No. 18-107

In the Supreme Court of the United States

R.G. & G.R. HARRIS FUNERAL HOMES, INC.
v.
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, *et al.*

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF OF *AMICUS CURIAE*
DR. PAUL R. MCHUGH, M.D.
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IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES................................iv

INTEREST OF AMICUS CURIAE........................1

SUMMARY OF THE ARGUMENT........................2

ARGUMENT..5

I. Gender Identity is Not Sex and a Person's Beliefs about Their Gender Identity Has No Bearing on Their Sex...5

II. Policy Should Not be Used to Enforce Bad Medicine — Treating Gender Dysphoria Through Social Transition and Mandatory Gender Affirmation Rests on Unreliable Testimonials.................14

A. The Evidence Does Not Demonstrate that Gender Affirmation and Social Transition are Necessary for the Well-Being of Those Suffering from Gender Dysphoria..................................15

1. Social Transition Encourages a Gender Dysphoric Person to Indulge in a Falsehood, Which does not Address the Root Issues Causing Clinical Distress and Makes it Harder for the Mind to Accept Reality..............19

2. Hormone Therapy has not been Proven Beneficial, and there are Harmful Consequences to Artificially Manipulating the Body.............21

3. Surgical Intervention has not Proven Beneficial, and there are Harmful Consequences to Surgically Altering Healthy Bodies............23

4. Ancillary Procedures................27

B. There is Insufficient Scientific Evidence to Support Treating Gender Dysphoric Children as if They are the Opposite Sex.....................28

1. Gender Dysphoric Children Suffer from a Psychological Disorder that Can Be Resolved through Therapy in Many Cases...........................28

2. Gender Affirmation and Medical Intervention for Gender Dysphoric Children is Not Helpful, and Can be Harmful.....................................29

III. Protocols Calling for Social Affirmation, Hormone Treatment, and Sex Reassignment Surgery are a Reflection of Ideology and Activism, Not Evidence Based Medicine..32

CONCLUSION..38

TABLE OF AUTHORITIES

Cases

Etsitty v. Utah Transit Auth., 502 F.3d 1215, 1224 (10th Cir. 2007) 12

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Decl. of Allan M. Josephson, M.D., Ex. J in Resp. to Opp'n for Mot. for Prelim. Inj., *United States of America v. State of North Carolina*, No. 16-425 (M.D.N.C., dismissed April 14, 2017) 19, 20, 34

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INTEREST OF *AMICUS CURIAE*[1]

Amicus Curiae Paul R. McHugh, M.D. is the University Distinguished Service Professor of Psychiatry at the Johns Hopkins University School of Medicine. From 1975 until 2011, Dr. McHugh was the Henry Phipps Professor of Psychiatry and the director of the Department of Psychiatry and Behavioral Science at Johns Hopkins. At the same time, he was psychiatrist-in-chief at Johns Hopkins Hospital with overall responsibility for the proper care and treatment of patients with, among other issues, sexual disorders.

Dr. McHugh appears as *amicus* not to discuss statutory construction but to critically evaluate, on the basis of his clinical and scientific expertise, Respondents' and the Court of Appeals' conflation of sex and gender identity. He also seeks to discuss the frequently heard claims about gender identity, which sometimes masquerade as science but are really ideological pronouncements not supported by scientific evidence. In addition to showing that sex, from a medical standpoint, does not include gender identity, Dr. McHugh's expertise is helpful in challenging the supposed scientific imperative for gender affirmation.[2]

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[1] No counsel for a party authored this brief in whole or in part, and no party, party's counsel, or any person other than *amicus curiae* or his counsel contributed money intended to fund preparation or submission of this brief. This brief is filed with consent of the parties.

[2] Gender affirmation refers not to the imperative that we all have to treat others with respect, but here specifically refers to the way persons are asked or required to affirm others' beliefs that they are the opposite sex.

SUMMARY OF THE ARGUMENT

At issue in this case is the meaning of sex under Title VII, and by extension, the meaning of sex under federal law generally. For the duration of *amicus's* long professional career (having graduated from Harvard Medical School in 1956), "sex" has consistently referred to being objectively and biologically male or female. "Gender identity" refers to something quite different from sex – namely, a person's subjective sense of being male or female or something else. Sex is innate, fixed, and binary; gender identity is a fluid belief system based on cultural constructs.

