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**IN THE FOURTH JUDICIAL DISTRICT COURT  
MISSOULA COUNTY**

**SCARLET VAN GARDEREN, a )  
minor by and through her )  
guardians Jessica van Garderen )  
and Ewout van Garderen; )  
JESSICA VAN GARDEREN, an )  
individual; EWOUT VAN )  
GARDEREN, an individual; )  
PHOEBE CROSS, a minor by )  
and through his guardians Molly )  
Cross and Paul Cross; MOLLY )  
CROSS, an individual; PAUL )  
CROSS, an individual; JANE )  
DOE, an individual; JOHN DOE, )  
an individual; JUANITA )  
HODAX, on behalf of herself and )  
her patients; KATHERINE )  
MISTRETTA, on behalf of herself )  
and her patients, )**

**Case No. DV-23-541**

**Hon. Judge: Jason Marks**

**Plaintiffs,**

**v.**

**STATE OF MONTANA; )  
GREGORY GIANFORTE, in his )  
official capacity as Governor of )  
the State of Montana; AUSTIN )  
KNUDSEN, in his official capacity )  
as Attorney General; MONTANA )  
BOARD OF MEDICAL )  
EXAMINERS; MONTANA )  
BOARD OF NURSING; )  
MONTANA DEPARTMENT OF )  
PUBLIC HEALTH AND )  
HUMAN SERVICES; CHARLIE )  
BRERETON, in his official )  
capacity as Director of DPHHS, )**

**Defendants.**

**EXPERT REBUTTAL REPORT OF**  
**JOHANNA OLSON-KENNEDY, M.D., M.S.**

I, Johanna Olson-Kennedy, M.D., M.S., hereby declare and state as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
2. I am over the age of 18. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.
3. I previously submitted an expert report in this case (“Olson-Kennedy Report”). I submit this report to respond to points raised in the reports of Defendants’ designated experts: James Cantor, PhD; Michael K. Laidlaw, M.D.; Dr. Sven Roman, Daniel Weiss, M.D.; and Dr. Geeta Nangia.
4. My background, qualifications, and compensation for my services in this case, and the bases for my opinions in this case are described in my original report.
5. In preparing this report, I was provided with and reviewed the reports from Defendants’ designated experts described above and the accompanying exhibits, as well as the expert report of Danielle Moyer, PhD, submitted by Plaintiffs.
6. In preparing this rebuttal report, I have relied on my training and years of research and clinical experience, as set out in my curriculum vitae (attached as **Exhibit A** to my original report) and on the materials listed therein; the materials listed in the bibliography attached as **Exhibit B** to my original report; and the additional materials listed in the supplemental bibliography

attached as an exhibit to this rebuttal report. The sources cited in each of these are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject, which include authoritative, scientific peer-reviewed publications.

7. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise. I may also further supplement these opinions in response to information produced by Defendants in discovery and in response to additional information from Defendants' designated experts.

### **EXPERT REBUTTAL OPINION**

8. Defendants' designated experts show a lack of familiarity and understanding regarding the existing research about gender identity, gender dysphoria and the treatment of gender dysphoria, as well as the clinical experience surrounding the treatment of gender dysphoria, particularly regarding transgender youth. This lack of familiarity and understanding makes sense. Dr. Laidlaw has no peer-reviewed original publications regarding transgender individuals, either adults or youth. While he is an adult endocrinologist, he does not have any cited experience in the clinical care of children, adolescents, or adults with gender dysphoria. Likewise, Dr. Cantor has no clinical experience in the care of, or in research related to transgender people, youth or otherwise. His field of expertise is in paraphilias. Dr. Roman states he has met with 35 youth with gender dysphoria. Dr. Roman does not indicate that he has ever diagnosed or treated a patient with gender dysphoria

and seems to base his credentials on the fact that he participated in an editorial debate in 2019 and has otherwise read reports that are widely available.

9. Here I respond to the central points and errors in these experts' reports. I do not specifically address each article or study cited, but instead explain the overall problems with their conclusions and provide data showing why such conclusions are erroneous.

**A. Defense Experts Both Misunderstand and Misrepresent the Frequency of Desistance, Which Is Rare Among Youth Whose Gender Dysphoria Persists Into Adolescence**

10. The studies pertaining to desistance – which refers to the experience of children who may have received a diagnosis of gender identity disorder or gender dysphoria but who ultimately identify with their sex assigned at birth – pertain to *pre-pubertal* youth, not adolescents. In fact, studies show that if gender dysphoria is present in adolescence, it usually persists.<sup>1</sup>

11. To be sure, there are a significant number of *pre-pubertal* children who demonstrate an interest or preference for clothing, toys, and games that are stereotypically of interest to members of the “other” gender. Some of these children are transgender and some are not. It is the study of such *pre-pubertal* children that has created confusion about the persistence of gender dysphoria into adolescence and adulthood. Specifically, the *pre-pubertal* children who were the subject of research endeavors in the late 20th century included both children who are transgender and children who are not, i.e., those who would have met current criteria for a diagnosis of “Gender Dysphoria in Children” and

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<sup>1</sup> de Vries, A.L., Steensma, T.D., Doreleijers, T.A., & Cohen-Kettenis, P.T. (2011). Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study. *The Journal of Sexual Medicine*, 8(8), 2276-2283

those who would be considered “sub-threshold” for this diagnosis, i.e. *not* meeting the criteria for a diagnosis.

12. At the time of these studies, the diagnosis of “Gender Dysphoria in Children” did not exist and therefore the study subjects did not need to meet criteria B, which is “the presence of clinically significant distress associated with the condition.” In addition, the criteria for the then-used “gender identity disorder in children (GID)” diagnosis did not require a child to have “a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender),” which the current “Gender Dysphoria in Children” diagnosis requires.

13. Thus, given the broader criteria used at the time, it is unsurprising that some of the research undertaken toward the end of the 20th century demonstrated that most children who exhibited gender-nonconforming behavior did not go on to have a transgender identity in adolescence; that is because, under contemporary diagnostic frameworks, they were not transgender in the first place. Yet, notwithstanding the inapplicability and outdated nature of these studies, they continue to be used to argue against medical treatment for adolescents.

14. What is more, these arguments about desistance in *pre-pubertal* children are wholly irrelevant to the question of coverage and provision of medical care as treatment for gender dysphoria in adolescents. That is because research to date shows that if transgender identification persists into

adolescence, then desistance is incredibly rare,<sup>2</sup> and no medical or surgical treatments are recommended for *pre-pubertal* children.

15. Additionally, no studies have ever demonstrated that gender affirmation in childhood “leads to” a child being transgender who otherwise might not have been.<sup>3</sup> Studies have demonstrated that the majority of youth whose gender dysphoria and cross-gender identity continue to be present, or those whose gender dysphoria emerges in adolescence, are highly unlikely to identify and live as cisgender individuals regardless of whether, when and which medical interventions are provided. Youth with gender dysphoria, particularly those who are unaffirmed and denied clinically-indicated care, are at high risk for depression, anxiety, isolation, self-harm and suicidality at the onset of puberty-related changes that feel wrong to them.

#### **B. Defense Experts’ Suggestion That Gender Dysphoria Results From Peer Influence Has No Basis**

16. There is no evidence that “social contagion” causes gender dysphoria, and “rapid-onset gender dysphoria” (ROGD) is not a diagnosis recognized by any medical or scientific institution. There is no scientific evidence in support of the existence of ROGD.

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<sup>2</sup> See generally de Vries, A.L., McGuire, J.K., Steensma, T.D., et al. (2014). Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment. *Pediatrics*, 134(4), 696-704., Turban, J.L., de Vries, A.L.C., & Zucker, K. (2018). Gender Incongruence & Gender Dysphoria. In Martin A., Bloch M.H., & Volkmar F.R. (Editors): *Lewis’s Child and Adolescent Psychiatry: A Comprehensive Textbook*, Fifth Edition. Philadelphia: Wolters Kluwer.

<sup>3</sup> See, e.g., Rae, J. R., Gülgöz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science*, 30(5), 669-81.

17. The concept of ROGD originated from a single article authored by Lisa Littman, a researcher who had no experience in the field of gender medicine, transgender issues, or gender dysphoria, prior to the publication of her article.<sup>4</sup>

18. Littman’s article was heavily criticized for its flawed methodology, potential for bias, and overrepresentation of its findings.<sup>5</sup> For example, Littman’s study was based solely on “parent observations and interpretations.” But parental reports are not necessarily a reliable basis for understanding a particular youth’s experience with their gender, let alone whether or not the youth has gender dysphoria.<sup>6</sup> This is especially true here because the study also failed to collect data from the adolescents and young adults (AYAs) or clinicians, which would have been necessary in order to come up with and validate ROGD as a new phenomenon. Moreover, most of the parents who participated in the study were recruited from websites targeted to parents likely to question their child’s gender self-identification and already doubtful of the current evidence-based health care approaches.

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<sup>4</sup> Littman L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PloS one*, 13(8), e0202330.

<sup>5</sup> See, e.g., Brandelli Costa, A. (2019) Formal comment on: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE* 14(3): e0212578; Restar A. J. (2020). Methodological Critique of Littman's (2018) Parental-Respondents Accounts of “Rapid-Onset Gender Dysphoria”. *Archives of sexual behavior*, 49(1), 61–66.

<sup>6</sup> See, e.g., Kennedy, N. (2022) Deferral: the sociology of young trans people’s epiphanies and coming out. *Journal of LGBT Youth*, 19:1, 53-75; Brandelli Costa (2019).



19. Following the numerous critiques of the Littman study, the journal that published the study retracted it, ordered a post-publication review, and republished the article with a correction notice,<sup>7</sup> along with an apology.<sup>8</sup>

20. The correction notice acknowledged, among other things, that:<sup>9</sup>

- a. “There is some information about the AYAs that the parents would not have access to and the answers might reflect parent perspectives” and that “consideration of what information parents may or may not have access to is an important element of the findings”;
- b. “The study’s output was hypothesis-generating rather than hypothesis-testing”;
- c. “Three of the sites that posted recruitment information expressed cautious or negative views about medical and surgical interventions for gender dysphoric adolescents and young adults and cautious or negative views about categorizing gender dysphoric youth as transgender”; and
- d. “There is expected variation in how objective parents can be about their own children” and that the “descriptive study was not designed to explore or measure the objectivity of participants.”

21. Thus, the correction ultimately acknowledged that the study “does not validate the phenomenon” of ROGD and that the term ROGD “should not

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<sup>7</sup> Littman L. (2019) Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE*, 14(3): e0214157.

<sup>8</sup> Heber, J. Correcting the scientific record on gender incongruence – and an apology, *PLoS ONE* (Mar. 19, 2019), <https://everyone.plos.org/2019/03/19/correcting-the-scientific-record-and-anapology/>.

<sup>9</sup> Littman (2019).

be used in a way to imply that it explains the experiences of all gender dysphoric youth nor should it be used to stigmatize vulnerable individuals.”<sup>10</sup> In the end, aside from the correction notice, the journal that published the study issued an apology “for oversights that occurred during the original assessment of the study.”<sup>11</sup>

22. To date, no study has been published that validates or proves the hypothesis of ROGD presented by the Littman study. Indeed, Lisa Littman herself said at the GenSpect 2021 Conference that ROGD was not a new phenomenon, but rather a re-naming of late onset gender dysphoria.

23. Defendants’ experts incorrectly allege that an increase in numbers of youth presenting for care related to gender dysphoria provides support for the “social contagion” theory. There is no evidence for this assertion; rather, the increase in referrals has coincided with greater awareness of gender dysphoria and access to medical care to treat it, as well as insurance coverage, meaning that families are more able to afford medical interventions to treat gender dysphoria, likely increasing referrals for evaluation. Moreover, not all adolescents who present for treatment ultimately receive gender-affirming medical interventions.<sup>12</sup> In a large study from a clinic in the Netherlands, the percentage of evaluated patients who actually started treatment has decreased over time, suggesting that while the diagnostic criteria for treatment remain stringent, the threshold for seeking an evaluation has lowered with increased

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<sup>10</sup> *Id.*

<sup>11</sup> Heber (2019).

<sup>12</sup> Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., ... & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, 15(4), 582-590.

knowledge about gender dysphoria as a condition and the potential for treatment.<sup>13</sup>

24. Varying estimates of prevalence are the result of inconsistent measures of transgender populations. Some studies have assessed the fraction of a population which had received the DSM-IV diagnosis of GID or the ICD-10 diagnosis of transsexualism, both of which were limited to clinical populations who sought a binary transition (male-to-female or female-to-male). For example, the prevalence reported in DSM-5 (0.005–0.014% for birth-assigned males; 0.002–0.003% for birth-assigned females) are based on people who received a diagnosis of Gender Identity Disorder or transsexualism and were seeking hormone treatment and surgery from gender specialty clinics, and, therefore, do not reflect the number of all individuals with gender dysphoria or who identify as transgender.<sup>14</sup> Other studies have reported on those who self-identified as transgender or gender incongruent and found that measuring self-identity yields much higher numbers. In 2016, data from the Center for Disease Control’s Behavioral Risk Factor Surveillance System suggested that 0.6% of U.S. adults identify as transgender, double the estimate utilizing data from the previous decade.<sup>15</sup> In other words, many of the claims made by Defendants’ experts about the rise in numbers of patients with gender dysphoria are not accurately measuring the number of people who are seeking medical treatment,

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<sup>13</sup> *Id.*

<sup>14</sup> Coleman, et al. (2022).

<sup>15</sup> Byne, W., Karasic, D. H., Coleman, E., Eyler, A. E., Kidd, J. D., Meyer-Bahlburg, H. F. L., ... Pula, J. (2018). Gender dysphoria in adults: An overview and primer for psychiatrists. *Transgender Health*, 3(1), 57-70.

being assessed for treatment and then going on to receive care – the relevant population for questions about medical intervention.

25. Ultimately, there is nothing surprising about the fact that more transgender people have begun identifying themselves to others as societal stigma has started to abate (though it remains significant), and nothing about that lends support to the “social contagion” theory. In an article entitled “Re-evaluation of the Dutch approach: are recently referred transgender youth different compared to earlier referrals?” the Dutch team evaluated whether there were differences in youth seeking services over time between 2000 and 2016, largely in response to the claims that social contagion was playing a role in the increasing numbers of youth seeking care. These authors concluded that except for an increase in the ratio of birth assigned girls to birth assigned boys, “The percentage of referrals diagnosed with gender dysphoria (mean 84.6%, range 75–97.4%) remained the same. The percentage of diagnosed adolescents that started with affirmative medical treatment (puberty suppression and/or gender-affirming hormones) did not change over time (mean 77.7%; range 53.8–94.9%). These findings suggest that the recently observed exponential increase in referrals might reflect that seeking help for gender dysphoria has become more common rather than that adolescents are referred to gender identity services with lower intensities of gender dysphoria or more psychological difficulties.”<sup>16</sup>

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<sup>16</sup> Arnoldussen M, Steensma TD, Popma A, van der Miesen AIR, Twisk JWR, de Vries ALC. Re-evaluation of the Dutch approach: are recently referred transgender youth different compared to earlier referrals? *European child & adolescent psychiatry*. 2020;29(6):803-811. doi:10.1007/s00787-019-01394-6.

### **C. “Transition-on-Demand” Is Not A Model Of Care For Transgender Youth With Gender Dysphoria In The United States**

26. Like all health care, gender-affirming care for every transgender person is individualized. There simply is no one specific route.

27. It is inaccurate to assume that every transgender young person wants and receives rapid access to services. For most transgender individuals seeking care, nothing about their process is rapid, especially when they are minors. Most individuals with gender dysphoria have engaged in a long, arduous and private process of understanding their gender to be different from the one assumed at birth: one study demonstrated that transgender people who first understood their gender identity in childhood waited a median of 14 **years** before sharing this with another person.<sup>17</sup> Moreover, for transgender adolescents with gender dysphoria, it is their parents or guardians who provide informed consent to medical care, with the adolescents themselves providing informed assent. It is often the case that the parents, by the time they bring their child to a clinician, have also gone through a long process of understanding and coming to terms with their child’s gender dysphoria. Regardless of how quickly an adolescent with gender dysphoria accesses gender-affirming medical care, that access is predicated on both on a qualified practitioner determining the care is clinically indicated and a parent or guardian providing consent.

28. The strawman of “transition-on-demand” does not reflect the reality of how gender-affirming medical care is provide to adolescents in the United States, and such a characterization reflects a skepticism of transgender

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<sup>17</sup> Turban, J. L., Dolotina, B., Freitag, T. M., King, D., & Keuroghlian, A. S. (2023). Age of Realization and Disclosure of Gender Identity Among Transgender Adults. *Journal of Adolescent Health, 72*(6), 852-59.

identity or the clinically-significant distress of gender dysphoria. Despite Dr. Cantor and the other defense experts' rejection of transgender patients' right to bodily autonomy and their capacity to make sound and informed decisions, clinicians in the United States can both affirm transgender identity while also using rigorous, objective diagnostic criteria for evaluating gender dysphoria.

29. There is likewise no basis to the suggestion that clinicians in the United States are manipulating or steering adolescent patients and their families in any particular direction. Ethical medical treatment involves the discussion of risks and benefits of treatment, exploration of a patient's gender identity, and the informed consent of parents and assent of adolescents. Any provider steering a patient in a particular direction would be practicing far outside of any acceptable guideline.

