EXHIBIT E

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
AT CHARLESTON

B.P.J., by her next friend and mother,
HEATHER JACKSON,

Plaintiff,

vs.

Civil Action No. 2:21-cv-00316
Hon. Joseph R. Goodwin

WEST VIRGINIA STATE BOARD OF EDUCATION; HARRISON COUNTY BOARD OF EDUCATION; WEST VIRGINIA SECONDARY SCHOOL ACTIVITIES COMMISSION; W. CLAYTON BURCH in his official capacity as State Superintendent; and, DORA STUTLER in her official capacity as Harrison County Superintendent,

Defendants.

DECLARATION OF JAMES M. CANTOR, PhD

I, Dr. James M. Cantor, PhD, pursuant to 28 U.S. Code § 1746, declare under penalty of perjury under the laws of the United States of America that my Expert Report of James M. Cantor, PhD attached hereto is true and correct to the best of my knowledge and belief.

Executed on 22 June, 2021.

JAMES M. CANTOR, PhD

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

ALLAN M. JOSEPHSON, *Plaintiff*, *v.* **NEELI BENDAPUDI**, *et al.*, *Defendants.*	Case No: 3:19-cv-00230-RGJ-CHL **THE HONORABLE** **REBECCA GRADY JENNINGS**

EXPERT REPORT OF JAMES M. CANTOR, PHD

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I. Background & Credentials

1. I am a clinical psychologist and Director of the Toronto Sexuality Centre in Canada. For my education and training, received my Bachelor of Science degree from Rensselaer Polytechnic Institute, where I studied mathematics, physics, and computer science. I received my Master of Arts degree in Psychology from Boston University, where I studied neuropsychology. I earned my Doctoral degree in psychology from McGill University, which included successfully defending my doctoral dissertation studying the effects of psychiatric medication and neurochemical changes on sexual behavior, and included a clinical internship assessing and treating people with a wide range of sexual and gender identity issues.

2. Over my academic career, my posts have included Psychologist and Senior Scientist at the Centre for Addiction and Mental Health (CAMH) and Head of Research for CAMH's Sexual Behaviour Clinic, Associate Professor of Psychiatry on the University of Toronto Faculty of Medicine, and Editor-in-Chief of the peer reviewed journal, Sexual Abuse. That journal is one of the top-impact, peer-reviewed journals in sexual behavior science and is the official journal of the Association for the Treatment of Sexual Abusers. In that appointment, I was charged to be the final arbiter for impartially deciding which contributions from other scientists in my field merited publication. I believe that appointment indicates not only my extensive experience evaluating scientific claims and methods, but also the faith put in me by the other scientists in my field. I have also served on the Editorial Boards of the *Journal of Sex Research*, the *Archives of Sexual Behavior*, and *Journal of Sexual Aggression*. Thus, although I cannot speak for other scientists, I regularly interact with and am routinely exposed to the views and opinions of most of the scientists active in our field today, within the United States and throughout the world.

3. My scientific expertise spans the biological and non-biological development of human sexuality, the classification of sexual interest patterns, the assessment and

treatment of atypical sexualities, and the application of statistics and research methodology in sex research. I am the author of over 50 peer-reviewed articles in my field, spanning the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities collectively referred to as *paraphilias*. I am the author of the past three editions of the gender identity and atypical sexualities chapter of the *Oxford Textbook of Psychopathology*. These works are now routinely cited in the field and are included in numerous other textbooks of sex research.

4. I began providing clinical services to people with gender dysphoria in 1998. I trained under Dr. Ray Blanchard of CAMH and have participated in the assessment of treatment of over one hundred individuals at various stages of considering and enacting both transition and detransition. My clinical experience includes the assessment and treatment of several thousand individuals experiencing other atypical sexuality issues. I am regularly called upon to provide objective assessment of the science of human sexuality by the courts (prosecution and defense), professional media, and mental health care providers.

5. I have served as an expert witness in a total of 10 cases, which are listed in my CV, attached here as Appendix 1.

6. A substantial proportion of the existing research on gender dysphoria comes from two clinics, one in Canada and one in the Netherlands. The CAMH gender clinic (previously, Clarke Institute of Psychiatry) was in operation for several decades, and its research was directed by Dr. Kenneth Zucker. I was employed by CAMH between 1998 and 2018. I was a member of the hospital's adult forensic program. However, I was in regular contact with members of the CAMH child psychiatry program (of which Dr. Zucker was a member), and we collaborated on multiple projects.

7. For my work in this case, I am being compensated at the hourly rate of $400 per hour. My compensation does not change based on the conclusions and opinions that I provide here or later in this case or on the outcome of this lawsuit.

II. Introduction

8. I have been asked to provide my expert opinion as to whether certain statements made by Dr. Allan Josephson concerning gender dysphoria and the treatment of gender dysphoria in children and adolescents were consistent with current science. As I explain in detail in this report, it is my opinion that they were.

9. To prepare the present report, I reviewed the video recording and a verbatim transcript of the complete panel discussion at the Heritage Foundation on 11 October 2021 including its question and answer session with Dr. Josephson and two other presenters, and I have compared his claims with the content the peer-reviewed research literature and professional statements on gender dysphoria and transsexualism. The points asserted were:

- A very high proportion ("almost all") adolescents expressing gender issues are struggling with other mental health difficulties, to which the gender issues may be secondary.
- The stigma of transgenderism does not explain all the mental health difficulties reported among children and adolescents presenting with gender issues.
- After explicating the use of the term "affirmation," affirming a new gender identity for a child should occur after rather than before ascertaining whether resolution of the child's other mental health issues would alleviate distress over gender.

10. As shown in the following, Dr. Josephson's claims are, without exception, entirely consistent with the contents of the peer-reviewed research literature, the empirically-based and internationally employed "Dutch Approach" to clinical practice with gender dysphoric children, and the clinical recommendations as set by the professional associations issuing them—including the World Professional Association of Transgender Health (WPATH) and the American Academy of Child & Adolescent Psychiatry (AACAP)—but with the single exception of the American Association of Pediatrics (AAP), which itself contradicts all the other professional associations. Dr. Josephson's remarks reflected not only the published science available when he made his comments in 2017, but also reflect the subsequent research published since that

time through this writing.

11. It is not possible to assess Dr. Josephson's comments relative to a consensus of my field, however. No such consensus is discernable. The current situation remains today as described by Dr. Rosalia Costa of the widely cited gender clinic at the Tavistock Centre in the United Kingdom (UK).

> Since the release of the Dutch model [detailed below], there has been disagreement about the appropriateness of treatment in minors. Some practitioners have questioned the ethics and safety of this intervention. Conversely, other healthcare professionals have argued that they have an obligation to alleviate suffering and it would be unethical to allow a patient to suffer through the distress of pubertal development when there was a way of preventing it.[1]

III. The Science of Transgenderism

A. Clarifying Terms

12. Most scientific discussions begin with the relevant vocabulary and definitions of terms. In the highly polarized and politicized debates surrounding transgender issues, that is less feasible: Different authors have used terms in differing, overlapping ways. Activists and the public (especially on social media) will use the same terms, but to mean different things, and some have actively misapplied terms so that original documents appear to assert something they do not.

13. For example, the word "child" is used in some contexts to refer specifically to children before puberty; in some contexts, to refer to children before adolescence (thus including ages of puberty); in still some contexts, to refer to people under the legal age of consent, which is age sixteen in the Netherlands (where much of the research was conducted) or age eighteen in much of North America. Thus, care should be taken in both using and interpreting the word "child" in this field.

14. Because the present document is meant to compare the claims made by others, it is the definitions used by those specific authors in those specific contexts which are relevant. Thus, definitions to my own uses of terms are provided where appropri-

[1] Costa, *et al.*, 2015, p. 2207.

ate, but primarily explicate how terms were defined and used in their original contexts.

B. Types of Gender Dysphoria

15. One of the most widespread public misunderstandings about transsexualism and people with gender dysphoria is that all cases of gender dysphoria represent the same phenomenon; however, the clinical science has long and consistently demonstrated that gender dysphoric children do not represent the same phenomenon as adult gender dysphoria, but coming to clinics at younger ages. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in every known regard, from brain structure, to sexual interest patterns, to responses to treatments. Very many misunderstandings in the media and public mind arise from the misapprehension that, because they both express the desire to be treated as the other gender, they are best served by the same treatment.

16. The research literature has long and consistently demonstrated there exist two well-characterized forms of gender dysphoria: childhood- (prepubertal) onset gender dysphoria and adult-onset, typically midlife.[2] These have also been called "early-onset" and "late-onset." A third presentation has recently become increasingly observed among people presenting to gender clinics: These cases appear to have an onset in adolescence in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or "rapid-onset."

1. Adult-Onset Gender Dysphoria

17. People with adult-onset gender dysphoria typically attend clinics requesting transition services in mid-adulthood, usually in their 30s or 40s. Such individuals are nearly exclusively male.[3] They typically report being sexually attracted to women and sometimes to both men and women. Some cases profess asexuality, but very few indicate any sexual interest in or behavior involving men.[4] Cases of adult-onset gen-

[2] Blanchard, 1985.
[3] Blanchard, 1990, 1991.
[4] Blanchard, 1988.

der dysphoria are typically associated with a sexual interest pattern (medically, a *paraphilia*) involving themselves in female form.[5]

18. Clinical research facilities studying gender dysphoria have repeatedly reported low rates of regret (less than 3%) among adult-onset patients who underwent complete transition (*i.e.*, social, plus hormonal, plus surgical transition). This has been widely reported by clinics in Canada,[6] Sweden,[7] and the Netherlands.[8]

19. Importantly, each of the Canadian, Swedish, and Dutch clinics for adults with gender dysphoria all performed "gate-keeping" procedures, disqualifying from medical services people with mental health or other contraindications. One would not expect the same results to emerge in the absence of such gate-keeping or when gate-keepers apply only minimal standards.

2. Childhood Onset (Pre-Puberty) Gender Dysphoria

20. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 3–6 biological male children to each female.[9]

a. Prospective Studies of "Natural Course": Desistance by Puberty in Majority

21. Prepubescent children (and their parents) have been approaching mental health professionals for help with their unhappiness with their sex and belief they would be happier living as the other for many decades. Projects following-up and reporting on such cases began being published in the 1970s, with subsequent generations of research employing increasingly sophisticated methods studying the outcomes of increasingly large samples. In total, there have now been a total of 11 such outcomes studies. *See* Appendix 2 (listing these studies).

22. In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, all spanning four decades, every study without

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5 Blanchard 1989a, 1989b, 1991.
6 Blanchard, *et al.*, 1989.
7 Dhejneberg, *et al.*, 2014.
8 Wiepjes, *et al.*, 2018.
9 Cohen-Kettenis, *et al.*, 2003.

exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender by puberty—ranging 61–88% desistance across the large, prospective studies. Such cases are often referred to as "desisters," whereas children who continue to feel gender dysphoria are often called "persisters."

23. Notably, in most cases, these children were receiving professional psychosocial support across the study period aimed, not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, its inclusion represents a complication for the interpretation of the results: That is, it is not possible to know to what extent the observed outcomes (predominant desistance, with a small but consistent occurrence of persistence) were influenced by the psychosocial support or would have emerged regardless. It can be concluded only that prepubescent children who suffer gender dysphoria and receive psychosocial support focused on issues other than "affirmation" of cross-gender identification do in fact desist in suffering from gender dysphoria, at high rates, over the course of puberty.

24. While the absolute number of those who present as prepubescent children with gender dysphoria and "persist" through adolescence is very small in relation to the total population, persistence in some subjects was observed in each of these studies. Thus, the clinician cannot take either outcome for granted.

25. It is because of this long-established and invariably consistent research finding that desistance is probable, but not inevitable, that the "watchful waiting" method became the standard approach for assisting gender dysphoric children. *See infra* Part III.A.2.b. The balance of potential risks to potential benefits is very different for groups likely to desist versus groups unlikely to desist: If a child is very likely to persist, then taking on the risks of medical transition might be more worthwhile than if that child is very likely to desist in transgender feelings.

26. The consistent observation of high rates of desistance among pre-pubertal children who present with gender dysphoria demonstrates a pivotally important—yet often overlooked—feature: because gender dysphoria so often desists on its own, clinical researchers cannot assume that therapeutic intervention cannot facilitate or speed desistance for at least some patients. Such is an empirical question, and there has not yet been any such study.

27. It is also important to note that research has not yet identified any reliable way to discern which children who present with gender dysphoria will persist, as against the majority who will desist, absent transition and "affirmation."

28. The more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can be weighted. Such "risk prediction" and behavioral "test construction" are standard components of applied statistics in the behavioral sciences. Multiple research teams have reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to assist in decision-making.[10]

29. A research team led by Dr. Kristina Olson attempted to develop a method of distinguishing persisters from desisters to develop a method of predicting outcomes in future groups.[11] That team created a single composite score representing a combination of children's "peer preference, toy preference, clothing preference, gender similarity, and gender identity."[12] They reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they described their result, "Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have

[10] Singh *et al.*, in press; Steensma *et al.*, 2013; Wallien *et al.*, 2009
[11] Rae, *et al.*, 2019.
[12] Rae, *et al.*, p. 671.

roughly a .48 probability."[13] Although the authors declared that "social transitions may be predictable from gender identification and preferences,"[14] their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.[15] Both of those are lower than the value of .75, so both of those would be less than 48% probable to transition. Thus, Olson's model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

30. Although it remains entirely possible for some future finding to yield a method to identity with sufficient accuracy which gender dysphoric children will persist, there does not exist such a method at the present time.

b. "Watchful Waiting" and "The Dutch Approach"

31. It was this state of the science—that the majority of prepubescent children will desist in their feelings of gender dysphoria and that we lack an accurate method of identifying which children will persist—that led to the development of a clinical approach, often called "The Dutch Approach" (referring to The Netherlands clinic where it was developed) including "Watchful Waiting" periods. Internationally, the Dutch Approach is currently the most widely respected and utilized method for treatment of children who present with gender dysphoria.

32. The purpose of these methods was to compromise the conflicting needs among: clients' desires upon assessment, the long-established and repeated observation that those preferences will change in the majority of (but not all) childhood cases, and that cosmetic aspects of medical transition are perceived to be better when they occur earlier rather than later.

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[13] Rae, *et al.*, p. 673.
[14] Rae, *et al.*, pp. 673, 679.
[15] Rae, *et al.*, 2019, p. 6, Table S1, bottom line.

33. The Dutch Approach (also called the "Dutch Protocol") was developed over many years by the Netherlands' child gender identity clinic, incorporating the accumulating findings from their own research as well as those reported by other clinics working with gender dysphoric children. They summarized and explicated the approach in their peer-reviewed report, *Clinical management of gender dysphoria in children and adolescents: The Dutch Approach* (de Vries & Cohen-Kettenis, 2012). The components of the Dutch Approach are:

- no social transition at all considered before age 12 (watchful waiting period),
- no puberty blockers considered before age 12,
- cross-sex hormones considered only after age 16, and
- resolution of mental health issues before any transition.

34. The Dutch Approach authors are explicit in indicating that these age cut-off's were not based on any research demonstrating their superiority over other potential age cut-off's. Rather, they were chosen to correspond to ages of consent to medical procedures under Dutch law. The authors were moreover explicit in indicating it is "conceivable that when more information about the safety of early hormone treatment becomes available, the age limit may be further adjusted."[16]

35. For youth under age 12, "the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty."[17]

36. The authors of the Dutch Approach repeatedly and consistently emphasize the need for extensive mental health assessment, including clinical interviews, formal psychological testing with validated psychometric instruments, and multiple sessions with the child and the child's parents. Indeed, those researchers' description of the appropriate response to other potentially relevant mental health issues is nearly identical to Dr. Josephson's panel remarks regarding unresolved issues of abuse as a potential confound:

[16] de Vries & Cohen-Kettenis, 2012, p. 311.
[17] de Vries & Cohen-Kettenis, 2012, p. 301.