The American Medical Association (AMA) and the American Psychiatric Association (APA) thoroughly confuse sex and gender identity or transpose them, as if gender identity is innate and fixed at birth, while sex is malleable and the body configurable to one's sense of gender identity. They attempt to obfuscate their ideological pronouncements as science. However, "[t]he hypothesis that gender identity is an innate, fixed property of human beings that is independent of biological sex — that a person might be 'a man trapped in a woman's body' or 'a woman trapped in a man's body' — is not supported by scientific evidence." Lawrence S. Mayer and Paul R. McHugh, *Sexuality and Gender: Findings from the Biological Psychological, and Social Sciences*, New Atlantis, Fall 2016, at 8. In addition, "[s]tudies comparing the brain structures of transgender and non-transgender individuals . . . do not provide any evidence for a

neurobiological basis for cross-gender identification." *Id*.

According to the Sixth Circuit, employers are required by law to treat employees in accordance with their asserted gender identity instead of their biological sex. There is, however, no scientific evidence that such a gender-affirming mandate helps people it aims to serve. Those identifying as the opposite sex have a disproportionate rate of mental health problems compared to the population as a whole, and they need help and compassion. However, "[t]here is a great chasm between much of the public discourse and what science has shown." *Id*, at 116. Indeed, there is insufficient scientific evidence that living one's life as a member of the opposite sex is the solution, and there is evidence that it is harmful.

The AMA and APA briefs demonstrate that when medical associations are committed to an ideology, it erodes the objectivity of their scientific claims. Dr. McHugh notes that unfortunately in his profession, "there is a deep prejudice in favor of the idea that nature is totally malleable."[3] However,

> [w]ithout any fixed position on what is given in human nature, any manipulation can be defended as legitimate. A practice that appears to give people what they want — and what some of them are prepared to clamor for — turns out to be difficult to combat

[3] Paul R. McHugh, *Surgical Sex*, First Things, November 2004. https://www.firstthings.com/article/2004/11/surgical-sex.

> with ordinary professional experience and wisdom. Even controlled trials or careful follow-up studies to ensure that the practice itself is not damaging are often resisted and the results rejected.

Id.

The AMA's and APA's prioritization of ideology over science is not good for anyone. "Sex change" is biologically impossible, and those associations are "doing no favors" to either the public or those who identify as transgender "by treating their confusions as a right in need of defending rather than as a mental disorder that deserves understanding, treatment and prevention."[4]

The treatment of gender identity is much like the famous Hans Christian Anderson tale, *The Emperor's New Clothes*, in which the spectators all pretend not to notice that the emperor walks through the streets wearing nothing.[5] Those watching "the contemporary transgender parade" know that "a disfavored opinion is worse than bad taste," so they shrink from stating clear facts. *Id*. McHugh recognized that he is "ever trying to be the boy among the bystanders who points to what's real. [He does] so not only because truth matters, but also

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[4] Paul R. McHugh, *Transgender Surgery Isn't the Solution*, Wall Street Journal, June 12, 2014 (updated May 13, 2016). https://www.wsj.com/articles/paul-mchugh-transgender-surgery-isnt-the-solution-1402615120.

[5] Paul R. McHugh, *Transgenderism: A Pathogenic Meme*, Public Discourse, June 10, 2015. https://www.thepublicdiscourse.com/2015/06/15145/.

because overlooked amid the hoopla . . . stand many victims." *Id.*

From a medical and scientific standpoint, the more something appears to be true based on what is observable, greater care is necessary before reaching an opposite conclusion. Here the biological reality of sex is undeniable, and the benefits of affirming persons' disbelief in this reality are unclear and the risks are significant. As such, interpreting the law in such a way to create gender affirming policies (policies that require persons to affirm others' beliefs that they are the opposite sex) may be causing rather than relieving suffering.

ARGUMENT

I. Gender Identity is Not Sex and a Person's Beliefs about Their Gender Identity Has No Bearing on Their Sex.

Sex refers to the two halves of humanity, male and female. It is well defined based on the binary roles that males and females play in reproduction. *See* New Atlantis, *supra*, at 86, 89. "In biology, an organism is male or female if it is structured to perform one of the respective roles in reproduction. This definition does not require any arbitrary measurable or quantifiable physical characteristics or behaviors, it requires understanding the reproductive system and the reproduction process."[6]

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[6] Sterility, birth defects, or even purposeful removal of healthy sex organs as in "sex reassignment surgery" does not change one's sex — "while a reproductive system structured to serve a particular reproductive role may be impaired in such a way that it cannot perform its function, the system is still

Id. at 90. The structural difference for the purpose of reproduction is the only "widely accepted" way of classifying the two sexes. *Id*. "This conceptual basis for sex roles is binary and stable, and allows us to distinguish males from females on the grounds of their reproductive systems, even when these individuals exhibit behaviors that are not typical of males or females." *Id* at 89.

