AB2119: VOTE NO ON PERMANENT HARM TO MINORS

July 14, 2018

Dear California Senator,

The ACLU of Rhode Island says gender-affirmative hormone treatment is controversial even within the medical profession itself.[1]

We oppose CA AB2119 because giving affirmative transgender treatment to minors causes these harms and injustices:

AB 2119 would send dysphoric children and adolescents onto a path of:
experimental puberty blockers and toxic hormones that combined *often sterilize them*[2] *and foreclose sexual functioning for life (they'll never have an orgasm),*[3] having their *breasts surgically removed, potential castration,* a lifetime of being a medical patient, a nearly 3 times higher persisting rate of psychiatric *hospitalizations* and a 19 times higher rate of *completed suicides* after sex change even if they live in a liberal and affirming community,[4] all with the assumption that 11, 14, or 16 year old minors are competent to choose these treatments—and all before they are old enough to drive.
This is hardly a cure for suicide. Sexual non-function will effectively isolate an adult.

Gender variant feelings carry a high probability of resolving naturally if not affirmed.
As many as 98% of boys and 88% of girls[5] and no less than 75% of boys and girls will come to embrace their body if getting therapy for individual problems and *not* living as the opposite sex which virtually assures many children who would have resolved their gender dysphoria naturally will instead head down a risky and grueling path.[6]
- American Psychiatric Association, *Diagnostic and Statistical Manual, Fifth Edition*
- American Psychological Association, *APA Handbook of Sexuality and Psychology*
- Endocrine Society and 6 co-sponsoring organizations including the World Professional Association for Transgender Health (WPATH), "An Endocrine Society Clinical Practice Guideline"[7] [8] [9]

8 *professional organizations* say there are psychological causes of gender incongruence. They caution: socially transitioning gender dysphoric children to live as the opposite sex may lock them in—exactly what AB2119 promotes, but talk therapy may resolve both underlying psychological causes and gender dysphoria and spare bodily harm.
- WPATH: gender incongruence may be "better accounted for by other diagnoses."[10]
- The Endocrine Society and 6 co-sponsoring organizations say "psychological interventions may be sufficient."[11]
- The American Psychological Association's *Handbook of Sexuality and Psychology* says transgender identity may have pathological causes. Affirmative treatment may neglect individual problems gender dysphoric minors are experiencing.[12]

- Some don't want medical treatment or social transitioning. Some want help to embrace their innate body. They should have the right to counseling to identify as *they* choose.
- Most children can say by 2 1/2 or 3 years of age that they are a boy or a girl. But they may not understand their sex is their's for life until they are older. Gender distressed children are still developing their gender identity until adolescence or adulthood. Affirmative treatment locks them in, forecloses natural resolution.

Affirmative treatments are NOT evidence-based as sponsors claim, carry high medical risks. This is not health.

- No science behind puberty blockers.[13] (National Institutes of Health)
- Puberty blockers can cause sudden cardiac death,[14] may affect brain development.[15]
- Science behind toxic cross-sex hormones is rated "low" and "very low" in quality.[16]
- High doses of high risk sex hormones have deadly blot clot and cancer risks & more.[17]

- Endocrine Society Clinical Practice Guidelines co-sponsored by 6 organizations
- World Professional Association for Transgender Health (WPATH) Standards of Care
- National Institutes of Health (NIH)

Under AB 2119, government approves an *experimental* treatment approach in cement before we even have the science to justify the known and permanent bodily harms. Science, not the state, should work out these decisions, and science is always changing.
Locking in these experimental treatments that have enormous known short- and long-term harms and risks is controversial within the medical and mental health professions. Should legislators rush in where professionals fear to tread?
The ACLU of Rhode Island says gender-affirmative hormone treatment is controversial even within the medical profession itself.

- Long term risk of 19 times higher rate for *completed* suicide is hardly a cure for suicide.
- A *persisting* nearly 3 times higher rate of psychiatric *hospitalizations before and after sex change, even in a liberal and supportive community,* is not addressing mental health.
- Destruction of healthy fertility, breasts, and reproductive organs is not health.
- Adolescents are still developing and cannot understand what it means to be a parent or to permanently give up the option to have an orgasm or bear their own children.

Transgender health is resolving both underlying causes and gender dysphoria while preserving a healthy body. Protect minors, because once sexual function, fertility, breasts, and reproductive organs are gone—there is no return.

Sincerely, Laura Haynes, Ph.D.

