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SUMMARY OF TESTIMONY

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Subcommittee on Health

1. Suicide of youth with gender dysphoria is extremely rare.

2. Gender dysphoria is a psychiatric condition. There is no established evidence of a biological cause. Most cases resolve on their own, by young adulthood.

3. There is no evidence that puberty blockers, cross-sex hormones, and gender surgeries are lifesaving or medically necessary.

4. The U.S. is increasingly an outlier in the treatment of youth with gender dysphoria

5. Health authorities in the UK, Finland, Sweden and Norway now recommend exploratory psychotherapy as the first line of treatment and have severely restricted hormonal interventions, reserving them for exceptional cases.

6. Those countries have done systemic reviews and concluded that long term benefit from medical interventions has not been established, while the risk of harm is significant.

7. In US hospitals, young teens' natural puberties are prevented. Girls as young as twelve are having mastectomies. Minors are also having genital surgeries. We have no long-term evidence of benefit of these drastic interventions in the current population.

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Child, Adolescent and Adult Psychiatry

Chair McMorris-Rodgers and members of the House Energy and Commerce Subcommittee on Health:

Thank you very much for the opportunity to testify this morning.

My name is Miriam Grossman and my psychiatric practice is focused on youth who have distress about being male or female, and their parents.

I'm here today to provide you with facts you haven't heard. You haven't heard them because when it comes to youth gender dysphoria (also called "transgenderism"), the public and most importantly parents, are, I am sad to say, consistently fed misinformation. It's for that reason I wrote a book - *Lost in Trans Nation: A Child's Psychiatrist's Guide Out of the Madness,* so that people and especially parents be truly informed.

I'll start with the claim that Gender Affirming Care (GAC) - puberty blockers, cross-sex hormones, and surgeries - are "lifesaving", and that restricting minors' access to them will result in a wave of suicides.

Let me be clear - we are all on the same page here. Every suicide is a tragedy. But this claim is both false and dangerous.

First, it conflates *suicidality* with actual suicide. Suicidality refers to thoughts about suicide and to self-injurious behaviors. The former might be thinking for a moment, "I wish I was never born". The latter would include making superficial scratches on one's arm with a paper clip. I am not minimizing the distress involved, but these thoughts and behaviors are extremely common, especially among teenagers, and certainly among teens with mental health issues. When people are questioned about past suicidality, they almost always say they did *not* wish to die.

When you hear about the alarmingly high risk to the well-being of transgender youth, what's meant is suicidality, not actual suicide. This is a critical distinction of which few are aware.

Actual suicide is thankfully extremely rare, even among transgender-identified teens. In the US there are no data on suicide rates in this population. In the U.K., a peer-reviewed study found the rate of suicide amongst 15,000 youth referred to a clinic for gender dysphoria during a 10 year period was 0.03% - there were 4 deaths - an extremely low rate.

Please note, two of the suicides were amongst patients being treated, and the other two were amongst those on the waiting list – not being treated. If GAC is indeed as we are told "lifesaving", we would expect suicides only among patients on the waiting list.

A longitudinal study in Sweden – one of the only long-term studies on this population - found that even after full sex reassignment, transsexual people were over 19 times more likely to die by suicide than population-matched controls.

The claim that kids who identify as transgender are at higher risk for suicidality than non-transgender identified kids is technically true, but it confuses correlation and causation. There is much more evidence that kids with severe mental health problems, which are independently linked to suicidality, are gravitating toward a transgender identity, perhaps believing that gender is the source of and the solution to their problems. By placing these immature and troubled patients in the driver's seat and allowing them to direct their medical care, medical professionals fail to provide the care they need, and instead compound their problems by adding to their emotional issues a lifetime of sterility and medical complications.

Not only is the suicide narrative false, but its use in public debates is outright dangerous. The CDC has long warned that there is never a single cause to suicide and that it's irresponsible to ignore the complex, underlying triggers for this behavior.

Finland's widely acknowledged expert on youth with gender dysphoria is Riittakerttu Kaltiala. When asked about the claim that trans youth have an increased risk of suicide and therefore urgently need treatment and support, she responded, "It's purposeful disinformation, the spreading of which is irresponsible."

The U.S. is increasingly an outlier in how we treat youth with gender dysphoria. Sweden, Finland, and the U.K. all had so-called "gender-affirming care" in their pediatric clinics for about a decade, and all have since backed away from that model in favor of a more conservative approach. Health authorities in all three countries now recommend exploratory psychotherapy as the first line of treatment and reserve hormonal interventions only for exceptional cases.