Sex is not and cannot be "assigned at birth," despite the assertions of the AMA, APA, and Respondents. *See* Stephen's Br. at 5 ("[S]ex assigned at birth refers to sex an infant is presumed to be at birth."). The language of "assigned at birth" is purposefully misleading and would be identical to an assertion that blood type is assigned at birth. Yes, a doctor can check your blood type and list it. But blood type, like sex, is objectively recognizable, not assigned. In fact, the sex of a child can be ascertained well before birth. *See* Keith L. Moore & T.V.N. Persaud, The Developing Human: Clinically Oriented Embryology 307 (Saunders 7th ed. 2003) ("[T]he type of sex chromosome complex established at fertilization determines the type of gonad that differentiates from the indifferent gonad. The type of gonads present then determines the type of sexual differentiation that occurs in the genital ducts and external genitalia.").[7]

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recognizably structured for that role, so that biological sex can still be defined strictly in terms of the structure of reproductive systems." *Id.* at 91.

[7] *Amicus* interACT argues that intersex individuals disprove the claim that "a person's status as male or female" is "objectively determined by anatomical and physiological factors, particularly those involved in reproduction." interACT

"Gender identity" has no bearing on a male's or a female's sex. Stephens maintains that, although in every biological and physiological way a man, Stephens is really a woman. *See* Stephens Br. at 5 (stating that Stephens recalls thinking this from a young age). Stephens felt a deep affinity towards things that are culturally and stereotypically associated with girls. But Stephens was not, and is not, a girl no matter how many of the stereotypes about girls Stephens adopts and no matter how deeply Stephens believes that affinity for those stereotypes about females transforms Stephens into a female. *See* New Atlantis, *supra*, at 93 ("No degree of supporting a little boy in converting to be considered, by himself and others, to be a little girl makes him biologically a little girl. The scientific definition of biological sex is, for almost all human beings, clear, binary, and stable, reflecting an underlying biological reality that is not contradicted by exceptions to sex-typical behavior, and cannot be altered by surgery or social conditioning.").

The "popular notion regarding gender identity" that says a person has a "boy mind in a girl body" or vice versa is merely an idiom used by a person seeking to describe some type of distress to others. Just as we have seen before during the height of the

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Br. at 26. Intersex is not an additional category that erodes our understanding of sex as male or female based on anatomy. Instead, intersex is an anomaly that highlights the norm of male and female anatomy. Science does not look to the anomaly to disprove the norm. By way of example, humans have twenty-three pairs of chromosomes. The anomaly faced by persons with Down Syndrome, a third copy of chromosome 21, does not change what is true about human genetics any more than intersex changes what is true about sex.

discredited multiple personality disorder era, such testimonials are not truth, even if one asserts it as a truth claim. Such a "view implies that gender identity is a persistent and innate feature of human psychology." *Id.* at 106. But based on "the neurobiological and genetic research on the origins of gender identity, there is little evidence that the phenomenon of transgender identity has a biological basis." *Id.* at 106. There are problems with the methodological limitations of any imaging study that assesses "girl brain" and "boy brain" theories:

> [I]t is now widely recognized among psychiatrists and neuroscientists who engage in brain imaging research that there are inherent and ineradicable methodological limitations of *any* neuroimaging study that simply associates a particular trait, such as a certain behavior, with a particular brain morphology. (And when the trait in question is not a concrete behavior but something as elusive and vague as "gender identity," these methodological problems are even more serious).

Id. at 103.

Therefore,

> there are no studies that demonstrate that any of the biological differences being examined have predictive power, and so all interpretations, usually in popular outlets, claiming or suggesting that a statistically significant difference

> between the brains of people who are transgender and those who are not is the cause of being transgendered or not — that is to say, that the biological differences determine the differences in gender identity — are unwarranted. In short, the current studies on associations between brain structure and transgender identity are small, methodologically limited, inconclusive, and sometimes contradictory.

Id. at 104.

In short, science does not support the notion that gender identity is an innate, immutable physical property of human beings. *See* Decl. of Lawrence S. Mayer, M.D., Ph.D., in Supp. of Pl.'s Mot. for Prelim. Inj. at 6, *Schwartz v. The City of New York*, 19-463 (E.D.N.Y., filed January 23, 2019). One's sense of self and one's desire to present to others as a member of the opposite sex have no bearing whatsoever upon the objective biological reality that one is male or female.

