Association of Secondary School Principals, The American School Counselor Association, The National Educational Association, and the Department of Education (Grossman, 2023) have all endorsed an agenda synonymous with activism rather than one with a focus on the education and welfare of children, in accordance with parental rights. Their ordinance is heavily compiled of policies that infringe on parental rights, such as prohibiting the notification of parents about changes in a student's physical or mental state related to transgender identification.

The National Association of School Psychologists (NASP) is the world's largest organization of school psychologists, composed of 25,000 school psychologists, graduate students, and related professionals, aiming to advance effective practices to improve student learning, behavior, and mental health (Teach for

America, n.d.). Their guidelines educate school psychologists that they should "Maintain confidentiality of the student's birth sex, gender identity, and gender expression by keeping identifying records separate and limiting unnecessary disclosure, doing so only with the explicit assent of the student. This also entails using discretion in disclosing identity or gender status in psychological reports when not relevant or necessary to explain educational or mental/behavioral health challenges" (NASP, 2022). This approach is counterintuitive, given the potential needs and risks often associated with this identity. Considering the mental health challenges commonly faced by this group, children may require additional support and access to mental health treatment, which necessitates parental awareness and involvement to ensure adequate care, which this policy prevents.

Amy Cannava, Chair of NASP's prominent LGBTQI2-S Committee and school psychologist, fought against a Virginia policy that requires schools to inform parents when their child presents as the opposite sex, stating on a podcast, "You have to sometimes break rules to do good for kids," continuing later on with, "I recognize that parental consent is a big deal, but when I'm doing anything LGBT, I don't worry about that. Let's be honest; it's an electronic permission slip. You type in a parent's name, and I'm like, 'Oh, that parent signed consent.' There's no actual signature" (Grossman, 2023). Cannava has also been affiliated with a practice of more significant concern- that of an organization called the Pride Liberation Project. On a private message board for the organization, Cannava was featured as a point of contact for kids who face 'familial rejection' (Grossman, 2023). The organization offers to pick up

children within 1-2 days who want to leave their homes and take them to a "supportive, queer-friendly" affirming home (Grossman, 2023).

Another organization, the National Association of Secondary School Principals, has called for cross-sex dressing, the use of opposite-sex locker rooms, and the use of opposite-sex overnight facilities (Grossman, 2023). However, they have since removed their "LGBTQ+ Students and Educators" and "Transgender Students" pages from their website. The LGBTQ+ section previously had threatened, regarding transgender status, that "Disclosure of that information to other school staff or parents/guardians could violate the school's obligations under FERPA or constitutional privacy" (NASSP, n.d).

A readily available position from the National Association of Elementary School Principals claims that for elementary students, "school should be a 'recess' for gender and disability that offers freedom and self-direction. This means allowing experimentation and space to play in terms of gender expression, roles, names and pronouns, and more, as well as a community that's supportive of students who wish to do so." (NAESP, 2021). The encouragement of prepubescent children to try out new names and pronouns is a dangerous stance to endorse because, as stated previously, those 6 to 7 years old who socially transition have a 97.5% persistence rate of continued gender dysphoria (Olson et al., 2022). This policy statement calls for the introduction of gender confusion to elementary school students, thereby producing transgender identities through suggestion to impressionable children who otherwise would not entertain the notion. Promoting this behavior will further lead to social

conditioning, influencing students to perceive themselves as transgender and socially transition, and subsequently leading to indefinite medicalization as a result of a decision made in elementary school.

The American School Counselor Association notes in its position statement that "If students have not disclosed their gender identity to a parent or guardian and as a result their name and/or gender marker cannot be changed on their student records, their chosen/affirmed name should be noted as a "preferred name" in the system.", continuing that, "Students have the right to use restrooms and locker rooms matching their gender identity. Schools should work with transgender and nonbinary students to ensure they feel safe and can use the selected facilities with dignity. Upon request from any student requesting additional privacy, schools should provide alternatives such as single-user bathrooms and curtains or stalls in changing areas" (ASCA, 2022).

The use of opposite-sex bathrooms or locker rooms equates an implied safety concern, especially for transgenders that are natal females. This is evident from laws introduced in response to injuries related to this issue, such as Virginia's Sage Law (Urquhart, 2023). Parents must be informed of any possible safety concerns and changes in gender identity fluctuation as the right to privacy and prohibition of disclosing student gender identity extends to students, parents, and guardians (Grossman, 2023). When faced with legislation to restrict indoctrination and require parental notification of a child's gender identity, the former President and Ethics Chairman of the American School Counselor Association, Carolyn Stone, informed

members at their annual 2022 conference to "Learn the rules, so you know how to break them." (Grossman, 2023).

The American Federation of Teachers, the second-largest teachers' union in the United States, similarly acts as an activist organization with vocal opposition to bills such as Florida's H.B.1557 (AFT, 2022). The first regulation in section 1 of this bill, which will be summarized in its entirety, requires that parents are notified of changes in their child's mental, emotional, and physical health and are permitted to access any of their student's education and health records created, maintained, or used by the school district (flsenate.gov, 2022). The second regulation restricts schools from adopting procedures or student forms that prohibit school district personnel from notifying parents of their child's state or practices that could encourage students to withhold information from parents and their involvement in critical decisions (flsenate.gov, 2022). The third states that classroom instruction on sexual orientation or gender identity may not occur in kindergarten through third grade or in a manner that is not age or developmentally appropriate (flsenate.gov, 2022).

The remainder of the bill states that student support service training must adhere to the standards of the Department of Education, parents must be informed of healthcare services offered at school each year, the school must provide any well-being questionnaires or health screening forms to parents and obtain permission prior to administering them in students kindergarten through third grade. Finally, the bill states that schools must adopt procedures for parents to be able to notify the principal of concerns, and the district must address these concerns in a timely manner

(flsenate.gov, 2022). This bill was designated the 'Don't Say Gay' bill by transgender activists and prompted nationwide outrage for the offense of stating that schools may not teach sexual orientation or gender ideology from kindergarten to third grade in the state of Florida.

This is an example of the exploitative nature of teachers' unions and organizations commandeered by radical activist leadership, undermining the rights of parents as well as the welfare and protection of the most suggestible group of children. The advocacy for the implementation of a curriculum that adopts gender ideology with a simultaneous condemnation of parental protections from medical and educational organizations represents a disturbing and disordered state of institutions. The prominent organizations that condemned this bill include medical organizations such as the American Psychological Association (APA, 2022), the American Academy of Child and Adolescent Psychology (AACAP, 2022), and the Florida Chapter of the American Academy of Pediatrics (FCAAP, 2022), and LGBTQ+ advocacy organizations such as the Trevor Project (Trevor Project, 2022), Human Rights Campaign (HRC, 2022), and GLAAD (GLAAD, 2022). The education organizations with greater influence who condemned the mild regulations include the American Federation of Teachers, GLSEN (GLSEN, 2022), and the National Educational Association (NEA, 2022).