**D. Defense Experts Are Incorrect That Social Affirmation In Childhood “Leads” Youth Into An Inexorable “Pathway To Physical Interventions”**

30. It is wrong to assert that affirmation “increases the probability of unnecessary transition and unnecessary medical risks.” There is no evidence to support the notion that affirmation of gender in pre-pubertal children, or at any age, leads to an inevitable physical transition with medical and/or surgical interventions. Medical interventions are not recommended and are not appropriate for pre-pubertal children.

31. If one's gender could be impacted by the role of rearing, there would be few transgender people who transition in adulthood, as most were reared in the

gender role that corresponded with their sex assigned at birth. It is not logical to suggest that although efforts to convince transgender people to be cisgender have been unsuccessful (and are so harmful so as to be considered unethical), lesser efforts would nonetheless be able to make someone who is cisgender into someone who is transgender, a directionality that may correspond with higher rates of discrimination, harassment, and even violence. There is no data to support any such notion that children who are permitted to socially transition in a pre-pubertal time period who then go on to embrace their assumed gender at birth are harmed by the affirmation of their understanding of their gender. In my clinical experience, I have encountered several such young people who are healthy and happy, who reported no harm from being allowed to socially transition, and whose mental health benefitted from being affirmed in their gender at all stages of their development.

32. Dr. Laidlaw argues that “[p]uberty blockers have been shown to dramatically alter natural desistance.” However, this assumption of causality has no support in the literature. Youth who are more gender dysphoric in childhood are more likely to persist in a transgender identity. They are also more likely to seek out a mechanism to avoid the development of secondary sex characteristics that are not aligned with their gender, and more likely to satisfy the diagnostic criteria prerequisite to receiving such an intervention. It is thus unsurprising that the youth whose gender dysphoria persisted until the onset of puberty and who presented for medical care were indeed the youth who are transgender. Research supports that gender identification is not significantly different before and after a social transition, that is, that any effect of social transition results from the fact that those who socially transition before puberty

have a stronger discordance between their sex assigned at birth and their gender identity, not that social transition itself increase gender discordance.<sup>18</sup>

33. Any claims from the defense experts asserting that “puberty blockers, rather than being a ‘pause’ to consider aspects of mental health, are instead a pathway towards future sterilizing surgeries” are wholly unsubstantiated. Again, youth with significant gender dysphoria pursue blockers because of the significant distress they are experience with the onset of puberty; they do not experience continued incongruence *because* of the intervention. This argument is akin to saying something like “youth who are treated with combined oral contraceptive pills for endometriosis in adolescence are more likely to undergo laparoscopic treatment for endometriosis because of the earlier OCP treatment.” Rather, adolescents whose endometriosis was severe enough to warrant treatment with medication are more likely to require surgical treatment later because they still suffer from severe endometriosis, not because the oral medication made their endometriosis persist. Similarly, youth who are prescribed GnRH analogs for gender dysphoria by definition have met the diagnostic criteria for clinically significant distress related to their gender incongruence, and so they are likely to go on to pursue gender-affirming hormone therapy because their gender dysphoria has continued to be clinically significant and require treatment. Dr. Laidlaw and others who assert that GnRH analogs are a “gateway” drug to gender-affirming hormone therapy and surgery make an unsubstantiated and false claim that gender incongruence dissipates in

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<sup>18</sup> Rae, J. R., Gülgöz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science*, 30(5), 669-81.



the majority of those who initiate care in adolescence. As discussed above, neither clinical experience nor research supports this claim.

**E. Defense Experts' Concern That Too Many Adolescents Receive Gender-Affirming Medical Treatment Is Not Supported By The Data**

34. Only about 15% of youth who receive a gender dysphoria diagnosis receive any treatment involving medical interventions in adolescence. In the Komodo analysis of youth in the United States receiving a diagnosis of gender dysphoria between 2017 and 2021, the report found that at least 121,882 youth between the ages of 6 and 17 years of age had received this diagnosis. They also note in that same time period, only around 4,800 had received puberty blockers, and another 15,000 had received gender affirming hormones. There is overlap in the patients who received both puberty blockers and gender affirming hormones, so that a total of 17,683 patients, ages 6 through 17, with a prior gender dysphoria diagnosis initiated either puberty blockers or hormones or both during the five-year period.<sup>19</sup>

35. These data support what clinicians know to be true: that providers of this care are extremely cautious in initiating medical interventions. Pre-pubertal youth are not appropriate for medical interventions, so the estimate of diagnosis numbers includes pre-pubertal children receiving the diagnosis, but it is far rarer for pre-pubertal children to present at clinics offering medical treatment. If we consider the entire country, there were estimated to be 50.7 million youth between 6 and 17 years old in the United States in 2021. While prevalence numbers are difficult to pin down, even at a conservative estimate of

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<sup>19</sup> <https://www.komodohealth.com/insights/komodo-findings-point-to-rising-healthcare-needs-for-transgender-youth>; accessed 8/10/23

0.5% there could potentially be 253,500 youth with a gender dysphoria diagnosis in the United States. With only around 18,000 receiving treatment (7% of the total number of those with a diagnosis), the idea that these treatments are overprescribed simply does not bear out in the actual data.

### **F. Randomized Controlled Trials Are Largely Unethical And Impractical To Study Gender-Affirming Medical Care For Adolescents**

36. Several of the Defendants' experts assert that the existing evidence demonstrating the benefits of medical and surgical intervention for transgender youth is either weak or non-existent. But this is not accurate. The care of transgender individuals and the treatment of gender dysphoria (and its precursor diagnoses) have a long history. As with all medical care, there is a range of quality in the existing data regarding the treatment of gender dysphoria,<sup>20</sup> and there is certainly a need for additional studies of a longitudinal nature. But again, that is true with most medical care.

37. Between 1963 and 1979, over 20 university-based gender identity clinics opened in the United States.<sup>21</sup> These clinics provided interdisciplinary care that included psychiatrists and other mental health professionals and played an important role in the provision of medical services to transgender people and in promoting research to improve their care. The majority of these clinics closed following a (now retracted) 1981 decision of the U.S. Department of Health and Human Services (HHS) that labeled sex reassignment surgery as experimental, in large part due to advocacy by Dr. Paul McHugh, who actively

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<sup>12</sup> See Deutsch (ed.) (2016) (UCSF Guidelines).

<sup>21</sup> Byne, et al. (2018).

attempted to suppress the research he now complains is lacking in the field. That decision was overturned by HHS in 2014 in a determination that concluded that the 1981 decision was “not reasonable” and found that gender-affirming surgery is “a safe and effective treatment option.”<sup>22</sup>

38. Over the last four decades, this field of medicine has grown and become more sophisticated: research has continued to occur in the United States and internationally. WPATH (formerly the Henry Benjamin International Gender Dysphoria Association) published the first iteration of the Standards of Care in 1979, which is now in its 8th version; the DSM and ICD stopped classifying transgender identification as a mental disorder; the American Psychological Association and Endocrine Society, as well as other medical organizations, adopted clinical guidelines consistent with the WPATH Standards of Care; and dozens of interdisciplinary gender clinics associated with research institutions and teaching hospitals have been providing gender-affirming care for transgender youth and adults with gender dysphoria across the United States.

39. One of the intrinsic elements of rating the quality of any evidence is the study design. Randomized controlled trials (RCTs) are considered the highest quality in the grading of evidence under the GRADE system. Many of the research studies on gender-affirming care get a “low quality” grade – a term of art under GRADE - due to the lack of RCTs in this area. Three important points need to be understood, though. First, a “low-quality” grade in medical care does not equate to poor or unreliable evidence in the colloquial sense.

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<sup>22</sup> U.S. Dep’t Health & Hum. Servs., NCD 140.3, Transsexual Surgery 18, 21 (2014); Byne, et al. (2018).

Second, such a grade does not detract from the existing literature supporting the efficacy of gender-affirming medical care, and the lack of RCTs is explained by both ethical concerns and practical limitations in study design. Third, “low-quality” grade evidence is very common in medicine.

40. It is well-established that creating a truly untreated control group is unethical in this context because gender-affirming medical interventions have been used for decades, resulting in a vast amount of clinical knowledge about their efficacy. Therefore, to conduct an RCT, one would generally have to pick a control group and, for those study participants, deny them access to medical interventions that are known to effectively treat a condition from which they are suffering.

41. I am aware of one recent study that attempted to ethically conduct an RCT using a unique study design which, rather than impose deny or delay care for the control group, instead accelerated the standard three-month wait time of the clinic for the intervention group.<sup>23</sup> That study demonstrated a decrease in gender dysphoria, clinically significant decrease in depression, and significant decrease in suicidality among those who received care more rapidly. With the possible exception of such study designs, i.e. those of limited duration and which do not delay care longer than the time to standard care, but rather make use of existing barriers to care, RCTs cannot be ethically or practically conducted, for the reasons discussed below, and even studies like this one still generally cannot be masked because of the nature of gender-affirming care.

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<sup>23</sup> Nolan, et al. (2023). Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinization: A Randomized Clinical Trial. *JAMA Network Open*, 2023;6(9):e2331919. doi.10.100/jamanetworkopen.2012.31919.

42. Even with this limitation, we do have a large de facto group of untreated individuals with gender dysphoria who experience significant psychiatric symptoms of untreated gender dysphoria because of widespread barriers to access to care. From this group, we are able to draw some important conclusions about the efficacy of treatment.

43. Clinicians who are competent in the care of transgender individuals practice according to a “first do no harm” ethic which understands that doing nothing is not a neutral option for those with gender dysphoria. Multiple studies have demonstrated the safety of gender-affirming hormones, and a growing body of evidence does the same with regards to the safety of GnRH analogues.<sup>24</sup> The same is true concerning surgical interventions.<sup>25</sup>

44. In addition, RCTs are ill-suited to studying the effects of gender-affirming interventions on psychological wellbeing and quality of life of trans people. Adequate masking (i.e. ensuring that participants do not know whether they are in the control group or intervention group), adherence, and generalizability are severely impeded in transgender care, thereby negating the superior scientific value of RCTs.<sup>26</sup>

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<sup>24</sup> Kuper, et al. (2020); Chew, D., Anderson, J., Williams, K., May, T., & Pang, K. (2018). Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review. *Pediatrics*, 141(4), e20173742; Colton-Meier, S. L., Fitzgerald, K. M., Pardo, S. T., & Babcock, J. (2011). The effects of hormonal gender affirmation treatment on mental health in female-to-male transsexuals. *Journal of Gay & Lesbian Mental Health*, 15(3), 281-299.

<sup>25</sup> Marano, A. A., Louis, M. R., & Coon, D. (2021). Gender-Affirming Surgeries and Improved Psychosocial Health Outcomes. *JAMA surgery*, 156(7), 685–687; Olson-Kennedy, et al. (2018); Murad, et al. (2010); Smith, et al. (2005); Pfafflin & Junge (1998).

<sup>26</sup> Florence Ashley, Diana M. Tordoff, Johanna Olson-Kennedy & Arjee J. Restar (2023). Randomized-controlled trials are methodologically inappropriate in adolescent transgender healthcare, *International Journal of Transgender Health*, DOI: 10.1080/26895269.2023.2218357.

45. Gender-affirming interventions have physiologically evident effects, making it impossible to mask RCTs. The purpose of puberty blockers, hormone therapy, and transition-related surgeries is to inhibit or produce visible bodily changes.

46. In an RCT, adolescents who are on puberty blockers would notice that their endogenous pubertal development had stopped, whereas those not on puberty blockers will notice that they had not. Hormonal suppression is achieved around four weeks after treatment is initiated, but it may take multiple months before participants notice that pubertal development has ceased.

47. Similarly, people with gender dysphoria given hormone therapy would notice bodily changes from taking estrogen or testosterone, whereas those in the control arm would notice no such changes. The onset of visible effects from hormone therapy varies from person-to-person. The first changes typically appear between one and six months of initiation, whereas other desired changes may not begin for up to a year.

48. Although it may take some time before participants are able to ascertain which treatment they were allocated to due to the delayed effect of puberty blockers and the progressive effect of and hormone therapy, large-scale unmasking is inevitable. Because the physiological changes are the primary purpose of gender-affirming care, meaningful effects on psychological wellbeing and quality of life are not expected until unmasking occurs. As such, while RCTs can be utilized to examine the effects of gender-affirming care on physiology, using RCTs to measure the effect of gender-affirming care on psychological wellbeing and quality of life would be inappropriate.

49. Unmasking an RCT of gender-affirming care would lead to non-compliance, cross-over, and response bias in the control arm of the study. Transgender people with gender dysphoria who pursue gender-affirming care are typically insistent and persistent in seeking the interventions. They are not ambivalent as to whether they are assigned to the intervention or control arm of the study. Upon realizing that they are in the control arm due to physiological effects or lack thereof, a large proportion of the study participants would likely withdraw from the study or pursue alternative sources of gender-affirming interventions.

50. Withdrawing from the study and noncompliance with the study protocol is most likely among people who have alternative means of securing gender-affirming care and who experience more severe bodily gender dysphoria, raising grave concerns of systematic bias. Intentional withdrawal with the goal of forcing the study to end is also possible. Resentment towards researchers for not allowing all participants to receive gender-affirming interventions may also increase the risk of response bias compared to observational studies.

51. Given that withdrawal rates could be high enough for studies to be terminated before they are concluded, RCTs may prove impossible to conduct altogether, except perhaps for short time periods using existing barriers to care (as opposed to creating new ones through a designated control group deprived of care). The likelihood of withdrawal, non-adherence, and response bias in the context of transgender care undermines RCTs' ability to detect true associations and avoid specious associations between the intervention and the outcomes.

52. Many disciplines and areas of research rely on observational studies because RCTs are considered impracticable or unethical. This is especially common when studying the mental health outcomes of physiologically evident interventions due to the impossibility of masking, and when studying the outcomes of highly desired interventions due to the risks of de-randomization.

53. Defendants' experts' descriptions of "evidence-based medicine" reveal a fundamental misunderstanding of this concept.

54. Evidence-based medicine, which originated in the second half of the 19th century, means the conscientious, explicit, judicious, and reasonable use of current best evidence in making decisions about the care of individual patients. Since its inception, evidence-based medicine has included an element of clinician expertise. Indeed, the modern understanding of evidence-based medicine is a systematic approach to clinical problem solving which allows the integration of the best available research evidence with *clinical expertise and patient values*.<sup>27</sup>

55. Contemporaneous evidence-based medicine is defined by the *integration of clinical knowledge and skills* with the best critically-appraised-evidence available *as well as patient values and preferences in order to make a clinical decision*. The research literature is continually growing as new discoveries unfold.

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<sup>27</sup> Masic, I., Miokovic, M., & Muhamedagic, B. (2008). Evidence based medicine - new approaches and challenges. *Acta informatica medica : AIM : journal of the Society for Medical Informatics of Bosnia & Herzegovina : casopis Drustva za medicinsku informatiku BiH*, 16(4), 219–225.



## **G. Defendant’ Experts Misrepresent The Use of “Off-Label” Medications, Which Is Common In Pediatrics**

56. Several of the Defendants’ designated experts express concern that the U.S. Food and Drug Administration (FDA) has not approved puberty blockers or hormone therapy for the treatment of gender dysphoria. These concerns are misleading.

57. The Defendants are referring to the medical practice of prescribing a medication “off-label,” which is the common practice in which a medication approved by the FDA for a particular population and indication is used to treat other indications. The use of “off-label” medications is extremely common across all fields in medicine and there are many medications that are used “off-label” in the pediatric population. Common medications that are used “off-label” in pediatrics include antibiotics, antihistamines, and antidepressants. **Most** of the therapies prescribed to children are on an off-label or unlicensed basis.<sup>28</sup> That is because the majority of drugs prescribed have not been tested in children and safety and efficacy of children’s medicines are frequently supported by “low quality” evidence, as that term is used in GRADE. This is explained by the lack of clinical research in this population, caused by ethical, scientific, and technical issues, as well as commercial priorities.

58. “From the FDA perspective, once the FDA approves a drug, healthcare providers generally may prescribe the drug for an unapproved use

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<sup>28</sup> Allen, H.C., Garbe, M.C., Lees, J., Aziz, N., Chaaban, H., Miller, J.L., Johnson, P., & DeLeon, S. (2018). Off-Label Medication use in Children, More Common than We Think: A Systematic Review of the Literature. *The Journal of the Oklahoma State Medical Association*, 111(8), 776–783.

when they judge that it is medically appropriate for their patient.”<sup>29</sup> Indeed, for over 40 years, the FDA has informed the medical community that “once a [drug] product has been approved ... a physician may prescribe it for uses or in treatment regimens of patient populations that are not included in approved labeling.”<sup>30</sup> Accordingly, the American Academy of Pediatrics has stated that “off-label use of medications is neither experimentation nor research.”<sup>31</sup> Thus, “[t]he administration of an approved drug for a use that is not approved by the FDA is not considered research and does not warrant special consent or review if it is deemed to be in the individual patient’s best interests.”

59. The use of off-label medications is common across all disciplines of pediatric medicine, including the use of cancer medications. Lest the argument be made that the types of medications listed above have little or no potential permanent effects, in fact more than 100 targeted anticancer agents have been approved to treat various oncologic diagnoses over the past 20 years, and most of these also do not carry a pediatric label indication.<sup>32</sup> By way of example, vincristine and procarbazine, medications commonly used off-label for cancer treatment, are not FDA-approved for use in breast cancer but are

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<sup>29</sup> U.S. Food and Drug Admin. Understanding Unapproved Use of Approved Drugs “Off Label” (Feb. 5, 2018), <https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatmentoptions/understanding-unapproved-use-approved-drugs-label>.