> If any [mental illness] is found, the possible relationship between the gender dysphoria and other diagnoses is investigated. In this way, for example, one can investigate whether an autistic boy's fascination for fancy dresses and long hair is more part of his autism or whether his autism reinforces certain aspects of his gender dysphoria. . . . If concomitant problems are observed (e.g., substantial problems with peers, psychiatric problems, or conflicts with parents or siblings), the child may be referred to a local mental health agency. The primary aim is for the child and, if necessary, the family to function better. If these problems have contributed to causing or keeping up some gender dysphoria, the dysphoria will likely disappear by tackling these other problems. Although there is little evidence that psychotherapeutic interventions can eliminate gender dysphoria in general, it is conceivable that in some cases gender variant behavior can change as a result of therapy. In our own practice, a reduction or disappearance of gender variant behavior seems to take place particularly when this behavior appeared to be a clear reaction to certain events or situations which in themselves are amenable to therapy (e.g., a boy suddenly dressing up and saying he wants to be a girl as an expression of extreme jealousy after the birth of a younger sister).[18]

37. Within the Dutch approach, there is no social transition before age twelve. That is, social affirmation of the new gender may begin at age 12—as desistance is less likely to occur past that age. "Watchful Waiting" refers to a child's developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Such children and families typically present with substantial distress involving both gender and non-gender issues. It is during the watchful waiting period that a child (and other family members as appropriate) would undergo therapy, resolving other issues which may be exacerbating psychological stress or dysphoria. As noted by the Dutch clinic, "[T]he adolescents in this study received extensive family or other social support . . . [and they] were all regularly seen by one of the clinic's psychologists or psychiatrists."[19] One is actively treating the person, while carefully "watching" the dysphoria.

38. In sum, Dr. Josephson's comments regarding the prevalence of comorbid mental health issues and the need to resolve them before making decisions about any type of transition are fully in line with the recommendations of the widely respected Dutch Model.

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[18] de Vries & Cohen-Kettenis, 2012, pp. 307, 309.
[19] de Vries, *et al.*, 2011, p. 2281.

39. The inclusion of psychotherapy and support during the watchful waiting period is, clinically, a great benefit to the gender dysphoric children and their parents. The inclusion of psychotherapy and support poses a scientific complication, however: It becomes difficult to know to what extent the outcomes of these cases might be related to receiving psychotherapy received versus being "spontaneous" desistance, which would have occurred on its own anyway. This situation is referred to in science as a "confound."

c. Prospective Studies of Social Transition and Puberty Blockers in Adolescence

i. The Dutch Approach (studies from before 2017): Mix of positive, negative, and neutral outcomes

40. The research confirms that some, but not all, adolescents improve on some, but not all, indicators of mental health and that those indicators are inconsistent across studies. Thus, the balance of potential benefits to potential risks differs across cases, and thus suggest different courses of actions across cases.

41. The Dutch clinical research team followed-up 70 youth undergoing puberty suppression at their clinic.[20] The youth were improved better on several variables upon follow-up than at the beginning, including depressive symptoms and general functioning. No changes were detected in feelings of anxiety or anger or in gender dysphoria; however, natal females suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics.[21]

42. As the report authors noted, it is possible that the improvement was due to the puberty-blockers, it is possible that the improvement was due to the mental health support, and it is possible that the improvement occurred only on its own with natural maturation. Because this study did not include a control group (another group of adolescents matching the first group, but *not* receiving medical or social support), these possibilities cannot be distinguished from each other, representing a

[20] de Vries, *et al*. 2011.
[21] Biggs, 2020.

confound. The authors of the study were explicit in noting this themselves: "All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents."[22]

43. The authors were careful not to overstate the implications of their results, "We *cautiously* conclude that puberty suppression may be a valuable *element* in clinical management of adolescent gender dysphoria."[23]

44. Of those 70 cases, 55 were re-examined in that clinic's report of surgical outcomes.[24] This updated report indicated the cases' level of functioning at baseline, after having undergone puberty blocking, and now after having undergone surgical sex reassignment. Changes were again positive in some variables, but without significant changes in depression, anger, or anxiety.

45. Costa, *et al.* (2015) reported on preliminary outcomes from the Tavistock and Portman NHS Foundation Trust clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication. Both groups improved in psychological functioning over the course of the study, but no statistically significant differences between the groups was detected at any point.[25] As those authors concluded, "Psychological support and puberty suppression were both associated with an improved global psychosocial functioning in GD adolescence. Both these interventions may be considered effective in the clinical management of psychosocial functioning difficulties in GD adolescence."[26]

ii. Clinicians and advocates have invoked the Dutch Approach while departing from its protocols in important ways.

46. The reports of partial success contained in de Vries, *et al.* 2011 called for additional research, both to confirm those results and to search for ways to maximize

[22] de Vries, *et al.* 2011, p. 2281.
[23] de Vries, *et al.* 2011, p. 2282, italics added.
[24] de Vries, *et al.*, 2014.
[25] Costa, *et al.*, Table 2, p. 2212.
[26] Costa, *et al.*, p. 2206.

beneficial results and minimize negative outcomes. Instead, many other clinics and clinicians proceeded on the basis of the positives only, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent psychiatric health. Comprehensive, longitudinal assessments (*e.g.*, one and a half *years*[27]) became approvals after a single assessment session. Validated, objective measures of youths psychological functioning were replaced with clinicians' subjective (and first) opinion, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

47. Most relevantly to Dr. Josephson's panel comments, instead of feelings of distress being explored and resolved as emphasized throughout the clinical recommendations, they are too often ignored entirely, dismissed at the outset as effects of stigma, but without empirical basis. *See infra* Part III.C.4 (discussing minority stress).

48. Notably, Dr. Thomas Steensma, central researcher of the Dutch clinic, has decried other clinics for "blindly adopting our research" despite the indications that those results may not actually apply: "We don't know whether studies we have done in the past can still be applied to this time. Many more children are applying, and also a different type."[28] Steensma opined that "every doctor or psychologist who engages in transgender care should feel the obligation to do a good before and after measurement." But few if any are doing so.

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[27] de Vries, *et al.*, 2011.
[28] Tetelepta, 2021.

iii. Studies by other clinicians in other countries have failed to reliably replicate the positive components of the results reported by the Dutch clinicians in de Vries et al. 2011.

49. The indications of potential benefit from puberty suppression in at least some cases has led some clinicians to attempt to replicate the positive aspects of those findings. These efforts have not succeeded.

50. The Tavistock and Portman clinic in the U.K. recently released its findings, attempting to replicate the outcomes reported by the Dutch clinic.[29] Study participants were ages 12–15 (Tanner stages 3 for natal males, Tanner 2 for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious psychiatric conditions (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients' or their parents' perspective.

51. A multidisciplinary team from Dallas published a prospective follow-up study which included 25 youths as they began puberty suppression.[30] (The other 123 study participants were undergoing cross-sex hormone treatment.) Interventions were administered according to "Endocrine Society Clinical Practice Guidelines."[31] Their analyses found *no statistically significant changes* in the group undergoing puberty suppression on any of the nine measures of wellbeing measured, spanning tests of body satisfaction, depressive symptoms, or anxiety symptoms.[32] (Although the authors reported detecting some improvements, these were only found when the large group undergoing cross-sex hormone treatment were added in.) Although the Dutch Approach includes age 12 as a minimum for puberty suppression treatment, this team

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29 Carmichael, *et al.*, 2021.
30 Kuper, *et al.*, 2020.
31 Kuper, *et al.*, p. 3, referring to Hembree, *et al.*, 2017.
32 Kuper, *et al.*, 2020, Table 2.

provided such treatment beginning at age 9.8 years (full range: 9.8–14.9 years).[33]

52. Achille, *et al.* (2020) at Stony Brook Children's Hospital in New York treated a sample of 95 youth with gender dysphoria, providing follow-up data on 50 of them. (The report did not indicate how these 50 were selected from the 95.) As well as receiving puberty blocking medications, "Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional."[34] The puberty blockers themselves "were introduced in accordance with the Endocrine Society and the WPATH guidelines."[35] Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, "*most predictors did not reach statistical significance*."[36] Moreover, "the numbers are too small to parse out the effects of pubertal suppression versus cross sex hormone therapy in the different genders."[37]

53. In a recent update, the Dutch clinic reported continuing to find improvement in transgender adolescents' psychological functioning, reaching age-typical levels, "after the start of specialized transgender care involving puberty suppression."[38] Unfortunately, because the transgender care method of that clinic involves both psychosocial support and puberty suppression, it cannot be known which of those (or their combination) is driving the improvement. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. As the study authors themselves noted, "The present study can, therefore, not provide evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes."[39]

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33 Kuper, *et al.*, 2020, p. 4.
34 Achille, *et al.*, 2020, p. 2.
35 Achille, *et al.*, 2020, p. 2.
36 Achille, *et al.*, 2020, p. 3, italics added.
37 Achille, *et al.*, 2020, p. 4.
38 van der Miesen, *et al.*, 2020, p. 699.
39 van der Miesen, *et al.*, 2020, p. 703.

54. It has not yet been determined why the successful outcomes reported by the Dutch child gender clinic failed to emerge when applied by others. It is possible that:

(1) The Dutch Approach itself does *not* work and that their originally successful results were a fluke;

(2) The Dutch Approach *does* work, but only in the Netherlands, with local cultural, genetic, or other unrecognized factors that do not generalize to other countries;

(3) The Dutch Approach itself *does* work, but that other clinics and individual clinicians are removing safeguards and adding short-cuts to the approach, and those changes are hampering success.

(4) The Dutch Approach *does* work, but that the cause of the improvement is the psychosocial support, rather than any medical intervention, which other clinics are *not* providing.

55. The failure of other clinics to repeat the already very qualified success of the Dutch clinic demonstrates the need for still greater caution before endorsing transition and the greater need to resolve potential mental health obstacles before doing so. Although there do exist authors citing only the positive from among these research findings, Dr. Josephson's explicit cautions in his presentation are consistent with the complete content of the scientific literature.

d. Affirmation vs. Affirmation-Only and Affirmation-on-Demand: Social Transition in Childhood (pre-puberty)

56. Colloquially, affirmation refers broadly to any actions that treat the person as belonging to a new gender. In different contexts, that could apply to social actions (use of a new name and pronouns), legal actions (changes to birth certificates), or medical actions (hormonal and surgical interventions). That is, social transition, legal transition, and medical transition (and subparts thereof) need not, and rarely do, occur at the same time. In practice, there are cases in which a child has socially only partially transitioned, such as presenting as one gender at home and another at school or presenting as one gender with one custodial parent and another gender with the other parent.

57. Referring to "affirmation" as a treatment approach is ambiguous: Although often used in public discourse to take advantage of the positive connotations of the

term, it obfuscates what exactly is being affirmed. This often leads to confusion, such as quoting a study of the benefits and risks of social affirmation in a discussion of medical affirmation, where the appearance of the isolated word "affirmation" refers to entirely different actions.

58. It is also an error to divide treatment approaches into affirmative versus non-affirmative. As noted already, the widely adopted Dutch Approach (and the guidelines of the multiple professional associations based on it) cannot be said to be either: It is a staged set of interventions, wherein social affirmation (and puberty blocking) may begin at age 12 and cross-sex hormonal and other medical interventions, later.

59. The false dichotomy categorizing interventions into affirmative versus non-affirmative typically occurs within polarized debates, where one side espouses affirmation-on-demand for all (or nearly all) cases and mischaracterizes any delay, including the watchful waiting period of the Dutch Approach—to constitute non-affirmation and a denial of "rights." Legitimate debate can (and should) be had regarding what ages or other developmental indicators would best guide clinical decision-making. Because almost all approaches discussed include affirmation, the most extreme is not accurately called the affirmation approach, but rather affirmation-*on-demand*.

60. There do not exist any prospective outcomes research on the Affirmation-on-Demand approach. All existing studies pertain to the step-wise use of affirmation, within a gate-keeper model, and with professionals diverting cases with other mental health issues or counter indicators as necessary. There have been attempts to use non-prospective research designs to demonstrate effects of prepubertal social transition. Although these studies are often cited as evidence of the benefits of early social transition, how the studies were conducted make them entirely unable to show what they are claimed to support. That is, non-prospective studies are being cited as if they

were prospective.

61. Olsen and colleagues used a novel research design, studying children recruited from the TransYouth Project—a convenience sample of socially transitioned youth and families, recruited by word of mouth and interested in participating in research. There were three groups of children for comparison: (i) children who had already socially transitioned, (ii) their siblings, and (iii) children in a university database of families interested in participating in child development research. As noted by the study authors, "For the first time, this article reports on socially transitioned gender children's mental health as reported by the children."[40] Reports from parents were also recorded.[41] In contrast, no reports or ratings were provided by any mental health care professional or researcher at all. That is, although adding self-assessments to the professional assessments might indeed provide novel insights, this project did not add self-assessment to professional assessment. Rather, it replaced professional assessment with self-assessment.

62. It is well established in the field of psychology that participant self-assessment can be severely unreliable for multiple reasons. For example, one well-known phenomenon in psychological research is known as "socially desirable responding"—the tendency of subjects to give answers that they believe will make themselves look good, rather than accurate answers. Specifically, subjects' reports that they are enjoying good mental health and functioning well could reflect the subjects' desire to be *perceived* as healthy and to have made good choices, rather than reflecting their actual mental health.

63. In their analyses, the study reported finding no significant differences between the transgender children, their non-transgender siblings, or the community controls. As the authors noted, "[t]hese findings are in striking contrast to previous

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40 Durwood, *et al*., 2016, p. 121, italics added.
41 *See* Olson, *et al*. (2016).

work with gender-nonconforming children who had not socially transitioned, which found very high rates of depression and anxiety."[42] The authors are correct to note that their result contrasts with the previous research, but they do not discuss that this could reflect a problem with the novel research design they used: The subjective self-reports of the children and their parents' reports may not be reflecting reality objectively, as professional researchers would. Because the study did not employ any method to detect and control for participants indulging in "socially desirable responding" or acting under other biasing motivations, this possibility cannot be assessed or ruled out.

64. Because this was a single-time study relying on self-reporting, rather than a before-and-after transition study relying on professional evaluation, it is not possible to know if the children reported as well-functioning are in fact well-functioning, nor if so whether they are well-functioning because they were permitted to transition, or whether instead the fact is that they were already well-functioning and therefore permitted to transition. Finally, because the TransYouth project lacks a prospective design, it cannot be known how many cases attempted transition, reacted poorly, and then detransitioned, thus never having entered into the study in the first place.

e. "Conversion Therapy"

65. There exist writers who have denounced all attempts to address mental health concerns *before* undergoing transition as "conversion therapy." The term makes no sense in this context. The purpose of the mental health support provided during the "watchful waiting" period before puberty is to address all the other mental health issues—anxiety, depression, drug use, etc. Clinical improvement in mental health is itself the purpose and would be deemed a success regardless of whether it resulted in a transgender child better prepared for the stresses of transition to come or a cis-gender child now ready to take on new challenges.

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[42] Durwood, *et al.*, 2017, p. 116.

66. Indeed, in the context of gender dysphoric children, "conversion therapy" is an oxymoron. It simply makes no sense to refer to externally induced conversion among gender dysphoric children, as this appears to be the usual outcome *regardless* of any attempt to change them.