The National Educational Association (NEA) is the largest labor union in the United States, headquartered in Washington, D.C. (Library of Congress, n.d.). With a budget of over 500 million (AFFT, n.d.) and over 3 million members, including

educators, students, activists, and workers, their goal is to "transform lives and create a more just and inclusive society." (NEA, n.d.).

In conjunction with the ACLU, Gender Spectrum, Human Rights Campaign, and the National Center for Lesbian Rights, the NEA co-produced a collective guideline entitled "Schools in Transition: A Guide for Supporting Transgender Students in K-12 Schools". (NEA, 2015). Their guide includes beliefs such as the male-female gender binary does not exist (Page 5, 49), the expression of transgender identity is healthy and appropriate for children (Page 3), children begin expressing transgender identity at 2 years old (Page 8), age-based objections to child gender transition are irrelevant (Page 3, 15), denying transgender identities lead to suicide (Page 8), parents do not need to know about their child's transition (Page 14, 16, 32), transgender students must be allowed to use a restroom matching their new gender identity regardless of feelings of peers (Page 24, 26), transgender students must be allowed to share accommodations with peers that match their identity in the circumstances of overnight trips and parents do not need to be informed (Page 27), and transgender students have no athletic advantage and must be allowed to participate in athletics matching their identity (Page 28) (NEA, 2015). Asaf Orr, an attorney and a lead author of the guidelines, also advocates for teachers to testify in custody battles on behalf of the parent that will support transitioning (Grossman, 2023).

Since the release of their guidelines, they have continued to endorse these sentiments and actively perform as a powerful lobby group. In 2021, the NEA adopted NBI 5 (new business item), which allocated $47,000 to "educate its state and local

affiliates and members about the dangers of anti-transgender legislation targeting transgender youth in sports and/or restricting their access to gender-affirming health care." (Archive.org). Despite NBIs no longer being publicly accessible since 2021 (Freedom Foundation, 2023), a letter from numerous members of Congress to the NEA revealed that contents of NBI 15 in 2022 included "plans to spend $140,000 to create an 'enemies list' of groups that have been identified as 'actively working to diminish a students' right to honesty in education, freedom of sexual and gender identity, and teacher autonomy.'" (Lankford.senate.gov, 2022). The NEA also holds influence in advising congressional representatives on how to vote on specific legislation, which has included pressure to vote against H.R.734 (the Protection of Women and Girls in Sports Act) (NEA, 2023) and against H.R.5 (The Parents Bill of Rights Act) (NEA, 2023) in 2023.

Although these are merely position statements from broad organizations, such policies are widely implemented across the United States, with some becoming increasingly radical. For instance, two Seattle public schools—Meany Middle School and Nova High School—operate on-site gender clinics offering medical and counseling services for gender-affirming care (meanyms.seattleschools.org); (novahs.seattleschools.org). Concurrently, Seattle Public Schools maintain explicit policies discouraging teachers from disclosing students' transgender status to parents and instructing them to avoid using pronouns when discussing transgender students with parents if unsure of how the student identifies at home (Parents Defending Education, 2023). Information about their clinics is listed on their respective school

websites. The implementation of gender identity guidelines is additionally indicated through the instances of teachers being fired because of moral convictions precluding them from abiding by school policies that infringe on parental protections, such as in the case of Jessica Tapia from California and Bonnie Manchester from Massachusetts (Grossman, 2023).

The catalyst in the institutional transformation of education is an organization called GLSEN (formerly the Gay, Lesbian & Straight Education Network). Initially established in 1990 by Kevin Jennings as a "teachers network," the organization underwent rebranding at HRC's 1995 Leadership Conference (Parents Defending Education, n.d.). During this event, Jennings discussed how strategically "reframing" their approach toward children's "safety" was to execute broader political wins and mentioned the effectiveness of using children as political tools (Parents Defending Education, n.d.). GLSEN's current executive director, Melanie Willingham-Jaggers, maintains similar convictions, having characterized schools as "breeding grounds" for activism (NBC News, 2022).

GLSEN states its efforts are to promote school safety and to "transform our nation's K-12 schools into the safe and affirming environment all youth deserve" (GLSEN, n.d.), and they have substantial authority to do so. GLSEN directly influences teacher training, school policy guides, curriculum, and gender and sexuality alliance (GSA) clubs in schools nationwide (Parents Defending Education, n.d.). GLSEN maintains an expansive network comprising over 1.5 million educators, students, and ‘education advocates.’ (GLSEN, n.d.). The organization operates a

public policy office in Washington, D.C., and it has over 500,000 downloads on their educational resources yearly (GLSEN);(the following information is from Parents Defending Education, n.d.).

GLSEN promotes its agenda indirectly through collaboration with school and professional organizations including the School Superintendents Association, the American School Counselor Association, the National Association of Elementary School Principals, the National Association of Independent Schools, the National Association of School Psychologists, the National Association of Secondary School Principals, the National School Boards Association, the National PTA, and the National Education Association. GLSEN's collaborations with major associations that accredit private and public schools often result in the associations enforcing compliance with GLSEN's programming. This programming includes "professional development" workshops for teachers that provide directions on procedures such as entering preferred names in school databases without parental knowledge and advocating for "LGBTQ+ affirming athletic policies". Rocio Inclan currently serves in dual positions as both GLSEN's Board of Directors Chairman and the NEA's Senior Director of Social Justice, highlighting the alignment of objectives between these organizations.

In 2021, GLSEN reported a revenue of $9,169,692, with more than a quarter allocated to media relations and marketing efforts. These funds support the development of marketing campaigns for "day of action" events, including "Solidarity Week," "No Name-Calling Week," and "Day of Silence," designed to promote the

LGBTQ agenda. A significant portion of their funding also supports their "Rainbow Library" program, which distributes "LGBTQ+ affirming K-12 text sets" (GLSEN, n.d.). This Rainbow Library initiative has been implemented in over 8,100 schools across 33 states, reaching more than 6.3 million students (GLSEN, n.d.).

Although GLSEN does not provide a catalog of books in the program, several titles from their 2021 list contained mature content (Reece, 2023). For instance, *All Boys Aren't Blue* and *Felix Ever After* include descriptions of explicit sexual activities, while *I Am Jazz* is a picture book that tells the story of a boy who identified as transgender at the age of two (Reece, 2023).