<sup>30</sup> U.S. Food and Drug Admin, “Citizen Petition Regarding the Food and Drug Administration’s Policy on Promotion of Unapproved Uses of Approved Drugs and Devices; Request for Comments,” 59 Fed. Reg. 59,820 (Nov. 18, 1994).

<sup>31</sup> Frattarelli, D. A., Galinkin, J. L., Green, T. P., Johnson, T. D., Neville, K. A., Paul, I. M., Van Den Anker, J. N., & American Academy of Pediatrics Committee on Drugs (2014). Off-label use of drug in children. *Pediatrics*, 133(3), 563–567.

<sup>32</sup> Lim M, Shulman DS, Roberts H, Li A, Clymer J, Bona K, Al-Sayegh H, Ma C, DuBois SG. Off-label prescribing of targeted anticancer therapy at a large pediatric cancer center. *Cancer Med*. 2020 Sep;9(18):6658-6666. doi: 10.1002/cam4.3349. Epub 2020 Aug 4. PMID: 32750219; PMCID: PMC7520353.

commonly used off-label for this purpose. Both medications have the potential to cause the development of other cancers, which could be life-altering, but this does not make their off-label use experimental or unsafe.

#### **H. Purported Concerns About The Diagnosis of Gender Dysphoria And the Use Of Self-Reports Reveal A Lack Of Familiarity With How Care Is Provided**

60. Dr. Laidlaw criticizes that the diagnosis of gender dysphoria is based, at least in part, on a patient's self-report and that it is "a subjective identification" that cannot be objectively identified. This critique demonstrates a fundamental misunderstanding of how gender-affirming care is provided.

61. After realizing that they are transgender, patients may come to believe that the distress they feel about the incongruence between their sex assigned at birth and their gender identity means they suffer from gender dysphoria, but recommendations regarding treatment do not rely on "self-diagnosis." It is not unusual or extraordinary in medicine for a provider to consider patients' reports of their symptoms as part of the medical assessment. Much like the diagnosis of many clinical conditions, providers rely on self-report to ascertain accurate diagnoses. Consider the diagnosis of chronic fatigue. The diagnostic criteria for this diagnosis include the following: fatigue so severe that it interferes with the ability to engage in pre-illness activities; of new or definite onset (not lifelong); not substantially alleviated by rest; worsened by physical, mental or emotional exertion. These diagnostic criteria, like those for gender dysphoria, involve an individual reporting their experiences to their provider. It is incumbent upon providers of gender-affirming care to acquire skills that help them ascertain many details about their

patient's experience including but not limited to the history, developmental trajectory, and expectations regarding treatment options.

62. The provision of gender-affirming care occurs in multi-disciplinary settings, and indeed, the WPATH SOC recommend such an approach.<sup>33</sup> The multiple health providers involved, from various fields, are well trained to conduct clinical interviews and to assess a patient's report to determine whether they meet the diagnostic criteria for GD. Diagnoses of gender dysphoria in adolescents are made based on those objective criteria, not based on an adolescent's self-report that they believe they have gender dysphoria. The criteria for assessing youth with gender dysphoria as outlined by WPATH are extensive and described here:

### **Statements of Recommendations**

6.1 We recommend health care professionals working with gender diverse adolescents:

6.1.a Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.

6.1.b Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.

6.1.c Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.

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<sup>33</sup> Chen, D., Hidalgo, M. A., Leibowitz, S., Leininger, J., Simons, L., Finlayson, C., & Garofalo, R. (2016). Multidisciplinary Care for Gender-Diverse Youth: A Narrative Review and Unique Model of Gender-Affirming Care. *Transgender health, 1*(1), 117–123; Coleman, et al. (2022); Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165-232.

6.1.d Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.

6.1.e Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.

6.2 We recommend health care professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so that no one particular identity is favored.

6.3 We recommend health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner.

6.4 We recommend health care professionals work with families, schools, and other relevant settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.

6.5 We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth.

6.6 We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including a review of the benefits and risks.

6.7 We recommend providers consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding.

6.8 We recommend health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender-related surgery until the transition is made to adult care.

6.9 We recommend health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.

6.10 We recommend health care professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to initiating treatment, of the reproductive effects including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development.

6.11 We recommend when gender-affirming medical or surgical treatments are indicated for adolescents, health care professionals working with transgender and gender diverse adolescents involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.

The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met):

6.12 We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:

6.12.a The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.

6.12.b The experience of gender diversity/incongruence is marked and sustained over time.

6.12.c The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.

6.12.d The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed.

6.12.e The adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent’s stage of pubertal development.

6.12.f The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.

6.12.g The adolescent had at least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

## **I. Defense Experts’ Purported Concerns About The Effectiveness Of Puberty Delaying Medications Do Not Reflect Existing Research And Treatment Protocols**

63. Several of the defense experts allege that the provision of puberty delaying medications for the treatment of gender dysphoria is not effective. This is not true.

64. A substantial body of evidence shows that gender-affirming medical interventions improve mental health outcomes for transgender persons with gender dysphoria, and who, without treatment, experience higher levels of depression, anxiety, and suicidality. Each of these studies—as with all studies in medicine—has strengths and limitations, and no one study design can answer all questions regarding an intervention. But taken together, these studies indicate that gender-affirming medical care improves mental health for adolescents who require such care.

65. Keeping this in mind, peer-reviewed cross-sectional and longitudinal studies have found that pubertal suppression is associated with a

range of improved mental health outcomes for transgender adolescents, including statistically significant improvements in internalizing psychopathology (e.g., anxiety and depression), externalizing psychopathology (e.g., disruptive behaviors), global functioning, and suicidality.<sup>34</sup>

66. For example, in the realm of cross-sectional studies, Turban et al. *Pediatrics* 2020 found that, after controlling for a range of other variables, those who accessed pubertal suppression had lower odds of lifetime suicidal ideation than those who desired but were unable to access this intervention during adolescence. A similar study by van der Miesen et al. in the *Journal of Adolescent Health*, noted above, compared 272 adolescents who had not yet received pubertal suppression with 178 adolescents who had been treated with pubertal suppression. Those who had received pubertal suppression had statistically significant lower “internalizing psychopathology” scores (a measure of anxiety and depression).<sup>35</sup>

67. Longitudinal studies have yielded similar results. For example, de Vries et al. in the *Journal of Sexual Medicine* (discussed above) found statistically significant improvements in symptoms of depression and general functioning following pubertal suppression for adolescents with gender dysphoria.<sup>36</sup>

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<sup>34</sup> See, e.g., Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA network open*, 5(2), e220978; Turban, et al. (2020); van der Miesen, et al. (2020); Achille, et al. (2020); de Vries, et al. (2014); de Vries, et al. (2011). See also paragraphs 25-30, *supra*.

<sup>35</sup> van der Miesen, et al. (2020).

<sup>36</sup> de Vries, et al. (2011).



68. Another important clinical point to keep in mind with the provision of puberty blockers is that their purpose in this population is to prevent the worsening of distress associated with the development of secondary sex characteristics that don't align with a patient's gender identity. Clinical observation and research demonstrating that a patient's mental health is sustaining – and not worsening – with the treatment is a positive and critical outcome.

**J. Defense Experts' Purported Concerns About The Safety of Puberty Delaying Medications Overstate The Risks And Discount The Benefits**

69. Defense experts emphasize the possible risks and side effects associated with the provision of gender-affirming care, including puberty blockers and gender affirming hormones. Every single medication has potential negative side effects, in addition to the possibility of new side effects that have not been historically documented. This is one of the reasons that evidence-based medicine relies heavily on experienced clinicians to exercise their expertise and judgement.

70. The risks associated with the provision of GnRH analogues are comparable when used for transgender and non-transgender patients alike. For example, many of the side effects and risks associated with the provision of GnRH analogues have been well-studied with regards to the use of these medications for the treatment of central precocious puberty (CPP).<sup>37</sup>

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<sup>37</sup> Eugster E. A. (2019). Treatment of Central Precocious Puberty. *Journal of the Endocrine Society*, 3(5), 965–972.

71. **The use of puberty blockers and sterility:** Drs. Cantor, Laidlaw, and Roman express concerns about fertility from cross-sex hormone therapy, and claim (inaccurately) that puberty blockers may cause infertility as well. There is no evidence that affirmation of pre-pubertal children in their identity or the provision of puberty blockers lead to sterility. Indeed, the effects of puberty blockers are reversible. To the extent a person who benefits from puberty blockers is determined to be a good candidate for hormone therapy or surgery later on, such care is not provided until after additional determinations that it is clinically indicated and informed consent about the risks and benefits of those separate interventions is obtained. Patients who may need a procedure or treatment that may affect fertility are informed of such consequences and are provided with alternative options such as fertility preservation before initiating such care<sup>38</sup>.

72. Given that puberty blockers are reversible, permanent sterility is not a side effect. There is no data to support that patients who have been treated with blockers for central precocious puberty are “sterilized” following its use. To the contrary, information regarding long-term outcomes of patients treated with GnRH analogues with respect to gonadal function are reassuring. In a manuscript published in 2019 entitled “Use of Gonadotropin-Releasing Hormone Analogs in Children: Update by an International Consortium”<sup>39</sup> the following statement regarding infertility and the use of GnRH analogs appears:

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<sup>38</sup> Chen, D., Simons, L., Johnson, E. K., Lockart, B. A., & Finlayson, C. (2017). Fertility preservation for transgender adolescents. *Journal of Adolescent Health, 61*(1), 120-123.

<sup>39</sup> Bangalore Krishna K, Fuqua JS, Rogol AD, et al. Use of Gonadotropin-Releasing Hormone Analogs in Children: Update by an International Consortium. *Horm Res Paediatr.* 2019;91(6):357-372. doi:10.1159/000501336

“There is no substantiated evidence that GnRHa treatment for CPP impairs reproductive function or reduces fertility. In most girls, gonadal function is restored promptly after cessation of therapy, with subsequent menarche and regular ovulatory menstrual cycles” (Bangalore, et al., 2019).

It is true that individuals who never go through endogenous puberty as a result of using GNRH analogs directly followed by gender-affirming hormone therapy will likely experience impacts on future fertility. It is for this reason that the standards of care caution clinicians to counsel patients and families about fertility when they use these medications so that they can make informed choices about future fertility and reproduction, which may include creating a window between GnRHa use and gender-affirming hormone therapy in order to collect and preserve gametes. Indeed, there have been transgender patients who have discontinued GNRH analogs or GnRHa/GAH in order to progress through puberty and undergo fertility preservation. These individuals resumed menstruation and/or underwent fertility induction for harvesting of mature eggs.<sup>40</sup>

73. **The use of puberty blockers and bone density:** During the course of treatment with pubertal delaying medication, bone density will increase at a pre-pubertal rate. During puberty, there is a marked increase in the rate of bone density accrual that results from the increase in estrogen or testosterone. Delaying puberty also delays this increase. Effects on bone density

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<sup>40</sup> Martin CE, Lewis C, Omurtag K. Successful oocyte cryopreservation using letrozole as an adjunct to stimulation in a transgender adolescent after GnRH agonist suppression. *Fertil Steril*. 2021 Aug;116(2):522-527. doi: 10.1016/j.fertnstert.2021.02.025. Epub 2021 Mar 29. PMID: 33795140.; Rothenberg SS, Witchel SF, Menke MN (2019) Oocyte cryopreservation in a transgender male adolescent. *N Engl J Med* 380(9):886–887. <https://doi.org/10.1056/NEJMc1813275>

are a potential temporary side effect that we discuss with all patients and their families. Studies show that with the cessation of puberty blockers or addition of gender affirming hormone therapy, bone mineral density begins to increase at the expected pubertal rate.<sup>41</sup> Studies regarding the use of GnRH analogues for the treatment of CPP document that following cessation of therapy with puberty delaying medications bone mineral accrual appears to be within the normal range compared with population norms. Indeed, patients treated with pubertal suppression for CPP are on pubertal blocking medication without affirming hormones for longer periods of time than patients treated with puberty blockers for the treatment of gender dysphoria and the same risks are present.<sup>42</sup>

74. In paragraphs 100 through 106 of his report, Dr. Laidlaw discusses the use of DEXA scans to evaluate changes in bone density. Dr. Laidlaw explains that DEXA scans compare bone density of **individuals of the same age**. It is expected that the bone density of someone who had their puberty delayed would demonstrate a lower bone density than their peers who had not had puberty delayed. However, as explained in my original report, following cessation of therapy with puberty-delaying medications, bone mineral accrual appears to be within the normal range compared with population norms. Dr. Laidlaw fails to disclose or respond to such studies.

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<sup>41</sup> Vlot, M. C., et al. (2017). Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone*, 95, 11–19; Klink, D., et al. (2015). Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *The Journal of clinical endocrinology and metabolism*, 100(2), E270–E275.

<sup>42</sup> Eugster (2019).

75. In paragraph 107, Dr. Laidlaw then states that “Amenorrhea is detrimental to bone health.” But while taking GnRH analogs, the body is not producing sex steroids. If someone discontinues GnRH analogs, their body will resume endogenous puberty (after some delay). If that individual has ovaries, they will begin to secrete estrogen, which stimulates and supports bone density. If that individual adds testosterone to their hormone regimen to undergo masculinization, the testosterone will support accrual and maintenance of bone density. Dr. Laidlaw is conflating amenorrheic women with hypothalamic hypogonadism, who have little or no sex steroids, to transmasculine individuals, who are taking testosterone that supports bone density. Such a comparison is inappropriate and his conclusions are not supported by relevant clinical observation and research.

76. In paragraph 109, Dr. Laidlaw opines about “unknown, but likely negative consequences to blocking normal puberty with respect to brain development.” Dr. Laidlaw’s assertion has at least two foundational problems. First, Dr. Laidlaw ignores the effect on cognition from untreated gender dysphoria, which ranges from persistently distressing to life threatening. Second, Dr. Laidlaw ignores that pubertal suppression in transgender youth does not delay puberty beyond the typical range.

77. Protocols used for transgender youth would tend to put them in latter third of typical puberty, but nothing outside of the typical range.<sup>43</sup> As such there is no reason to assume, and no data to support, Dr. Laidlaw’s assumption

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<sup>43</sup> Hembree, W.C., Cohen-Kettenis, P.T., Gooren, L., et al. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, 102(11): 3869–3903.

that slightly delaying puberty within typical ranges will have negative short-or-long-term consequences.

78. Drs. Cantor and Laidlaw also refer to puberty-delaying treatment as affecting height. Ultimate adult height is the result of multiple factors, including genetic potential, epigenetic factors, and environmental factors. The use of puberty blockers may impact height, but primarily in ways that are consistent with ameliorating or reducing gender dysphoria: puberty-delaying treatment may provide an opportunity for transmasculine youth to grow taller, which is generally a desirable feature, or may reduce ultimate adult height in transgender girls, which, again, may be desirable given that women are, on average, shorter than men.

79. **The use of GnRH analogs and sexual function:** There is no evidence to suggest that sexual dysfunction will occur if an individual has their endogenous puberty blocked in its earliest stages. To the contrary, there is both existing evidence and clinical evidence that orgasm does occur both in prepubertal youth, as well as transgender youth who have utilized GnRH analogs to treat gender dysphoria.<sup>44</sup>

80. Some of the defense experts make reference to a statement by Dr. Marci Bowers regarding a lack of orgasmic potential of transfeminine individuals who had their endogenous puberty blocked early. Dr. Bowers addressed that statement at WPATH's 2022 Conference. She acknowledged in a surgical workshop about vaginoplasties in girls who had received blockers that "I went back and counted. It was actually about half who had not achieved

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<sup>44</sup> Leung AKC, Robson LM. Childhood Masturbation. *Clinical Pediatrics*. 1993;32(4):238-241. doi:10.1177/000992289303200410.

orgasm.” The issues surrounding self-pleasure in girls who received puberty blockers in early in puberty are more complex than the ideas and assumptions made by the defense “experts.” I have had many conversations with transfeminine patients who had early suppression of endogenous puberty. In fact, many of my patients have negative thoughts and feelings about experiencing sexual pleasure with the genitals they are born with.

81. This is related to several factors. First, most transgender girls have been misgendered their whole lives because of their genitals. This has a proclivity to create an adversarial relationship with their genitals and very severe dysphoria. Second, there are many transgender girls who feel like masturbation would make them “less of a girl.” Some girls have heard the incorrect suggestion that masturbation and ejaculation raise testosterone levels. It is incumbent upon professionals doing this work to be able to have sensitive conversations with patients about these issues.

82. **Psychosocial effects:** Drs. Cantor and Laidlaw expresses concern that puberty-delaying medication will create poorer psychosocial functioning and lesser educational achievement. Their assertions that puberty suppression for a limited time has adverse effects on cognition is not supported by evidence within the realm of transgender youth care, or on the more extensive studies of the use of puberty blockers to treat CPP. Additionally, puberty suppression does not impact somatic growth or emotional maturation. Defense experts also ignore that experiencing the changes of a puberty that do not align with one’s gender identity creates significant problems for transgender and nonbinary youth, including an exacerbation of anxiety, depression, isolation, and sometimes poor coping mechanisms including self-harm and substance abuse.