3. Adolescent-Onset Gender Dysphoria

67. A third profile has begun to present to clinicians or socially, characteristically distinct from the previously identified ones.[43] Unlike adult-onset gender dysphoria (and also unlike childhood-onset, *see supra* Part III.B.2), this group is predominately biologically female. This group first presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is this feature which led to the term Rapid Onset Gender Dysphoria (ROGD).[44] The majority of cases appear to occur within clusters of peers and in association with increased social media use[45] and especially among people with autism or other neurodevelopmental or psychiatric disorders.[46]

68. It cannot be easily determined whether the self-reported gender dysphoria is a result of other underlying issues or if those mental health issues are the result of the stresses of being a stigmatized minority.[47] *See infra* Part III.C (discussing mental health). Importantly, and unlike other presentations of gender dysphoria, "coming out" in this group was often (47.2%) associated with *declines* rather than improvements in mental health.[48] Although long-term outcomes have not yet been reported, these distinctions argue against generalizing findings from the other types of gender dysphoria to this one.

69. There do not yet exist prospective outcomes studies for medical interventions for people with this presentation. At least, no study has yet been organized in

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43 Kaltiala-Heino, *et al.*, 2015; Littman, 2018.
44 Littman, 2018.
45 Littman, 2018.
46 Kaltiala-Heino, *et al.*, 2015; Littman, 2018; Warrier et al., 2020.
47 Boivin, *et al.*, 2020.
48 Biggs, 2020; Littman, 2018.

such a way as to allow for an analysis of this group, as distinct from childhood-onset or adult-onset cases. Many of the newer clinics (not the original clinics systematically tracking and reporting on their case results) fail to distinguish between people who had childhood-onset gender dysphoria and have aged into adolescence and people whose onset was not until adolescence. Similarly, there are clinics failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria. Studies selecting groups according to their current age instead of their ages of onset can produce only confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

C. Dr. Josephson's views regarding the importance of addressing mental health co-morbidities before deciding questions of transition are well supported by science and professional standards.

70. The role of mental illness in gender dysphoria is central to providing appropriate and effective care. Dr. Josephson's comments included noting the very high rates of mental health concerns among gender dysphoric youth. His statements in this regard were accurate. As demonstrated by the research summarized below, psychiatric issues are repeatedly observed to be present in the majority of samples seeking transition services, not only among gender dysphoric youth, but also for people with gender dysphoria of all age groups.

71. The need to address mental health concerns—and to do so *before* embarking on a gender transition—was also emphasized in Dr. Josephson's comments. That very protocol appears ubiquitously across medical associations providing such standards. *See infra* Part V (reviewing comprehensively medical associations' statements).

72. Many claims published about mental health among people with gender dysphoria pertain to suicidality—variously referring to suicidal ideation, threats, attempts, or actual completed suicides. The role of suicide in mental health is not itself

straight-forward, sometimes reflecting severe depression and hopelessness and sometimes reflecting emotionally manipulative gestures in persons with substantial histories of self-harm. *See infra* Part IV.B (reviewing suicidality).

73. The research evidence on mental illness in gender dysphoria indicates it to be different between adult-onset versus adolescent-onset versus prepubescent-onset types. Although childhood-onset cases are the most directly relevant to the present proceedings, those findings are best understood in the context of what is known about the other age groups. Therefore, those findings are also summarized briefly.

1. Mental Illness in Adult-Onset Gender Dysphoria

74. The co-occurrence of psychiatric illness with gender dysphoria in adults is widely recognized and widely documented.[49] A research team in 2016 published a comprehensive and systematic review of all studies examining rates of mental illness in transgender adults.[50] There were 38 studies in total. The review indicated that many studies were methodologically weak, but nonetheless concluded that (1) rates of mental illness among people are highly elevated, and (2) rates of psychopathology decreased on average among those who completed transition. Analyses were not conducted in a way so as to compare the elevation in mental illness observed among people newly attending clinics to improvement after transition. Also, several studies showed more than 40% of patients becoming "lost to follow-up." With attrition rates that high, it is unclear to what extent the information from the available participants genuinely reflects the whole sample.

75. In a survey of the board-certified psychiatrists in the Netherlands, 186 respondents answered questions about their experiences with a total of 584 cross-gender identified patients. The survey indicated: "In 270 (75%) of these 359 patients, cross-gender identification was interpreted as *an epiphenomenon of other psychiatric*

[49] *See, e.g.*, Hepp, *et al.*, 2005.
[50] Dhejne, *et al.*, 2016.

illnesses, notably personality, mood, dissociative, and psychotic disorders."[51] The survey also asked about the age at which individuals should be permitted to transition. Acknowledging on the one hand that the Netherlands may have social attitudes differing from the United States and on the other hand that such attitudes may have shifted since this 2003 survey, the results nonetheless indicated: "[T]here is little consensus, at least among Dutch psychiatrists, about diagnostic features of gender identity disorder or about the minimum age at which sex reassignment therapy is a safe option."[52]

76. More recently, an international consortium of gender clinics formed the European Network for the Investigation of Gender Incongruence, spanning the Netherlands, Belgium, Germany, and Norway.[53] They recorded systematically on all adult patients evaluated at any of the clinics, totaling 305 participants over a three-and-a-half year period. Rather than rely on self-descriptor narratives, degree of gender dysphoria experience was measured with the Utrecht Gender Dysphoria Scale (UGDS).[54] The presence of psychiatric disorders was assessed with two standard instruments, the Mini International Neuropsychiatric Interview—Plus and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders. When tabulated, "Almost 70% of the final sample of 305 participants show one or more Axis I disorders current and lifetime,"[55] which were primarily affective disorders (such as depression) and anxiety disorders.

77. An important caution applies to interpreting these results: These very high proportions of mental illness come from people who are attending a clinic for the first time and are undergoing assessment. Clinics serving a "gate-keeper" role diverted candidates with mental health issues away from medical intervention. The side-effect

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51 Campo, *et al.*, 2003, p. 1332, italics added.
52 Campo, *et al.*, 2003, p. 1332.
53 Heylens, *et al.*, 2014, p. 152.
54 Cohen-Kettenis & van Goozen, 1997.
55 Cohen-Kettenis & van Goozen, 1997, page 152.

of gate-keeping is that if a researcher compared the average mental health of individuals coming into the clinic with the average mental health of individuals after medical transition, then there would seem to have been a substantial improvement, even though transition had no effect at all: The removal of people with poorer mental health can create the statistical illusion of improvement among the remaining people.

2. Mental Illness in Adolescent-Onset Gender Dysphoria

78. In 2019, a Special Section of the *Archives of Sexual Behavior* was published: "Clinical Approaches to Adolescents with Gender Dysphoria." It included this brief yet thorough summary of rates of mental illnesses among adolescents expressing gender dysphoria by Dr. Aron Janssen, of the Department of Child and Adolescent Psychiatry of New York University:[56] The literature varies in the range of percentages of adolescents with co-occurring disorders. The range for depressive symptoms ranges was 6–42%,[57] with suicide attempts ranging 10 to 45%.[58] Self-injurious thoughts and behaviors range 14–39%.[59] Anxiety disorders and disruptive behavior difficulties including Attention Deficit/Hyperactivity Disorder are also prevalent.[60] Gender dysphoria also overlaps with Autism Spectrum Disorder.[61]

79. There is one mental illness of specific concern in the context of adolescent onset gender dysphoria, *Borderline Personality Disorder* (BPD). The DSM criteria for BPD are:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
> 2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devalu-

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56 Janssen, *et al.*, 2019.
57 Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013; Wallien, *et al.*, 2007.
58 Mustanski et al., 2015.
59 Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013.
60 de Vries, *et al.*, 2011; Mustanski, *et al.*, 2010; Wallien, *et al.*, 2007.
61 de Vries, *et al.*, 2010; Jacobs, *et al.*, 2014; Janssen, *et al.*, 2016; May, *et al.*, 2016; Strang, *et al.*, 2014, 2016.

ation.

3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Italics added.)

80. It is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria are actually cases of BPD. That is, some people may be misinterpreting their experiences to represent a gender identity issue, when it instead represents the "identity disturbance" noted in symptom Criterion 3. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence, is substantially more common among biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people. Thus, if even only a portion of people with BPD had an 'identity disturbance' that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.

81. A primary cause for concern is symptom Criterion 5: recurrent suicidality. Regarding the provision of mental health care, this is a crucial distinction: A person with BPD going undiagnosed will not receive the appropriate treatments (the currently most effective of which is Dialectical Behavior Therapy). A person with a cross-gender identity would be expected to feel relief from medical transition, but someone

with BPD would not: The problem was not about *gender* identity, but about having an *unstable* identity. Moreover, after a failure of medical transition to provide relief, one would predict for these people increased levels of hopelessness and increased risk of suicidality. One would predict also that misdiagnoses would occur more often if one reflexively dismissed or discounted symptoms of BPD as responses to "minority stress." *See infra* Part III.C.4 (discussing minority stress).

82. Regarding research, there have now been several attempts to document rates of suicidality among gender dysphoric adolescents. *See infra* Part IV.B. The scientific concern presented by BPD is that it poses a potential confound: samples of gender dysphoric adolescents could appear to have elevated rates of suicidality, not because of the gender dysphoria (or transphobia in society), but because of the number of people with BPD in the sample.

3. Mental Illness in Childhood-Onset Gender Dysphoria

83. Elevated rates of multiple mental illnesses among gender dysphoric children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed 52% fulfilled criteria for a DSM axis-I disorder.[62] A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, but a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment instruments (Child Behavior Check List, or CBCL) demonstrated that the average score was in the clinical rather than healthy range, among children in both clinics.[63] When expressed as percentages, among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample were in the clinical range.

84. A systematic, comprehensive review of all studies of Autism Spectrum Dis-

[62] Wallien, *et al.*, 2007.
[63] Cohen-Kettenis, *et al.*, 2003.

orders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children was recently conducted. It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD I youth with gender dysphoria. Studies reviewing medical records of children and adolescents referred to gender clinics showed 5–26% to have been diagnosed with ASD.[64] Moreover, those authors gave specific caution on the "considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results."[65] The rate of ADHD among children with GD was 8.3–11%. Conversely, in data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported "gender variance."[66]

4. Dr. Josephson's observations that the negative mental health of children with gender dysphoria cannot be sufficiently explained by social stigma is well supported by the available science.

85. Dr. Josephson's panel comments included that stigma was not a sufficient explanation for the all the mental health issues observed among children with gender dysphoria. The research evidence supports him in this assertion.

86. The elevated levels of mental health problems among lesbian, gay, and bisexual populations is a well-documented phenomenon, and the idea that it is caused by living within a socially hostile environment is called the *Minority Stress Hypothesis*.[67] The association is not entirely straight-forward, however. For example, although lesbian, gay, and bisexual populations are more vulnerable to suicide ideation overall, the evidence specifically on adult lesbian and bisexual women is unclear. Meyer did not include transgender populations in originating the hypothesis, and it remains a legitimate question to what extent and in what ways it might apply to

64 Thrower, *et al.*, 2020.
65 Thrower, *et al.*, 2020, p. 703.
66 Janssen, *et al.*, 2016.
67 Meyer, 2003.

gender identity.

87. Minority stress is associated, in large part, with being a visible minority. There is little evidence that transgender populations show the patterns suggested by the hypothesis. For example, the minority stress hypothesis would predict differences according to how visibly a person is discernable as a member of the minority, which often changes greatly upon transition. Biological males who are very effeminate stand out throughout childhood, but can successfully blend in as adult females; whereas the adult onset transitioners blend in very much as heterosexual cis-gendered males during their youth and begin visibly to stand out in adulthood, only for the first time.

88. Also suggesting minority stress cannot be the full story is that the mental health symptoms associated with minority stress do not entirely correspond with those associated with gender dysphoria. The primary symptoms associated with minority stress are depressive symptoms, substance use, and suicidal ideation.[68] The symptoms associated with gender dysphoria indeed include depressive symptoms and suicidal ideation, but also includes anxiety symptoms, Autism Spectrum Disorders, and personality disorders.

IV. Scientific Claims Assessed

A. Assessment of Claims that All Childhood Outcome Studies Are Wrong

89. There exist authors asserting and re-asserting that the entire set of prospective outcomes studies on prepubescent children is wrong; that desistance is not, in fact, the usual outcome for gender dysphoric children; and that results from various retrospective studies are the more accurate picture.[69] As indicated in the responses published from authors of several prospective outcomes studies (and as summarized below), the arguments are not at all valid.[70]

90. There have been accusations that some of the prospective outcome studies

[68] Meyer, 2003.
[69] Temple Newhook, *et al*., 2018; Winters, *et al*., 2018.
[70] Steensma, *et al*., 2018; Zucker, *et al*. 2018.

(see Appendix 2 for a full list) are old. This criticism would be valid only if newer studies showed different results from the older studies; however, the findings of desistance are the same, indicating that age of the studies is not, in fact, a factor.

91. There have been accusations that some studies failed to use a DSM diagnosis, and should therefore be rejected. That would be a valid criticism only if studies using the DSM showed different results from studies not using the DSM. Because both kinds of studies showed the same results, one may conclude that DSM status was not a factor, even if using a DSM diagnosis would have been a preferred method.

92. There have been criticisms that some studies are too small to provide a reliable result. It is indeed true that if larger studies showed different results from the smaller studies, we would tend to favor the results of the larger studies. Because the smaller studies came to the same conclusion as the larger studies, however, the criticism is, once again, entirely moot.

93. There have been accusations that studies did not use the current DSM-5 as their method of diagnosing gender dysphoric children. This criticism would be valid only if there existed any studies using the DSM-5 against which to compare the existing studies. The DSM-5 is still too recent for there yet to have been long-term follow-up studies. It can be seen, however, that the outcome studies are the same across the DSM-III, DSM-III-R, DSM-IV, and DSM-IV-TR.

94. In science, there cannot be any such thing as a perfect study. Especially in medical research, where we cannot manipulate people in ways that would clear up difficult questions, all studies will have a fault. In science, we do not, however, reject every study with any identifiable short-coming—rather, we gather a diversity of observations, made with their diversity of compromises to safety and ethics (and time and cost, etc.), and tentatively accept the most parsimonious (simplest) explanation of the full set, weighting each study according to their individual strengths and weaknesses.

B. Assessment of Claims of Suicidality

95. The polarized context of gender dysphoria has led to the use of increasingly hyperbolic claims and terms. Typically, as part of an emotion-based effort to effect behavior change, reports of suicidality have been rhetorically weaponized, scarcely representing the content of the research literature.

96. Despite the frequency with which writers refer to "suicidality," few explicate what they mean by the term. The research literature distinguishes importantly among suicidal ideation (which may range from fleeting to chronic), suicide gestures and attempts (which may range from expressions of cries for help range to actual intents to die), threats (which may or may not be sincere or involve lethal means), and actual deaths by suicide.

97. The scientific study of suicide is inextricably link to that of mental illness. For example, as noted in the preceding, suicidality is a well-documented symptom of Borderline Personality Disorder (as are chronic identity issues), and personality disorders are highly elevated among transgender populations, especially adolescent-onset. Thus, the elevations of suicidality among gender dysphoric adolescents may not be a result of anything related to transition (or lack of transition), but to the overlap with mental illnesses of which suicidality is a substantial part. Conversely, improvements in suicidality reported in some studies may not be the result of anything related to transition, but rather to the concurrent general mental health support which is reported by the clinical reported prospective outcomes. Studies that include more than one factor at the same time without accounting for each other represent a "confound," and it cannot be known which factor (or both) is the one causing the effects observed. That is, when a study provides both mental health services and medical transition services at the same time, it cannot be known which (or both) is what caused any changes.