To qualify for puberty blockers, an adolescent's gender issues will need to have started in early childhood. In addition, any co-occurring mental health problems the patient has will have to be reasonably well-controlled. The Europeans have stipulated these two conditions because they've recognized that a majority of minors presenting at their clinics were teenagers with no childhood history of gender issues and with many psychological problems, including autism, ADHD, and history of sexual abuse.

If American clinics were to adopt these eligibility criteria, it would automatically exclude most of the teenagers getting sex change drugs today.

Sweden, Finland, and the U.K. also require that any medical interventions be done strictly within research settings. This is because puberty blockers and cross-sex hormones have not been adequately studied. As Finland's Council for Choices in Healthcare has said, this is "an experimental practice."

Earlier this year, Norway's healthcare watchdog UKOM said that the affirmative model is not safe and contains too many risks and unknowns. It did this after receiving complaints from former patients and families who said they were rushed into medical transition. Norway is expected to join the list of countries that have severe restrictions on hormonal interventions.

In France, the National Academy of Medicine has urged "great caution" in the use of puberty blockers and cross-sex hormones to treat gender-related distress in minors. Two months ago, the director of Belgium's Center for Evidence Based Medicine said that he would throw the World Professional Association for Transgender Health's guidelines "into the bin." And just a few weeks ago, a major insurance company in Australia decided it would no longer be offering medical malpractice insurance to doctors in private practice who prescribe hormonal interventions for gender issues.

In short, other countries are turning away from the treatment model known as “gender-affirming care,” recognizing that its risks are serious and that its benefits are unproven.

Here in the United States, doctors and hospitals are fully committed to the affirmative model. At the heart of that model is the belief that being transgender is innate, and that a child knows their permanent transgender identity from as early as age 2. Practitioners of the affirmative model regularly tell us that because “trans kids know who they are,” it’s unethical to use exploratory therapy to discern whether a child’s rejection of her body in favor of some alternative “gender identity” is being caused by some underlying mental health issue or as a response to family issues, trauma, the social pressures of adolescence, or other factors.

In 2018 the American Academy of Pediatrics explicitly called exploratory therapy, the treatment recommended by European countries, “conversion therapy” and declared it unethical. Dr. Megan Mooney, who is president of the Texas Psychological Association, recently told lawmakers in Texas that she uncritically “affirms”—that is, agrees with—the transgender self-identification of any child who enters her practice, regardless of circumstance. When asked if she has ever refused to write a letter of support recommending hormonal treatments for any of her patients, Dr. Mooney couldn’t or wouldn’t recall a single instance.

In February, a brave whistleblower, Jamie Reed, signed a sworn affidavit documenting egregious and harmful practices at the pediatric clinic of the Washington University Transgender Center in St. Louis, Missouri. Parents were promised full psychological evaluation and support but received little or none. Instead, their children were instantly “affirmed” and put on the medical track. The psychological support their kids received was in the form of therapists agreeing with their self-diagnosis of being transgender.

Doctors and clinics that practice affirmative medicine claim that care is individualized and multidisciplinary. This is highly misleading. In practice, all of the clinicians and staff who work at these centers are committed to the affirmative approach: the child knows best who they are and what they need.

How do I know? They say so. At the Oregon Health and Science University Transgender Health Program, for example, a social worker recently explained that every single physician, mental

health professional, social worker, and staff member is affirming. This means that no one examines a particular patient's self-diagnosis. Jamie Reed described the same thing at her clinic. It didn't matter how mentally ill the patient was, if he or she claimed a transgender identity, it was at once accepted. This would not be acceptable in any other field of medicine.

When affirmative clinicians say that care is "individualized," they don't mean that the circumstances of every patient that led him or her to adopt a trans identity and seek drugs and surgeries is carefully scrutinized. What they mean, instead, is that clinicians appreciate that each patient's "embodiment goals" are different. One patient might want testosterone but no double mastectomy. Another might want a double mastectomy but no genital surgery. A third might want "non-binary" surgery, a new category of procedures that essentially removes all genitals, and a vagina-preserving phalloplasty, which leaves the patient with a vagina and a surgically crafted penile shaft.