While there is no evidence that suppressing puberty has any negative effect on emotional maturation, any such potential for negative effects would still have to be compared with the known negative effects of untreated gender dysphoria. Youth going through an endogenous puberty that does not align with their gender express that it is difficult for them to participate in school, therapy, family and social activities.

### **K. Defense Experts’ Purported Concerns About The Efficacy Of Gender Affirming Hormones Ignore The Evidence Of Benefit To Adolescents With Gender Dysphoria**

83. Peer-reviewed research studies have found improved mental health outcomes following gender-affirming hormone treatment (*e.g.*, estrogen or testosterone) for individuals with gender dysphoria, including adolescents.<sup>45</sup> These include statistically significant improvements in internalizing psychopathology (*e.g.*, anxiety and depression), general well-being, and suicidality. For example, Allen et al. followed a cohort of 47 adolescents with gender dysphoria, and found statistically significant improvements in general well-being and suicidality, as measured by the National Institutes of Health “Ask Suicide Screening Questions” instrument.<sup>46</sup>

84. A German observational study from Becker-Hebly et al. reported that among the participants at follow-up, adolescents in the gender-affirming

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<sup>45</sup> See, *e.g.*, Achille, et al. (2020); de Lara, D.L., Rodríguez, O.P., Flores, I.C., *et al.* (2020). Psychosocial Assessment in Transgender Adolescents. *Anales de Pediatría (English Edition)*, 93(1), 41-48; Grannis, et al. (2021); Allen, L.R., Watson, L.B., Egan, A.M., & Moser, C.N. (2019). Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311.

<sup>46</sup> Allen, et al. (2019).



hormone (GAH) and surgery (GAS) group reported emotional and behavioral problems and physical quality of life scores similar to the German norm mean.<sup>47</sup>

85. Also from Germany, Neider et al. reported that among a group of 75 adolescents with gender dysphoria satisfaction improved the further along the treatment course had progressed.<sup>48</sup>

86. From the United States, Kuper et al. carried out a prospective study and reported their cohort of transgender and non-binary youth starting either pubertal blockade or GAH demonstrated improvement at follow up (around a year) in depression, anxiety and body esteem.<sup>49</sup>

87. While small, Grannis et al. demonstrated decreased depression and anxiety in a group of transmasculine youth taking testosterone versus an untreated control group.<sup>50</sup>

88. Most recently our team at the Trans Youth Care United States (TYC-US) reported in the *New England Journal of Medicine* an improvement

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<sup>47</sup> Becker-Hebly, I., Fahrenkrug, S., Campion, F., Richter-Appelt, H., Schulte-Markwort, M., & Barkmann, C. (2021). Psychosocial health in adolescents and young adults with gender dysphoria before and after gender-affirming medical interventions: A descriptive study from the Hamburg Gender Identity Service. *European Child & Adolescent Psychiatry*, 30(11), 1755–1767.

<sup>48</sup> Nieder, T. O., Mayer, T. K., Hinz, S., Fahrenkrug, S., Herrmann, L., & Becker-Hebly, I. (2021). Individual treatment progress predicts satisfaction with transition-related care for youth with gender dysphoria: A prospective clinical cohort study. *The Journal of Sexual Medicine*, 18(3), 632–645.

<sup>49</sup> Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. *Pediatrics*, 145(4).

<sup>50</sup> Grannis, C., Leibowitz, S. F., Gahn, S., Nahata, L., Morningstar, M., Mattson, W. I., Chen, D., Strang, J. F., & Nelson, E. E. (2021). Testosterone treatment, internalizing symptoms, and body image dissatisfaction in transgender boys. *Psychoneuroendocrinology*, 132, 105358, 1–8.

among 315 youth in positive affect and life satisfaction as well as a decrease in depressive and anxiety symptoms after two years of GAH.<sup>51</sup>

89. The data documenting the efficacy of hormone treatment in transgender adults is as robust and goes back even further. Numerous longitudinal studies document improvement in various mental health parameters including depression, anxiety, self-confidence, body image and self-image, general psychological functioning.

**L. Defense Experts’ Purported Concerns About The Safety of Gender Affirming Hormones Overstate The Risks And Discount The Benefits**

90. The claim that treating gender dysphoria with medically supervised and recommended hormone treatment is particularly risky or causes serious mental health effects is not supported by data. What is more, the side effects and risks associated with these treatments are not unique to transgender individuals placed on these therapies, and are, in any event, rare or easily managed.

91. While starting a transgender individual with gender dysphoria on gender affirming hormones can raise their risk for certain health conditions, their risk profile remains similar to their cisgender counterparts. Many times the lipid profiles, hematologic profiles, and findings are equivalent to that of the gender these individuals identify with, as opposed to that of their sex assigned at birth.

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<sup>51</sup> Chen D, Berona J, Chan YM, Ehrensaft D, Garofalo R, Hidalgo MA, Rosenthal SM, Tishelman AC, Olson-Kennedy J. Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *N Engl J Med*. 2023 Jan 19;388(3):240-250. doi: 10.1056/NEJMoa2206297. PMID: 36652355; PMCID: PMC10081536.

92. **Disease and mortality:** Defendants’ experts suggest that a series of health effects are associated with gender-affirming care. These claims simply demonstrate a lack of familiarity with how these medical interventions are provided. As with every area of medicine, the risks and benefits of treatment are discussed with the patient, and patients are monitored to ensure that their risk profile remains within the normal range.

93. Some of the defense experts claim that the use of testosterone in transmasculine individuals increases the risk of cardiovascular disease. Dr. Laidlaw states in paragraph 124 of his report that “[l]ong-term clinical safety trials have not been conducted to assess the cardiovascular outcomes of testosterone replacement therapy in men.” This is untrue, as there have been studies examining the metabolic effect of testosterone in transgender men, including a review by Aranda et al. in 2021 titled “Cardiovascular Risk Associated With Gender Affirming Hormone Therapy in Transgender Population.” This review and other studies have demonstrated that while transgender men using testosterone have a higher risk of myocardial infarction as compared to cisgender females, their risk is comparable to the risks for as cisgender men.<sup>52</sup>

94. In paragraph 125 of his report, Dr. Laidlaw cites a drug label insert for the proposition that “[t]here have been postmarketing reports of venous thromboembolic events [blood clots], including deep vein thrombosis (DVT)

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<sup>52</sup> Aranda, Gloria & Halperin, Irene & Gómez-Gil, Esther & Hanzu, Felicia & Seguí, Núria & Guillamón, Antonio & Mora, Mireia. (2021). Cardiovascular Risk Associated With Gender Affirming Hormone Therapy in Transgender Population. *Frontiers in Endocrinology*. 12. 718200. 10.3389/fendo.2021.718200.

[blood clot of the extremity such as the leg] and pulmonary embolism (PE) [blood clot of the lung which may be deadly], in patients using testosterone products, such as testosterone cypionate.” However, in a meta-analysis of studies examining the relationship between testosterone and venous thromboembolism (VTE), the authors concluded: “Results: Six RCTs (n = 2236) and 5 observational studies (n = 1,249,640) were included. Five RCTs were performed in men with documented hypogonadism. The observational studies included: 2 case-control studies, 2 retrospective cohorts, and 1 retrospective cohort with a nested case-control study. There was no evidence of a statistically significant association between VTE and testosterone (OR 1.41, 95%CI 0.96-2.07). Heterogeneity was high (I-squared = 84.4%). The association remained nonsignificant when the analysis was stratified by study design: RCTs (2.05, 95% CI 0.78-5.39); cohort (1.06, 95% CI 0.85-1.33); and case-control (1.34, 95% CI 0.78-2.28). The overall risk of bias was moderate.”<sup>53</sup>

95. In paragraph 127, Dr. Laidlaw states that “[p]rolonged use of high doses of androgens ... has been associated with development of hepatic adenomas [benign tumors], hepatocellular carcinoma [cancer], and peliosis hepatis [generation of blood-filled cavities in the liver that may rupture] —all potentially life-threatening complications.” However, the types of liver damage discussed by Dr. Laidlaw have not been reported in transgender men taking testosterone in the literature, nor in clinical professional spaces. Again, the goal

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<sup>53</sup> Houghton DE, Alsawas M, Barrioneuvo P, Tello M, Farah W, Beuschel B, Prokop LJ, Layton JB, Murad MH, Moll S. Testosterone therapy and venous thromboembolism: A systematic review and meta-analysis. *Thromb Res.* 2018 Dec;172:94-103. doi: 10.1016/j.thromres.2018.10.023. Epub 2018 Oct 28. PMID: 30396049.

of gender-affirming hormone therapy is to raise levels of serum testosterone in transmasculine individuals to within the same range as that of cisgender men.

96. In paragraph 123 of his report, Dr. Laidlaw opines “that testosterone applied to the adolescent will cause premature closure of the growth plates, stopping further gains in height in the growing individual, and ultimately making the person shorter than they otherwise would have been.” Professionals using gender-affirming hormone therapy in youth with gender dysphoria understand the mechanism of epiphyseal plate fusion, and so testosterone dosing is ramped up in a manner equivalent to that of testosterone administration in youth with hypogonadal hypogonadism in order to mimic a cisgender male pubertal process.

97. In paragraph 281 of his report, Dr. Laidlaw seems to imply that the growth of breast tissue in transgender females is akin to gynecomastia, but breast development is a positive side effect of estrogen and indeed a desired effect for transgender women, not an unwanted risk of treatment. It is not gynecomastia as Dr. Laidlaw suggests.

98. In paragraph 138, Dr. Laidlaw claims “that changes of voice and hair growth could be psychologically troubling should a patient decide to detransition and attempt to reintegrate into society as female.” However, Dr. Laidlaw ignores that someone who identifies as male would desire a lower voice and male pattern facial and body hair. The proportion of people who “detransition,” is orders of multitude lower than those who do not. There is no field of medicine where we prioritize a false positive by discontinuing care for all of the true positives. What is much more common than detransition among transgender women is delayed care, resulting in far more transfeminine

individuals who experience an endogenous male puberty and develop a deep voice that cannot be altered without surgery later in their lives.

99. In paragraph 140 of his report, Dr. Laidlaw cites a paper by Hall et al. in 2005 to argue that 23% of subjects with “medium steroid use (between 300 and 1000 mg/week of any AAS) and high use (more than 1000 mg/week of any AAS)” “met the DSM-III-R criteria for a major mood syndrome (mania, hypomania, and major depression) and that 3.4% — 12% developed psychotic symptoms.” However, dosage of 300 to 1000 mg/week is markedly higher than the doses prescribed for transgender men and transmasculine adolescents. The dosing for the purposes of masculinization are usually between 20 and 100 mg/week. Thus, the Hall paper is irrelevant to the risk to this population.

100. In paragraph 153 of his report, Dr. Laidlaw states “[t]here is strong evidence that estrogen therapy for trans women increases their risk for venous thromboembolism over 5 fold.” But Dr. Laidlaw reveals his lack of familiarity with gender-affirming medical care by failing to explain that this risk is related to the use of ethinyl estradiol, a synthetic estrogen that was used in both cisgender and transgender women, and that when this risk was identified, clinicians changed their practices to utilize only bioidentical estrogen (17  $\beta$  estradiol), reducing the risk.

101. Dr. Laidlaw states in paragraph 139 of his report that “[p]otential cancer risks from high dose testosterone include ovarian and breast cancer.” However, there are no data substantiating increased ovarian or breast cancer risk in transgender men taking testosterone. As far as breast cancer, testosterone is thought to have a protective effect, and estrogen a stimulating effect.

102. A large study performed by Grynberg and colleagues studied the ovaries of 112 trans men who underwent hysterectomy-salpingo-oophorectomy – meaning the study looked at the ovarian characteristics of patients who had their ovaries removed as part of clinically indicated surgical intervention. In this study, mean ovarian volume was increased, with histopathological characteristics of polycystic ovaries in 89 transmen. They did not find any ovarian cancer cases.<sup>54</sup> In other words, the characteristics of patients’ ovaries after testosterone resembled non-cancerous ovaries of cisgender women.

103. In paragraph 154 of his report, Dr. Laidlaw speaks of the risk of breast cancer in transgender women after estrogen, but as stated previously, it is not surprising that establishing a hormone milieu similar to that of a cisgender female would also increase risk relative to that of a cisgender male. Moreover, in the study Dr. Laidlaw references, the risk of breast cancer was actually lower in transgender women than cisgender women. The risk factor profile associated with hormone use is discussed during the consent process and as in all medicine, clinicians are continually assessing the best possible methods of medication administration to decrease risk.

104. **The misperception of “supraphysiologic” hormone levels:** Supraphysiologic levels refers to the presence of a substance (in this case, hormone) that is higher than would normally appear in a body. In relationship to testosterone, this definition is related to its use for sports enhancement, i.e. a

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<sup>54</sup> Grynberg, M et al, Histology of genital tract and breast tissue after long-term testosterone administration in a female-to-male transsexual population, *Reproductive BioMedicine Online*, Volume 20, Issue 4, 2010, Pages 553-558, ISSN 1472-6483, <https://doi.org/10.1016/j.rbmo.2009.12.021>.

cisgender man using testosterone to enhance athletic performance resulting in serum levels that are two to three or even higher than is normal for cisgender men. Treatment for gender dysphoria involves titrating someone's hormone level to that of their cisgender counterparts of the same gender. In other words, for a transmasculine individual, a testosterone level ranging between 350 ng/dL and 950 ng/dL. There are no studies that demonstrate damage from this process. In fact, the side effects of these levels are those that are primarily desired in individuals undergoing this treatment.

105. Overall, the defense experts allege that evidence of benefit from puberty blockers, gender affirming hormones and surgeries is lacking and the risks and harms due to these interventions are very high. Such opinions are not supported by, and in fact are contradicted by, the existing evidence. As discussed in my original report, there are many studies demonstrating the safety and efficacy of gender affirming hormones, as well as GnRH analogs, to treat gender dysphoria. *See* Olson-Kennedy Report, at ¶¶50-62. The same is true with regards to surgery. *See* Olson-Kennedy Report, at ¶¶63-65. By contrast, there is no existing research demonstrating that such interventions are harmful, and these experts cite to none.

106. Safety and efficacy in medicine is not and cannot be measured by any single study. Indeed, every study has limitations. To determine whether a treatment is safe and effective, we look at the whole body of research and clinical experience. By this measure, gender-affirming medical care as treatment for gender dysphoria has been shown to be safe, effective, and is not experimental or investigational.



107. **Fertility:** The sweeping suggestion that hormone therapy precludes fertility in all patients is simply incorrect. Many transgender individuals conceive children or contribute to pregnancy after undergoing hormone therapy.<sup>55</sup> Pregnancy among transgender men even after testosterone therapy is common.<sup>56</sup> A recent eight-year study demonstrated that, four months after stopping testosterone treatment, transgender men had comparable egg yields to non-transgender women.<sup>57</sup> Conceiving or contributing to a pregnancy while on hormone therapy is so common that, in my clinical practice, I inform my patients that hormone therapy is not birth control. In any event, for patients for whom fertility is of particular concern, fertility preservation remains an option, and all adolescent patients and their parents undergo an informed consent process that sets forth both what we know and do not know about the impacts of hormone therapy on future fertility.

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<sup>55</sup> Light A.D., Obedin-Maliver J., Sevelius J.M., et al. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstetrics Gynecology*. 2014; 124(6): 1120-27; Maxwell S., Noyes N., Keefe D., Berkeley A.S., et al. Pregnancy Outcomes After Fertility Preservation in Transgender Men. *Obstetrics Gynecology*. 2017; 129(6):1031-34; Neblett M.F. & Hipp H.S. Fertility Considerations in Transgender Persons. *Endocrinology and Metabolism Clinics*. 2019; 48(2): 391-402.

<sup>56</sup> See, e.g., Moseson, H., Fix, L., Hastings, J., et al. Pregnancy intentions and outcomes among transgender, nonbinary, and gender-expansive people assigned female or intersex at birth in the United States: Results from a national, quantitative survey. *International Journal of Transgender Health*. 2020; 22(1-2): 30-41. doi: <https://doi.org/10.1080/26895269.2020.1841058>.

<sup>57</sup> Leung, A., Sakkas, D., Pang, S., et al. Assisted reproductive technology outcomes in female to-male transgender patients compared with cisgender patients: a new frontier in reproductive medicine. *Fertility and Sterility*. 2019; 112(5): 858-65.

### **M. Defense Experts' Misuse And Misrepresent Existing Data**

108. In paragraph 214 of his report, Dr. Laidlaw misrepresents and misuses the data from Djhene et al.'s study. This Dutch study of surgical outcomes found that suicide rates among transgender people after surgical treatment remain higher than the general population. The Dhejne study did not compare treated vs. untreated transgender women; in other words, the comparison was not between those transgender people who had treatment and those who needed treatment but couldn't access it. It is unsurprising that even after treatment – particularly during a period of time of greater stigma than today – transgender patients experience higher rates of poor mental health outcomes than the general population. The study itself warns against drawing the very conclusions drawn by Defendants' experts regarding the effectiveness of surgery as a treatment for gender dysphoria. The study states: “For the purpose of evaluating whether sex reassignment is an effective treatment for gender dysphoria, it is reasonable to compare reported gender dysphoria pre and post treatment. Such studies have been conducted either prospectively or retrospectively, and suggest that sex reassignment of transsexual persons improves quality of life and gender dysphoria.”<sup>58</sup>

109. Dr. Laidlaw criticizes my study pertaining to chest surgery in transgender adolescents as “flawed and unethical.” It was neither. While it is true that at the time of the study the Chest Dysphoria Scale was not yet formally validated, the individual elements of the scale are taken directly from ten years

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<sup>58</sup> Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Långström N, Landén M (2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. PLoS ONE 6(2): e16885. <https://doi.org/10.1371/journal.pone.001685>.

of experience caring for transmasculine young people seeking chest surgery. Additionally, the scale has now been demonstrated to correlate with depression and anxiety.