Even if evidence existed that brain studies showed differences, which they do not, it would not tell us whether the brain differences are the *cause* of transgender identity or a *result* of identifying and acting upon their own stereotypes about the opposite sex, through what is known as "neuroplasticity."[8]

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[8] "Neuroscientist Richard Davidson says you can change your brain with experience and training. . . . 'Our brains are continuously being sculpted, whether you like it or not, wittingly or unwittingly.' It's called neuroplasticity." Barbara

Regardless of the extent transgender identities and aspects of the brain could correlate in some way, none of this speaks to the question of biological sex. Even if there was a biological basis for people to think they're the opposite sex, that does not make them so.

No matter how difficult the condition of gender dysphoria may be, nothing about it affects the objective reality that those suffering from it remain the male or female persons that they were in the womb, at birth, and thereafter – any more than an anorexic's belief that she is overweight changes the fact that she is, in reality, slender. See *Infra* Section II.

Gender identity is not immutable, but is based on persons' beliefs associating themselves with whatever stereotypes they have about people of the opposite sex. It is a subjective perception not limited to the two sexes, but expands to categories other than male or female. Contrarily, sex is not a belief. It is an objective and scientifically demonstrable reality.

Stephens, as well as the APA and AMA, asserts that "everyone has a gender identity, which is 'one's internal, deeply held sense of gender.'" Stephen's Br. at 5. The APA's and the AMA's proffered descriptions of gender identity operate, in all essentials, analogous to a religious belief system. But neither the sincerity of a religious belief nor the

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Hagerty, *Prayer May Reshape Your Brain, and Your Reality*, NPR, May 2009, https://www.npr.org/templates/story/story.php?storyId=104310443.

sincerity of a person's beliefs about gender identity determine reality.[9] Even the Sixth Circuit noted that gender identity has an "internal genesis that lacks a fixed external referent," and much like religion, should be "authenticat[ed]" through professions of identity rather than "medical diagnoses." Pet. App. at 24a-25a n.4. But because it is more like a belief system, it does a great disservice to everyone, those suffering with gender dysphoria and others who are affected, to treat gender identity like sex. A person is either a man or a woman, regardless of what anyone — including that person — happens to believe.

Some of the errors described above may have led to the Sixth Circuit's mistaken conclusion that employers that have sex-specific policies based on their employees' sex instead of their gender identity "necessarily" rely on "stereotypical notions of how sexual organs and gender identity ought to align." App. 26a-27a. However, the exact opposite is true. Gender identity is a social construct that stands in contradistinction to sex. The biological reality of sex is not a stereotype or social construct. *See Nguyen v. INS*, 533 U.S. 53, 68 (2001) (rejecting plaintiff's argument that childbirth is merely a feminine stereotype rather than an operative biological fact

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[9] Saying everyone has a gender identity is the equivalent of asserting that everyone has a religion or everyone has a political philosophy. It is only in the philosophical sense that one may argue that indifference to religion, political philosophy, or gender identity is, in fact, a religion, political philosophy, or gender identity. "[F]or most people, their own gender identity is probably not a significant concern." New Atlantis, *supra* at 93.

contrasting the sexes).[10] *See also Etsitty v. Utah Transit Auth.*, 502 F.3d 1215, 1224 (10th Cir. 2007) ("Use of a restroom designated for the opposite sex does not constitute a mere failure to conform to sex stereotypes.").

The irony of course is that labeling sex itself as an illicit stereotype turns everything on its head and actually elevates stereotypes as a reason to treat members of the same sex differently. An employer that has sex-specific policies would be treating all employees equally based on their sex. But, an employer who instead, had "gender identity-specific" policies, would by definition be treating employees of the same sex differently, and basing the different treatment on socially constructed sex stereotypes.

Sex matters in various contexts. Getting the definition wrong affects those areas. If the definition of "sex" is rewritten to mean "gender identity," doing

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[10] Justice Kennedy explained that sexual differences between the two halves of humanity are not a stereotype:

> To fail to acknowledge even our most basic biological differences — such as the fact that a mother must be present at birth but the father need not be — risks making the guarantee of equal protection superficial, and so disserving it. Mechanistic classification of all our differences as stereotypes would operate to obscure those misconceptions and prejudices that are real. . . . The difference between men and women in relation to the birth process is a real one, and the principle of equal protection does not forbid Congress to address the problem at hand in a manner specific to each gender.

Id. at 73.

so both deconstructs the meaning of "sex" and undermines the ability to account for those situations where the distinctions between the two halves of humanity matter. In addition to bodily privacy in locker rooms, restrooms, and changing facilities (where sex distinctions are crucial based on the bodily differences between the sexes, which accounts for separate facilities in the first place) or the ability to maintain competitive athletic environments for females (again due to bodily differences), we must maintain both the language and the legal construct to recognize sex in other settings such as where strip searches must occur. An inability to do so will put those being searched — including children — in situations where a person of the opposite sex (who identifies with their sex) conducts the search.