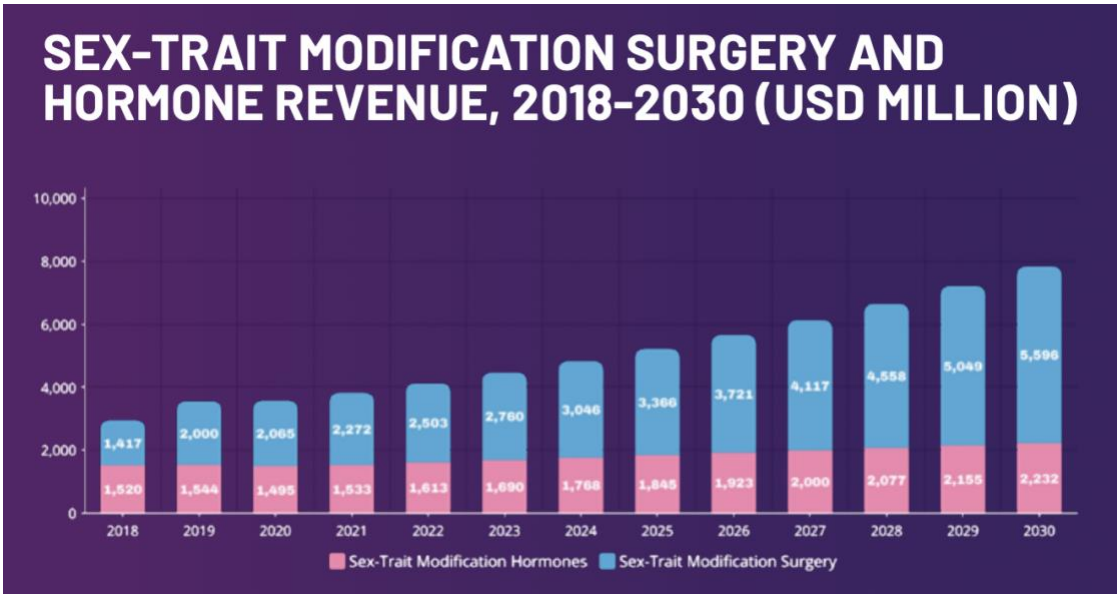
Due to the graphic nature of such ‘children's books’ installed in libraries across the country, numerous states have enacted regulations to remove unsafe content from school and children's sections of libraries. GLSEN's response to these regulations is to disregard state laws. The "2024-2025 Rainbow Library Request" form on their website includes an excerpt on what to do if you live in a state with these regulations, stating, "Yes, you should still request a Rainbow Library! U.S. public school students have a constitutional right to access books that affirm BIPOC and LGBTQ+ people. We have sent hundreds of Rainbow Library sets to schools in states and districts with unconstitutional, discriminatory anti-LGBTQ book censorship policies, and have heard countless stories of the positive impacts these books have for students. A public school that denies its students access to a book, because it contains LGBTQ+ affirming content, violates that student's constitutional rights and puts itself at risk for federal investigations and civil rights lawsuits. Because federal constitutional

protections supersede any local policies or state laws that undermine these rights, when laws conflict, it is the responsibility of school district staff to uphold students' federal constitutional rights." (GLSEN, 2025).

Economic Overview

The U.S. gender-affirming surgery and drug market is a competitive industry occupied by a multitude of pharmaceutical and sex-trait modification surgery companies within the market. The market, tightly knit with NGO activist organizations, is divided between pharmaceutical companies and health systems, populated with various entities varying from specialized clinics to established institutions. Both components are continuously adopting strategies to solidify their presence in the market, including the production of prosthetics used in surgeries and expansion upon available surgeries, respectively, as a part of the competitive landscape. The best available data reviewing the market holistically is from 2022; however, market dynamics can fluctuate due to factors such as medical advancements, legislation, and societal attitudes. The United States' sex-reassignment surgery market size was estimated to be $4.12 billion in 2022, with an expected compound annual growth rate (CAGR) of 8.4% from 2023 to 2030 (American Principles Project, 2024). Mastectomies dominated the surgery market with the largest revenue share in 2022, while estrogen had the largest revenue share in the hormone market (This and the following information is from American Principles Project, 2024).

Figure 10



(Grand View Research, 2022)

Although available data exists on the industry's size and revenue, multiple indicators suggest these figures significantly undercount the actual numbers. Reports from sources like Reuters (partnering with Komodo) that calculate recipients of gender-affirming care exclude treatments not covered by insurance and only count patients with formal gender dysphoria diagnoses. No figures exist for gender-affirming treatments provided outside insurance coverage, and as previously mentioned, there are numerous accounts of practitioners prescribing treatments without recording the associated diagnosis. Another barrier to accurate information is that many drugs used in the transition process are prescribed off-label, creating difficulty in determining how much revenue is attributed to their usage in gender-affirming care, and the

statistics fail to account for individuals obtaining puberty blockers through unregulated online suppliers. Collectively, these factors demonstrate the considerable challenges in accurately compiling and analyzing this information.

Dr. Devin Coon, an associate professor of surgery at Harvard and board-certified plastic surgeon, shared his insights with CNN after analyzing the 2022 market data. He concluded that the figures are likely underestimated, stating, "It's very easy to say who had a knee replacement. It is not like that for gender-affirming surgeries," Coon said, "It is reasonable to look at the study, though, and say the trends in here are probably reflective of the overall trends." (Christensen, 2023). Coon acknowledged that while the trends are likely reflective of broader patterns, the total market size remains imprecise due to challenges such as treatment coding issues (Christensen, 2023).

One instance of self-reported and intentional mis-coding of transgender care prompted Tennessee's Governor, Bill Lee, to launch an investigation into the responsible parties. This investigation was sparked by Dr. Shayne Taylor, a university professor and a physician at the Vanderbilt Clinic for Transgender Health, who previously stated in a lecture, "These surgeries make a lot of money. So, female-to-male chest reconstruction could bring in $40,000. A patient just on routine hormone treatment, who we're only seeing a few times a year, can bring in several thousand dollars because it requires lots of visits and labs that actually makes money for the hospital. Now, these I got from the internet, but it's from the Philadelphia Center for Transgender Surgery, which has—does a lot of surgery for patients. I just wanted to

give you an idea of how much these bottom surgeries are making. And this is—I think this has to be an underestimate. This is for vaginoplasty, they're saying, they're quoting roughly around $20,000 for a vaginoplasty, but that doesn't include your hospital stay, that doesn't include your post-op visits, that doesn't include your anesthesia, your OR. So, I would think this has to be a gross underestimate. I think that's just, like, the surgeon's piece of it." (Taylor, 2022). In the circumstance that prompted the investigation, Taylor detailed her fraudulent activity in a 2019 video admitting to manipulating billing codes to get paid by insurance companies who won't cover gender-affirming care, stating, "For the patient who gets a big bill because their insurance doesn't cover any transgender-related codes, I usually write 'endocrine disorder – not otherwise specified' to allow me to order the labs that I want," (NewsChannel5, 2023).