98. Overall, rates of suicidal ideation and suicidal attempts appear to be re-

lated—not to transition status—but to the social support received: The research evidence shows that support decreases suicidality, but that transition itself does not. Indeed, in some situations, social support was associated with increased suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support.[71]

V. Statements from Professional Associations

99. The value of position statements from professional associations should be neither over- nor underestimated. In the ideal, an organization of licensed health care professionals would convene a panel of experts who would systematically collect all the available evidence about an issue, synthesizing it into recommendations or enforceable standards for clinical care, according to the quality of the evidence for each alternative. For politically neutral issues, with relevant expertise contained among association members, this ideal can be readily achievable. For controversial issues with no clear consensus, the optimal statement will summarize each perspective and explicate the strengths and weaknesses of each, providing relatively reserved recommendations and suggestions for future research that might resolve the continuing questions. Several obstacles can hinder that goal, however. Committees within professional organizations are typically volunteer activities, subject to the same internal politics of all human social structures. That is, committee members are not necessarily committees of experts of a topic—they are often committees of generalists handling a wide variety of issues or members of an interest group who feel strongly about political implications of an issue, instead of scientists engaged in the objective study of the topic.

100. Thus, documents from professional associations may represent required standards, the violation of which may merit sanctions, or may represent only recommendations or guidelines. A document may represent the views of an association's

[71] Bauer, *et al*. (2015).

full membership or only of the committee's members (or majorities thereof). Documents may be based on systematic, comprehensive reviews of the available research or selected portions of the research. In sum, the weight best placed on any association's statement is the amount by which that association employed evidence versus other considerations in its process.

101. In the presently highly politicized context, official statements of professional associations have been widely misrepresented. At the end of the Heritage panel discussion in which Dr. Josephson participated, audience member Zack Ford made a claim I have seen frequently on social and in mainstream media: "You all have beliefs that stand in stark contradiction to almost all of the major medical organizations." That claim is demonstrably untrue.

102. In preparing the present report, I searched the professional research literature for documentation of statements from these bodies and from my own files, for which I have been collecting such information for many years. I was able to identify statements from six such organizations (below). Although not strictly a medical association, the World Professional Association for Transgender Health (WPATH) also distributed a set of guidelines in wide use and on which other organizations' guidelines are based.

Association	**Acronym**	**Statement Publication Date**
American Academy of Pediatrics	AAP	2018
Endocrine Society (and Pediatric Endocrine Society)	ES/PES	2017 (2020)
American College of Obstetricians & Gynecologists	ACOG	2017
American College of Physicians	ACP	2015
American Academy of Child and Adolescent Psychiatry	AACAP	2012

Association	Acronym	Statement Publication Date
European Society for Pediatric Endocrinology & Lawson Wilkins Pediatric Endocrine Society	ESPE-LWPES	2009
World Professional Association for Transgender Health	WPATH	2011/2012

103. The professional associations statements addressed different subsets of the various aspects of transition. Nonetheless, with the broad exception of the American Academy of Pediatrics (AAP),[72] the statements repeatedly noted:

- Desistance of gender dysphoria occurs in the majority of prepubescent children.
- Mental health issues need to be assessed as potentially contributing factors and need to be addressed before transition.
- Puberty-blocking medication is an experimental, not a routine, treatment.
- Social transition is not generally recommended until after puberty.

Although some other medical associations have published broad statements of moral support for sexual minorities and against discrimination, they did not include any specific standards or guidelines regarding medical- or transition-related care.

104. Notably, despite that all these medical associations reiterate the need for mental health issues to be resolved before engaging in medical transition, only the AACAP members have medical training in mental health. The other medical specialties include clinical participation with this population, but their assistance in transition generally assumes the mental health aspects have already been assessed and treated beforehand.

105. I was unable to identify any statement from Dr. Josephson that contradicted the major medical associations, with the exception of the AAP, which itself contradicted all the other major medical associations. That is, AAP appears to be the only major medical association advocating an affirmation-only approach, despite the

[72] Rafferty, *et al.*, 2018.

lack of any objective evidence justifying their departure. I review each of these statements by professional organizations below.

A. World Professional Association for Transgender Health (WPATH)—2011

106. The WPATH standards as they relate to prepubescent children begin with the acknowledgement of the known rates of desistance among gender dysphoric children:

> [I]n follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).[73]

107. That is, "In most children, gender dysphoria will disappear before or early in puberty."[74]

108. Dr. Josephson's comments about the mental health of gender dysphoric children were entirely consistent with the WPATH standards, including the need to "[a]ssess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment)."[75] Indeed, the WPATH standards agree explicitly with Dr. Josephson's expressed purpose: "The role of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses."[76]

109. Although WPATH does not refer to puberty blocking medications as "experimental," the document indicates the non-routine, or at least inconsistent availability of the treatment:

> Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs

[73] Coleman, *et al.*, 2012, p. 172.
[74] Coleman, *et al.*, 2012, p. 173.
[75] Coleman, *et al.*, 2012, p. 174.
[76] Coleman, *et al.*, 2012, p. 180.

> among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre, van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press).[77]

110. WPATH neither endorses nor proscribes social transitions before puberty, instead recognizing the diversity among families' decisions:

> Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.[78]

111. It does caution, however, "Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria."[79]

B. Endocrine Society (ES)—2017

112. The 150,000-member Endocrine Society appointed a nine-member task force, plus a methodologist and a medical writer, who commissioned two systematic reviews of the research literature and, in 2017, published an update of their 2009 recommendations, based on the best available evidence identified. The guideline was co-sponsored by the American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Paediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society (PES), and the World Professional Association for Transgender Health (WPATH).

113. The document acknowledged the frequency of desistance among gender dysphoric children:

> Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence. . . . In adolescence, a significant number of these desisters identify as homosexual or bisexual.[80]

114. The statement similarly acknowledges inability to predict desistance or persistence, "With current knowledge, we cannot predict the psychosexual outcome

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77 Coleman, *et al.*, 2012, p. 173.
78 Coleman, *et al.*, 2012, p. 173.
79 Coleman, *et al.*, 2012, p. 176 (quoting Drummond, *et al.*, 2008; Wallien & Cohen-Kettenis, 2008).
80 Hembree, *et al.*, 2017, p. 3876.

for any specific child."[81]

115. Although outside their area of professional expertise, mental health issues were also addressed by the Endocrine Society, repeating the need to handle such issues before engaging in transition, "In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues."[82] This ordering—to address mental health issues before embarking on transition—avoids relying on the unproven belief that transition will solve such issues.

116. The Endocrine Society did not endorse any affirmation-only approach. The guidelines were neutral with regard to social transitions before puberty, instead advising that such decisions be made only under clinical supervision: "We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional."[83]

117. Among his contributions to the panel, Dr. Josephson related a disagreement he had with a colleague regarding clinical judgments about clients' thoughts about transition. The Endocrine Society guidelines side with Dr. Josephson, making explicit that, after gathering information from adolescent clients seeking medical interventions and their parents, the clinician "provides correct information to prevent unrealistically high expectations [and] assesses whether medical interventions may result in unfavorable psychological and social outcomes."[84]

C. Pediatric Endocrine Society and Endocrine Society (ES/PES)—2020

118. In 2020, the 1500-member Pediatric Endocrine Society partnered with the Endocrine Society to create and endorse a brief, two-page position statement.[85] Although strongly worded, the document provided no specific guidelines, instead

[81] Hembree, *et al.*, 2017, p. 3876.
[82] Hembree, *et al.*, 2017, 3877.
[83] Hembree, *et al.*, 2017, p. 3872.
[84] Hembree, *et al.*, 2017, p. 3877.
[85] PES, online; Pediatric Endocrine Society & Endocrine Society, 2020, December 15.

deferring to the Endocrine Society guidelines.[86]

119. It is not clear to what extent this endorsement is meaningful, however. According to the PES, the Endocrine Society "recommendations include evidence that treatment of gender dysphoria/gender incongruence is medically necessary and should be covered by insurance."[87] However, the Endocrine Society makes neither statement. Although the two-page PES document mentioned insurance coverage four times, the only mention of health insurance by the Endocrine Society was: "If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action."[88] Despite the PES asserting it as 'medically necessary', the Endocrine Society stopped short of that. Its only use of that phrase was instead limiting: "We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being."[89]

120. Thus, Dr. Josephson's comments, including those about evaluating child clients' thinking and the need to resolve mental health issues before transition, are entirely consistent also with the guidelines of the Pediatric Endocrine Society.

D. American Academy of Child & Adolescent Psychiatry (AACAP)—2012

121. The 2012 statement of the American Academy of Child & Adolescent Psychiatry (AACAP) is not an affirmation-only policy. It notes:

> Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects. . . . In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least

86 Hembree, *et al.*, 2017.
87 PES, online, p. 1.
88 Hembree, *et al.*, p. 3883.
89 Hembree, *et al.*, p. 3872, repeated on p. 3894.

> until the wish to change sex is unequivocal, consistent, and made with appropriate consent.[90]

122. The AACAP's language repeats the description of the use of puberty blockers only as an exception "For situations in which deferral of sex reassignment decisions until adulthood is *not clinically feasible*, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues."[91]

123. The AACAP statement acknowledges the long-term outcomes literature for gender dysphoric children: "In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood,"[92] adding that "[c]linicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality."[93]

124. The policy similarly includes a provision for resolving mental health issues: "Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and *treatment of associated mental health problems*."[94] The document also includes minority stress issues and the need to deal with mental health aspects of minority status (*e.g.*, bullying).[95]

125. Rather than endorse social transition for prepubertal children, the AACAP indicates: "There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender discordant children to school in their desired gender. Such decisions must be made based on clinical judg-

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90 Adelson & AACAP, 2012, p. 969.
91 Adelson & AACAP, 2012, p. 969, italics added.
92 Adelson & AACAP, 2012, p. 963.
93 Adelson & AACAP, 2012, p. 968.
94 Adelson & AACAP, 2012, p. 970, italics added.
95 Adelson & AACAP, 2012, p. 969.

ment, bearing in mind the potential risks and benefits of doing so."

E. American College of Obstetricians & Gynecologists (ACOG)—2017

126. The American College of Obstetricians & Gynecologists (ACOG) published a "Committee Opinion" expressing recommendations in 2017. The statement indicates it was developed by the ACOG's Committee on Adolescent Health Care, but does not indicate participation based on professional expertise or a systematic method of objectively assessing the existing research. It includes the disclaimer: "This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed."[96]

127. Prepubertal children do not typically have clinical contact with gynecologists, and the ACOG recommendations include that the client additionally have a primary health care provider.

128. The ACOG statement cites the statements made by other medical associations—ESPE, PES, and the Endocrine Society—and by WPATH. It does not cite any professional association of *mental* health care providers, however. The ACOG recommendations repeat the previously mentioned eligibility/readiness criteria of having no psychiatric illness that would hamper diagnosis and no psychiatric (or other medical) contraindications to treatment. It notes that "*before* any treatment is undertaken, the patient must display eligibility and readiness (Table 1), meaning that the adolescent has been evaluated by a mental health professional, has no contraindications to therapy, and displays an understanding of the risks involved."[97] Dr. Josephson's comments are entirely in line with this recommendation.

129. The "Eligibility and Readiness Criteria" also include, "Diagnosis established for gender dysphoria, transgender, transsexualism."[98] This standard, requir-

[96] ACOG, 2017, p. 1.
[97] ACOG, 2017, p. 3 (citing the Endocrine Society guidelines, italics added).
[98] ACOG, 2017, Table 1, p. 3.

ing a formal diagnosis, forestall affirmation-on-demand because self-declared self-identification is not sufficient for DSM diagnosis.

130. ACOG's remaining recommendations pertain only to post-transition, medically oriented concerns. Pre-pubertal social transition is not mentioned in the document, and the outcomes studies of gender dysphoric (prepubescent) children are not cited.

F. American College of Physicians (ACP)—2015

131. The American College of Physicians published a position paper broadly expressing support for the treatment of LGBT patients and their families, including nondiscrimination, antiharassment, and defining "family" by emotional rather than biological or legal relationships in visitation policies, and the inclusion of transgender health care services of public and private health benefit plans.[99]

132. ACP did not provide guidelines or standards for child or adult gender transitions. The policy paper opposed attempting "reparative therapy;" however, the paper confabulated sexual orientation with gender identity in doing so. That is, on the one hand, ACP explicitly recognized that "[s]exual orientation and gender identity are inherently different."[100] It based this statement on the fact that "the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change *sexual orientation*."[101] The APA's document, entitled "Report of the American Psychological Task Force on appropriate therapeutic responses to *sexual orientation*" (italics added) does not include or reference research on gender identity. Despite citing no research about transgenderism, the ACP nonetheless included in its statement: "Available research does not support the use of reparative therapy as an effective method in the treatment of LGB*T* persons."[102] That is, the inclusion of "T" with "LGB" is based on something other than the existing evidence.

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99 Daniel & Butkus, 2015a, 2015b.
100 Daniel & Butkus, 2015b, p. 2.
101 Daniel & Butkus, 2015b, p. 8, italics added.
102 Daniel & Butkus, 2015b, p. 8, italics added.

133. There is another statement,[103] which was funded by ACP and published in the Annals of Internal Medicine under its "*In the Clinic*" feature, noting that "'In the Clinic' does not necessarily represent official ACP clinical policy."[104] The document discusses medical transition procedures for adults rather than for children, except to note that "no medical intervention is indicated for prepubescent youth,"[105] "a mental health provider can assist the child and family with identifying an appropriate time for a social transition,"[106] and that "the child should be assessed and managed for coexisting mood disorders during this period because risk for suicide is high than in their cisgender peers."[107]

134. I could find no contradictions between Dr. Josephson's comments and the content of these documents.

G. American Academy of Pediatrics (AAP)—2018

135. The policy of the American Academy of Pediatrics (AAP) is unique among the major medical associations in being the only one to endorse an affirmation-on-demand policy, including social transition before puberty without any watchful waiting period. Although changes in recommendations can obviously be appropriate in response to new research evidence, the AAP provided none. Rather, the research studies AAP cited in support of its policy simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting.[108] Moreover, of all the outcomes research published, the AAP policy cited *none*.

136. I conducted a point-by-point fact-check of the claims asserted in the AAP policy and the references it cited in support of them. I submitted it to the *Journal of Sex & Marital Therapy*, a well-known research journal of my field, where it under-

[103] Safer & Tangpricha, 2019.
[104] Safer & Tangpricha, 2019, p. ITC1.
[105] Safer & Tangpricha, 2019, p. ITC9.
[106] Safer & Tangpricha, 2019, p. ITC9.
[107] Safer & Tangpricha, 2019, p. ITC9.
[108] Cantor, 2020.

went blind peer review and was published. I append that article as part of this report. See Appendix 3.

137. A great deal of published attention ensued; however, the AAP has yet to respond to the errors I demonstrated in its policy. Writing for *The Economist* about the use of puberty blockers, Helen Joyce asked AAP directly, "Has the AAP responded to Dr Cantor? If not, have you any response now?" The AAP Media Relations Manager, Lisa Black, emailed: "We do not have anyone available for comment."

H. The ESPE-LWPES GnRH Analogs Consensus Conference Group—2009

138. Included in the interest of completeness, there was also a collaborative report in 2009, between the European Society for Pediatric Endocrinology (ESPE) and the Lawson Wilkins Pediatric Endocrine Society (LWPES). Thirty experts were convened, evenly divided between North American and European labs and evenly divided male/female, who comprehensively rated the research literature on gonadotropin-release hormone analogs in children.