Similarly, if we are to disconnect sex from our anatomical differences, other unreasonable demands will be made of persons, such as beauticians in the business of waxing being asked to wax the genitals of a man who identifies as a woman.[11] Even our understanding of sexual orientation is based on sex, not gender identity. *See* APA Br. at 8 ("Sexual acts and romantic attractions are categorized as homosexual or heterosexual according to *the biological sex of the individuals*, relative to each other."). Because distinctions based on sex matter in myriad contexts (many of which may only be discovered as the consequences of this experiment

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[11] *See* Eva Uguen-Csenge, *Transgender woman testifies at human rights tribunal after being refused Brazilian wax*, CBC News, July 26, 2019, https://www.cbc.ca/news/canada/british-columbia/transgender-woman-human-rights-waxing-1.5227434.

unfold), this Court should be slow to muddle the definitions of sex and gender identity.

II. Policy Should Not be Used to Enforce Bad Medicine — Treating Gender Dysphoria Through Social Transition and Mandatory Gender Affirmation Rests on Unreliable Testimonials.

While this case involves the question of whether the term "sex" in federal law means gender identity or includes gender identity through application of *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), the AMA asks the Court to consider the policy implications, namely the notion that protections under Title VII are necessary to advance the treatment goals of those with gender dysphoria. *See* AMA Br. at 3-4. It claims that science shows that transgender individuals benefit from being affirmed in their beliefs about their sex, from social transition, from hormonal interventions, and from surgeries.

However, these professional associations rely on mere testimonials rather than evidence-based medicine. They treat the supposed benefits of gender affirmation as fact, rather than a clinical judgment call. And we ought not make policy decisions in the name of science when the kind of evidence necessary to support these "treatments" simply does not exist.[12] Instead, those who are affirmed in their

[12] "The significant lack of evidence for treatments and interventions which may be offered to people with dysphoria is a major issue facing this area of healthcare." Royal College of General Practitioners, *The role of the GP in caring for gender-questioning and transgender patients*, June 2019, at 5,

gender beliefs progress from social transition to surgical interventions at their peril.[13] Indeed, if the evidence shows us anything, it indicates that those who progress all the way through surgery fare poorly.

A. The Evidence Does Not Demonstrate that Gender Affirmation and Social Transition are Necessary for the Well-Being of Those Suffering from Gender Dysphoria.

The AMA suggests that the many difficulties that are sadly experienced by those who identify with the opposite sex are caused by social stigma. What is necessary, they claim, is that those with gender dysphoria be affirmed in their beliefs. From there, the protocol calls for three phases: 1) social

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https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2019/RCGP-position-statement-providing-care-for-gender-transgender-patients-june-2019.ashx?la=en.

[13] *See* Public Discourse, *supra*:

> Gender dysphoria — the official psychiatric term for feeling oneself to be of the opposite sex — belongs in the family of similarly situated disordered assumptions about the body, such as anorexia nervosa and body dysmorphic disorder. Its treatment should not be directed at the body as with surgery and hormones any more than one treats obesity-fearing anorexic patients with liposuction. The treatment should strive to correct the false, problematic nature of the assumption and to resolve the psychosocial conflicts provoking it.

transition, 2) hormone therapy, and 3) surgical interventions. AMA Br. at 14.

However, subjecting gender dysphoric persons to this protocol is risky because there is little evidence that social transition is the panacea that the AMA makes it out to be. Often it is a self (or therapist[14]) fulfilling prophecy. Worse, gender affirmation does not end with social transition, but leads to medical and surgical interventions. Even the World Professional Association for Transgender Health (WPATH) itself admits that "no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition."[15]

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[14] While the following refers to multiple personality disorders, there is danger here too that

> the therapist will be likely to find, or worse yet, manufacture, evidence that supports the diagnosis. Even more alarming is that some clinicians actually encourage behaviors that seem consistent with the label, which increases the likelihood that the client will act more like the label and begin to "fit" into this diagnostic category. The net result is that the real, underlying psychological disturbance won't be properly addressed and the client will fail to derive any true therapeutic benefits from the "treatment."

Clifford N. Lazarus, *Why DID or MPD is a Bogus Diagnosis*, Psychology Today, Dec. 29, 2011. https://www.psychologytoday.com/us/blog/think-well/201112/why-did-or-mpd-is-bogus-diagnosis.