A study published in Medical Care, an official journal of the American Public Health Association, asserted that large administrative databases often do not log gender identity data, which limits the ability of researchers to identify transgender-identified persons, thereby complicating the study of the population (Jasuja et al., 2020). The authors retrospectively analyzed administrative claims data for those adults with insurance utilizing two strategies of using "endocrine disorder not otherwise specified" (Endo NOS) codes and a transgender-related procedure code (Jasuja et al., 2020). They then looked for receipts "of sex hormones not associated with the sex recorded in the patient's chart (sex-discordant hormone therapy) and an Endo NOS

code or transgender-related procedure code." and with this method, they identified thousands of unreported transgender-identified patients (Jasuja et al., 2020).

Even using a fraction of the total U.S. transgender population's estimate, such as the estimated 300,000 children who are transgender out of the 1.6 million total (Williams Institute 2022), would result in a substantial change in the market valuation. Based on the Philadelphia Center of Transgender Surgery's data, the cost of fully transitioning ranges from $124,000 to $140,450, and even multiplying the lower figure by the reduced population (300,000) still produces a projected market of over $37 billion (APP, 2024). Some transgender activists, such as CEO Robbi Katherine Anthony of Euphoria, a transition-tech company, would consider that estimate to even be conservative, claiming in an interview with Forbes, "Our estimates place the average cost of transition at $150,000 per person. Multiply that by an estimated population of 1.4 million transgender people, we're taking about a market in excess of $200B. That is significant. That's larger than the entire film industry." (Wright, 2020).

It is difficult to precisely project the revenue of sex-trait hormone and surgical modification as there is significant variation in procedures, costs, and unknowns of complications and follow-ups (APP, 2024). However, based on the available data, the substantially conservative figure of a $4.1 billion market share in 2022, which does not include costs such as visits to the emergency room, costs arising from transition-related complications, and revision surgeries, is the best indication of market size available and is also applicable to the analysis of trends in the industry (APP, 2024).

The estimated cost range to fully transition, which will be broken down in subsequent sections, ranges from $66,500 to $605,500 for female-to-male transition and from $87,300 to $410,600 for male-to-female (APP, 2024). These figures are calculated assuming 5 years of puberty blockers and 60 years of hormone usage, respectively, and an additional $1,200 for males for hair removal treatment and vocal training (APP, 2024). The prominent organizations within this market include pharmaceutical companies, Pfizer, AbbVie Inc, Endo International plc, Novartis, LILLY (ELI LILLY), and surgical providers, Cedars Sinai, Cleveland Clinic, Regents of the University of Michigan, CNY Cosmetic & Reconstructive Surgery, Mount Sinai Health System, Transgender Surgery Institute, Kaiser Permanente, The Johns Hopkins University, Mayo Clinic (Transgender and Intersex Specialty Care Clinic), New York Presbyterian Hospital for Transgender Health, and University of California, San Francisco Center of Excellence.

Pfizer is an organization that engages in the discovery, development, and production of pharmaceuticals, with a portfolio consisting of vaccines and medicines, and has operations in over 125 countries. They are one of the leading companies in sex-trait modification pharmaceuticals with a diverse array of hormone products, including testosterone, estrogen, and puberty blockers, across 181 locations in the world. Pfizer has a significant market share due to initiatives to strengthen their hormone offerings and brand recognition in the progesterone and estrogen markets.

AbbVie is a biopharmaceutical company that originated from Abbot Pharmaceuticals. It specializes in therapeutics such as oncology, virology,

immunology, neuroscience, and general medicine. Among its portfolio are testosterone, estrogen, and puberty blockers.

Endo International plc is a global specialty pharmaceutical company focused on developing, manufacturing, and marketing both branded and generic therapeutic pharmaceuticals. Their role in the gender-affirming care market includes the production of estrogen and puberty blockers.

With a specialization in pharmaceuticals and oncology, Novartis has operations in over 140 countries globally, filling a role in the hormone market with estrogen production.

Eli Lilly and Company has a global operation with a significant presence in the U.S., Europe, and Japan. It is involved with the discovery, development, and delivery of pharmaceuticals, with a focus on therapeutic areas such as oncology, neurology, endocrinology, diabetes, and immunology. Its share of the hormone market comes from the production of estrogen and testosterone.

Sex-Trait Modification Surgeries

Sex-trait modification surgeries can come with a high financial burden, often exceeding $140,000 due to various costs such as anesthesia, medications, and medical expertise. The financial impact varies based on the transition direction, with male-to-female transitions generally being slightly more expensive than female-to-male transitions. Beyond direct surgery costs, some procedures are considered cosmetic and are not covered by insurance. Conversely, these surgeries are a lucrative industry for the organizations performing them, amassing significant capital.

Cedars-Sinai is a Los Angeles nonprofit academic healthcare organization with over 1 million patients yearly in over 40 locations and more than 4,500 physicians and nurses. In June 2018, Cedars expanded its sex-trait modification services before establishing an LGBTQ+ Center in May 2023. In 2022, Cedars-Sinai had the largest revenue and market share (8.2%) of sex-trait modification surgeries, amassing $205.7 million in revenue from their procedures.

Regents of The University of Michigan Health System offers sex-trait modification procedures, including hysterectomy, breast augmentation, and vaginectomy, for both transgender-identified males and females. In April 2019, the University expanded its coverage to include hormones, transition-related mastectomy, bottom surgery, and counseling. As of 2022, they had the second largest market share (6.1%), with $152.9 million in revenue from sex-trait modification surgeries.

The Mount Sinai Health System, founded in 1852, consists of eight hospitals, over 400 ambulatory centers, 7,200 doctors, and 13 joint venture centers. It became the first organization in New York City to offer gender transition surgery in 2016, launching the Centers for Transgender Medicine and Surgery. They provide hormone therapy, transgender surgeries, primary care, and behavioral health support that includes medical services of endocrinology, plastic surgery, gynecology, urology, otolaryngology, and mental health services. In 2019, they performed 445 transgender surgeries and provided hormones for 820 patients. In May 2022, they received $20 million for "healthy equity" research at its Institute for Health Equity Research from

Royalty Pharma Plc. They brought in $136.5 million in revenue from sex trait modification surgeries in 2022, accounting for 5.5% of the market share.

Kaiser Permanente is a statewide managed care health system with over 200,000 employees in California. Its offerings for gender-affirming care include transgender-marketed services such as hormones and sex-trait modification surgeries, with its East Bay Gender-Affirming Center location having a specialized team for transgender services. This has resulted in $120.2 million in revenue in 2022 and a 4.8% market share of transgender surgeries.

With a 2022 market share of 4.6% and $116.3 million in revenue, The Mayo Clinic's Transgender and Intersex Specialty Care Clinic offers specialized care for transgender-identified individuals, providing surgical interventions, behavioral health services, fertility counseling, and voice and communication therapy. In 2018, they began to offer transgender surgeries in their Transgender and Intersex Specialty Care Clinic.