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Representing the National Task Force for Therapy Equality (TherapyEquality.org)
See this letter/fact sheet *with endnotes* at TherapyEquality.org

Endnotes:

[1] Medical transitioning treatment is controversial in the medical profession itself:
ACLU of Rhode Island (March 22, 2017), blog, http://www.riaclu.org/blog/post/the-aclu-of-rhode-island-opposes-conversion-therapy
YouthTransCriticalProfessionals.org.
4thWaveNow.com
Cross-sex hormones and other transsexual treatments have many health risks and their use is not evidence-based:
World Professional Association for Transgender Health (2011), Standards of care for the health of transsexual, transgender, and gender nonconforming people, Seventh Revision, pp. 37-40, 47, 50, 63-67, 97-104, http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351.
Hembree, W., Cohen-Kettenis, P., Gooren, L., Hannema, S., Meyer, W., Murad, M., Rosenthal, S., Safer, J., Tangpricha, V., & T'Sjoen, G. (2017) Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guildeline. *J Clin Endocrinol Metab, 102*: 1–35, https://academic.oup.com/jcem/article-abstract/doi/10.1210/jc.2017-01658/4157558/Endocrine-Treatment-of-Gender-Dysphoric-Gender
The Endocrine Society Guideline is co-sponsored by 6 additional organizations: American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

[2] Endocrine Society Guideline (6 co-sponsors) (2017), pp. 14-15.

[3] Testimony of Michael Laidlaw, M.D., endocrinologist. CA Senate Judicial Committee, 6/26/2018. See also Laidlaw, M., April 5, 2018, Gender dysphoria and children: An endocrinologist's evaluation of *I am Jazz*, Public Discourse. http://www.thepublicdiscourse.com/2018/04/21220/

[4] Cecilia, D., Lichtenstein, P., Boman, M., Johansson, A., Langstrom, N., Landen, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden.,*Plos One*

[5] American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, Arlington, VA: American Psychiatric Association. Desistance rates calculated from persistence rates on p. 455.

[6] Bockting, W. (2014). Chapter 24: Transgender Identity Development. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology* (2 volumes). Washington D.C.: American Psychological Association, *1*: 744.

[7] The Endocrine Society Guideline is co-sponsored by 6 additional organizations: American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

[8] Endocrine Society Guideline (6 co-sponsors) (2017), p. 10.

[9] Zucker, K. (May 29, 2018). The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. *International Journal of Transgenderism*, published online. https://doi.org/10.1080/15532739.2018.1468293

[10] WPATH, Standards of Care (2011), p. 24.

[11] Endocrine Society Guideline (6 co-sponsors) (2017), p. 12.

[12] *APA Handbook of Sexuality and Psychology (2014), 1*: 743-744, 750.

[13] PUBERTY BLOCKER TREATMENT NOT EVIDENCE-BASED: As yet, we have *no* science on the long term medical effects of blocking puberty. This treatment is not evidence-based as supporters claim. The NIH in 2015 began the largest-ever study of transgender youth, and it is the first to track medical effects of delaying puberty and only the second to follow its psychological impacts. It will not be completed until 2020.
Olson, J., Garofalo, R., Rosenthal, St., Spack, N. (2015-2010) The Impact of Early Medical Treatment in Transgender Youth. National Institutes of Health. (Grant study description.)
http://grantome.com/grant/NIH/R01-HD082554-01A1
"This multi-center study will be the first in the U.S. to evaluate longitudinal outcomes of medical treatment for transgender youth and will provide essential evidence-based data on the physiological and psychosocial effects and safety of treatments currently used for transgender youth."

[14] PUBERTY BLOCKERS CAUSE SUDDEN CARDIAC DEATH: Gagliano-Juca, T., Traveison, T., Kantoff, P. Nguyen, P. L., Taplin, M-E, Kibel, A., Huang, G., Bearup, R., Schram, H., Manley, R., Beleva, Y., Edwards, R., Basaria, S. (2018). Androgen Deprivation Therapy is Associated with Prolongation of QTc Interval in Men With Prostate Cancer. *Journal of the Endocrine Society, 2*: 485-496. The same artificial hormone is used as a puberty blocker in minors.

[15] PUBERTY BLOCKERS MAY AFFECT BRAIN DEVELOPMENT: Endocrine Society Guideline (6-cosponsors), (2017), pp. 14-15.

[16] CROSS-SEX HORMONE TREATMENT NOT EVIDENCE-BASED: WPATH Standards of Care (2011), p. 24. "To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition."
Endocrine Society Guideline (with 6 co-sponsoring organizations) (2017), see research ratings throughout the Guideline indicated by a row of circles.

[17] HIGH RISK TOXIC CROSS-SEX HORMONES: Standards of Care (2011), pp. 37-40, 50, 97-104. Risks for women: polycythemia, weight gain, balding, sleep apnea, possible cardiovascular disease, diabetes type 2, bone density loss, and increased risk of cancers (breast, cervical, ovarian, and uterine). Risks for men: gallstones, weight gain, blood clots (venous thromboembolisms), and sexual dysfunction; also possible cardiovascular disease, diabetes type 2, and breast cancer. Hembree et al. (2017), PP. 21-25. Testimony of Michael Laidlow, M.D., Endocrinologist, CA Senate Judiciary Committee, 6/26/2018.