[15] World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 7th version (2011), 47,

Moreover, some patients wish to detransition, and "the potential that patients undergoing medical and surgical sex reassignment may want to return to a gender identity consistent with their biological sex suggests that reassignment carries considerable psychological and physical risk." *Id.* at 108. This also "suggests that patients' pre-treatment beliefs about an ideal post-treatment life may sometimes go unrealized." *Id.*

This protocol begins with the notion that gender affirmation is necessary in order to avoid social stigma. And while we should all agree that all persons should be treated with respect, blame should not be laid at the feet of friends, relatives, or coworkers who believe that social transition may not be in a person's best interest. In fact, even in environments that are fully supportive of transition, "a large number of people who have the surgery . . . remain traumatized — often to the point of committing suicide."[16]

> The most thorough follow-up of sex reassigned people — extending over thirty years and conducted in Sweden, where the culture is strongly supportive . . . documents their lifelong mental unrest. Ten to fifteen years after surgical reassignment, the suicide rate of those who had undergone sex-

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https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf.

[16] *See* David Batty, *Mistaken Identity*, The Guardian, July 30, 2004, http://www.theguardian.com/society/2004/jul/31/health.socialcare.

> reassignment surgery rose to twenty times that of comparable peers.

Public Discourse, *supra*. Clearly poor outcomes cannot be blamed on lack of acceptance.[17]

Contrary to what the AMA proposes, there is insufficient evidence that any phase of treatment is helpful. Instead, some studies suggest that *not* following the protocol may have more positive results. It is unacceptable to have lower standards of care for a group already at a far greater risk for psychological problems and suicide. Doctor Susan Bewley told the BBC in a *Newsnight* special that "We must not miss the opportunity to do good research now, helping . . . concerned clinicians actually deal with the uncertainty of what they're doing."[18]

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[17] The problem with such a claim becomes even more apparent when we apply the same logic to comparable mental disorders. The APA states that "more than 70 percent of outpatients with dissociative identity disorder have attempted suicide." American Psychiatric Association, "What are Dissociative Disorders?" https://www.psychiatry.org/patients-families/dissociative-disorders/what-are-dissociative-disorders.

However, the APA indicates the appropriate treatment involves psychotherapy. *See id.* And while "people with dissociative identity disorder may feel . . . as if their bodies may feel different (e.g., like a small child, like the opposite gender, huge and muscular)," the APA does not suggest affirming, for instance, the adult's belief that their body is in fact that of a small child or requiring others to affirm the belief that the adult's body is the problem. *See id.*

[18] Dr. Susan Bewley, *Transgender treatment: Puberty blockers study under investigation*, BBC Newsnight, July 22, 2019. https://www.youtube.com/watch?v=1bIt5MQIozc.

1. Social Transition Encourages a Gender Dysphoric Person to Indulge in a Falsehood, Which does not Address the Root Issues Causing Clinical Distress and Makes it Harder for the Mind to Accept Reality.

Previous editions of the American Psychiatric Association's *Diagnostic & Statistical Manual of Mental Disorders*, as recent as 2013, listed "gender identity disorder" rather than "gender dysphoria." And until recently, clinical distress was not a part of the diagnosis criteria, indicating professional concern for anyone who manifests an incongruence between biological sex and gender identity — not just those who experience distress.

People who identify as transgender "suffer a disorder of 'assumption' like those in other disorders familiar to psychiatrists." Wall Street Journal, *supra*. "The 'disordered assumption' of those who identify as the opposite sex . . . is similar to the faulty assumption of those who suffer from anorexia nervosa, who believe themselves to be overweight when in fact they are dangerously thin." *Id*.

Dr. Anne Lawrence, who is transgender, has argued that body integrity disorder, which involves a person who identifies as disabled and feels trapped by a fully functional body, draws parallels to gender dysphoria. Dr. Josephson describes this type of phenomenon as a "delusion . . . [to] a fixed, false belief which is held despite clear evidence to the contrary." Decl. of Allan M. Josephson, M.D., Ex. J in Resp. to Opp'n for Mot. for Prelim. Inj. at 9,

United States of America v. State of North Carolina, No. 16-425 (M.D.N.C., dismissed April 14, 2017).

To illustrate in another way, someone with anorexia may feel overweight and know that they are not. As a result, they struggle with their feelings until they come to believe that they are fat. Similarly, someone with gender dysphoria begins by feeling like they are the opposite sex but know they are not. They then struggle with those feelings until they come to believe they are the opposite sex and try to act accordingly.