The University of California, San Francisco (UCSF) Center of Excellence for Transgender Health offers hormones, primary care, and surgeries including phalloplasty, chest reconstruction, and vaginoplasty, bringing in $112.5 million in revenue. They accept children as young as 3 years old, provide advocacy and legal support to children (UCSF, n.d.), and account for 4.5% of the market, bringing in $112.5 million (APP, 2024).

CNY Cosmetic and Reconstructive Surgery is a New York medical practice that offers a variety of cosmetic surgeries and transition-related services, including

mastectomies and breast augmentations. In 2022, it had a market share of 3.9% and a revenue of $97.5 million.

The Cleveland Clinic, a nonprofit academic medical center, provides various services, including clinical, hospital care, research, and education facilities. The organization has over 226 outpatient locations and 21 hospitals with 6,496 beds, along with a significant gender-affirming surgery division, generating earnings of $97.6 million (3.9% of the market)

The Transgender Surgery Institute of Southern California was founded in 2018 and is regarded as a premier facility in sex-trait modification surgery, accounting for 3.8% of the market. They are known to offer metoidioplasty and secondary reconstruction to transgender-identified females, including vaginoplasty and secondary genital reconstruction for transgender-identified males, generating $95.1 million.

The Johns Hopkins University is the research university that pioneered transgender surgery. After closing their transgender clinic in 1979, they resumed operations in 2017, offering transition-related facial surgery, child and adolescent care, and obstetrics. In 2022, they updated insurance plans to cover various procedures, including surgeries, hormones, fertility preservation, and mental health services. They had a revenue of $95.1 million, accounting for 3.8% of the market.

The New York Presbyterian Hospital, gaining $75.1 million in revenue from 2022 gender operations, is an academic medical center that offers sex-trait

modification surgeries, including vaginoplasty, breast augmentation, and mastectomies, claiming 3% of the market.

Sex-trait modification surgeries, for female to male, include mastectomy, hysterectomy, phalloplasty, chest masculinization surgery, scrotoplasty, and metoidioplasty. For male-to-female transgenders, operations include facial feminization surgery, augmentation mammoplasty, vaginoplasty, orchiectomy, electrolysis or laser hair removal, voice feminization surgery, and reduction Thychondroplasty.

Figure 11

COST OF PROCEDURES

PROCEDURE	COST (USD)
Augmentation Mammoplasty	$6,000-12,000
Voice Feminization Surgery	$5,000 -9,000
Reduction Thyrochondroplasty	$3,500-7,000
Orchiectomy	$5,000-8,000
Vaginoplasty	$10,000-40,000
Chest Masculinization Surgery	$6,000-10,000
Scrotoplasty	$4,000- 6,000
Hysterectomy	$9,500-22,500
Phalloplasty	$20,000- $150,000
Mastectomy	$15,000-$50,000
Metoidioplasty	$20,000-30,000
Facial Feminization Surgery	$20,000-50,000+
Electrolysis	$50-200 (1 hour Session)
Laser hair removal	$200-1,000
Vocal Training	$50-$200 per hour

(APP, 2024)

The costs associated with sex-trait modification surgery for males include: $20,000 to $50,000 for facial feminization surgery, which is a reconstructive surgical procedure to transform male facial features to become more female-appearing; $6,000-$12,000 for augmentation mammoplasty, which is conducted to create female-appearing breasts; $10,000-$40,000 for vaginoplasty, which is a bottom surgery to construct artificial female features; $5,000-8,000 for orchiotomy, which is a surgical procedure to remove testicles; $50-1,000 per session for electrolysis or laser hair removal, which may be performed on transgender-identified males as a form of sex-trait modification; $50-$200 per session for vocal training, which trains individuals to speak using a higher or lower vocal pitch; $5,000-9,000 for voice feminization surgery, which is a procedure on vocal cords to make one's voice sound more feminine; and $3,500-7,000 for reduction thychondroplasty, which is also known as a tracheal shave or Adam's apple reduction, where the prominence of the laryngeal is reduced.

For females, the costs associated with sex-trait modification surgery include mastectomy or removal of breasts, costing between $15,000-50,000; hysterectomies ($9,500-$22,500) which is a surgical procedure to remove the uterus, phalloplasty ($20,000-$150,000), which is a bottom surgery to artificially create male-appearing features using skin from other parts of the body; chest masculinization surgery (6,000-$10,000) which is the removal of breast tissue to appear more male; scrotoplasty ($4,000-$6,000), which is a bottom surgery to create male-appearing features; and

metoidioplasty ($20,000- $30,000), which is a procedure conducted to allow standing urination.

Komodo's analysis of insurance claims data indicates that mastectomies represent the most frequently performed procedure among adolescent populations (Reuters, 2022). A letter from Vanderbilt University School of Medicine published in *Jama Pediatrics* reported a 389% increase in the annual number of gender affirming chest surgeries between 2016 and 2019 with 77% of patients using private insurance or self-pay with an average cost of $30,000 (Karan Das et al., 2023); (The following information is from APP, 2024)

Sex-Trait Modification Hormones

The annual cumulative cost of hormone therapy for transgender-identified individuals can be substantial. A study that utilized the formulary files of the Centers for Medicare and Medicaid Services' prescription drug plan discovered that the out-of-pocket expense for transition-related hormones ranged from $84 to $2,716 in 2010, increasing to between $72 and $3,792 in 2018 (Baker & Restar, 2022). Without health insurance, the cost of gender transition hormones can range from $500 to nearly $5,000 per year (APP, 2024). The lifetime accumulation of these charges can produce dramatically significant figures. For example, if one begins lifetime usage of hormones at the age of 18, the total cost could range from $31,000 to $300,000 or even more when assuming a life span of 80 years (APP, 2024).

For those not covered by insurance, Medicaid may assume financial responsibility for gender-affirming procedures, as twenty-seven states have

implemented Medicaid policies that explicitly incorporate transgender-related healthcare services (LGBTMap, 2025). According to 2022 estimates from the Williams Institute, approximately 276,000 of the 1.3 million adults who self-identified as transgender were enrolled in Medicaid programs (Williams Institute, 2022). Within this population, 60% possess access to coverage for gender-affirming interventions under their state's statutory Medicaid (Williams Institute, 2022). The precise number of individuals utilizing Medicaid resources to obtain various forms of gender-affirming care remains indeterminate.

The use of public dollars toward gender affirming care is notable in states such as Pennsylvania and New York. According to documentation from the Pennsylvania Family Institute in October 2023, in excess of $20 million in state taxpayer resources had been allocated to subsidize gender-affirming interventions for minors since 2015 (pafamily.org, 2023). The procurement of this information through a Right-to-Know Request with the Pennsylvania Department of Human Services raises methodological questions regarding its inclusion in previously referenced analyses. The institute reports that the Commonwealth of Pennsylvania was expending approximately $14,000 daily in 2022 on transgender-related services and surgical procedures. "From 2015 to 2022, Pennsylvania has had a more than 8,200 percent increase in taxpayer funding for these drugs, surgeries, and services through these state insurance programs for children," according to institutional documentation (pafamily.org, 2023). This expanded funding followed advocacy efforts by Pennsylvania medical facilities seeking to broaden state coverage of gender-affirming care in 2015. Subsequently, in

the following year, the Pennsylvania Department of Human Services announced the state Medicaid program would cover all related services (APP, 2024).