110. In a study utilizing the Chest Dysphoria Scale we developed, entitled “Association of Chest Dysphoria with Anxiety and Depression in Transmasculine and Non-binary Adolescents Seeking Gender Affirming Care,” the authors wrote: “One hundred fifty-six patients met inclusion criteria. Mean age was 15.3 years (standard deviation [SD] = 1.7). Most patients identified as transmasculine (n = 132); 18 identified as nonbinary and 6 as questioning. Mean (SD) YI-4 symptom severity scores were 10.67 (6.64) for anxiety and 11.99 (7.83) for depression. Mean (SD) Chest Dysphoria Measure composite score was 30.15 (9.95); range 2-49.” The study concluded that “Chest dysphoria was positively correlated with anxiety (r = .146; p = .002) and depression (r = .207; p < .001). In multivariate linear regression models, chest dysphoria showed a significant, positive association with anxiety and depression, after accounting for gender dysphoria, degree of appearance congruence, and social transition status.”<sup>59</sup>

111. In addition within this same cohort, Ascha et al. found an improvement in chest dysphoria, transgender congruence and body esteem after surgery.<sup>60</sup>

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<sup>59</sup> Sood R, Chen D, Muldoon AL, Chen L, Kwasny MJ, Simons LK, Gangopadhyay N, Corcoran JF, Jordan SW. Association of Chest Dysphoria With Anxiety and Depression in Transmasculine and Nonbinary Adolescents Seeking Gender-Affirming Care. *J Adolesc Health*. 2021 Jun;68(6):1135-1141. doi: 10.1016/j.jadohealth.2021.02.024. Epub 2021 Apr 10. PMID: 33849759; PMCID: PMC8903018.

<sup>60</sup> Ascha M, Sasson DC, Sood R, Cornelius JW, Schauer JM, Runge A, Muldoon AL, Gangopadhyay N, Simons L, Chen D, Corcoran JF, Jordan SW. Top Surgery and Chest Dysphoria Among Transmasculine and Nonbinary Adolescents and Young Adults. *JAMA*

112. Finally, there is no need for validation of the question “Do you regret having chest surgery?” In my study, only one participant responded “sometimes.”

113. In paragraph 244-247 of his report, Dr. Laidlaw criticizes a study by Mehringer et al. in 2021. But the Mehringer et al. study was a qualitative study asking respondents specifically about chest distress.<sup>61</sup> Attributing chest dysphoria to a side effect of testosterone is wholly unfounded, particularly given that the adverse responses Dr. Laidlaw is referring to are related to “high doses” of testosterone, which as discussed before is not what is used in gender-affirming hormone therapy.

114. In paragraph 248 of his report, Dr. Laidlaw makes the unfounded accusation that both my study and the Mehringer study “appear to have been designed, at least in part, to justify insurance companies paying for mastectomy procedure for minors with GD, even though they have provided no long-term statistical evidence of benefit.” This is false. Our study was undertaken to better understand the impact of chest surgery in transgender adolescents, as well as to document regret (if any). Additionally, we undertook the study to determine if the impact was different depending on the age of the individual undergoing surgery (it was not). Finally, we wanted to determine if time on testosterone was a useful benchmark and requirement for chest surgery.

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Pediatr. 2022 Nov 1;176(11):1115-1122. doi: 10.1001/jamapediatrics.2022.3424. PMID: 36156703; PMCID: PMC9513704.

<sup>61</sup> Mehringer JE, Harrison JB, Quain KM, Shea JA, Hawkins LA, Dowshen NL. Experience of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth. *Pediatrics*. 2021 Mar;147(3):e2020013300. doi: 10.1542/peds.2020-013300. Epub 2021 Feb 3. PMID: 33536330.

Clinically we understood that chest distress actually increases with time on testosterone, so it was important to test and see if this actually was the case (it was). There is no existing data that even suggests that chest masculinizing surgery is problematic for people. To suggest that this procedure is of dubious efficacy or harmful is unsubstantiated.

**N. Defense Experts Incorrectly State That Using Gender Affirming Hormones To Treat Gender Dysphoria Is Experimental; It Is Not**

115. In paragraphs 174 and 175 of his report, Dr. Laidlaw opines that the use of testosterone in assigned females and estrogen in assigned males is experimental. Experimental medications are either brand new medicines, or existing medicines that are being used in a new or different way. The implication here is that testosterone use in transgender males and estrogen use in transgender females is new. The use of testosterone and estrogen in transgender patients has been happening for close to 100 years. Testosterone and estrogen were synthesized in the late 1920s or early 1930s, and around that same time they began to be used for changing the secondary sex characteristics in individuals who experienced what we now call gender dysphoria. And while much of Dr. Laidlaw's report refers to "high dose" use of these interventions, as discussed above, the treatment doses are not "high dose."

**O. Defense Experts Claim Psychotherapy Alone Is Sufficient for the Treatment Of Gender Dysphoria; It Is Not**

116. Defense experts claim that because the study subjects who were recipients of both gender-affirming hormones or puberty blockers, on the one hand, and psychotherapy, on the other hand, demonstrated improvements in mental health, that the medical interventions could not be differentiated as

responsible for the improvement, and therefore that psychotherapy alone is adequate to treat gender dysphoria. That is false: therapy alone cannot treat gender dysphoria in those individuals for whom medical treatment is clinically indicated.

117. Defense experts misrepresent research to support their false assertions. For example, Dr. Weiss states that “Exploratory, non-judgmental psychotherapy can alleviate suffering in patients with “gender dysphoria” and may help them accept their natal sex” and goes on to cite two studies, neither of which support that proposition. The first study, R. D'Angelo and others, 'One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria', *Arch Sex Behav*, 50 (2021), does not indicate that therapy may help someone “accept their natal sex.” Rather, it discusses the author’s opinion related to the importance of neutral therapy. The second study, A. Churcher Clarke and A. Spiliadis, "Taking the Lid Off the Box': The Value of Extended Clinical Assessment for Adolescents Presenting with Gender Identity Difficulties', *Clin Child Psychol Psychiatry*, 24 (2019), evaluated adolescents whose desire for medical intervention allegedly dissipated during their assessment phase. Interestingly, only 12 youth met the study’s criteria for inclusion, and of those 9, only three had a diagnosis of gender dysphoria. It is unsurprising that the majority of youth who do not have gender dysphoria would not desire medical intervention to treat a condition they do not have.

118. Historically the psychotherapy professional world advocated for a “therapy only” model to address gender dysphoria. As early as the 1920s and 1930s it became evident to the preeminent scholars in the field that gender dysphoria (named something else at that time) was refractory to psychotherapy.

As noted in 1966 in Harry Benjamin's *The Transsexual Phenomenon*, "Allegedly, transsexualism, although basically a psychiatric condition, is paradoxically resistant to psychiatric help."<sup>62</sup> In this statement, Harry Benjamin acknowledges that psychiatric intervention cannot alter people's gender, nor does it lead to a diminishing of the distress that arises from gender incongruence. There has been an abundance of opportunity to demonstrate unequivocally that gender dysphoria is best treated with psychotherapy alone, and yet it never has been. To suggest this is now an appropriate approach simply because transgender people are coming out at younger ages is illogical.

**P. Adolescents Are Capable Of Providing Informed Assent To Gender-Affirming Medical Care, And Care Is Only Provided With A Parent Or Guardian's Informed Consent**

119. Physicians engaged in patient-physician relationships involving medical informed consent have a moral responsibility to identify the best treatments for each patient on the basis of available medical evidence and to discuss with patients the hoped-for benefits and the potential risks. Physicians must allow for patients' questions about the proposed treatments, benefits, and risks and must answer those questions from the available medical literature and their professional experience. This exchange of information and ideas is the foundation of the patient-physician partnership and promotes informed decision making in the most complex medical situations.<sup>63</sup>

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<sup>62</sup> Benjamin, Harry. 1966. *The Transsexual Phenomenon*. Julian Press, New York, N.Y.

<sup>63</sup> Paterick TJ, Carson GV, Allen MC, Paterick TE. Medical informed consent: general considerations for physicians. *Mayo Clin Proc.* 2008 Mar;83(3):313-9. doi: 10.4065/83.3.313. PMID: 18315998.

120. There is a body of evidence indicating that adolescents do have the capacity to make informed decisions in the context of medical care and provide assent, particularly at age 14 and above. That capacity to make informed decisions is recognized as the ability to provide informed assent before the age of majority, and is known as informed consent once an individual reaches the age of majority. Moreover, part of informed decision-making is knowledge of, even if not particular existing studies, then what is not understood or what is poorly understood. This is discussed with patients and their parents/guardians. Moreover, parents/guardians routinely consent to treatments in other areas of medicine that result in irreversible changes (including infertility) for their minor children, including chemotherapy and other cancer-related treatments such as surgery and radiation.

121. The argument that youth cannot provide adequate informed assent or consent for gender affirming care is not supported by evidence, and additionally undervalues the role of parents/legal guardians in the process, who are capable of providing informed consent.

122. As noted above, speaking from my own clinical experience, at our center we strive to ensure that we are obtaining informed assent or consent from every patient (and their parent/guardian) throughout the course of treatment. An integral part of my practice in adolescent medicine is the ability to assess capacity to provide informed assent or consent and to work with patients and families appropriately to ensure that any course of treatment is provided only after a thorough review of the risks and benefits not only of treatment, but also of the risks and benefits of withholding or delaying clinically-indicated interventions.



## **Q. Defense Experts' Assertion That There Is No Biological Basis For Gender Identity Is False**

123. Several of the defense experts criticize gender-affirming care by stating that “[t]here are no laboratory, imaging, or other objective tests to diagnose a true transgender child” as Laidlaw states in paragraph 19 of his report. That statement is incorrect in several respects. First, as a general matter, there are no laboratory or imaging tests for psychiatric conditions, not just gender dysphoria: that is not a reason to withhold treatment. Rather, that is why psychiatric diagnoses are made using clinical interviews and applying objective criteria to the information gathered from and about a patient. Second, “transgender” is not a diagnosis, because being transgender is not a psychiatric condition to be treated or cured, unlike gender dysphoria, which is diagnosable and can be treated. Third, even though being transgender is not a condition to be treated or cured, the naturally occurring phenomenon of transgender identity has biological bases.

124. There is a substantial body of peer-reviewed scientific literature demonstrating that transgender identity has a strong biological basis. A review by Ristori et al of the studies examining the biologic basis of gender identity formation conclude that “the evidence from these studies support the idea that brain sexual differentiation and the development of gender identity have a polygenic basis, involving interactions among multiple genes and polymorphism.” This body of literature is growing, and supports the assertion that gender identity does indeed have a biologic basis, and is not a “purely

psychological phenomenon” as the defense experts would have us believe.<sup>64</sup> Indeed, studies of identical twins (with the same DNA) as compared to fraternal twins (with different DNA) have found that identical twins of transgender people are far more likely to be transgender than fraternal twins of transgender people, pointing to a strong genetic link.<sup>65</sup>

125. While it is true that there is no objective test to determine someone’s gender identity yet, this does not mean there are no objective criteria to diagnose someone with gender dysphoria. It also ignores that the lack of such “objective tests” is not uncommon for other medical conditions. Take chronic fatigue syndrome, for example. The CDC says this about chronic fatigue syndrome: “Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) is a serious, long-term illness that affects many body systems ... Researchers have not yet found what causes ME/CFS, and there are no specific laboratory tests to diagnose ME/CFS directly. Therefore, doctors need to consider the diagnosis of ME/CFS based on in-depth evaluation of a person’s symptoms and medical history.” (CDC, 2021).

126. Several defense experts argue that gender incongruence, and therefore gender dysphoria, is a purely psychological phenomenon. There is no existing data to demonstrate that gender incongruence is a psychological phenomenon: as set forth above, a growing body of research demonstrates that gender identity has biological bases. Human developmental trajectories that are

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<sup>64</sup> Ristori J, Cocchetti C, Romani A, Mazzoli F, Vignozzi L, Maggi M, Fisher AD. Brain Sex Differences Related to Gender Identity Development: Genes or Hormones? *Int J Mol Sci.* 2020 Mar 19;21(6):2123. doi: 10.3390/ijms21062123. PMID: 32204531; PMCID: PMC7139786.

<sup>65</sup> Diamond, M. (2013). Transsexuality among twins: identity concordance, transition, rearing, and orientation. *International Journal of Transgenderism*, 14(1), 24-38.

not yet fully understood are often considered psychopathological: for example, being left-handed or being homosexual were previously considered deviant, as opposed to part of natural human variation. Although gender incongruence is relatively rare, that does not render it pathological: same sex attraction is also the non-dominant trajectory of romantic/sexual development, and was viewed the same way that defense experts currently view gender incongruence, i.e. that “some internal defect or external pathogenic agent causes homosexuality and that such events can occur pre- or postnatally (i.e., intrauterine hormonal exposure, excessive mothering, inadequate or hostile fathering, sexual abuse, etc.)”<sup>66</sup>

127. But just as “homosexuality” was first pathologized and then de-pathologized within the DSM, ultimately being removed altogether, gender incongruence has been de-pathologized within the DSM, moving from “gender identity disorder” to “gender dysphoria.” This changed within the DSM-5 came about because “[t]he presence of *gender variance is not the pathology* but dysphoria is the distress caused by the body and mind not aligning and/or societal marginalization of gender-variant people.”<sup>67</sup>

## **R. The Inappropriate Labeling of Professionals as Political Advocates**

128. Many of the defense experts posit that the professionals with the highest levels of experience and acumen in both clinical care and research concerning the health and well-being of transgender people are the least reliable

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<sup>66</sup> Drescher J. Out of DSM: Depathologizing Homosexuality. *Behav Sci (Basel)*. 2015 Dec 4;5(4):565-75. doi: 10.3390/bs5040565. PMID: 26690228; PMCID: PMC4695779.

<sup>67</sup> Crocq MA. How gender dysphoria and incongruence became medical diagnoses - a historical review. *Dialogues Clin Neurosci*. 2022 Jun 1;23(1):44-51. doi: 10.1080/19585969.2022.2042166. PMID: 35860172; PMCID: PMC9286744.

to be experts in the field. Additionally, these experts assert that said individuals are inherently political and one-sided advocates. In my clinical work, I am motivated by my desire to provide the best possible care for my patients, using my professional judgment, which is guided by my clinical and research experience and the best-available studies. My research is similarly motivated by the desire to learn more about what does and does not improve outcomes for my patients to better inform the care that other clinicians and I provide. Because of what I know about gender-affirming medical care—that it is safe and effective—and to fulfill my ethical duties to my patients, I (and other clinicians like me) advocate for evidence-based public policies that will result in better health outcomes for the patient population that I treat. Such advocacy is no more political than the efforts of endocrinologists to increase access to affordable insulin, or the efforts of oncologists to expand access to early cancer screenings.

129. For example, in paragraph 197 of his report, Dr. Laidlaw takes issue with the overlap in authorship between the WPATH SOC and the Endocrine Society Guidelines. But expertise within a field does not represent a conflict of interest. This is akin to suggesting that a co-author of guidelines published by the American Heart Association should not be able to co-author any recommendations from the American College of Cardiology. The people that are co-authors of the WPATH SOC and the Endocrine Society Guidelines are tasked with this responsibility by the organizations because they have expertise and experience in the field of transgender health care, unlike Defendants' designated experts.

## **S. Defense Experts Misrepresent The State Of Care In Europe, Where Gender-Affirming Medical Care Is Still Available For Adolescents**

130. Defense experts' portrayal of the state of gender-affirming medical care in Europe is inaccurate. Although some countries have changed how care is provided, neither the United Kingdom nor Sweden, Norway, or France have categorically prohibited care for minors the way that Montana's law does.

### **The United Kingdom**

131. Dr. Cantor presents testimony outlining the changes that have occurred in the UK related to the provision of transgender youth care. First, it is important to recognize that the court case *Bell v. Tavistock* that resulted in a decision to halt the use of puberty blockers in youth under the age of 16 without court approval was overturned, at least in part because, according to the higher court, "In practice the guidance would have the effect of denying treatment in many circumstances for want of resources to make such an application coupled with inevitable delay through court involvement." It is also important to note that in the United Kingdom, unlike in the United States, adolescents are able to consent to treatment on their own, rather than through a parent or guardian, so a different set of legal assessments were being made in the *Tavistock* cases.

132. Although *Bell v. Tavistock* was overturned, the NHS nonetheless undertook an effort to review the practices related to the provision of gender affirming care for minors in the United Kingdom.