Yet, just as you would not treat an anorexic person's delusion by helping that person to lose weight, it is unwise to treat a gender dysphoric person's delusion by encouraging them to indulge in that falsehood. When false beliefs about reality are not addressed by helping people come to accept reality, their false beliefs "are not merely emotionally distressing . . . but also life-threatening." Michelle A. Cretella, *Gender Dysphoria in Children and Suppression of Debate*, 21 J. of Am. Physicians & Surgeons 51 (2016). Treatment should "assess and guide them in ways that permit them to work out their conflicts and correct their assumptions." Public Discourse, *supra*. Instead, some in the scientific community want gender dysphoric individuals to "find only gender counselors who encourage them in their sexual misassumptions." *Id.* Indeed, there are no other health issues where doctors modify healthy bodies to align with a mind's misperception or where they would call a healthy body a "birth defect" rather than working with the mind to accept bodily reality.

A more appropriate treatment would be to show gender dysphoric individuals that feelings are not the same as reality. "Psychiatrists obviously must challenge the solipsistic concept that what is in the mind cannot be questioned." Wall Street Journal, *supra*. "Disorders of consciousness, after all, represent psychiatry's domain; declaring them off-limits would eliminate the field." *Id*. Indeed, when treatment is focused on helping patients align their subjective gender identity with their objective biological sex by use of normal counseling methods such as talk therapy, gender dysphoria has proven to be significantly reduced. *See* Kenneth J. Zucker et al., *A Developmental Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder,* 59 J. of Homosexuality 369-97 (2012).

Given the harms of the next two phases of the WPATH protocol, social transition should not be encouraged. Not only does it not address the root issues causing clinical distress, it also makes it more likely for patients to forge ahead into hormone therapy and physical alteration of their body.

2. Hormone Therapy has not been Proven Beneficial, and there are Harmful Consequences to Artificially Manipulating the Body.

Hormone therapy has not been proven to improve the overall quality of life or reduce psychological symptoms or other negative outcomes. At best, the scientific data is inconclusive. At worst, it is harmful.

Hayes Inc., a company which focuses on "unbiased" "evidence-based assessments of health technologies and clinical programs to determine their impact on patient safety," gave the quality of evidence for hormone treatment its lowest possible rating. *See* Hayes, Inc., "Hormone Therapy for the Treatment of Gender Dysphoria," *Hayes Medical Technology Directory* (May 19, 2014) at 4.[19] The Hayes Directory explains that some groups advocate for hormonal treatments as "medically necessary treatments." *See Id.* at 2. However, these treatments do "not readily fit traditional concepts of medical necessity since research to date has not established anatomical or physiological anomalies associated with [gender dysphoria]." *See Id.*

After reviewing twenty-one studies, the Hayes Directory concluded that the studies "were inconsistent with respect to a relationship between hormone therapy and general psychological health, substance abuse, suicide attempts, and sexual function and satisfaction." *See Id.* at 3. For quality of life, "[d]ifferences between treated and untreated study participants were very small or of unknown magnitude," *see id.* suggesting little evidence of effectiveness.

Alarmingly, and contrary to the AMA's and the APA's narrative, the Hayes Directory reports that the studies show the prevalence of suicide attempts was not affected by hormone therapy. *See id.*

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[19] The Hayes Rating is an industry benchmark for evaluating the strength of evidence for the use of various medical practices and technologies. Hayes, Inc., "The Hayes Rating," https://www.hayesinc.com/hayes/about/hayes-rating/.

Additionally, hormone therapy increased risk of cardiovascular disease, cerebrovascular and thromboembolic events, osteoporosis, and cancer. *See Id.* No proof of improved mortality, suicide rates, or death from illicit drug use was observed. *See id.*

Similarly, in 2010, Mohammad Hassan Murad of the Mayo Clinic studied the body of research involving the outcomes of hormonal therapies used in advance of sex reassignment procedures. New Atlantis, *supra* at 112. He found there to be "very low quality evidence" that hormonal interventions "likely improve[] gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life." Mohammad Hassan Murad et al., *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes*, 72 Clinical Endocrinology (2010) 214-231.

Without well-designed studies that provide conclusive results that treatments designed to block natural maturation of the body are helpful, public policy should not be used to mandate the kind of gender affirmation that result in such treatments.

3. Surgical Intervention has not Proven Beneficial, and there are Harmful Consequences to Surgically Altering Healthy Bodies.

Scientific support for sex reassignment surgery is equally lacking. After one of the first studies addressing the efficacy of surgical transition occurred in 1979, Johns Hopkins Medical Center discontinued surgical intervention. First Things,

supra. A study performed by Jon K. Meyer and Donna J. Reter found that when individuals who underwent sex reassignment surgery reported improvement, it did not rise to the level of statistical significance, but those who opted not to undergo sex reassignment surgery showed statistically significant improvement. Jon K. Meyer and Donna J. Reter, *Sex Reassignment: Follow-up*, 36 Issue 9 Archives of General Psychiatry 1010, 1015 (1979). Those authors concluded that "sex reassignment surgery confers no objective advantage . . . ." *Id.* at 1015.