In New York, Governor Kathy Hochul's administration has implemented measures directing public resources toward enhancing accessibility to gender-affirming care. The New York State Department of Health has allocated $500,000 in new contractual agreements for "The Transgender Clinical Scholars Training Pilot Program" to Mount Sinai Hospital, with additional financial support extended to Community Health Care Project-Callen Lorde Health Center in Manhattan and Mary Imogene Bassett Hospital in Cooperstown (Campanile, 2023). This professional development initiative aims to provide specialized training for currently licensed clinicians to facilitate patient support during gender transition processes (Campanile, 2023). Mount Sinai Center for Transgender Medicine and Surgery reported conducting 861 surgical procedures in 2021 alone (CTMS, 2021).

Hormonal sex-trait modification consists of GnRH Agonists (Puberty blockers) which are used to block the onset or continuation of puberty in transgender-identifying adolescents, testosterone which is used for developing male secondary sexual characteristics and suppression of female characteristics, estrogen which is used for developing female secondary sexual characteristics and suppression of male characteristics, and anti-androgens which are used in combination with estrogen that reduce the effects of androgens (male hormones). The estrogen market has a CAGR of 4.81%, the puberty blocker market has a CAGR of 3.98%, and the testosterone market has a CAGR of 3.14%.

For those who are uninsured, puberty blockers range from $3,000 to $25,0000 per year. For male-to-female transitioners, the annual costs of estrogen and anti-androgens are between $240 and $4,200 and $120 and $240, respectively. For female-to-male transitioners, testosterone ranges from $200 to $4,200 per year. The following market shares per pharmaceutical company, likely underrepresented, were estimated considering criteria such as market presence, service offering, locations, overall revenue, strategic initiatives, and state regulations (APP, 2024).

Figure 12

U.S. HORMONE THERAPY PRODUCT MARKET & REVENUE SHARE, BY COMPANY, 2022 (USD MILLION)

COMPANY	OVERALL ESTIMATED MARKET SHARE (%)	THERAPY TYPE			OVERALL REVENUE (USD MILLIONS)
		ESTROGEN	TESTOSTERONE	PUBERTY BLOCKERS	
Pfizer Inc.	4.6%	$48.21	$18.54	$7.42	$100,330.00
AbbVie Inc.	3.2%	$30.96	$12.90	$7.74	$58,054.00
Endo International plc	2.9%	$32.73	--	$14.03	$2,320.00
Novartis AG	2.1%	$33.86	--	--	$50,545.00
Lilly (Eli Lilly)	1.8%	$16.93	$11.29	--	$28,541.40

(APP, 2024)

The leading pharmaceutical company in the 2022 hormone therapy product market is Pfizer, whose product catalog consists of drugs such as Duavee, Viviant, Premarin, PREMPRO/ PREMPHASE, Depo-Testosterone, and Orgovyx. Their diversified portfolio has resulted in a market share of 4.6%, with $48.21 million in revenue for estrogen, $18.54 million for testosterone, and $7.42 million for puberty blockers.

The second highest-grossing pharmaceutical company is AbbVie, with a portfolio consisting of drugs including AndroGel, ALORA, ESTRACE, Oriahnn, CRINONE, and Prometrium (progesterone). With a market share of 3.2% in 2022, their revenue ($58 million) is comprised of $30.96 million from estrogen, $12.9 million from testosterone, and $7.74 million from puberty blockers.

Endo International plc held a 2.9% market share in 2022, with a revenue of $32.73 million from estrogen and $14.03 million in puberty blockers. Their revenues are based on sales of drugs such as AVEED, TESTOPEL, TESTIM, FORTESTA, and SUPPRELIN LA.

Novartis's revenue is attributed to its sales of products such as VIVELLE-DOT and ESTRADOT. These sales contribute to their 2.1% market share in 2022 and $33.86 million in revenue within the industry.

Eli Lilly's market share consisted of products such as Axiron, Evista, VIVELLE-DOT, and ESTRADOT, equating to a 1.8% share, including $16.93 million in estrogen revenue and $11.29 million in revenue from testosterone production.

The Gender-Industrial Complex

Pharmaceutical companies have shown significant financial incentives in the expansion of the gender-affirming care industry, investing heavily in research, production, and marketing. The interrelation between the affirming care industry and pharmaceutical companies has been present since the emergence of the Dutch protocol, being funded in 2006 by the producer of a puberty-blocking drug (Biggs, 2022). The pharmaceutical industry's direct and indirect contribution to the continued application of gender affirming care can be discerned by the actions of the trade association representing the U.S. pharmaceutical industry, PhRMA (Pharmaceutical Research and Manufacturers of America). Those affiliated as member companies with PhRMA include leaders in the gender-affirming care industry, such as Pfizer, Eli Lilly, AbbVie, and Novartis (PhRMA, n.d.); (The following information is from the American Accountability Foundation, 2024).

Between 2017 and 2021, PhRMA was found to have funded numerous activist organizations that actively promote transgender ideology. Among the organizations funded by PhRMA are Equity California, who supported bills such as one that required California teachers to undergo "LGBTQ+ cultural competency training" and one that requires affirmation of parent be considered during child custody decisions; The American Academy of Child & Adolescent Psychiatry, who endorse transition for children; Diversity Richmond, which sponsors "drag bingos"; The Human Rights Campaign, which pushes the LGBTQ agenda in schools and workplaces; The LGBTQ

Victory Institute, which aims to place LGBTQ individuals in presidential appointments; The Trevor Project, which offers gender transition counseling to teenages without parental consent; The Maine Transgender Network, which opposed a bill to establish a rating system for books in school libraries and opposed a bill to allow only females to participate in girls sports; and The Center for Black Equity, which sponsor black LGBTQ pride events as "an alternative to the largely white mainstream LGBTQ+ movement". The pharmaceutical industry actively funds organizations that promote and normalize gender ideology, particularly targeting children. In turn, this generates patients who require life-long treatment and, therefore, perpetual revenue through the establishment of medical dependency on their treatment.

PhRMA and Pfizer both financially supported the Human Rights Campaign's medical index that pushes LGBTQ ideologies on young patients while penalizing hospitals that do not follow its index criteria. The HRC introduced its Healthcare Equality Index (HEI) in 2022, a scorecard that surveys if U.S. hospitals are "dedicated to the equitable treatment and inclusion of their LGBTQ+ patients, visitors, and employees" (HEI, 2024). Their guidelines maintain that for hospitals to attain a perfect score, they must exhibit LGBTQ symbols, administer HRC-approved training programs, and use preferred pronouns (HEI, 2024). The criteria pressures doctors to provide gender affirmation treatment to patients who claim to be transgender without symptoms of gender dysphoria, and it punishes institutions who oppose this procedure (HRC, 2024). The index also deducts points from facilities for conduct deemed

discriminatory and for refusal to perform mastectomies or hysterectomies on young patients (HRC, 2024).