133. The Cass Report is an interim report. The final document has not been released. While Dr. Cantor represents that the interim report treats gender-affirming medical care as experimental and prohibits it for youth with gender dysphoria, that is not the case: the Cass Report itself is clear that it "does not set

out final recommendations at this stage.” The Report’s author, Hillary Cass, wrote in a letter to transgender youth: “I have heard that young service users are particularly worried that I will suggest that services should be reduced or stopped. I want to assure you that this is absolutely not the case – the reverse is true. I think that more services are needed for you, closer to where you live.”<sup>68</sup>

134. To suggest that the Cass Report resulted in the pulling back of services is not accurate. The Cass Report itself acknowledged the fact that the services for transgender youth in the UK were inadequate.

135. There has been a false assertion that the UK stopped gender affirming care for minors, exceptions only for those involved in research protocols. To the contrary, the Cass Report recommends greater research, more multidisciplinary involvement in care, and informed consent for treatment, not less care overall:

- “Prospective consent of children and young people should be sought for their data to be used for continuous service development, to track outcomes, and for research purposes. Within this model, children and young people put on hormone treatment should be formally followed up into adult services, ideally as part of an agreed research protocol, to improve outcome data.” (Recommendation 7, page 22).
- “Paediatric endocrinologists should become active partners in the decision making process leading up to referral for hormone

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<sup>68</sup> Independent review of gender identity services for children and young people: Interim report, February 2022. <https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf>, accessed 9/10/23.

treatment by participating in the multidisciplinary team meeting where children being considered for hormone treatment are discussed.” (Recommendation 12, page 23).

- “Within clinical notes, the stated purpose of puberty blockers as explained to the child or young person and parent should be made clear. There should be clear documentation of what information has been provided to each child or young person on likely outcomes and side effects of all hormone treatment, as well as uncertainties about longer term outcomes.” (Recommendation 13, Page 24).

136. The United Kingdom has not banned gender-affirming medical care for minors. Rather, it is evaluating the best way to deliver appropriate and timely care given that the current system with one facility (Tavistock) providing this care was inadequate to serve the needs of the community. Of additional relevance is the fact that the United Kingdom delivers care through a socialized medical system where research protocols differ greatly because of centralized tracking and treatment protocols through the National Health Service. It is difficult to compare health protocols from countries like the UK with the system that we have in the United States, which is vastly different.

## Sweden

137. As Cantor states, the SBU released English-language results of its review first as a policy summary of conclusions and then the review itself.

138. Although the review purported to survey existing scientific studies, in fact the conclusions document<sup>69</sup> states that it excluded hundreds of manuscripts from the review for such reasons as “short-term follow up”; “not exclusive to gender incongruence”; and “medication not used in Sweden,” suggesting that the authors were not sufficiently aware of the existing robust literature on the safety or efficacy of gender-affirming medical care in minors.

139. In paragraph 26, Dr. Cantor writes: “A series of cases of regret and suicide following medical transition were reported in the Swedish media. (Orange 2020.) In 2019, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) therefore initiated its own systematic review of the research.”

140. Characterizing this report as a “series of regret cases,” is misleading and inaccurate. This reference discusses a single case of a detransitioner with regret, and the story of a 32 year old trans woman who died by suicide. There is no indicator that her death was related to regret.

141. Allegedly in response to one article and one television program negatively covering gender-affirming medical care, Dr. Cantor claims that Sweden stopped initiating hormone treatments in youth under 16 and the Karolinska clinic announced that patients ages 16–18 would receive such treatments only within research settings.

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<sup>69</sup> <https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/>



142. Dr. Cantor’s interpretation of those recommendations as discontinuing care or even “a dramatic reversal” in policy is disingenuous. In a country such as Sweden, it is possible for every patient to be enrolled in research because they have a national health service model, unlike in the US, and there are over 1000 health insurance entities that file with the National Association of Insurance Commissioners.<sup>70</sup>

143. Moreover, Sweden’s actual recommendation was that “treatment with hormones should continue to be given within the framework of research. Increased knowledge is needed, among other things, about the treatment's impact on gender dysphoria as well as the mental health and quality of life of minors, in both the short and long term...” While a research study is put in place, Sweden continues to offer treatments “in exceptional cases,” unlike the law in Montana, which contains no such exception.

144. When the English language version of the actual review was later published in 2023,<sup>71</sup> it noted that, of the six studies examined for psychosocial function, three studies found “significantly improved overall psychosocial function after GnRHa treatment as measured by the Children's Global Assessment Scale (CGAS)” and two studies found “significantly improved self-rated quality of life after treatment measured through Kidscreen-27, Short

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<sup>70</sup> Financial Regulatory Services Division Financial Analysis and Examinations Department, NAIC, <https://content.naic.org/sites/default/files/inline-files/2020-Annual-Health-Insurance-Industry-Analysis-Report.pdf> accessed 9/10/23.

<sup>71</sup> Ludvigsson, JF, Adolfsson, J, Höistad, M, Rydelius, P-A, Kriström, B, Landén, M. A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. *Acta Paediatr.* 2023; 00: 1–14. <https://doi.org/10.1111/apa.16791>

Form-8 (SF-8), Child Behaviour Checklist (CBCL) (parent report), and Youth Self Report (YSR).”

### **Norway**

145. Norway also revised its recommendations for youth care, but Dr. Cantor focuses on the portions of the new recommendations that support the false narrative that European countries are stopping the care.

146. Dr. Cantor’s false narrative ignores the actual recommendations, which provide that puberty blockers “are started at the earliest at developmental stage Tanner 2 and take place after an individual assessment and interdisciplinary assessment.” That is consistent with WPATH SOC 8 and the Endocrine Society Guideline. Similarly, Norway’s recommendations provide for hormone therapy beginning at 16 years old. While WPATH SOC 8 and the Endocrine Society Guideline do not have a strict age threshold for hormone therapy, in practice most adolescents who receive hormone therapy do so later in adolescence. And, as with Sweden and the UK, Norway also notes that further studies would be beneficial, and though more research is needed, “*it is still not a basis for denying people health care*. People with gender incongruence have the same need for health care and health promotion and preventive services as other patients. There is extensive clinical experience in treating people with gender incongruity.”<sup>72</sup>

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<sup>72</sup> Knowledge base and competence about gender incongruence. Helsediktoratet. <https://www.helsedirektoratet.no/retningslinjer/kjonnsinkongruens/kunnskapsgrunnlag-og-kompetanse-om-kjonnsinkongruens#kunnskapsgrunnlaget-og-forskningen-om-kjonnsinkongruens-bor-oppdateres-og-styrkes-begrunnelse> [unofficial translation]

## **France**

147. Dr. Cantor purports to address a 2022 memo from the Académie Nationale de Médecine of France. Although that memo noted the need for “great medical caution” around gender-affirming medical care, it did not assert that great care was not already taken. In my clinical practice, I also take great care with recommending and prescribing gender-affirming medical care, as I do with all complex interventions in adolescents. Taking such caution is not inconsistent with providing care when medically indicated and should be a central part of medical practice when treating all conditions particularly in pediatrics.

148. Finally, with regard to these new guidelines arising in European countries, it is largely relevant that these countries have national health services that allow for a more centralized mechanism of collecting data related to the treatment of youth with gender dysphoria. The health care system in the US is vastly different, with over 1000 insurance entities and thousands of intermediaries. The populations of these countries is orders of magnitude smaller than here in the US. Norway is 5.4 million; Finland is 5.4 million, Sweden is 10.4 million. In the two countries with substantially higher populations, we see much broader recommendations with considerations for wait times and quality of care (France; 67 million, United Kingdom; 67.3 million) and less emphasis on adding requirements for accessing care.

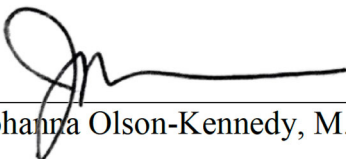
## **CONCLUSION**

24. In conclusion, nothing in Defendants’ experts’ reports changes the opinions in my initial report that gender-affirming medical treatment for adolescents is safe, effective and medically necessary for those adolescents for

whom it is indicated. As with every field of medicine, there is more to learn in the field of transgender youth care. That is why I became an investigator. However, there is room to provide gender affirming medical interventions in a thoughtful manner that extrapolates from relevant fields of science and medicine, existing data, and clinical expertise while simultaneously carrying out further investigations. The denial of much needed care only serves to harm transgender people. There are people suffering today and as clinicians we have to treat them. Doing nothing is not a neutral act and withholding treatment when it is indicated causes dire and predictable harms. We will continue to adapt our clinical protocols to the research as it evolves, but halting evidence-based treatment to await further research is not ethical or safe.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 14th day of September, 2023.

  
\_\_\_\_\_  
Johanna Olson-Kennedy, M.D., M.S.

# **Exhibit A**

**CURRICULUM VITAE**  
**JOHANNA OLSON-KENNEDY MS, MD**  
**JUNE 28, 2023**

**PERSONAL INFORMATION:**

<b>Work</b>	<b>Home</b>
4650 Sunset Blvd. MS 2 Los Angeles, CA 90027	1621 Fair Oaks Ave South Pasadena, CA 91030
Phone: 323-361-3128	Citizenship: USA
Fax: 323-953-8116	
Work Email: jolson@chla.usc.edu	

**EDUCATION AND PROFESSIONAL APPOINTMENTS**

**EDUCATION:**

<i>Year</i>	<i>Degree, Field, Institution, City</i>
1992	BA, Mammalian Physiology, UC San Diego, San Diego
1993	MS, Animal Physiology, The Chicago Medical School, Chicago
1997	MD, Medical Doctor, The Chicago Medical School, Chicago
2015	MS, Clinical and Biomedical Investigations in Translational Science, USC, Los Angeles

**POST-GRADUATE TRAINING:**

<i>Year-Year</i>	<i>Training Type, Field, Mentor, Department, Institution, City</i>
1997 - 1998	Internship, Pediatrics, Children's Hospital Orange County, Orange
1998 - 2000	Residency, Pediatrics, Antonio Arrieta, Children's Hospital Orange County, Orange
2000 - 2003	Fellowship, Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles
2012 - 2015	Master's Degree, Clinical and Biomedical Investigations in Translational Science, USC

**ACADEMIC APPOINTMENTS:**

<i>Year-Year</i>	<i>Appointment</i>	<i>Department, Institution, City, Country</i>
2006 - 2016	Assistant Professor of Clinical Pediatrics	Division of Adolescent Medicine, Children's Hospital Los Angeles/USC Keck School of Medicine, Los Angeles, USA
2016 - Present	Associate Professor of Clinical Pediatrics	Division of Adolescent Medicine, Children's Hospital Los Angeles/USC Keck School of Medicine, Los Angeles, USA

**CLINICAL/ADMINISTRATIVE APPOINTMENTS:**

2008 - 2012	Fellowship Director	Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, USA
2012 - present	Medical Director	The Center for Transyouth Health and Development, Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, USA

2021 - present	Clinical consultant	Santa Barbara Neighborhood Clinics
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**LICENSURE, CERTIFICATIONS**

**LICENSURE:**

<i>Year</i>	<i>License number, State, Status</i>
2000	A-67352, California, Active

**BOARD CERTIFICATION OR ELIGIBILITY:**

<i>Year</i>	<i>Board, State, Status</i>
2001, 2009, 2015	Pediatrics, California, active

**SPECIALTY CERTIFICATION:**

<i>Year</i>	<i>Specialty Certification, Status</i>
2003, 2013	Adolescent Medicine, California, active

**HONORS, AWARDS:**

<i>Year</i>	<i>Description</i>	<i>Awarding agency, address, city</i>
2009	Health Care Advocacy Champion	Democratic Advocates for Disability Issues, Los Angeles
2010	Clinical Research Academic Career Development Award	Saban Research Center TSRI Program: Community Health Outcomes and Intervention, Los Angeles
2012	Extraordinary Service Award	Equality California, 202 W 1st St., Suite 3-0130, Los Angeles
2013	Top Doctor	Castle Connolly
2014	Anne Marie Staas Ally Award	Stonewall Democratic Club; 1049 Havenhurst Drive #325, West Hollywood
2014	Top Doctor	Castle Connolly
2014	Recognition Award for Outstanding, Compassionate and Innovative Service	SoCal Society for Adolescent Health and Medicine Regional Chapter, Los Angeles
2015	The Champion Award	The Division of Adolescent Medicine; CHAMPION FUND 5000 Sunset Blvd. Los Angeles
2016	America's Most Honored Professional's – Top 10%	America's Most Honored Professional's
2016	Regional Top Doctor	Castle Connolly
2017	Exceptional Women in Medicine	Castle Connolly
2017	Regional Top Doctor	Castle Connolly
2017	America's Most Honored Professional's – Top 5%	America's Most Honored Professional's
2018	Regional Top Doctor	Castle Connolly
2019	Benjamin Meaker Visiting Professorship	University of Bristol, Bristol UK
2019	Regional Top Doctor	Castle Connolly
2019	L.A's Top Docs	Los Angeles Magazine
2019	Top Docs	Pasadena Health
2019	America's Most Honored Professional's – Top 1%	America's Most Honored Professional's
2020	Regional Top Doctor	Castle Connolly
2020	Southern California Top Doc	Castle Connolly

2020	Southern California Top Doctors	
2020	L.A.'s Top Docs	Los Angeles Magazine
2020	America's Most Honored Professional's – Top 1%	America's Most Honored
2021	Southern California Top Doc	Castle Connolly
2021	America's Most Honored Doctors – Top 1%	America's Most Honored
2021	Top Doctors	Castle Connolly
2022	America's Most Honored Doctors – Top 1%	America's Most Honored
2022	Top Doctors	Castle Connolly

## **TEACHING**

### **DIDACTIC TEACHING:**

#### *Keck School of Medicine at USC*

<i>Year-Year</i>	<i>Course Name</i>	<i>Units/Hrs</i>	<i>Role</i>
2019	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth	One hour	Curriculum development and delivery
2020, 2021, 2022	Approach to the Care of Gender Non-conforming Children and Transgender Youth	One hour	Curriculum development and delivery
2023	Transgender and Non-binary Youth and Young Adults 101	One hour	Curriculum development and delivery

#### *CalState Fullerton*

<i>Year-Year</i>	<i>Course Name</i>	<i>Units/Hrs</i>	<i>Role</i>
2017	Gender Nonconforming and Transgender Youth	One hour	Curriculum development and delivery

### **UNDERGRADUATE, GRADUATE AND MEDICAL STUDENT (OR OTHER) MENTORSHIP:**

<i>Year-Year</i>	<i>Trainee Name</i>	<i>Trainee Type</i>	<i>Dissertation/Thesis/Project Title</i>
2015 - 2016	David Lyons	MD	Transgender Youth Clinical Clerkship
2016 - 2019	Jonathan Warus	MD	Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts
2019 - 2021	Laer Streeter	MD	Comparison of Histrelin Implants
2020 - Present	Richard Mateo Mora	MD	Fertility Preservation Among Transgender Women
2022	Avery Everhart	PhD	Incomplete Data & Insufficient Methods: Transgender Population Health Research in the US



**GRADUATE STUDENT THESIS, EXAM AND DISSERTATION COMMITTEES:**

<i>Year-Year</i>	<i>Trainee Name</i>	<i>Committee Type</i>	<i>Student Department</i>
2022	Avery Everhart	Dissertation	Social Work

**POSTGRADUATE MENTORSHIP:**

<i>Year-Year</i>	<i>Trainee Name</i>	<i>If past trainee, current position and location</i>
2012-2013	Lisa Simons, MD	Clinical Instructor – Lurie Children’s Hospital
2013	Shelley Aggarwal, MD	Clinical Instructor – Stanford University School of Medicine
2014	Julie Spencer, MD	Adolescent Medicine Provider Kaiser Hospital
2014-2015	Michael Haymer, MD	Program Director, Psychiatry Department UCLA
2015-2017	Patrick Shepherd, MD	CHLA Endocrinology Fellow
2015-2018	Jonathan Warus, MD	Faculty, CHLA/USC Keck School of Medicine
2015-2020	Shannon Dunlap, PhD	Postdoctoral Scholar - Research Associate, University of Southern California, Suzanne Dworak-Peck School of Social Work
2020-Present	Marianela Gomez-Rincon, MD	Adolescent Medicine Fellow
2020-Present	Jonathan Warus, MD	CHLA, Assistant Professor of Clinical Pediatrics
2022	Emmett Henderson, PhD, MS	USC Suzanne Dworak-Peck School of Social Work Senior mentor K99; USC

**MENTORSHIP OF FACULTY:**

<i>Year-Year</i>	<i>Mentee Name</i>	<i>Mentee Department</i>
2021 - present	Jonathan Warus, MD	Division of Adolescent Medicine, CHLA
2022 - present	Brigid Conn, PhD	Clinical Psychologist, CHLA

**SERVICE****DEPARTMENT SERVICE:**

<i>Year-Year</i>	<i>Position, Committee</i>	<i>Organization/Institution</i>
2010-2015	Secretary, The CHAMPION Fund Executive Board	The Division of Adolescent Medicine, Children’s Hospital Los Angeles

**HOSPITAL OR MEDICAL GROUP SERVICE:**

<i>Year-Year</i>	<i>Position, Committee</i>	<i>Organization/Institution</i>
2021 - present	Committee Member	SOGI work group, CHLA

**PROFESSIONAL SERVICE:**

<i>Year-Year</i>	<i>Position, Committee</i>	<i>Organization/Institution</i>
2012-present	Member, LGBT Special Interest Group	Society for Adolescent Health and Medicine
2022	Secretary, Executive Board of Directors	US Professional Association of Transgender Health
2016-present		

**CONSULTANTSHIPS AND ADVISORY BOARDS:**

<i>Year</i>	<i>Position, Board</i>	<i>Organization/Hospital/School, Institution</i>
2010-2017	Member, Advisory Board	Transyouth Family Allies
2017-present	Member, National Medical Committee	Planned Parenthood
2017 - Present	Board Member	US Professional Association of Transgender Health
2021	Expert Panelist	Robert Wood Johnson Foundation - National Commission on Data Transformation for Health Equity
2021	Member, Advisory Board	The National LGBTQIA+ Health Education Center
2023	Working Group Member; Expanding the Evidence Base in Gender-Affirming Care for Transgender and Gender Diverse Populations	NIH, Sexual & Gender Minority Research Office
2023	Consultant	Behavioral Health Excellence-Technical Assistance Center funded by the Health Resources and Services Administration (HRSA) to provide technical assistance, training, resources, tools, and consultation to their BHWET (Behavioral Health Workforce Education and Training), OWEP (Opioid Workforce Expansion Program) and GPE (Graduate Psychology Education) grantees.