139. The effort concluded that "[u]se of gonadotropin-releasing hormone analogs for conditions other than central precocious puberty requires additional investigation and cannot be suggested routinely." However, gender dysphoria was not explicitly mentioned as one of those other conditions.

VI. Conclusions

140. In sum, the research literature consists of a relatively small number of studies on a diverse phenomenon, which show mixed results from potential treatments (and non-treatment). Many debates, both public and professional ones, repeatedly provided only selected portions of these findings, thus misrepresenting the state of the science to appear one-sided rather than mixed.

141. Given the only tentative and incomplete nature of the science, the continuing and active misrepresentation of the science by extremists, and the large risks potentially posed to the long-term well-being of children, my field requires not only

additional research, but also vigorous debate among all potential interpretations.

142. The negative effect of shutting down a single side of an issue can be seen best with a specific example. A recent study "estimated homicide rates for transgender residents and transfeminine, Black, Latin@, and young (aged 15–34 years) subpopulations during the period 2010 to 2014 using Transgender Day of Remembrance and National Coalition of Anti-Violence Programs transgender homicide data."[109] The analyses demonstrated that homicide rates were highly elevated among Black, trans, drug-involved sex workers, but otherwise were lower than among the remainder of the transgender population as compared to the general mainstream population.

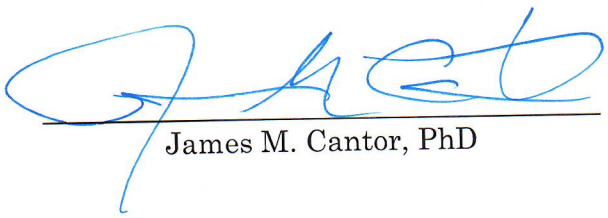
143. If an observer were provided only with the first of these findings, then it would appear that transphobia is adding to the victimization of those in already victimized groups. A policy-maker would want to respond by allocating resources into combatting transphobic violence; however, such efforts would be mostly misapplied, going to portions of the community who don't need it. Conversely, if the observer were provided only with the second of these findings, then one would conclude that there is no transphobia problem at all—the trans community would already be doing better than average. That, however, would lead to a failure to allocate protections where they are indeed needed to save people who are indeed suffering high rates of homicide. It is only when an observer has access to both of these findings that one can identify the best means to benefit the public: to help drug-involved sex workers, for which the Black transpeople would disproportionately benefit exactly as they are disproportionately victimized.

144. Acknowledging the contested nature of many claims in public and professional discussions of this topic, Dr. Josephson's claims are uniformly consistent with medical association guidelines and with the contents of the scientific literature. If

[109] Dinno, 2017, p. 1441.

experts and care providers are unable to share the information they have, then clients and their families will be unable to become informed enough to provide informed consent, and policy makers will be led away from applying resources to where they may do their intended good.

Date: 31 March 2021



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Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*, 90–97.

Appendix 1

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EDUCATION

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Doctor of Philosophy Sep., 1993–Jun., 2000
Psychology • McGill University • Montréal, Canada

Master of Arts Sep., 1990–Jan., 1992
Psychology • Boston University • Boston, MA

Bachelor of Science Sep. 1984–Aug., 1988
Interdisciplinary Science • Rensselaer Polytechnic Institute • Troy, NY
Concentrations: Computer science, mathematics, physics

EMPLOYMENT HISTORY

Director Feb., 2017–Present
Toronto Sexuality Centre • Toronto, Canada

Senior Scientist (Inaugural Member) Aug., 2012–May, 2018
Campbell Family Mental Health Research Institute
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Senior Scientist Jan., 2012–May, 2018
Complex Mental Illness Program
Centre for Addiction and Mental Health • Toronto, Canada

Head of Research Nov., 2010–Apr. 2014
Sexual Behaviours Clinic
Centre for Addiction and Mental Health • Toronto, Canada

Research Section Head Dec., 2009–Sep. 2012
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Psychologist May, 2004–Dec., 2011
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Clinical Psychology Intern Sep., 1998–Aug., 1999
Centre for Addiction and Mental Health • Toronto, Canada

Teaching Assistant Sep., 1993–May, 1998
Department of Psychology
McGill University • Montréal, Canada

Pre-Doctoral Practicum Sep., 1993–Jun., 1997
Sex and Couples Therapy Unit
Royal Victoria Hospital • Montréal, Canada

Pre-Doctoral Practicum May, 1994–Dec., 1994
Department of Psychiatry
Queen Elizabeth Hospital • Montréal, Canada

ACADEMIC APPOINTMENTS

Associate Professor Jul., 2010–May, 2019
Department of Psychiatry
University of Toronto Faculty of Medicine • Toronto, Canada

Adjunct Faculty Aug. 2013–Jun., 2018
Graduate Program in Psychology
York University • Toronto, Canada

Associate Faculty (Hon) Oct., 2017–Dec., 2017
School of Behavioural, Cognitive & Social Science
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Assistant Professor Jun., 2005–Jun., 2010
Department of Psychiatry
University of Toronto Faculty of Medicine • Toronto, Canada

Adjunct Faculty Sep., 2004–Jun., 2010
Clinical Psychology Residency Program
St. Joseph's Healthcare • Hamilton, Canada

PUBLICATIONS

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PUBLICATIONS

LETTERS AND COMMENTARIES

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11. Cantor, J. M. (2003, Summer). Review of the book *The Man Who Would Be Queen* by J. Michael Bailey. *Newsletter of Division 44 of the American Psychological Association, 19*(2), 6.
12. Cantor, J. M. (2003, Spring). What are the hot topics in LGBT research in psychology? *Newsletter of Division 44 of the American Psychological Association, 19*(1), 21–24.
13. Cantor, J. M. (2002, Fall). Male homosexuality, science, and pedophilia. *Newsletter of Division 44 of the American Psychological Association, 18*(3), 5–8.
14. Cantor, J. M. (2000). Review of the book *Sexual Addiction: An Integrated Approach. Journal of Sex and Marital Therapy, 26*, 107–109.

EDITORIALS

1. Cantor, J. M. (2012). Editorial. *Sexual Abuse: A Journal of Research and Treatment, 24*.

2. Cantor, J. M. (2011). Editorial note. *Sexual Abuse: A Journal of Research and Treatment, 23,* 414.
3. Barbaree, H. E., & Cantor, J. M. (2010). Performance indicates for *Sexual Abuse: A Journal of Research and Treatment* (SAJRT) [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 22,* 371–373.
4. Barbaree, H. E., & Cantor, J. M. (2009). *Sexual Abuse: A Journal of Research and Treatment* performance indicators for 2007 [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 21,* 3–5.
5. Zucker, K. J., & Cantor, J. M. (2009). Cruising: Impact factor data [Editorial]. *Archives of Sexual Research, 38,* 878–882.
6. Barbaree, H. E., & Cantor, J. M. (2008). Performance indicators for *Sexual Abuse: A Journal of Research and Treatment* [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 20,* 3–4.
7. Zucker, K. J., & Cantor, J. M. (2008). The *Archives* in the era of online first ahead of print[Editorial]. *Archives of Sexual Behavior, 37,* 512–516.
8. Zucker, K. J., & Cantor, J. M. (2006). The impact factor: The *Archives* breaks from the pack [Editorial]. *Archives of Sexual Behavior, 35,* 7–9.
9. Zucker, K. J., & Cantor, J. M. (2005). The impact factor: “Goin’ up” [Editorial]. *Archives of Sexual Behavior, 34,* 7–9.
10. Zucker, K., & Cantor, J. M. (2003). The numbers game: The impact factor and all that jazz [Editorial]. *Archives of Sexual Behavior, 32,* 3–5.

FUNDING HISTORY

Principal Investigators:	Doug VanderLaan, Meng-Chuan Lai
Co-Investigators:	James M. Cantor, Megha Mallar Chakravarty, Nancy Lobaugh, M. Palmert, M. Skorska
Title:	*Brain function and connectomics following sex hormone treatment in adolescents experience gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Behavioural Sciences-B-2
Funds:	$650,250 / 5 years (July, 2018)
Principal Investigator:	Michael C. Seto
Co-Investigators:	Martin Lalumière , James M. Cantor
Title:	*Are connectivity differences unique to pedophilia?*
Agency:	University Medical Research Fund, Royal Ottawa Hospital
Funds:	$50,000 / 1 year (January, 2018)
Principal Investigator:	Lori Brotto
Co-Investigators:	Anthony Bogaert, James M. Cantor, Gerulf Rieger
Title:	*Investigations into the neural underpinnings and biological correlates of asexuality*
Agency:	Natural Sciences and Engineering Research Council (NSERC), Discovery Grants Program
Funds:	$195,000 / 5 years (April, 2017)
Principal Investigator:	Doug VanderLaan
Co-Investigators:	Jerald Bain, James M. Cantor, Megha Mallar Chakravarty, Sofia Chavez, Nancy Lobaugh, and Kenneth J. Zucker
Title:	*Effects of sex hormone treatment on brain development: A magnetic resonance imaging study of adolescents with gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Transitional Open Grant Program
Funds:	$952,955 / 5 years (September, 2015)
Principal Investigator:	James M. Cantor
Co-Investigators:	Howard E. Barbaree, Ray Blanchard, Robert Dickey, Todd A. Girard, Phillip E. Klassen, and David J. Mikulis
Title:	*Neuroanatomic features specific to pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$1,071,920 / 5 years (October, 2008)
Principal Investigator:	James M. Cantor
Title:	*A preliminary study of fMRI as a diagnostic test of pedophilia*
Agency:	Dean of Medicine New Faculty Grant Competition, Univ. of Toronto
Funds:	$10,000 (July, 2008)

Principal Investigator:	James M. Cantor
Co-Investigator:	Ray Blanchard
Title:	*Morphological and neuropsychological correlates of pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$196,902 / 3 years (April, 2006)

KEYNOTE AND INVITED ADDRESSES

1. Cantor, J. M. (2019, May 1). *Introduction and Q&A for 'I, Pedophile.'* StopSO 2nd Annual Conference, London, UK.
2. Cantor, J. M. (2018, August 29). *Neurobiology of pedophilia or paraphilia? Towards a 'Grand Unified Theory' of sexual interests.* Keynote address to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
3. Cantor, J. M. (2018, August 29). *Pedophilia and the brain: Three questions asked and answered.* Preconference training presented to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
4. Cantor, J. M. (2018, April 13). *The responses to* I, Pedophile *from We, the people.* Keynote address to the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
5. Cantor, J. M. (2018, April 11). *Studying atypical sexualities: From vanilla to* I, Pedophile. Full day workshop at the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
6. Cantor, J. M. (2018, January 20). *How much sex is enough for a happy life?* Invited lecture to the University of Toronto Division of Urology Men's Health Summit, Toronto, Canada.
7. Cantor, J. M. (2017, November 2). Pedophilia as a phenomenon of the brain: Update of evidence and the public response. Invited presentation to the 7th annual SBC education event, Centre for Addiction and Mental Health, Toronto, Canada.
8. Cantor, J. M. (2017, June 9). Pedophilia being in the brain: The evidence and the public's reaction. Invited presentation to *SEXposium at the ROM: The science of love and sex,* Toronto, Canada.
9. Cantor, J. M., & Campea, M. (2017, April 20). *"I, Pedophile" showing and discussion.* Invited presentation to the 42nd annual meeting of the Society for Sex Therapy and Research, Montréal, Canada.
10. Cantor, J. M. (2017, March 1). *Functional and structural neuroimaging of pedophilia: Consistencies across methods and modalities.* Invited lecture to the Brain Imaging Centre, Royal Ottawa Hospital, Ottawa, Canada.
11. Cantor, J. M. (2017, January 26). *Pedophilia being in the brain: The evidence and the public reaction.* Inaugural keynote address to the University of Toronto Sexuality Interest Network, Toronto, Ontario, Canada.
12. Cantor, J. M. (2016, October 14). *Discussion of CBC's "I, Pedophile."* Office of the Children's Lawyer Educational Session, Toronto, Ontario, Canada.
13. Cantor, J. M. (2016, September 15). *Evaluating the risk to reoffend: What we know and what we don't.* Invited lecture to the Association of Ontario Judges, Ontario Court of Justice Annual Family Law Program, Blue Mountains, Ontario, Canada. [Private link only: https://vimeo.com/239131108/3387c80652]
14. Cantor, J. M. (2016, April 8). *Pedophilia and the brain: Conclusions from the second generation of research.* Invited lecture at the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.
15. Cantor, J. M. (2016, April 7). *Hypersexuality without the hyperbole.* Keynote address to the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.
16. Cantor, J. M. (2015, November). *No one asks to be sexually attracted to children: Living in*

Daniel's World. Grand Rounds, Centre for Addiction and Mental Health. Toronto, Canada.

17. Cantor, J. M. (2015, August). *Hypersexuality: Getting past whether "it" is or "it" isn't.* Invited address at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
18. Cantor, J. M. (2015, July). *A unified theory of typical and atypical sexual interest in men: Paraphilia, hypersexuality, asexuality, and vanilla as outcomes of a single, dual opponent process.* Invited presentation to the 2015 Puzzles of Sexual Orientation conference, Lethbridge, AL, Canada.
19. Cantor, J. M. (2015, June). *Hypersexuality.* Keynote Address to the Ontario Problem Gambling Provincial Forum. Toronto, Canada.
20. Cantor, J. M. (2015, May). *Assessment of pedophilia: Past, present, future.* Keynote Address to the International Symposium on Neural Mechanisms Underlying Pedophilia and Child Sexual Abuse (NeMUP). Berlin, Germany.
21. Cantor, J. M. (2015, March). *Prevention of sexual abuse by tackling the biggest stigma of them all: Making sex therapy available to pedophiles.* Keynote address to the 40th annual meeting of the Society for Sex Therapy and Research, Boston, MA.
22. Cantor, J. M. (2015, March. *Pedophilia: Predisposition or perversion?* Panel discussion at Columbia University School of Journalism. New York, NY.
23. Cantor, J. M. (2015, February). *Hypersexuality.* Research Day Grand Rounds presentation to Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario, Canada.
24. Cantor, J. M. (2015, January). *Brain research and pedophilia: What it means for assessment, research, and policy.* Keynote address to the inaugural meeting of the Netherlands Association for the Treatment of Sexual Abusers, Utrecht, Netherlands.
25. Cantor, J. M. (2014, December). *Understanding pedophilia and the brain: Implications for safety and society.* Keynote address for The Jewish Community Confronts Violence and Abuse: Crisis Centre for Religious Women, Jerusalem, Israel.
26. Cantor, J. M. (2014, October). *Understanding pedophilia & the brain.* Invited full-day workshop for the Sex Offender Assessment Board of Pennsylvania, Harrisburg, PA.
27. Cantor, J. M. (2014, September). *Understanding neuroimaging of pedophilia: Current status and implications.* Invited lecture presented to the Mental Health and Addition Rounds, St. Joseph's Healthcare, Hamilton, Ontario, Canada.
28. Cantor, J. M. (2014, June). *An evening with Dr. James Cantor.* Invited lecture presented to the Ontario Medical Association, District 11 Doctors' Lounge Program, Toronto, Ontario, Canada.
29. Cantor, J. M. (2014, April). *Pedophilia and the brain.* Invited lecture presented to the University of Toronto Medical Students lunchtime lecture. Toronto, Ontario, Canada.
30. Cantor, J. M. (2014, February). *Pedophilia and the brain: Recap and update.* Workshop presented at the 2014 annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Cle Elum, WA.
31. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, February). *Functional connectivity in pedophilia.* Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario, Canada.
32. Cantor, J. M. (2013, November). *Understanding pedophilia and the brain: The basics, the current status, and their implications.* Invited lecture to the Forensic Psychology Research Centre, Carleton University, Ottawa, Canada.