Supporters of "gender-affirming care" regularly deny that surgeries are happening. In Texas, lawyer and physicians Cody Miller Pyke told state senators that "children under the age of eighteen in this country do not have gender reassignment surgery. There isn't a single case." Louis Apel, president of the Texas chapter of the American Academy of Pediatrics, and Jessica Zwiener, a Houston-based endocrinologist, testified in the same hearing that "surgeries are not part of the standard of care for minors." Dr. Zwiener also said that "no one is touching these kids' genitals. There is not surgery done on minors."

The facts tell another another story. First of all, the World Professional Association for Transgender Health, whose Standards of Care are cited by American doctors and hospitals as authoritative, does include surgeries—including genital surgeries—within its standard of care for minors. Indeed, shortly after publishing its latest standards of care last year, WPATH quickly eliminated all age minimums for physical interventions.

The Reuters investigation from last year found evidence of at least 56 genital surgeries on children ages 13-17 between 2019 and 2021. This number doesn't include children whose parents paid for the procedure out of pocket. A 2017 peer-reviewed article titled "Age is Just a

Number" found WPATH-affiliated surgeons reporting "a definite increase in the number of minors seeking vaginoplasty."

Meanwhile, the number of bilateral mastectomies for teenage girls has surged. Double-mastectomies—known euphemistically as "top surgery"—increased 13-fold between 2013 and 2020, and by 500% percent between 2016 and 2019 alone. The youngest document patient to receive a "gender-affirming" double mastectomy was 12 years old.

The Biden administration's Department of Health and Human Services has said double mastectomies as well as genital surgeries are "typically used in adulthood or case-by-case in adolescents."

The affirmative model of care is driven by a potent combination of radical gender ideology and profit motives. In 2018, the director of the Vanderbilt University Medical Center transgender program told an audience at her grand rounds that sex change procedures are a source of profit for hospitals. Genital surgeries in particular, she said, are "huge moneymakers."

This is not medicine. It's pharmaceutical and surgical consumerism. And it preys on society's most vulnerable population: children, and loving parents who are in crisis and trust the professionals to whom they turn for guidance.

Why have European countries backed away from "gender-affirming care"? What do health authorities in these countries know that our medical associations don't? Why is there a growing international consensus against "gender-affirming care"?

Sweden, Finland, and the U.K. have all done systematic reviews of evidence for the use of puberty blockers and cross-sex hormones in this context. All three countries came to the same conclusion. In the words of Sweden's SBU, the risks of early physical interventions "currently outweigh the possible benefits."

In evidence-based medicine, systematic reviews of evidence constitute the highest level of evidence evaluation for a particular intervention. The expert opinion of doctors constitutes the

lowest level, meaning the least reliable source of information, due to its vulnerability to confirmation bias.

In contrast to their European counterparts, American medical associations have either not done or have not based their recommendations on systematic reviews of evidence. The American Academy of Pediatrics' policy statement, for example, was written by a single doctor fresh out of residency and cherry-picks studies and blatant omissions and mischaracterizations of the available research. It is precisely this kind of biased review of the literature that systematic reviews are designed to prevent.

An investigative report published in the prestigious British Medical Journal earlier this year interviewed the world's leading experts in evidence-based medicine, including Professor Gordon Guyatt. The report found that although U.S. guidelines for treating youth gender dysphoria are "consensus-based," they are not "evidence-based."

Even this consensus, however, is a mirage. The AAP, for instance, has spent the past five years doing everything in their power to silence pediatricians who argue that guidelines should be based on systematic reviews and not the whim of one inexperienced doctor.

In sum, around the world medical authorities are slowly but surely aligning their practices with the principles of evidence-based medicine. They are taking seriously their commitment to the principle of "first, do no harm." Here in the U.S., I regret to say, professional medical associations are allowing a small group of ideologically driven activists to dictate the standard of care.

Last year, England's National Health Service decided to close its main pediatric gender clinic. In her report to the NHS, Dr. Hilary Cass, who evaluated the clinic, said that clinicians and staff "feel under pressure to adopt an unquestioning affirmative approach [that is] at odds with the standard process of clinical assessment and diagnosis…" This affirmative approach, Dr. Cass said, "originated in the USA."

I want to conclude by debunking two common myths about "gender-affirming care." The first is that puberty blockers are safe and fully reversible, and merely provide children with "time to think" about their identities and whether to continue on to cross sex hormones.

This is simply untrue.