**PROFESSIONAL SOCIETY MEMBERSHIPS:**

<i>Year- Year</i>	<i>Society</i>
2003 - present	Society for Adolescent Health and Medicine
2005 - present	American Academy of Pediatrics
2006 - 2011	Los Angeles Pediatric Society (Past president 2010)
2010 - present	Professional Association for Transgender Health
2014 - present	Society for Pediatric Research
2017 - present	US Professional Association for Transgender Health

**MAJOR LEADERSHIP POSITIONS: (E.G., DEAN, CHAIR, INSTITUTE DIRECTOR, HOSPITAL ADMINISTRATION, ETC.)****RESEARCH AND SCHOLARSHIP****EDITORSHIPS AND EDITORIAL BOARDS:**

<i>Year-Year</i>	<i>Position</i>	<i>Journal/Board Name</i>
2015 - present	Associate Editor	Journal of Transgender Health

**MANUSCRIPT REVIEW:**

<i>Year-Year</i>	<i>Journal</i>
2014 - present	Pediatrics
2014 - present	Journal of Adolescent Health
2014 - present	LGBT Health
2014 - present	International Journal of Transgenderism
2015 - present	Journal of Transgender Health
2018 - present	Clinical Child Psychology and Psychiatry
2018 - present	Journal of Sexual Medicine
2021 - present	JAMA Peds

**GRANT REVIEWS:**

<i>Year</i>	<i>Description</i>	<i>Awarding agency, City, State, Country</i>
2017	Cognition and Perception Study Section	National Institutes of Health, Bethesda, Maryland, USA
2017	Neurological, Aging and Musculoskeletal Epidemiology Study Section	National Institutes of Health, Bethesda, Maryland, USA
2018	Social Psychology, Personality and Interpersonal Processes Study Section	National Institutes of Health, Bethesda, Maryland, USA
2018	Neurological, Aging and Musculoskeletal Epidemiology Study Section	National Institutes of Health, Bethesda, Maryland, USA
2019	Special Emphasis Panel Review of Research Conference (R13) Grants	National Institutes of Health, Bethesda, Maryland, USA
2019	The Einstein Foundation Award for Promoting Quality in Research	Einstein Foundation, Berlin
2020	Biobehavioral and Behavioral Sciences Study Section	National Institutes of Health, Bethesda, Maryland, USA
2021	Social Psychology, Personality and Interpersonal Processes Study Section	National Institutes of Health, Bethesda, Maryland, USA

**MAJOR AREAS OF RESEARCH INTEREST**

Research Areas
1. Transgender and non-binary children, adolescents and young adults
2. HIV medication adherence

**GRANT SUPPORT - CURRENT:**

<i>Grant No. (PI)2R01HD082554-06A1 (Olson-Kennedy)</i>	<i>Dates of Award: 2021-2026</i>
<i>Agency: NICHD</i>	<i>Percent Effort 25%</i>
<i>Title: The Impact of Early Medical Treatment in Transgender Youth</i>	
<i>Description: This is the continuations of a multicenter study, the first of its kind in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.</i>	

<i>Role: Principle Investigator</i>	
<i>Total Direct Costs: \$4,918,586</i>	

<i>Grant No. 1R01HD097122-01 (Hidalgo)</i>	<i>Dates of Award: 2019-2024</i>
<i>Agency: NICHD</i>	<i>Percent Effort 2.5%</i>
<i>Title: A Longitudinal Study of Gender Nonconformity in Prepubescent Children</i>	
<i>Description: The purpose of this study is to establish a national cohort of prepubertal transgender/gender nonconforming (TGNC) children (and their parents), and longitudinally observe this cohort to expand the body of empirical knowledge pertaining to gender development and cognition in TGNC children, their mental health symptomology and functioning over time, and how family-initiated social gender transition may predict or alleviate mental health symptoms and/or diagnoses.</i>	
<i>Role: Site PI</i>	
<i>Total Direct Costs: \$2,884,950</i>	

<i>Grant No. LGBT Health Equity</i>	<i>Dates of Award: 2023-2025</i>
<i>Agency: California Department of Public Health</i>	<i>Percent Effort 10%</i>
<i>Title: Beliefs, Knowledge, and Attitudes of Pediatric Primary Care Providers Serving Latine Communities Regarding Gender-Affirming Care for Minors</i>	
<i>Description: This study aims to better understand the current barriers facing Latine pubertal TGNC youth and their parents/caretakers in accessing gender affirming care, assess the attitudes, beliefs, knowledge, perspectives, and comfort level of pediatric primary care providers serving people in predominately Latine communities regarding TGNC youth.</i>	
<i>Role: Principle Investigator</i>	
<i>Total Direct Costs: \$237,857</i>	

**GRANT SUPPORT - PAST:**

<i>Grant No. (PI) 1R01HD082554-01A1</i>	<i>Dates of Award: 2015-2020</i>
<i>Agency: NICHD</i>	<i>Percent Effort 45%</i>
<i>Title: The Impact of Early Medical Treatment in Transgender Youth</i>	
<i>Description: This is a multicenter study, the first of its kind in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.</i>	
<i>Role: Principle Investigator</i>	
<i>Total Direct Costs: \$4,631,970</i>	
<i>Grant No. (COI) R01AI128796-01</i>	<i>Dates of Award: 2/24/17-1/31/18</i>
<i>Agency: NIAID</i>	<i>Percent Effort: 5%</i>
<i>Title: Maturation, Infectibility and Trauma Contributes to HIV Susceptibility in Adolescents</i>	

<p>Description: This proposal explores the overarching hypothesis that fluctuations in sex steroid levels and mucosal trauma (sexual activity) are key determinants of mucosal immune activation and epithelial integrity, and that microbial communities are central to these processes. We will pursue this hypothesis by examining longitudinal changes in the anogenital microbiome as well as protein expression at these mucosal sites during sexual maturation (cisgender youth) and in hormonally-controlled sexual maturation (transgender youth). Associations between sex steroid levels, microbial community composition, mucosal trauma, and vaginal proteins will be determined and modeled.</p>
<p><i>Role: Co-Investigator</i></p>
<p><i>Total Direct Costs: \$44,816</i></p>

<p><i>Grant No. (PI) U01HD040463</i></p>	<p><i>Dates of Award 2006 – 2016</i></p>
<p><i>Agency: NIH/NICHD</i></p>	<p><i>Percent Effort: 10%</i></p>
<p><i>Title: Adolescent Medicine Trials Network for HIV/AIDS</i></p>	
<p><i>Description: Adolescent Medicine Trials Network for HIV/AIDS</i></p>	
<p><i>Role: Co-Investigator</i></p>	
<p><i>Total Direct Costs: 2,225,674</i></p>	

<p><i>Grant No. (PI) SC CTSI 8KL2TR000131</i></p>	<p><i>Dates of Award: 2012-2014</i></p>
<p><i>Agency: KL2 Mentored Career Research Development Program of the Center for Education, Training and Career Development</i></p>	<p><i>Percent Effort: 37.5%</i></p>
<p><i>Title: The Impact of Hormone Blockers on the Physiologic and Psychosocial Development of Gender Non-Conforming Peri-Pubertal Youth</i></p>	
<p><i>Description: This study aimed to understand the impact of puberty blocking medications on mental health and physiologic parameters in peri-pubertal transgender youth.</i></p>	
<p><i>Role: Principal Investigator</i></p>	
<p><i>Total Direct Costs: 191,525</i></p>	

### Invited Lectures, Symposia, keynote addresses

<i>Date</i>	<i>Type</i>	<i>Title, Location</i>
2014	Invited Lecture	Transgender Youth; Needs, Risks, Outcomes and the Role of the System, Including Permanency and Inclusion for Our Youth, Administrative Office of the Courts, Center for Families and Children, San Diego, California
2015	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Lopez Family Foundation Special Lecture for Puerto Rico and Panama, Lopez Family Foundation, Children’s Hospital Los Angeles, Los Angeles, California
2015	Symposium	Transgender Youth – An Overview of Medical and Mental Health Needs of Gender Non-Conforming Children and Transgender Adolescents, Public Child Welfare Training Academy, Academy for Professional Excellence at San Diego State University School of Social Work, San Diego, California
2015	Invited Lecture	Meeting the Needs of Transgender Adolescents; 1 <sup>st</sup> Annual Southern California LGBT Health Symposium; USC/UCLA, Los Angeles, California

2015	Symposium	Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; GetReal California's Initiative; "Integrating Sexual Orientation, Gender Identity, and Expression (SOGIE) into California's Child Welfare System," Oakland, California
2016	Invited Symposium	Caring for Gender Nonconforming and Transgender Youth; Idyllwild, California
2016	Educational symposium	Gender 101: A Primer; Vista Mar, California
2016	Invited Lecture	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach, California Association of Marriage and Family Therapists, Los Angeles, California
2016	Invited Lecture	Caring for Gender Nonconforming Children and Transgender Youth, California Psychological Association, Continuing Education Institute, Irvine, California
2016	Invited Lecture	Health Issues Related to Transgender Youth; LA City Health Commission, Los Angeles, California
2016	Invited Lecture	Caring for Gender Nonconforming and Transgender Youth, Medical Directors 12th Annual Update on Reproductive Health and Medical Leadership, Planned Parenthood, Steamboat Springs, Colorado
2016	Invited Lecture	Caring For Transgender Teens, UCLA Meet the Professor, Los Angeles, CA
2017	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Santa Barbara, CA
2017	Invited Lecture	Healthcare for TGNC Youth, Expanding Competency for LGBT Youth in the System Conference, Center for Juvenile Justice Reform, Washington DC
2017	Invited Lecture	Gender Non-conforming and Transgender Children and Youth; Center for Early Education, West Hollywood, CA
2017	Invited Lecture	Gender Non-Conforming Children and Transgender Youth, Board of Behavioral Sciences, Orange, CA
2017	Invited Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, Santa Monica Rape Treatment Center, Santa Monica, CA
2017	Invited Lecture	Transgender Youth Care in the New Millennium, USC Law and Global Health Initiative, Los Angeles, CA
2018	Invited Lecture	Supporting Gender Diverse and Transgender Youth: A Deeper Look at Gender Dysphoria, Invited lecture, Oakwood School, Studio City, California, 2018
2018	Invited Lecture	Working with Trans and Gender Non-Conforming Youth, Children's Hospital Orange County, CA
2018	Invited Lecture	Caring for gender Non-conforming and Transgender Youth and Young Adults, Ascend Residential, Encino CA
2018	Invited Lecture	Caring for gender Non-conforming and Transgender Youth and Young Adults, California State University Northridge, Northridge, CA
2018	Invited Lecture	Gender Dysphoria; School Nurse Association of Idaho Annual Conference, School Nurse Association of Idaho Association, Boise Idaho
2018	Invited Lecture	Gender and What You Should Know, Archer School for Girls, Brentwood, CA
2018	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Oceanside, CA
2018	Invited Lecture	Gender Dysphoria: Beyond the Diagnosis, Advance LA Thriving Through Transitions Conference, The Help Group, Los Angeles, California

2018	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Andrology Society of America Clinical Symposium, Andrology Society of America, Portland, Oregon
2018	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Los Angeles, CA
2018	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Center for Early Education, Los Angeles, CA
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Cal State Los Angeles, California
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Claremont Colleges, California
2019	Symposium	TransYouth Care; Flagstaff, AZ
2019	Invited Lecture	Transgender and Gender Non-conforming Youth, Invited lecture, Elevations Residential Treatment, Salt Lake City, Utah
2019	Invited Lecture	Gender Diverse and Transgender Youth; What Pediatricians Should Know, Common Problems in Pediatrics Conference, Utah AAP, Utah
2019	Invited Lecture	Caring for Gender Diverse and Transgender Youth, Grand Rounds, UCLA Olive View, CA
2019	Invited Lecture	Caring for Gender Diverse and Transgender Youth, Grand Rounds, Good Samaritan, Los Angeles, California
2019	Invited Lecture	Puberty Suppression in Youth with Gender Dysphoria, Fenway Trans Health Program, Boston
2019	Invited Lecture	Recognizing the Needs of Transgender Youth, California Department of Corrections and Rehabilitation, Ventura, CA
2019	Invited Lecture	Gender Dysphoria; Beyond the Diagnosis, Gender Education Demystification Symposium, Gender Education and Demystification, Atlanta, Georgia
2019	Invited Lecture	Caring for Gender Nonconforming and Transgender Youth, Los Angeles Superior Court/Los Angeles Bar Association Training, CA
2019	Invited Lecture	Supporting Gender Diverse and Transgender Youth; A Deeper Look at Gender Dysphoria, Oakwood School, CA
2020	Symposium	Trans Youth Care, Chico Transgender Week, Virtual Presentation
2020	Invited Lecture	Gender Nonconforming and Transgender Youth, Novartis, Virtual Presentation
2020	Invited Lecture	Advanced Hormones; More than Just T and E, CHLA, Virtual Presentation
2020	Invited Lecture	Video Telehealth and Transgender Youth, Telehealth Best Practices for the Trans Community, The Central Texas Transgender Health Coalition, Virtual Presentation
2020	Invited Lecture	Gear Talk, Transforming Families, Virtual Lecture
2020	Invited Lecture	Tips for Parenting a Trans or Gender Diverse Youth, Models of Pride, Virtual Presentation
2020	Invited Lecture	Caring for Gender Diverse and Transgender Youth, LGBTQ+ Clinical Academy, Palo Alto University, Virtual presentation
2020	Invited Lecture	Medical Interventions for transgender youth, Cal State Los Angeles, Los Angeles
2020	Plenary Session	Understanding Issues Involving Gender Non-Conforming and Transgender Individuals Coming to a Courtroom Near You, Mid-Winter Workshop for Judges of the Ninth Circuit, Palm Springs, CA

2021	Invited Lecture	Gender Affirmation through a Social Justice Lens; Center for Gender Equity in Medicine and Science (GEMS) at Keck School of Medicine, Los Angeles
2021	Invited Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Providence Medical Group – South Bay Pediatrics (Torrance, San Pedro, Redondo Beach), virtual lecture
2021	Invited Lecture	Caring for Gender Diverse and Transgender Youth. San Luis Obispo Acceptance, Cal Poly, Virtual Presentation
2022	Invited Lecture	Transgender and Non-binary children and youth, Board of Behavioral Sciences
2022	Invited Lecture	Gender Affirmation through a Social Justice Lens; University of Arizona Health Sciences LGBTQ+ Symposium & Health Fair
2022	Invited Lecture	Gender Dysphoria in Children, Adolescents and Young Adults, MedLambda and PsychSIG Keck USC School of Medicine, Virtual Lecture
2022	Invited Lecture	Caring for Transgender and Gender Nonconforming Youth, Presbyterian Healthcare Services, New Mexico, Virtual lecture
2022	Invited Lecture	Transgender and Non-Binary Youth, Rogers Behavioral Health, Virtual Lecture
2023	Invited Lecture	<b>Transgender and Non-binary Youth and Young Adults 101</b> , When Healthcare Gets Political; Health Justice and Systems of Care course, Keck USC School of Medicine, Los Angeles
2023	Invited Lecture	Transgender and Non-Binary Youth; Navigating Gender Care in 2023, Improving Outcomes Conference, UC Davis, Sacramento, CA
2023	Invited Lecture	Gender Affirming Medical and Mental Health Care for Transgender Adolescents, California Association of Marriage and Family Therapists Annual Conference, Santa Clara, CA
2023	Invited Lecture	Trans Youth Care in 2023; What's New, What's Not, Behavioral Health Excellence-Technical Assistance Center

### Invited Grand Rounds, CME Lectures

<i>Date</i>	<i>Type</i>	<i>Title, Location</i>
2014	Grand Rounds	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach; Seattle Children's Hospital, Seattle, Washington
2014	CME lecture	Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; Eisenhower Medical Center Transgender Health Symposium, Palm Springs, California
2014	Grand Rounds	Toddlers to Teens: Comprehensive Health Care for the Transgender Child, Cultural Psychiatry Lecture Series, University of Iowa Carver College of Medicine, Iowa City, Iowa
2014	Grand Rounds	Caring for Gender Non-conforming Children and Teens in the New Millennium; A Multidisciplinary Team Approach, Children's Hospital Los Angeles, Los Angeles, California
2014	CME lecture	Difficult Cases, Gender Spectrum Family Conference, Gender Spectrum, Moraga, California
2014	CME lecture	Cross-sex Hormones for Teenagers, How Young is Too Young? Philadelphia Trans Health Conference, Philadelphia, Pennsylvania