Pharmaceutical companies also have a demonstrated history of funding inaccurate, self-serving research within the literature, contributing to the proliferation of the perception of safety. One example of this pattern can be perceived through the conduct of Dr. Jack Turban, a prominent gender-identity expert and researcher. In many of Turban's published papers, the funding sources reveal severe conflicts of interest. Much of Turban's research funding comes from the AACAP, which is financially supported by producers of off-label puberty blockers, including Pfizer and Arbor. AACAP is an outspoken advocate against restrictions on puberty blockers, hormone therapy, and sex change surgeries for children. Researchers in collaboration with AACAP, whose research committee makes their final decision on project or researcher funding, would presumably be aware of their well-established stance on gender-affirming care when accepting funding.

Research shows that industry-funded studies are significantly more likely to yield results favorable to the sponsor than independently funded research, often due to biases introduced in study design, outcome reporting, or data interpretation (Schott et al., 2010; Lexchin et al., 2003). For a 2020 study, *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, co-authored by Turban, he received a $15,000 Pilot Research Award for General Psychiatry Residents from the AACAP and conveniently found that adolescent puberty suppression results in improved mental health (Turban et al., 2020). Biggs reviewed the study, critiquing

methodological flaws that invalidate its findings, including its reliance on a low-quality survey. Other studies co-authored by Turban and funded by the AACAP include *Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults*, which received financial support from Arbor and Pfizer, according to a Stanford Press release (Stanford, 2022). The study claimed to find evidence that children who undergo medical transition experienced an improvement in mental health (Turban et al., 2022).

A California neuorologist, Dr. Diana Blum, reviewed the methodological flaws within the research that prompted a correction such as its use of surveys instead of a double-blind placebo-controlled trial and stated that “if Pfizer is producing hormone therapies then of course there’s incentives to promote studies that push those. Even though things get published in academic journals, a lot of the funding comes from the pharmaceutical industry.” (Lendrum, 2022). The study was promoted by outlets such as NBC News, the Today Show, Psychology Today, and USA Today without providing disclosure of financial bias (Lendrum, 2022). Additional funding to Turban’s research came through "expert witness" payments from the ACLU, an organization whose activism includes gender-affirming care advocacy for children (Turban et al., 2022). Another Turban study, *Sex Assigned at Birth Ratio Among Transgender and Gender Diverse Adolescents in the United States*, attempts to challenge the social contagion theory but does so using vague data that prevents substantiated conclusions (Turban et al., 2022).

Turban, who is heavily cited in the literature, represents a significant portion of researchers in this field, producing predetermined research conclusions in alignment with the position of the respective funding organization. Turban's studies, supported by direct AACAP funding and indirect benefactors, have generated extensive media coverage, spreading false or incorrect interpretations of their findings. Given the $30 billion annually that the pharmaceutical industry spends on advertisements (Statista, 2024), there is a lack of incentive for media organizations to challenge the safety of a financial partner's product. Approximately ⅓ of all commercial time across evening news programs is direct-to-consumer prescription drug advertisements from pharmaceutical companies (Durbin.senate.org, 2025), resulting in hundreds of millions in revenue to media outlets from pharmaceutical companies (Kim et al., 2022).

Potential conflicts of interest arising from commercial sponsorship may influence media coverage of scientific research, particularly when findings contradict established narratives. Financial relationships between media organizations and corporate sponsors could theoretically inhibit the comprehensive reporting of studies that present unfavorable outcomes regarding gender-affirming interventions. The prospect of compromising revenue streams or jeopardizing strategic partnerships may serve as a disincentive for media outlets to disseminate research findings that cast doubt on the efficacy or safety of treatments offered by sponsoring entities, potentially contributing to publication bias in the academic discourse surrounding gender-affirming care methodologies.

PhRMA's financial contributions to advocacy organizations such as the Trevor Project, which produces research in the literature, also potentially influence the research environment surrounding gender-affirming interventions. Given the organization's advocacy-oriented mission, their published studies demonstrate methodological predispositions toward generating findings supportive of affirmative treatment approaches. Consequently, pharmaceutical industry funding channeled through such organizations may indirectly shape the evidential landscape by subsidizing research initiatives to organizations with confirmatory bias regarding affirmative care paradigms.

The pharmaceutical industry operates within a cyclical dynamic concerning transgender healthcare. Pharmaceutical companies directly or indirectly allocate research funding toward investigations to yield favorable outcomes regarding hormonal therapies and surgical procedures for gender transition, thus shaping an alleged clinical consensus and societal attitudes. This selective research investment subsequently generates increased utilization of pharmaceutical products and medical interventions manufactured by the funding entities, creating substantial financial return. This self-reinforcing mechanism is further consolidated as clinical decision-making and patient treatment processes rely upon the literature base, which has been influenced by commercial entities possessing direct pecuniary interests in implementing and expanding these therapeutic modalities.

Pharmaceutical companies are not the only entities that profit in this industry. Activist NGOs such as HRC have a substantial base of corporate benefactors such as

Amazon, Apple, CVS, Google, Lyft, Marriott, JPMorgan Chase, Microsoft, Pfizer, and Disney (HRC, n.d.). These organizations also play a crucial role in being facets of the supply chain, lobbying for legislation, and influencing the actions of organizations with substantial means to do so. For example, the HRC's corporate equality index (CEI) rates a corporation's DEI policies and benefits that they provide to lesbian, gay, bisexual, transgender, and queer employees. The HRC has announced that their 2026 CEI criteria will be updated to require corporations to offer insurance coverage for child sex change medications to obtain a top CEI score (HRC, 2024). This independent market rating can be influential in talent acquisition as most Fortune 500 companies have participated in the survey, while those with low ratings can receive backlash and media criticism and can influence investor behavior (The following information is from APP, 2024).

Another emerging market is in the transgender technology market. In this sector, significant financial investment has coalesced around digital platforms facilitating gender transition processes. Euphoria, self-described as the "Adobe equivalent" for gender transition, secured over $250,000 in funding in 2021, with Chelsea Clinton and LGBTQ venture capital firm Gaingels (which has raised over $800 million) among its notable investors. The company offers three applications: Bliss (financial planning for transition expenses), Solace (a comprehensive transition resource guide), and Devotion (affirmation messaging based on user data). While Bliss and Devotion are available to users aged four and above, Solace is accessible to individuals aged 17 and older, featuring a "child mode" for parental utilization.