33. Cantor, J. M. (2013, November). *Mistaking puberty, mistaking hebephilia.* Keynote address presented to the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
34. Cantor, J. M. (2013, October). *Understanding pedophilia and the brain: A recap and update.* Invited workshop presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
35. Cantor, J. M. (2013, October). *Compulsive-hyper-sex-addiction: I don't care what we all it, what can we* do*?* Invited address presented to the Board of Examiners of Sex Therapists and Counselors of Ontario, Toronto, Ontario, Canada.
36. Cantor, J. M. (2013, September). *Neuroimaging of pedophilia: Current status and implications.* McGill University Health Centre, Department of Psychiatry Grand Rounds presentation, Montréal, Québec, Canada.
37. Cantor, J. M. (2013, April). *Understanding pedophilia and the brain.* Invited workshop presented at the 2013 meeting of the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, MN.
38. Cantor, J. M. (2013, April). *The neurobiology of pedophilia and its implications for assessment, treatment, and public policy.* Invited lecture at the 38th annual meeting of the Society for Sex Therapy and Research, Baltimore, MD.
39. Cantor, J. M. (2013, April). *Sex offenders: Relating research to policy.* Invited roundtable presentation at the annual meeting of the Academy of Criminal Justice Sciences, Dallas, TX.
40. Cantor, J. M. (2013, March). *Pedophilia and brain research: From the basics to the state-of-the-art.* Invited workshop presented to the annual meeting of the Forensic Mental Health Association of California, Monterey, CA.
41. Cantor, J. M. (2013, January). *Pedophilia and child molestation.* Invited lecture presented to the Canadian Border Services Agency, Toronto, Ontario, Canada.
42. Cantor, J. M. (2012, November). *Understanding pedophilia and sexual offenders against children: Neuroimaging and its implications for public safety.* Invited guest lecture to University of New Mexico School of Medicine Health Sciences Center, Albuquerque, NM.
43. Cantor, J. M. (2012, November). *Pedophilia and brain research.* Invited guest lecture to the annual meeting of the Circles of Support and Accountability, Toronto, Ontario, Canada.
44. Cantor, J. M. (2012, January). *Current findings on pedophilia brain research.* Invited workshop at the San Diego International Conference on Child and Family Maltreatment, San Diego, CA.
45. Cantor, J. M. (2012, January). *Pedophilia and the risk to re-offend.* Invited lecture to the Ontario Court of Justice Judicial Development Institute, Toronto, Ontario, Canada.
46. Cantor, J. M. (2011, November). *Pedophilia and the brain: What it means for assessment, treatment, and policy.* Plenary Lecture presented at the Association for the Treatment of Sexual Abusers, Toronto, Ontario, Canada.
47. Cantor, J. M. (2011, July). *Towards understanding contradictory findings in the neuroimaging of pedophilic men.* Keynote address to 7th annual conference on Research in Forensic Psychiatry, Regensberg, Germany.
48. Cantor, J. M. (2011, March). *Understanding sexual offending and the brain: Brain basics to the state of the art.* Workshop presented at the winter conference of the Oregon Association for the Treatment of Sexual Abusers, Oregon City, OR.

49. Cantor, J. M. (2010, October). *Manuscript publishing for students.* Workshop presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
50. Cantor, J. M. (2010, August). *Is sexual orientation a paraphilia?* Invited lecture at the International Behavioral Development Symposium, Lethbridge, Alberta, Canada.
51. Cantor, J. M. (2010, March). *Understanding sexual offending and the brain: From the basics to the state of the art.* Workshop presented at the annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Blaine, WA.
52. Cantor, J. M. (2009, January). *Brain structure and function of pedophilia men.* Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario.
53. Cantor, J. M. (2008, April). *Is pedophilia caused by brain dysfunction?* Invited address to the University-wide Science Day Lecture Series, SUNY Oswego, Oswego, NY.
54. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, September). *MRIs of pedophilic men.* Invited presentation at the 25th annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
55. Cantor, J. M., Blanchard, R., & Christensen, B. K. (2003, March). *Findings in and implications of neuropsychology and epidemiology of pedophilia.* Invited lecture at the 28th annual meeting of the Society for Sex Therapy and Research, Miami.
56. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, July). *Neuropsychological functioning in pedophiles.* Invited lecture presented at the 27th annual meeting of the International Academy of Sex Research, Bromont, Canada.
57. Cantor, J. M., Blanchard, R., Christensen, B., Klassen, P., & Dickey, R. (2001, February). *First glance at IQ, memory functioning and handedness in sex offenders.* Lecture presented at the Forensic Lecture Series, Centre for Addiction and Mental Health, Toronto, Ontario, Canada.
58. Cantor, J. M. (1999, November). *Reversal of SSRI-induced male sexual dysfunction: Suggestions from an animal model.* Grand Rounds presentation at the Allan Memorial Institute, Royal Victoria Hospital, Montréal, Canada.

PAPER PRESENTATIONS AND SYMPOSIA

1. Cantor, J. M. (2020, April). "I'd rather have a trans kid than a dead kid": Critical assessment of reported rates of suicidality in trans kids. *Paper presented at the annual meeting of the Society for the Sex Therapy and Research.* Online in lieu of in person meeting.
2. Stephens, S., Lalumière, M., Seto, M. C., & Cantor, J. M. (2017, October). *The relationship between sexual responsiveness and sexual exclusivity in phallometric profiles.* Paper presented at the annual meeting of the Canadian Sex Research Forum, Fredericton, New Brunswick, Canada.
3. Stephens, S., Cantor, J. M., & Seto, M. C. (2017, March). *Can the SSPI-2 detect hebephilic sexual interest?* Paper presented at the annual meeting of the American-Psychology Law Society Annual Meeting, Seattle, WA.
4. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Victim choice polymorphism and recidivism.* Symposium Presentation. Paper presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
5. McPhail, I. V., Hermann, C. A., Fernane, S. Fernandez, Y., Cantor, J. M., & Nunes, K. L. (2014, October). *Sexual deviance in sexual offenders against children: A meta-analytic review of phallometric research.* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
6. Stephens, S., Seto, M. C., Cantor, J. M., & Goodwill, A. M. (2014, October). *Is hebephilic sexual interest a criminogenic need?: A large scale recidivism study.* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
7. Stephens, S., Seto, M. C., Cantor, J. M., & Lalumière, M. (2014, October). *Development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI–2).* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, September). *Pedophilia and the brain: White matter differences detected with DTI.* Paper presented at the 13th annual meeting of the International Association for the Treatment of Sexual Abusers, Porto, Portugal.
9. Stephens, S., Seto, M., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2014, March). *The role of hebephilic sexual interests in sexual victim choice.* Paper presented at the annual meeting of the American Psychology and Law Society, New Orleans, LA.
10. McPhail, I. V., Fernane, S. A., Hermann, C. A., Fernandez, Y. M., Nunes, K. L., & Cantor, J. M. (2013, November). *Sexual deviance and sexual recidivism in sexual offenders against children: A meta-analysis.* Paper presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
11. Cantor, J. M. (2013, September). *Pedophilia and the brain: Current MRI research and its implications.* Paper presented at the 21st annual World Congress for Sexual Health, Porto Alegre, Brazil. [Featured among Best Abstracts, top 10 of 500.]
12. Cantor, J. M. (Chair). (2012, March). *Innovations in sex research.* Symposium conducted at the 37th annual meeting of the Society for Sex Therapy and Research, Chicago.
13. Cantor, J. M., & Blanchard, R. (2011, August). fMRI versus phallometry in the diagnosis of pedophilia and hebephilia. In J. M. Cantor (Chair), *Neuroimaging of men's object*

preferences. Symposium presented at the 37th annual meeting of the International Academy of Sex Research, Los Angeles, USA.

14. Cantor, J. M. (Chair). (2011, August). *Neuroimaging of men's object preferences.* Symposium conducted at the 37th annual meeting of the International Academy of Sex Research, Los Angeles.
15. Cantor, J. M. (2010, October). A meta-analysis of neuroimaging studies of male sexual arousal. In S. Stolerú (Chair), *Brain processing of sexual stimuli in pedophilia: An application of functional neuroimaging.* Symposium presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
16. Chivers, M. L., Seto, M. C., Cantor, J. C., Grimbos, T., & Roy, C. (April, 2010). *Psychophysiological assessment of sexual activity preferences in women.* Paper presented at the 35th annual meeting of the Society for Sex Therapy and Research, Boston, USA.
17. Cantor, J. M., Girard, T. A., & Lovett-Barron, M. (2008, November). *The brain regions that respond to erotica: Sexual neuroscience for dummies.* Paper presented at the 51st annual meeting of the Society for the Scientific Study of Sexuality, San Juan, Puerto Rico.
18. Barbaree, H., Langton, C., Blanchard, R., & Cantor, J. M. (2007, October). *The role of age-at-release in the evaluation of recidivism risk of sexual offenders.* Paper presented at the 26th annual meetingof the Association for the Treatment of Sexual Abusers, San Diego.
19. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, July). *Pedophilia and brain morphology.* Abstract and paper presented at the 32nd annual meeting of the International Academy of Sex Research, Amsterdam, Netherlands.
20. Seto, M. C., Cantor, J. M., & Blanchard, R. (2006, March). *Child pornography offending is a diagnostic indicator of pedophilia*. Paper presented at the 2006 annual meeting of the American Psychology-Law Society Conference, St. Petersburg, Florida.
21. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2005, August). *Interaction of fraternal birth order and handedness in the development of male homosexuality.* Abstract and paper presented at the International Behavioral Development Symposium, Minot, North Dakota.
22. Cantor, J. M., & Blanchard, R. (2005, July). *Quantitative reanalysis of aggregate data on IQ in sexual offenders.* Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
23. Cantor, J. M. (2003, August). *Sex reassignment on demand: The clinician's dilemma.* Paper presented at the 111th annual meeting of the American Psychological Association, Toronto, Canada.
24. Cantor, J. M. (2003, June). *Meta-analysis of VIQ–PIQ differences in male sex offenders.* Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
25. Cantor, J. M. (2002, August). *Gender role in autogynephilic transsexuals: The more things change…* Paper presented at the 110th annual meeting of the American Psychological Association, Chicago.

26. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, June). *IQ, memory functioning, and handedness in male sex offenders.* Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
27. Cantor, J. M. (1998, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 106th annual meeting of the American Psychological Association.
28. Cantor, J. M. (1997, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 105th annual meeting of the American Psychological Association.
29. Cantor, J. M. (1997, August). *Convention orientation for lesbian, gay, and bisexual students*. Paper presented at the 105th annual meeting of the American Psychological Association.
30. Cantor, J. M. (1996, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 104th annual meeting of the American Psychological Association.
31. Cantor, J. M. (1996, August). *Symposium: Question of inclusion: Lesbian and gay psychologists and accreditation*. Paper presented at the 104th annual meeting of the American Psychological Association, Toronto.
32. Cantor, J. M. (1996, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 104th annual meeting of the American Psychological Association.
33. Cantor, J. M. (1995, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 103rd annual meeting of the American Psychological Association.
34. Cantor, J. M. (1995, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 103rd annual meeting of the American Psychological Association.
35. Cantor, J. M. (1994, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 102nd annual meeting of the American Psychological Association.
36. Cantor, J. M. (1994, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 102nd annual meeting of the American Psychological Association.
37. Cantor, J. M., & Pilkington, N. W. (1992, August). *Homophobia in psychology programs: A survey of graduate students.* Paper presented at the Centennial Convention of the American Psychological Association, Washington, DC. (ERIC Document Reproduction Service No. ED 351 618)
38. Cantor, J. M. (1991, August). *Being gay and being a graduate student: Double the memberships, four times the problems*. Paper presented at the 99th annual meeting of the American Psychological Association, San Francisco.

POSTER PRESENTATIONS

1. Klein, L., Stephens, S., Goodwill, A. M., Cantor, J. M., & Seto, M. C. (2015, October). *The psychological propensities of risk in undetected sexual offenders.* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
2. Pullman, L. E., Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Why are incest offenders less likely to recidivate?* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
3. Seto, M. C., Stephens, S. M., Cantor, J. M., Lalumiere, M. L., Sandler, J. C., & Freeman, N. A. (2015, August). *The development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI-2).* Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
4. Soh, D. W., & Cantor, J. M. (2015, August). *A peek inside a furry convention.* Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
5. VanderLaan, D. P., Lobaugh, N. J., Chakravarty, M. M., Patel, R., Chavez, S. Stojanovski, S. O., Takagi, A., Hughes, S. K., Wasserman, L., Bain, J., Cantor, J. M., & Zucker, K. J. (2015, August). *The neurohormonal hypothesis of gender dysphoria: Preliminary evidence of cortical surface area differences in adolescent natal females.* Poster presentation at the 31st annual meeting of the International Academy of Sex Research. Toronto, Canada.
6. Cantor, J. M., Lafaille, S. J., Moayedi, M., Mikulis, D. M., & Girard, T. A. (2015, June). *Diffusion tensor imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses.* Harvey Stancer Research Day, Toronto, Ontario Canada.
7. Newman, J. E., Stephens, S., Seto, M. C., & Cantor, J. M. (2014, October). *The validity of the Static-99 in sexual offenders with low intellectual abilities.* Poster presentation at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Lykins, A. D., Walton, M. T., & Cantor, J. M. (2014, June). *An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior.* Poster presentation at the 30th annual meeting of the International Academy of Sex Research, Dubrovnik, Croatia.
9. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, November). *The utility of phallometry in the assessment of hebephilia.* Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
10. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, October). *The role of hebephilic sexual interests in sexual victim choice.* Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
11. Fazio, R. L., & Cantor, J. M. (2013, October). *Analysis of the Fazio Laterality Inventory (FLI) in a population with established atypical handedness.* Poster presented at the 33rd annual meeting of the National Academy of Neuropsychology, San Diego.
12. Lafaille, S., Hannah, J., Soh, D., Kucyi, A., Girard, T. A., Mikulis, D. M., & Cantor, J. M. (2013, August). *Investigating resting state networks in pedohebephiles.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.

13. McPhail, I. V., Lykins, A. D., Robinson, J. J., LeBlanc, S., & Cantor, J. M. (2013, August). *Effects of prescription medication on volumetric phallometry output.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
14. Murray, M. E., Dyshniku, F., Fazio, R. L., & Cantor, J. M. (2013, August). *Minor physical anomalies as a window into the prenatal origins of pedophilia.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
15. Sutton, K. S., Stephens, S., Dyshniku, F., Tulloch, T., & Cantor, J. M. (2013, August). *Pilot group treatment for "procrasturbation."* Poster presented at 39th annual meeting of the International Academy of Sex Research, Chicago.
16. Sutton, K. S., Pytyck, J., Stratton, N., Sylva, D., Kolla, N., & Cantor, J. M. (2013, August). *Client characteristics by type of hypersexuality referral: A quantitative chart review.* Poster presented at the 39th annual meeting of the International Academy of Sex Research, Chicago.
17. Fazio, R. L., & Cantor, J. M. (2013, June). *A replication and extension of the psychometric properties of the Digit Vigilance Test.* Poster presented at the 11th annual meeting of the American Academy of Clinical Neuropsychology, Chicago.
18. Lafaille, S., Moayedi, M., Mikulis, D. M., Girard, T. A., Kuban, M., Blak, T., & Cantor, J. M. (2012, July). *Diffusion Tensor Imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses.* Poster presented at the 38th annual meeting of the International Academy of Sex Research, Lisbon, Portugal.
19. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010, July). *Sexual arousal to female children in gynephilic men.* Poster presented at the 38th annual meeting of the International Academy of Sex Research, Prague, Czech Republic.
20. Cantor, J. M., Girard, T. A., Lovett-Barron, M., & Blak, T. (2008, July). *Brain regions responding to visual sexual stimuli: Meta-analysis of PET and fMRI studies.* Abstract and poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
21. Lykins, A. D., Blanchard, R., Cantor, J. M., Blak, T., & Kuban, M. E. (2008, July). *Diagnosing sexual attraction to children: Considerations for DSM-V.* Poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
22. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, October). *Physical height in pedophilia and hebephilia.* Poster presented at the 26th annual meeting of the Association for the Treatment of Sexual Abusers, San Diego.
23. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, August). *Physical height in pedophilia and hebephilia.* Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
24. Puts, D. A., Blanchard, R., Cardenas, R., Cantor, J., Jordan, C. L., & Breedlove, S. M. (2007, August). *Earlier puberty predicts superior performance on male-biased visuospatial tasks in men but not women.* Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
25. Seto, M. C., Cantor, J. M., & Blanchard, R. (2005, November). *Possession of child pornography is a diagnostic indicator of pedophilia.* Poster presented at the 24th annual meeting of the Association for the Treatment of Sexual Abusers, New Orleans.

26. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove. S. M., & Ellis, L. (2005, July). *Interaction of fraternal birth order and handedness in the development of male homosexuality.* Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
27. Cantor, J. M., & Blanchard, R. (2003, July). *The reported VIQ–PIQ differences in male sex offenders are artifactual?* Abstract and poster presented at the 29th annual meeting of the International Academy of Sex Research, Bloomington, Indiana.
28. Christensen, B. K., Cantor, J. M., Millikin, C., & Blanchard, R. (2002, February). *Factor analysis of two brief memory tests: Preliminary evidence for modality-specific measurement.* Poster presented at the 30th annual meeting of the International Neuropsychological Society, Toronto, Ontario, Canada.
29. Cantor, J. M., Blanchard, R., Paterson, A., Bogaert, A. (2000, June). *How many gay men owe their sexual orientation to fraternal birth order?* Abstract and poster presented at the International Behavioral Development Symposium, Minot, North Dakota.
30. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, November). *Fluoxetine inhibition of male rat sexual behavior: Reversal by oxytocin*. Poster presented at the 26th annual meeting of the Society for Neurosciences, Washington, DC.
31. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, June). *An animal model of fluoxetine-induced sexual dysfunction: Dose dependence and time course*. Poster presented at the 28th annual Conference on Reproductive Behavior, Montréal, Canada.
32. Cantor, J. M., O'Connor, M. G., Kaplan, B., & Cermak, L. S. (1993, June). *Transient events test of retrograde memory: Performance of amnestic and unimpaired populations*. Poster presented at the 2nd annual science symposium of the Massachusetts Neuropsychological Society, Cambridge, MA.

EDITORIAL AND PEER-REVIEWING ACTIVITIES

Editor-in-Chief

Sexual Abuse: A Journal of Research and Treatment Jan., 2010–Dec., 2014

Editorial Board Memberships

Journal of Sexual Aggression Jan., 2010–Present
Journal of Sex Research, The Jan., 2008–Present
Sexual Abuse: A Journal of Research and Treatment Jan., 2006–Dec., 2019
Archives of Sexual Behavior Jan., 2004–Present
The Clinical Psychologist Jan., 2004–Dec., 2005

Ad hoc Journal Reviewer Activity

American Journal of Psychiatry
Annual Review of Sex Research
Archives of General Psychiatry
Assessment
Biological Psychiatry
BMC Psychiatry
Brain Structure and Function
British Journal of Psychiatry
British Medical Journal
Canadian Journal of Behavioural Science
Canadian Journal of Psychiatry
Cerebral Cortex
Clinical Case Studies
Comprehensive Psychiatry
Developmental Psychology
European Psychologist
Frontiers in Human Neuroscience
Human Brain Mapping
International Journal of Epidemiology
International Journal of Impotence Research
International Journal of Sexual Health
International Journal of Transgenderism
Journal of Abnormal Psychology
Journal of Clinical Psychology
Journal of Consulting and Clinical Psychology
Journal of Forensic Psychology Practice
Journal for the Scientific Study of Religion
Journal of Sexual Aggression
Journal of Sexual Medicine
Journal of Psychiatric Research
Nature Neuroscience
Neurobiology Reviews
Neuroscience & Biobehavioral Reviews
Neuroscience Letters
Proceedings of the Royal Society B (Biological Sciences)
Psychological Assessment
Psychological Medicine
Psychological Science
Psychology of Men & Masculinity
Sex Roles
Sexual and Marital Therapy
Sexual and Relationship Therapy
Sexuality & Culture
Sexuality Research and Social Policy
The Clinical Psychologist
Traumatology
World Journal of Biological Psychiatry

GRANT REVIEW PANELS

2017– Member, College of Reviewers, *Canadian Institutes of Health Research,* Canada.

2017 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2017 Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2016 Reviewer. National Science Center [*Narodowe Centrum Nauki*], Poland.

2016 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2015 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2015 Reviewer. *Czech Science Foundation,* Czech Republic.

2015 Reviewer, "Off the beaten track" grant scheme. *Volkswagen Foundation,* Germany.

2015 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada

2015 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2014 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2014 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada.

2014 Panel Member, Dean's Fund—Clinical Science Panel. *University of Toronto Faculty of Medicine*, Canada.

2014 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2013 Panel Member, Grant Miller Cancer Research Grant Panel. *University of Toronto Faculty of Medicine*, Canada.

2013 Panel Member, Dean of Medicine Fund New Faculty Grant Clinical Science Panel. *University of Toronto Faculty of Medicine,* Canada.

2012 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence (2nd round). *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2012 External Reviewer, University of Ottawa Medical Research Fund. *University of Ottawa Department of Psychiatry*, Canada.

2012 External Reviewer, Behavioural Sciences—B. *Canadian Institutes of Health Research*, Canada.

2011 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

TEACHING AND TRAINING

PostDoctoral Research Supervision
Law & Mental Health Program, Centre for Addiction and Mental Health, Toronto, Canada

Dr. Katherine S. Sutton	Sept., 2012–Dec., 2013
Dr. Rachel Fazio	Sept., 2012–Aug., 2013
Dr. Amy Lykins	Sept., 2008–Nov., 2009

Doctoral Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Michael Walton • University of New England, Australia	Sept., 2017–Aug., 2018
Debra Soh • York University	May, 2013–Aug, 2017
Skye Stephens • Ryerson University	April, 2012–June, 2016

Masters Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Nicole Cormier • Ryerson University	June, 2012–present
Debra Soh • Ryerson University	May, 2009–April, 2010

Undergraduate Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Kylie Reale • Ryerson University	Spring, 2014
Jarrett Hannah • University of Rochester	Summer, 2013
Michael Humeniuk • University of Toronto	Summer, 2012

Clinical Supervision (Doctoral Internship)
Clinical Internship Program, Centre for Addiction and Mental Health, Toronto, Canada

Katherine S. Sutton • Queen's University	2011–2012
David Sylva • Northwestern University	2011–2012
Jordan Rullo • University of Utah	2010–2011
Lea Thaler • University of Nevada, Las Vegas	2010–2011
Carolin Klein • University of British Columbia	2009–2010
Bobby R. Walling • University of Manitoba	2009–2010

TEACHING AND TRAINING

Clinical Supervision (Doctoral- and Masters- level practica)
Centre for Addiction and Mental Health, Toronto, Canada

Tyler Tulloch • Ryerson University	2013–2014
Natalie Stratton • Ryerson University	Summer, 2013
Fiona Dyshniku • University of Windsor	Summer, 2013
Mackenzie Becker • McMaster University	Summer, 2013
Skye Stephens • Ryerson University	2012–2013
Vivian Nyantakyi • Capella University	2010–2011
Cailey Hartwick • University of Guelph	Fall, 2010
Tricia Teeft • Humber College	Summer, 2010
Allison Reeves • Ontario Institute for Studies in Education/Univ. of Toronto	2009–2010
Helen Bailey • Ryerson University	Summer, 2009
Edna Aryee • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Iryna Ivanova • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Jennifer Robinson • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Zoë Laksman • Adler School of Professional Psychology	2005–2006
Diana Mandelew • Adler School of Professional Psychology	2005–2006
Susan Wnuk • York University	2004–2005
Hiten Lad • Adler School of Professional Psychology	2004–2005
Natasha Williams • Adler School of Professional Psychology	2003–2004
Lisa Couperthwaite • Ontario Institute for Studies in Education/Univ. of Toronto	2003–2004
Lori Gray, née Robichaud • University of Windsor	Summer, 2003
Sandra Belfry • Ontario Institute for Studies in Education/Univ. of Toronto	2002–2003
Althea Monteiro • York University	Summer, 2002
Samantha Dworsky • York University	2001–2002
Kerry Collins • University of Windsor	Summer, 2001
Jennifer Fogarty • Waterloo University	2000–2001
Emily Cripps • Waterloo University	Summer, 2000
Lee Beckstead • University of Utah	2000

PROFESSIONAL SOCIETY ACTIVITIES

OFFICES HELD

2018–2019	Local Host. Society for Sex Therapy and Research.
2015	Member, International Scientific Committee, World Association for Sexual Health.
2015	Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers
2012–2013	Chair, Student Research Awards Committee, Society for Sex Therapy & Research
2012–2013	Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers
2011–2012	Chair, Student Research Awards Committee, Society for Sex Therapy & Research
2010–2011	Scientific Program Committee, International Academy of Sex Research
2002–2004	Membership Committee • APA Division 12 (Clinical Psychology)
2002–2003	Chair, Committee on Science Issues, APA Division 44
2002	Observer, Grant Review Committee • Canadian Institutes of Health Research Behavioural Sciences (B)
2001–2009	Reviewer • APA Division 44 Convention Program Committee
2001, 2002	Reviewer • APA Malyon-Smith Scholarship Committee
2000–2005	Task Force on Transgender Issues, APA Division 44
1998–1999	Consultant, APA Board of Directors Working Group on Psychology Marketplace
1997	Student Representative • APA Board of Professional Affairs' Institute on TeleHealth
1997–1998	Founder and Chair • APA/APAGS Task Force on New Psychologists' Concerns
1997–1999	Student Representative • APA/CAPP Sub-Committee for a National Strategy for Prescription Privileges
1997–1999	Liaison • APA Committee for the Advancement of Professional Practice
1997–1998	Liaison • APA Board of Professional Affairs
1993–1997	Founder and Chair • APA/APAGS Committee on LGB Concerns

PROFESSIONAL SOCIETY ACTIVITIES

MEMBERSHIPS

2017–Present Member • *Canadian Sex Research Forum*

2009–Present Member • *Society for Sex Therapy and Research*

2006–Present Member (elected) • *International Academy of Sex Research*

2006–Present Research and Clinical Member • *Association for the Treatment of Sex Abusers*

2003–2006 Associate Member (elected) • *International Academy of Sex Research*

2002 Founding Member • CPA Section on Sexual Orientation and Gender Identity

2001–2013 Member • *Canadian Psychological Association* (CPA)

2000–2015 Member • *American Association for the Advancement of Science*

2000–2015 Member • *American Psychological Association* (APA)

APA Division 12 (Clinical Psychology)

APA Division 44 (Society for the Psychological Study of LGB Issues)

2000–2020 Member • *Society for the Scientific Study of Sexuality*

1995–2000 Student Member • *Society for the Scientific Study of Sexuality*

1993–2000 Student Affiliate • *American Psychological Association*

1990–1999 Member, American Psychological Association of Graduate Students (APAGS)

CLINICAL LICENSURE/REGISTRATION

Certificate of Registration, Number 3793
College of Psychologists of Ontario, Ontario, Canada

AWARDS AND HONORS

2017 Elected Fellow, Association for the Treatment of Sexual Abusers

2011 Howard E. Barbaree Award for Excellence in Research
Centre for Addiction and Mental Health, Law and Mental Health Program

2004 fMRI Visiting Fellowship Program at Massachusetts General Hospital
American Psychological Association Advanced Training Institute and NIH

1999–2001 CAMH Post-Doctoral Research Fellowship
Centre for Addiction and Mental Health Foundation and Ontario Ministry of Health

1998 Award for Distinguished Contribution by a Student
American Psychological Association, Division 44

1995 Dissertation Research Grant
Society for the Scientific Study of Sexuality

1994–1996 McGill University Doctoral Scholarship

1994 Award for Outstanding Contribution to Undergraduate Teaching
"TA of the Year Award," from the McGill Psychology Undergraduate Student Association

MAJOR MEDIA

(Complete list available upon request.)

Feature-length Documentaries

Vice Canada Reports. *Age of Consent.* 14 Jan 2017.
Canadian Broadcasting Company. *I, Pedophile.* Firsthand documentaries. 10 Mar 2016.

Appearances and Interviews

24 Apr 2017. Sastre, P. Pédophilie: une panique morale jamais n'abolira un crime. *Slate France.*
12 Feb 2017. Payette, G. Child sex doll trial opens Pandora's box of questions. *CBC News.*
26 Nov 2016. Det morke uvettet ["The unknown darkness]". *Fedrelandsvennen.*
13 July 2016. Paedophilia: Shedding light on the dark field. *The Economist.*
1 July 2016. Debusschere, B. Niet iedereen die kinderporno kijkt, is een pedofiel: De mythes rond pedofilie ontkracht. *De Morgen.*
12 Apr 2016. O'Connor, R. Terence Martin: The Tasmanian MP whose medication 'turned him into a paedophile'. *The Independent.*
8 Mar 2016. Bielski, Z. 'The most viscerally hated group on earth': Documentary explores how intervention can stop pedophiles. *The Globe and Mail.*
1 Mar 2016. Elmhirst, S. What should we do about paedophiles? *The Guardian.*
24 Feb 2016. The man whose brain tumour 'turned him into a paedophile'. *The Independent.*
24 Nov 2015. Byron, T. The truth about child sex abuse. *BBC Two.*
20 Aug 2015. The Jared Fogle case: Why we understand so little about abuse. *Washington Post.*
19 Aug 2015. Blackwell, T. Treat sex offenders for impotence—to keep them out of trouble, Canadian psychiatrist says. *National Post.*
2 Aug 2015. Menendez, J. BBC News Hour. *BBC World Service.*
13 July 2015. The nature of pedophilia. *BBC Radio 4.*
9 July 2015. The sex-offender test: How a computerized assessment can help determine the fate of men who've been accused of sexually abusing children. *The Atlantic.*
10 Apr 2015. NWT failed to prevent sex offender from abusing stepdaughter again. *CBC News.*
10 February 2015. Savage, D. "The ethical sadist." In Savage Love. *The Stranger.*
31 January 2015. Begrip voor/van pedofilie [Understanding pedophilia]. *de Volkskrant.*
9 December 2014. Carey, B. When a rapist's weapon is a pill. *New York Times*.
1 December 2014. Singal, J. Can virtual reality help pedophiles? *New York Magazine.*
17 November 2014. Say pedófile, busco aydua. *El Pais.*
4 September 2014. Born that way? *Ideas, with Paul Kennedy.* CBC Radio One.
27 August 2014. Interrogating the statistics for the prevalence of paedophilia. BBC.
25 July 2014. Stephenson, W. The prevalence of paedophilia. *BBC World Service.*
21 July 2014. Hildebrandt, A. Virtuous Pedophiles group gives support therapy cannot. *CBC.*
26 January 2014. Paedophilia a result of faulty wiring, scientists suggest. *Daily Mail.*
22 December 2013. Kane, L. Is pedophilia a sexual orientation? *Toronto Star.*
21 July 2013. Miller, L. The turn-on switch: Fetish theory, post-Freud. *New York Magazine.*
1 July 2013. Morin, H. Pédophilie: la difficile quête d'une origine biologique. *Le Monde.*
2 June 2013. Malcolm, L. The psychology of paedophilia. *Australian National Radio.*
1 March 2013. Kay, J. The mobbing of Tom Flanagan is unwarranted and cruel. *National Post.*
6 February 2013. Boy Scouts board delays vote on lifting ban on gays. *L.A. Times.*
31 August 2012. CNN Newsroom interview with Ashleigh Banfield. *CNN.*
24 June 2012. CNN Newsroom interview with Don Lemon. *CNN.*

LEGAL TESTIMONY, PAST 4 YEARS

2019	US vs Peter Bright	Southern District, New York
2019	Probate and Family Court	Boston, Massachusetts
2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, Illinois
2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, NY
2018	Re Commitment of Fernando Little (Frye Hearing)	Utica, NY
2018	Canada vs John Fitzpatrick (sentencing hearing)	Toronto, Ontario, Canada
2017	Re Commitment of Nicholas Bauer (Frye Hearing)	Lee County, Illinois
2017	US vs William Leford (presentencing hearing)	Warnock, Georgia

Appendix 2

1. Phil S. Lebovitz, *Feminine Behavior in Boys: Aspects of Its Outcome*, 128 AM. J. PSYCH. 1283 (1972).

2. Bernard Zuger, *Effeminate Behavior Present in Boys from Childhood: Ten Additional Years of Follow-Up*, 19 COMPREHENSIVE PSYCH. 363 (1978).