2014	CME lecture	Pediatric Update, Philadelphia Trans Health Conference, Philadelphia, Pennsylvania
2015	Grand Rounds	Caring for Gender Nonconforming and Transgender Youth, Stanford Division of Adolescent Medicine, Palo Alto, CA
2015	CME Educational Lecture	Update on the Transgender Patient for the PCP, St. Joseph's Providence, Burbank, CA
2015	CME Educational Lecture	Caring for Gender Non-Conforming Children and Transgender Teens, Providence Tarzana, CA
2015	Grand Rounds	Caring for Gender Nonconforming and Transgender Youth, University of Southern California, Los Angeles, California
2015	Grand Rounds	Puberty Blockers and Cross Sex Hormones, Pediatric Endocrinology, Children's Hospital Los Angeles, Los Angeles, California
2015	CME lecture	Youth and Hormones, 2015 Gender Expansion Conference, University of Montana, Missoula Montana
2015	CME lecture	Transyouth Healthcare, 2015 Gender Expansion Conference, University of Montana, Missoula Montana
2015	CME lecture	Supporting Transgender Youth, Southern Oregon University Student Health and Wellness Center Workshop, Southern Oregon University, Ashland, Oregon
2015	PCS Grand Rounds	Caring for Gender Nonconforming Children and Transgender Youth, Children's Hospital Los Angeles, Los Angeles, California
2015	CME lecture	Medical Care for Gender Non-Conforming Children, Transgender Adolescents and Young Adults in the New Millennium, Continuing Medical Education of Southern Oregon, Medford, Oregon
2015	Grand Rounds	Medical Care for Gender Non-Conforming Children and Transgender Youth, Olive View Medical Center-UCLA, Sylmar, California
2015	Grand Rounds	Caring for Gender Non-conforming Children and Transgender Teens, Harbor-UCLA Department of Pediatrics, Torrance, California
2015	CME lecture	Caring for Gender Non-conforming Children and Teens in the New Millennium, Healthcare Partners Pediatric Town Hall Meeting, Healthcare Partners CME, Glendale, California
2016	Pediatric Grand Rounds	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth; Children's Hospital Los Angeles, Los Angeles, California
2016	Endocrine Grand Rounds	Approach to Care of Gender Non-Conforming Children and Transgender Adolescents; Cedars Sinai Hospital, Los Angeles, California
2016	Pediatric Grand Rounds	Care of Gender Non-Conforming Children and Transgender Adolescents in the New Millennium, Stanford Lucille Packard Children's Hospital, Palo Alto, California
2016	Pediatric Update	Caring for Gender Variant Children and Adolescents, Pediatric Update for the Primary Provider, Children's Hospital St. Louis, St. Louis, Missouri
2016	Grand Rounds	Care of Gender Non-Conforming Children and Transgender Adolescents in the New Millennium, St. Jude's Grand Rounds, Memphis, Tennessee
2016	CME Educational Lecture	Transgender and Gender Non-Conforming Youth: Innovative Approaches to Care in 2016; Integrating Substance Use, Mental Health, and Primary Care Services: Courageous and Compassionate Care, Los Angeles, California

2016	CME; professional conference	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach, Arizona Psychiatric Society, Tempe, Arizona
2016	CME/Educational Symposium	Caring for Gender Nonconforming and Transgender Youth, San Diego, California
2016	CME/CEU Educational Training	Medical Interventions for Transgender Youth and Young Adults, San Diego State University, San Diego, California
2016	Grand Rounds	Caring for Gender Nonconforming Children and Transgender Youth, Mt. Sinai Hospital, Pediatric Grand Rounds George J. Ginandes Lecture, New York, New York
2016	CME Educational Lecture	The Transgender Experience, Providence Tarzana, CA
2017	CME Educational Seminar	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, San Diego, CA
2017	CME Educational Seminar	The Care of Gender Non-Conforming children and Transgender Youth; Orange County Health Care Agency, Orange County, CA
2017	CME Educational Lecture	Rethinking Gender, Adolescent Grand Rounds, Children's Hospital Los Angeles, Los Angeles, CA
2017	CME Educational Lecture	Gender Non-Conforming Children and Transgender Youth, CME lecture for OB/Gyn, Omnia-Prova Education Collaborative, inc. Pasadena, California
2017	CME Educational Lecture	Gender Non-Conforming and Transgender Children and Adolescents, Developmental Pediatrics continuing education lecture, Children's Hospital Los Angeles, CA
2017	CME Educational Lecture	Care of Gender Non-Conforming Children and Transgender Adolescents, Lopez Family Foundation Educational Lecture, Los Angeles, CA
2017	CME Educational Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, USC Keck School of Medicine Reproductive Health, Los Angeles, CA
2017	CME Educational Seminar	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, San Diego, CA
2018	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Glendale Unified School District, CA
2018	CME Educational Lecture	Caring for Gender Non-Conforming Children and Transgender Youth, CME by the Sea, CA
2018	CME Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Austin, TX
2018	CME Educational Lecture	Approach to the Care of Gender Non-Conforming Children and Transgender Youth, Desert Oasis Healthcare, Palm Desert, CA

2018	CME Workshop	Mental and Medical Healthcare for Transgender Adolescents, California Association of Marriage and Family Therapists, Garden Grove, CA
2018	CME Educational Lecture	Approach to the Care of Gender Non-Conforming Children and Transgender Youth, Keck School of Medicine, Los Angeles, CA
2018	Grand Rounds	Caring for Gender Non-Conforming Children and Transgender Adolescents, Primary Children's Hospital, Salt Lake City, UT
2018	CME Educational Lecture	Caring for Transgender Youth, Chico Trans Week, Chico, CA
2018	CME Educational Lecture	Rethinking Gender, UCSD Medical School, San Diego, CA
2018	CME Educational Lecture	Rethinking Gender, UCLA Medical School, Los Angeles, CA
2019	Symposium	Recognizing the Needs of Transgender Youth, California Department of Corrections and Rehabilitation, Stockton, CA
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Cal State Los Angeles, California
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Claremont Colleges, California
2019	CME Lecture	Gender Diverse and Transgender Youth, Harbor UCLA Medical Center Grand Rounds, Torrance, CA
2019	CME Lecture	Gender Dysphoria – Beyond the Diagnosis, Gender Odyssey San Diego, San Diego, CA
2019	Grand Rounds	Transgender Youth; What's New in 2019?, Children's Hospital Los Angeles, CA
2019	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Children's Hospital Orange County, CA
2019	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Stanislaus County Behavioral Health and Recovery Services, CA
2019	CME Educational Lecture	Rethinking Gender, Olive View Medical Center Grand Rounds, CA
2020	CME Lecture	Gender Affirmation Through a Social Justice Lens, SAHM Conference, Virtual Presentation
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, AAP Conference, Virtual Lecture
2020	CME Lecture	Conversations with LGBTQ youth; the role of the pediatrician, AAP Conference, Virtual Lecture
2020	Grand Rounds	Creating Affirming Environments for Trans and Gender Diverse Patients, USC OB/Gyn Grand Rounds, Virtual Presentation
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Resident Lecture, CHLA
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Facey Medical Group, Los Angeles, CA

2020	Plenary Lecture	Reframing Gender Dysphoria, LEAH Conference, Los Angeles, CA
2020	CME Lecture	Gender Affirming Care for Pre and Peri-pubertal Trans and Gender Diverse Youth, LEAH Conference, Los Angeles, CA
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Division of Endocrinology, USC, Los Angeles, CA
2021	CME Lecture	Transitioning from Invalidation and Trauma to Gender Affirming Care; ACCM Grand Rounds, Children's Hospital Los Angeles, Virtual presentation
2021	CME Symposium	TransYouth Care; Transfamily Support San Diego, Virtual Symposium
2021	Symposium	TransYouth Care for Parents; Santa Clara, CA
2022	CME Lecture	Gender affirming medical interventions; An Evolving landscape, Critical Issues in Child and Adolescent Mental Health Conference, San Diego, California
2022	CME Symposium	TransYouth Care for Mental Health Providers; Santa Clara, CA
2022	CME Symposium	TransYouth Care; Transfamily Support San Diego, Virtual Symposium

### International Lectures

<i>Date</i>	<i>Type</i>	<i>Title, Location</i>
2013	Keynote	Caring for Gender Non-conforming Children and Adolescents in the New Millennium, Vancouver, Canada
2016	CME; professional conference	Social Transitions in Pre-pubertal Children; What do we know? World Professional Association of Transgender Health, Amsterdam, The Netherlands
2016	CME; professional conference	Beyond Male and Female; Approach to Youth with Non-Binary Gender Identities, World Professional Association of Transgender Health, Amsterdam, The Netherlands
2016	CME; professional conference	Workgroup on Gender Nonconforming/Transgender Youth: Biopsychosocial Outcomes and Development of Gender Identity, World Professional Association of Transgender Health, Amsterdam, The Netherlands
2017	Invited Lecture	Gender Dysphoria, Beyond the Diagnosis, Pink Competency, Oslo Norway
2017	Invited Lecture	Caring for Gender Non-Conforming Children and Transgender Adolescents: A United States Perspective, Pink Competency, Oslo Norway
2017	Invited Lecture	Caring for Gender Non-conforming and Transgender youth and Young Adults, Diverse Families Forum: The Importance of Family Support in The Trans And LGBT Children, Organized by COPRED and The

		International Association Of Families For Diversity (FDS), Mexico City, Mexico
2018	Invited Lecture	Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults: Comparison of Nonsurgical and Postsurgical Cohorts, Buenos Aires, Argentina
2018	Invited Lecture	Transgender Youth and Gender Affirming Hormones; A 6-8 year follow-up, Buenos Aires, Argentina
2018	Invited Lecture	Transyouth Care – An NIH Multisite Study About the Impact of Early Medical Treatment in Transgender Youth in the US, Buenos Aires, Argentina
2018	Invited Lecture	Uso de Hormonas Reafirmantes de Genero en Adolescentes Transgenero, Trans Amor Congreso Nacional de Transexualidad Juvenil y Infantes, Monterey, Mexico
2018	Invited Lecture	Bloqueadores de la Pubertad, Trans Amor Congreso Nacional de Transexualidad Juvenil y Infantes, Monterey, Mexico
2018	CME Educational Lecture	Puberty Blockers and Gender Affirming Hormones for Transgender Youth: What Do We Know, and What Have We Learned, Pediatric Academic Societies, Toronto, Canada
2019	Grand Rounds	Rethinking Gender, Grand Rounds, The Hospital for Sick Children, Toronto, Canada
2019	Keynote	<b><i>Gender Dysphoria; Beyond the Diagnosis</i></b> , Promoting Innovation and Collaboration to Support Gender Diverse Youth Conference, The Hospital for Sick Children, Toronto, Canada, December 2019
2019	Invited Lecture	Hormonas que Affirman el Genero pasa Juventud y Adultos Menores Trans, Transformando Desde el Amor y Las Familias, Colombia
2019	Invited Lecture	Infancia Trans y da Genero Diverso, Transformando Desde el Amor y Las Familias, Colombia
2019	Invited Lecture	Transgender Youth: Medical and Mental Health Needs, Bristol, United Kingdom
2019	Invited Lecture	Rethinking Gender, University of Bristol, United Kingdom
2019	CME; professional conference	Male Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults, European Professional Association of Transgender Health, Rome Italy
2019	CME; professional conference	Transgender Youth and Gender Affirming Hormones; 5-7 Year Follow Up, European Professional Association of Transgender Health, Rome Italy
2019	CME Educational Lecture	Gender Dysphoria; Beyond the Diagnosis, European Professional Association of Transgender Health, Rome Italy
2022	Plenary Session	The Landscape of Gender Affirming Care for Youth in the US, AusPATH, Virtual
2022	CME; professional conference	Emotional Functioning of Adolescents with Gender Dysphoria After Two Years of Treatment; WPATH Conference, Montreal, Canada

2022	CME; Professional Conference	Creating Enduring Materials; WPATH Conference, Montreal, Canada
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### Keynote/Plenary Presentations

<i>Date</i>	<i>Type</i>	<i>Title, Location</i>
2015	Keynote	The Future of Trans Care in the New Millennium, Gender Infinity Conference, Houston, Texas
2016	Plenary Session	Caring for Trans Youth and Gender Non-Conforming Children, Transgender Spectrum Conference, St. Louis, Missouri
2017	Invited Lecture	Rethinking Gender, Keynote, Annual Convocation Welcome Luncheon for the LGBTA Community, University of Massachusetts, Worcester, Massachusetts, 2017
2018	Keynote	Future Directions, USPATH, Washington DC
2019	Keynote	Gender Dysphoria; A Deeper Dive Beyond the Diagnosis, Inaugural LGBTQ summit, Santa Clara CA
2021	CME; professional conference	Advances and Challenges in the Care of Transgender/Gender Diverse Youth; USPATH Conference, Virtual presentation
2022	Keynote	Gender Affirmation Through a Social Justice Lens, Indiana University School of Medicine
2022	Invited Lecture	Transgender and Non-Binary Youth, Supporting the Well-Being of LGBTQ Youth Certificate Program Center for Juvenile Justice Reform Georgetown University, virtual training
2022	Invited Lecture	Transgender and Non-Binary Youth, Young Women's Career Conference (YWCC) for the Girls Academic Leadership Academy; virtual lecture

### PUBLICATIONS:

\* INDICATES TRAINEES

\*\* INDICATE YOURSELF AS CO-FIRST OR CO-CORRESPONDING OR SENIOR AUTHORS

### REFEREED JOURNAL ARTICLES:

1. Belzer M, Sanchez K, **Olson J**, Jacobs AM, Tucker D. Advance supply of emergency contraception: a randomized trial in adolescent mothers. *J Pediatr Adolesc Gynecol*. 2005 Oct;18(5):347-54. PubMed PMID: 16202939.
2. Puccio JA, Belzer M, **Olson J**, Martinez M, Salata C, Tucker D, Tanaka D. The use of cell phone reminder calls for assisting HIV-infected adolescents and young adults to adhere to highly active antiretroviral therapy: a pilot study. *AIDS Patient Care STDS*. 2006 Jun;20(6):438-44. PubMed PMID: 16789857.
3. **Olson J\*\***, Forbes C, Belzer M. Management of the transgender adolescent. *Arch Pediatr Adolesc Med*. 2011 Feb;165(2):171-6. doi: 10.1001/archpediatrics.2010.275. Review. PubMed PMID: 21300658.

4. Simons L\*, Schragger SM, Clark LF, Belzer M, **Olson J\*\***. Parental support and mental health among transgender adolescents. *J Adolesc Health*. 2013 Dec;53(6):791-3. DOI: 10.1016/j.jadohealth.2013.07.019. Epub 2013 Sep 4. PubMed PMID: 24012067; PubMed Central PMCID: PMC3838484.
5. Belzer ME, Naar-King S, **Olson J**, Sarr M, Thornton S, Kahana SY, Gaur AH, Clark LF; Adolescent Medicine Trials Network for HIV/AIDS Interventions. The use of cell phone support for non-adherent HIV-infected youth and young adults: an initial randomized and controlled intervention trial. *AIDS Behav*. 2014 Apr;18(4):686-96. doi: 10.1007/s10461-013-0661-3. PubMed PMID: 24271347; PubMed Central PMCID: PMC3962719.
6. **Olson J\*\***, Garofalo R. The peripubertal gender-dysphoric child: puberty suppression and treatment paradigms. *Pediatr Ann*. 2014 Jun;43(6):e132-7. doi: 10.3928/00904481-20140522-08. PMID: 24972421.
7. **Olson J\*\***, Schragger SM, Clark LF, Dunlap SL, Belzer M. Subcutaneous Testosterone: An Effective Delivery Mechanism for Masculinizing Young Transgender Men. *LGBT Health*. 2014 Sep;1(3):165-7. doi: 10.1089/lgbt.2014.0018. Epub 2014 Jun 26. PMID: 26789709.
8. Schragger SM, **Olson J**, Beharry M\*, Belzer M, Goldsich K\*, Desai M, Clark LF. Young men and the morning after: a missed opportunity for emergency contraception provision? *J Fam Plann Reprod Health Care*. 2015 Jan;41(1):33-7. doi: 10.1136/jfprhc-2013-100617. Epub 2014 Jan 24. PubMed PMID: 24465024.
9. Belzer M, Kolmodin MacDonell K, Clark L, Huang J, **Olson J**, Kahana S, Naar S, Sarr M, Thornton S. Acceptability and Feasibility of a Cell Phone Support Intervention for Youth Living with HIV with Nonadherence to Antiretroviral Therapy, *AIDS Patient Care and STDs*, Vol. 29, No. 6, June 2015: 338-345. doi: 10.1089/apc.2014.0282; PMID: 25928772
10. Klein DA, Ellzy JA, **Olson J\*\***. Care of a Transgender Adolescent. *Am Fam Physician*. 2015 Jul 15;92(2):142-8. PMID: 26176373.
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16. **Olson J**, Just a Boy, Just a Girl, Gender Spectrum, Gender Spectrum Professional Conference, Moraga, California, 2015
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# **Exhibit B**

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