Transgender telehealth companies operate predominantly on subscription-based revenue models, representing an unquantified market segment. Plume charges up to $99 monthly for specialized transgender healthcare services (excluding prescription costs), equalityMD begins at $79 monthly for access to culturally competent practitioners, and Folx requires a $39.99 monthly membership with additional costs for treatments (e.g., estradiol patches ranging from $175 to $582 per 90-day supply).

Despite being a relatively nascent industry, transgender telehealth has attracted substantial venture capital investment, with Plume and Folx raising $14 million and $25 million, respectively, in Series A funding in 2021. This investment pattern indicates recognition of substantial market growth potential in transgender medicine, with additional questions emerging regarding the economic value of associated data mining practices.

Conclusion

The confluence of maladaptive coping strategies and diagnostic overshadowing practices within clinical environments has contributed to widespread mistreatment of conditions and consequent implementation of unwarranted and potentially detrimental interventions for this demographic. The phenomenon of runaway diffusion is exemplified within this sector through the comprehensive adoption of research protocols despite insufficient empirical validation and the absence of longitudinal outcome data to substantiate their clinical application.

While the United States incorporated the Dutch protocol framework, critical exclusionary criteria were omitted, particularly the contraindication of treatment for individuals with psychiatric comorbidities and the requirement for concurrent psychotherapeutic intervention throughout the transition process. Despite the high prevalence of psychiatric conditions and acute-onset presentations within contemporary patient populations—characteristics that would have precluded participation in the original Dutch research—these individuals are encouraged to pursue medical interventions while therapeutic support is positioned as optional or potentially contraindicated.

Co-rumination and deviancy training mechanisms significantly influence the concentration of transgender identification within specific social networks, including peer groups and virtual communities. These environments facilitate the introduction and reinforcement of conceptualizations suggesting gender transition as a remedial approach to pre-existing mental health conditions.

The redefinition of informed consent has established a clinical paradigm prioritizing patient autonomy over comprehensive diagnostic assessment for a condition characterized by poor diagnostic stability. The systematic integration of gender identity frameworks within educational and healthcare institutions has fundamentally transformed professional practices, normalizing and broadly institutionalizing gender-affirming interventions throughout society. This institutional transformation simultaneously advances financial interests within the gender industrial complex through the generation of substantial revenue streams.

Future advancements necessary for establishing a transparent clinical environment conducive to comprehensive patient care include: enhanced professional liability frameworks for practitioners providing gender-affirming interventions; expanded allocation of resources toward methodologically rigorous research initiatives free from conflicts of interest; and substantive leadership restructuring within influential medical societies and educational institutions. Such systemic modifications would facilitate informed decisions through improved access to objective data regarding treatment outcomes and associated risks. From 50 years within the field of transgender care, Stephen Levine assesses that "Nowhere in medicine has free speech been as limited as it has been in the trans arena. Skeptics are being institutionally suppressed, critical letters to the editor are refused publication, symposia submitted for presentation at national meetings are rejected, scheduled lectures are cancelled, and pressure has been exerted to get respected academics fired." (Grossman, 2023).

The requisite evolution of gender-affirming interventions requires enhanced professional accountability mechanisms. Implementation of strengthened liability frameworks for practitioners would likely precipitate more judicious patient selection criteria and emphasize comprehensive psychological assessment protocols. The integration of more thorough mental health evaluation procedures would substantially mitigate the occurrence of diagnostic overshadowing. Establishing heightened personal and institutional liability would result in the discontinued use of interventions lacking demonstrated longitudinal efficacy.

A comprehensive leadership transformation within influential medical organizations is essential to reestablish methodological rigor and objectivity in scientific inquiry. Such restructuring would facilitate the appropriate allocation of resources toward methodologically sound research initiatives and create institutional environments conducive to nuanced scholarly discourse regarding gender-affirming interventions. The current governance structures within prominent medical associations contribute to publication bias and selective endorsement of research findings that align with predetermined ideological positions. Leadership reconfiguration could potentially dismantle existing barriers to open scientific debate and facilitate the critical examination of evidence from multiple theoretical frameworks.

Implementing leadership changes could foster institutional cultures that prioritize patient welfare through evidence-based practice rather than ideological conformity. Such transformation would likely generate research agendas characterized by enhanced methodological pluralism, longer follow-up periods, and more comprehensive assessment of both beneficial and adverse outcomes. Additionally, reformed leadership might establish improved safeguards against conflicts of interest, ensuring that financial relationships with industry stakeholders do not unduly influence research priorities or clinical recommendation formulation (The following information is from Grossman, 2023).

While the United States has embraced blockers, hormones, and surgeries on demand, progressive nations in Western Europe and Scandinavia have pulled back

significantly. Sweden restricted medical interventions for minors following a malpractice case. Finland's health authority established psychotherapy, not puberty blockers and cross-sex hormones, as the first-line treatment for gender dysphoria in minors. In Finland, medical interventions have been limited to two centralized research clinics and are approved only on a case-by-case basis.

The Norwegian healthcare investigation board revised their guidelines: "The knowledge base, especially research-based knowledge for gender affirming treatment is deficient and the long-term effects are little-known." They noted this is particularly true for the teenage population.

The Royal Australian and New Zealand College of Psychiatrists cautioned, "There is a paucity of quality evidence on the outcomes of those presenting with gender dysphoria. In particular, there is a need for better evidence in relation to outcome for children and young people." They advocated for a psychotherapy-first approach before initiating hormones and altering the physical nature of the child. The United States serves as a medical outlier in the continued endorsement and treatment of gender affirming care.

Due to the dynamic nature of U.S. federal policy on gender affirming care from the administration change in the executive government, I have opted to omit federal policy as it is subject to change. However, federal changes will also play an influential role in the development of the industry. In February 2025, President Donald Trump issued executive orders that included the termination of federal funding for providers of gender affirming care for those under the age of 19, which is currently

under review in court (ACLU, 2025). Due to pending court decisions on gender affirming care regulations, policy revisions are subject to change.

At both an organizational and government capacity, argument ends where good governance begins. With the proper reconfiguration of organizational leadership structures and the contemporaneous revision of policy at the federal level, the gender affirming care industry may be restructured to mandate thorough evaluation and provide an accurate depiction of treatment instead of the portrayal of a medical consensus.

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Statement Regarding Generative AI use

All use of Generative AI (GAI) in this thesis complies with the Honors Tutorial College Thesis Guidelines. Below is Subsection 3 of the HTC generative AI Guidelines:]

3. ***Using AI to generate arguments or interpret sources (primary or secondary).***

This is unacceptable use because students must offer an innovative interpretation of important issues or ideas in their field. If AI generates this work, then the student does not fulfill this criterion.

At no point was Generative AI used to construct arguments or interpret sources beyond the scope explicitly defined in the methodology. Grammarly and Claude.ai were used for checking grammar and rephrasing sentences in some places.