3. John Money & Anthony J. Russo, *Homosexual Outcome of Discordant Gender Identity/Role in Childhood: Longitudinal Follow-Up*, 4 J. PEDIATRIC PSYCH. 29 (1979).

4. Bernard Zuger, *Early Effeminate Behavior in Boys: Outcome and Significance for Homosexuality*, 172 J. NERVOUS & MENTAL DISEASE 90 (1984).

5. Charles W. Davenport, *A Follow-Up Study of 10 Feminine Boys*, 15 ARCHIVES OF SEXUAL BEHAV. 511 (1986).

6. Richard Green, THE "SISSY BOY SYNDROME" AND THE DEVELOPMENT OF HOMOSEXUALITY (1987).

7. Robert J. Kosky, *Gender-Disordered Children: Does Inpatient Treatment Help?*, 146 MED. J. AUSTL. 565 (1987).

8. Madeleine S. C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual Outcome of Gender-Dysphoric Children*, 47 J. AM. ACAD. CHILD & ADOL. PSYCH. 1413 (2008).

9. Kelley D. Drummond et al., *A Follow-Up Study of Girls with Gender Identity Disorder*, 44 DEVELOPMENTAL PSYCH. 34 (2008).

10. Thomas D. Steensma et al., *Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study*, 52 J. AM. ACAD. CHILD & ADOL. PSYCH. 582 (2013).

11. Devita Singh et al., *A Follow-Up Study of Boys with Gender Identity Disorder*, 12 FRONTIERS IN PSYCH. 297 (2021).

Appendix 3

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Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

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ABSTRACT

The American Academy of Pediatrics (AAP) recently published a policy statement: *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping gender diverse (GD) children, the AAP statement instead rejected that consensus, endorsing *gender affirmation* as the only acceptable approach. Remarkably, not only did the AAP statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its citations, which repeatedly said the very opposite of what AAP attributed to them.

The American Academy of Pediatrics (AAP) recently published a policy statement entitled, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, 2018). These are children who manifest discontent with the sex they were born as and desire to live as the other sex (or as some alternative gender role). The policy was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping transgender and gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only *gender affirmation.* That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition. With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy, however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.

The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in the aggregate—It was merely disappeared. (The list of all existing studies appears in the appendix.) As they make clear, *every* follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition. AAP is, of course, free to establish whatever policy it likes on

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whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.

AAP divided clinical approaches into three types—conversion therapy, watchful waiting, and gender affirmation. It rejected the first two and endorsed *gender affirmation* as the only acceptable alternative. Most readers will likely be familiar already with attempts to use conversion therapy to change sexual orientation. With regard to gender identity, AAP wrote:

> "[C]onversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. … Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42]

The citations were:

38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol.* 1994;62(2):221–227.

29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 2012;51(9):957–974.

39. Byne W. Regulations restrict practice of conversion therapy. *LGBT Health.* 2016;3(2):97–99.

40. Cohen-Kettenis PT, Delemarrevan de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med.* 2008;5(8):1892–1897.

41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Soc Policy.* 2006;3(3):23–39.

42. World Professional Association for Transgender Health. *WPATH De-Psychopathologisation Statement.* Minneapolis, MN: World Professional Association for Transgender Health; 2010.

AAP's claims struck me as odd because *there are no studies of conversion therapy for gender identity.* Studies of conversion therapy have been limited to *sexual orientation,* and, moreover, to the sexual orientation *of adults,* not to gender identity and not of children in any case. The article AAP cited to support their claim (reference number 38) is indeed a classic and well-known review, but it is a review of sexual orientation research *only.* Neither gender identity, nor even children, received a single mention in it. Indeed, the narrower scope of that article should be clear to anyone reading even just its title: "The practice and ethics of *sexual orientation* conversion therapy" [italics added].

AAP continued, saying that conversion approaches for GD children have already been rejected by medical consensus, citing five sources. This claim struck me as just as odd, however—I recalled associations banning conversion therapy for sexual orientation, but not for gender identity, exactly because there is no evidence for generalizing from adult sexual orientation to childhood gender identity. So, I started checking AAP's citations for that, and these sources too pertained only to sexual orientation, not gender identity (specifics below). What AAP's sources *did* repeatedly emphasize was that:

A. Sexual orientation of adults is unaffected by conversion therapy and any other [known] intervention;
B. Gender dysphoria in childhood before puberty desists in the majority of cases, becoming (cis-gendered) homosexuality in adulthood, again regardless of any [known] intervention; and
C. Gender dysphoria in childhood persisting after puberty tends to persist entirely.

That is, in the context of GD children, it simply makes no sense to refer to externally induced "conversion": The majority of children "convert" to cisgender or "desist" from transgender

regardless of any attempt to change them. "Conversion" only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that "gender identity is not synonymous with 'sexual orientation'" (Rafferty et al., 2018, p. 3), they went ahead to treat them as such nonetheless.

To return to checking AAP's fidelity to its sources: Reference 29 was a practice guideline from the Committee on Quality Issues of the American Academy of Child and Adolescent Psychiatry (AACAP). Despite AAP applying this source to *gender identity,* AACAP was quite unambiguous regarding their intent to speak to sexual orientation and *only* to sexual orientation: "Principle 6. Clinicians should be aware that there is no evidence that *sexual orientation* can be altered through therapy, and that attempts to do so may be harmful. There is no established evidence that change in a predominant, enduring *homosexual* pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter *homosexuality*. Psychiatric efforts to alter *sexual orientation* through 'reparative therapy' *in adults* have found little or no change in *sexual orientation,* while causing significant risk of harm to self-esteem" (AACAP, 2012, p. 967, italics added).

Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP's actual view was decidedly neutral, noting the lack of evidence: "Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed" (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: "In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood" (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP's actual view.

Next, in reference 39, Byne (2016) also addressed only sexual orientation, doing so very clearly: "Reparative therapy is a subset of conversion therapies based on the premise that *same-sex attraction* are reparations for childhood trauma. Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing *same-sex attractions*" (Byne, 2016, p. 97). Byne does not say this of gender identity, as the AAP statement misrepresents.

In AAP reference 40, Cohen-Kettenis et al. (2008) did finally pertain to gender identity; however, this article never mentions conversion therapy. (!) Rather, in this study, the authors presented that clinic's lowering of their minimum age for cross-sex hormone treatment from age 18 to 16, which they did on the basis of a series of studies showing the high rates of success with this age group. Although it did strike me as odd that AAP picked as support against conversion therapy an article that did not mention conversion therapy, I could imagine AAP cited the article as an example of what the "mainstream of traditional medical practice" consists of (the logic being that conversion therapy falls outside what an 'ideal' clinic like this one provides). However, what this clinic provides is the very *watchful waiting* approach that AAP rejected. The approach

espoused by Cohen-Kettenis (and the other clinics mentioned in the source—Gent, Boston, Oslo, and now formerly, Toronto) is to make puberty-halting interventions available at age 12 because: "[P]ubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved" (Cohen-Kettenis et al., 2008, p. 1894).

Reference 41 presented a very interesting history spanning the 1960s–1990s about how feminine boys and tomboyish girls came to be recognized as mostly pre-homosexual, and how that status came to be entered into the DSM at the same time as homosexuality was being *removed* from the DSM. Conversion therapy is never mentioned. Indeed, to the extent that Bryant mentions treatment at all, it is to say that treatment is entirely irrelevant to his analysis: "An important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the DSM and not unique to GIDC)" (Bryant, 2006, p. 35). How this article supports AAP's claim is a mystery. Moreover, how AAP could cite a 2006 history discussing events of the 1990s and earlier to support a claim about the *current* consensus in this quickly evolving discussion remains all the more unfathomable.

Cited last in this section was a one-paragraph press release from the World Professional Association for Transgender Health. Written during the early stages of the American Psychiatric Association's (APA's) update of the DSM, the statement asserted simply that "The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide." Very reasonable debate can (and should) be had regarding whether gender dysphoria should be removed from the DSM as homosexuality was, and WPATH was well within its purview to assert that it should. Now that the DSM revision process is years completed however, history has seen that APA ultimately retained the diagnostic categories, rejecting WPATH's urging. This makes AAP's logic entirely backwards: That WPATH's request to depathologize gender dysphoria was *rejected* suggests that it is *WPATH's* view—and therefore the AAP policy—which fall "outside the mainstream of traditional medical practice." (!)

AAP based this entire line of reasoning on their belief that conversion therapy is being used "to prevent children and adolescents from identifying as transgender" (Rafferty et al., 2018, p. 4). That claim is left without citation or support. In contrast, what is said by AAP's sources is "delaying affirmation should *not* be construed as conversion therapy or an attempt to change gender identity" in the first place (Byne, 2016, p. 2). Nonetheless, AAP seems to be doing exactly that: simply relabeling any alternative approach as equivalent to conversion therapy.

Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP's stated claim about the existing science on gender identity at all, never mind gender identity of children.

AAP also dismissed the watchful waiting approach out of hand, not citing any evidence, but repeatedly calling it "outdated." The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling watchful waiting the current standard. According to AAP:

> [G]ender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47]

The citations from AAP's reference list are:

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. *Int J Transgend.* 2018;19(2):251–268

47. Olson KR. Prepubescent transgender children: what we do and do not know. *J Am Acad Child Adolesc Psychiatry.* 2016;55(3):155–156.e3

I was surprised first by the AAP's claim that watchful waiting's delay to puberty was somehow "arbitrary." The literature, including AAP's sources, repeatedly indicated the pivotal importance of puberty, noting that outcomes strongly diverge at that point. According to AAP reference 29, in "*prepubertal* boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance" (Adelson & AACAP, 2012, p. 963, italics added), whereas "when gender variance with the desire to be the other sex is present *in adolescence,* this desire usually does persist through adulthood" (Adelson & AACAP, 2012, p. 964, italics added). Similarly, according to AAP reference 40, "Symptoms of GID *at prepubertal ages* decrease or even disappear in a considerable percentage of children (estimates range from 80–95%). Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting *into early puberty* appears to be highly persistent" (Cohen-Kettenis et al., 2008, p. 1895, italics added). That follow-up studies of prepubertal transition differ from postpubertal transition is the very meaning of non-arbitrary. AAP gave readers exactly the reverse of what was contained in its own sources. If AAP were correct in saying that puberty is an arbitrarily selected age, then AAP will be able to offer another point to wait for with as much empirical backing as puberty has.

Next, it was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim. The people in such programs often receive substantial support during this period. Also unclear is on what basis AAP could already know exactly which treatments are "critical" and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: It is only if one were already pre-convinced that gender affirmation is the only acceptable alternative that would make watchful waiting seem to withhold critical support—What it delays is gender affirmation, the method one has already decided to be critical.

Although AAP's next claim did not have a citation appearing at the end of its sentence, binary notions of gender were mentioned both in references 45 and 47. Specifically, both pointed out that existing outcome studies have been about people transitioning from one sex to the other, rather than from one sex to an in-between status or a combination of masculine/feminine features. Neither reference presented this as a reason to reject the results from the existing studies of complete transition however (which is how AAP cast it). Although it is indeed true that the outcome data have been about complete transition, some future study showing that partial transition shows a different outcome would not invalidate what is known about complete transition. Indeed, data showing that partial transition gives better outcomes than complete transition would, once again, support the watchful waiting approach which AAP rejected.

Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot.

Reference 47 was a one-and-a-half page commentary in which the author off-handedly mentions criticisms previously made of three of the eleven outcome studies of GD children, but does not provide any analysis or discussion. The only specific claim was that studies (whether early or late) had limited follow-up periods—the logic being that had outcome researchers lengthened the follow-up period, then people who seemed to have desisted might have returned to the clinic as

cases of "persistence-after-interruption." Although one could debate the merits of that prediction, AAP instead simply withheld from the reader the result from the original researchers having tested that very prediction directly: Steensma and Cohen-Kettenis (2015) conducted another analysis of their cohort, by then ages 19–28 (mean age 25.9 years), and found that 3.3% (5 people of the sample of 150) later returned. That is, in long-term follow-up, the childhood sample showed 66.7% desistence instead of 70.0% desistance.

Reference 45 did not support the claim that watchful-waiting is "outdated" either. Indeed, that source said the very opposite, explicitly referring to watchful waiting as the *current* approach: "Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model *favored by the standards,* we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5" (Ehrensaft et al., 2018, p. 255). Moreover, Ehrensaft et al. said there are cases in which they too would still use watchful waiting: "When a child's gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child" (p. 259). Ehrensaft et al. are indeed critical of the watchful waiting model (which they feel is applied too conservatively), but they do not come close to the position the AAP policy espouses. Where Ehrensaft summaries the potential benefits and potential risks both to transitioning and not transitioning, the AAP presents an ironically binary narrative.

In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all. AAP claimed, "This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population"; however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, "Current available research and expert opinion from clinical and research leaders … will serve as the basis for recommendations" (pp. 1–2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion.

AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with Rafferty, however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence.

Disclosure statement

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Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*, 1413–1423. doi:10.1097/CHI.0b013e31818956b9

Appendix

Count	Group	Study
2/16 4/16 10/16	gay* trans-/crossdress straight*/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
2/16 2/16 12/16	trans- uncertain gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19,* 363–369.
0/9 9/9	trans- gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
2/45 10/45 33/45	trans-/crossdress uncertain gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
1/10 2/10 3/10 4/10	trans- gay uncertain straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,* 511–517.
1/44 43/44	trans- cis-	Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.
0/8 8/8	trans- cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
21/54 33/54	trans- cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
3/25 6/25 16/25	trans- lesbian/bi- straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*, 34–45.
17/139 122/139	trans- cis-	Singh, D. (2012). *A follow-up study of boys with gender identity disorder*. Unpublished doctoral dissertation, University of Toronto.
47/127 80/127	trans- cis-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.

*For brevity, the list uses "gay" for "gay and cis-", "straight" for "straight and cis-", etc.