The claim about reversibility is based on the drug's original use in treating precocious puberty – which unlike dysphoria is *a medical condition*. Kids with dysphoria have no physical abnormalities. Furthermore, studies over the past decade have consistently shown that 93 to 98 percent of children who take puberty blockers for gender dysphoria end up going further down the medical pathway, on cross sex hormones. You have to be either naïve or deeply immersed in gender ideology to believe that the reason for this extremely high rate of persistence is the clinicians' ability to avoid false positives. A far more plausible explanation is that puberty blockers themselves lock in feelings of dysphoria and interfere with the natural process of dysphoria resolution, *which is puberty itself*. We know, for instance, that between two-thirds and four-fifths of kids with gender dysphoria will desist from it by adulthood—meaning, they will come to terms with their bodies and their sex. Most, in fact, will turn out to be gay.

Even the Dutch clinicians who pioneered this work have recognized the possibility that puberty blockers cause the very thing they purport to cure. In a paper published in February, the Dutch team acknowledged the possibility that "starting [puberty blockers] in itself makes adolescents more likely to continue medical transition."

Last year, New Zealand's health ministry deleted the words "safe and fully reversible" from its website when discussing puberty blockers. In her book on what happened at the Tavistock clinic, for which she interviewed dozens of clinicians who worked there, BBC Hannah Barnes documents the disillusionment that so many of these clinicians experienced when they saw the near certainty with which kids whose puberty was blocked would continue with medical transition. As one clinician who worked there put it: "It totally exploded the idea that when we were offering puberty blockers, we were actually offering time to think."

American doctors who practice "gender-affirming care" insist that puberty blockers are safe. They can't possibly know that as there have never been randomized controlled trials to assess

what the risks are and whether they are worth any purported benefits. Proponents of puberty blockers for gender dysphoric teens claim that such trials would be unethical because puberty blockers are known to improve mental health. But that is precisely what they cannot know without randomized controlled trials.

The assertion that puberty blockers improve mental health does not stand up to critical scrutiny. It is based on a small number of highly flawed studies with serious methodological problems. For example, a 2022 study at Seattle Children's Hospital found no evidence of improvement among those who received puberty blockers. It did find mental health deterioration among those who did not receive puberty blockers, but even this wasn't a reliable finding because 80% of the non-intervention group dropped out by the end of the study. It's possible, and I'd argue likely, that many or most of these kids dropped out because they got better without puberty blockers. The researchers have thus far refused to publish their data, so it's impossible to know.

The European health institutions that did systematic reviews of evidence looked at these studies and rated the quality of their evidence as "low" or "very low."

The final myth I want to address is the claim that regret and detransition – returning to the identity consistent with one's body - are extremely rare. There is absolutely no evidence to support this assertion. The studies that are cited in support of this claim were done primarily on those who "transitioned" as adults, and the few minors who are included were transitioned under the Dutch, not the affirmative, protocol. We are dealing with an entirely different population now. Again, today's gender dysphoric youth would have been excluded from the original Dutch study, as they would not have met their strict criteria, including a stable mental health status.

More recent studies have found rates of hormone discontinuation of up to 30 percent. A 2021 study found that three-quarters of detransitioners never report their decision to their providers, often because they feel shame. Others feel that their providers don't want to hear about regret or mistakes in diagnosis. Whistleblower Jamie Reed's sworn affidavit confirms that doctors at the St. Louis clinic were uninterested in following up on patient outcomes.

The truth is that we don't know how common regret and detransition are, and likely won't know for at least a decade. That's because the affirmative model of treatment, which actively opposes

any "gatekeeping," has only been in use for about a decade, and most cases of medicalization have happened in the past few years alone.

We know that rates of trans identification and medicalization among youth are soaring. Between 1.4 and 9.2 percent of Generation Z now identifies as transgender. According to data from Reuters, 121,882 new diagnoses of gender dysphoria for children ages 6-17 were added between 2017 and 2021. That includes a 20% year-over-year increase between 2017 and 2020, and a 70% percent increase between 2020 and 2021—the year that COVID lockdowns resulted in more teenage isolation and social medica addiction. The Doernbecher Children's Hospital in Portland, Oregon, saw a 4,500 percent increase in pediatric referrals between 2013 and 2021.

In sum, the American medical establishment is clearly unwilling or unable to regulate itself in the interest of patient health. It is the duty of Congress to protect children and families, including from those who have taken an oath to "first, do no harm."

Thank you all for your service to the citizens of your districts and our nation. I look forward to your questions.