Other studies have shown *negative* consequences. In a study performed by Cecilia Dhejne with the Karolinska Institute and Gothenburg University in Sweden, it was found that "transsexual individuals had an approximately three times higher risk for psychiatric hospitalization than the control groups, even after adjusting for prior psychiatric treatment." Cecilia Dhejne et al., *Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden*, 6 Issue 2 PLOS ONE e16885 (2011). "[M]ost alarmingly, sex reassigned individuals were 4.9 times more likely to attempt suicide and 19.1 times more likely to die by suicide compared to controls." *Id*.

In 2009, a longitudinal study performed by Annette Kuhn in Switzerland found that over a fifteen year period the quality of life for fifty-five sex-reassigned individuals was "considerably lower" than females who had pelvic surgery for other reasons. Annette Kuhn et al., *Quality of Life 15 Years After Sex Reassignment Surgery for*

Transsexualism, 92 Fertility & Sterility 1685, 89 (2009). Moreover, "none of the studies included the bias-limiting measures of randomization . . . and only three of the studies included control groups." New Atlantis, *supra* at 112. While the Mayo Clinic report indicated that 80% of sex reassigned patients reported improvement in gender dysphoria, 78% improvement in psychological symptoms, and 80% improvement in quality of life, none of the studies included the bias-limiting measure of randomization or control groups. *Id.* Thus, the claim that improvement occurred after surgical transition is merely comprised of testimonials.

Another Hayes Directory report, this time addressing surgical interventions, concluded that there is not good scientific evidence to support surgical modifications. *See* Hayes, Inc., "Sex Reassignment Surgery for the Treatment of Gender Dysphoria" *Hayes Medical Technology Directory* (May 15, 2014) at 4. It concluded that the "evidence was too sparse to allow any conclusion regarding the comparative benefits of different [sex reassignment surgery] procedures." *See Id* at 3. The "very low" quality of evidence was "due to limitations of individual studies, including small sample sizes, studies lacking evaluating any one outcome, retrospective data, lack of randomization, failure to "blind outcome," lack of a control or comparator group, and other problems. *See Id.* Unbiased assessment of the claims leads to the following conclusion:

> The scientific evidence summarized suggests we take a skeptical view toward the claim that sex reassignment

> procedures provide the hoped-for benefits or resolve the underlying issues that contribute to elevated mental health risks among the transgender population. While we work to stop maltreatment and misunderstanding, we should also work to study and understand whatever factors may contribute to the high rates of suicide and other psychological and behavioral health problems among the transgender population, and to think more clearly about the treatment options that are available.

New Atlantis, *supra*, at 112-113.

There is no good evidence that this dramatic surgery produces the benefits espoused by the AMA. There is, however, evidence that surgical modification poses health risks.[20] Moreover, one unalterable consequence is that anyone who goes through with "sex change" surgery will be sterilized. Without firm scientific evidence, the medical and psychiatric community should not follow the WPATH protocol to progress from social transition, to medical interventions, and ultimately to surgery, which therefore calls into question the AMA's claim that government policy should require persons to affirm others' beliefs that they are the opposite sex.

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[20] *See* Batty, *supra* (in an assessment of more than 100 follow-up studies on post-operative transsexuals, concluding that none of the studies proved that sex reassignment is beneficial for patients or thoroughly investigated "[t]he potential complications of hormones and genital surgery, which include deep vein thrombosis and incontinence").

4. Ancillary Procedures

Another Hayes Directory report reviewed all the relevant literature on ancillary procedures and services for the treatment of gender dysphoria, such as voice training, facial modifications, reduction of the Adam's apple, and other cosmetic surgeries to feminize or masculinize features. *See* Hayes, Inc., "Ancillary Procedures and Services for the Treatment of Gender Dysphoria," *Hayes Medical Technology Directory* (May 9, 2014), at 1. These too do "not readily fit traditional concepts of medical necessity since research to date has not established anatomical or physiological anomalies associated with [gender dysphoria]." *See Id.* at 2. As with its conclusion on hormone therapies as well as surgical modifications, the Hayes Directory gave the scientific support for these treatments its lowest possible rating. *See Id.* at 3. The studies not only had limitations such as small sample sizes, separating procedures by category, and a lack of control or comparator group, they also measured "technical success and patient satisfaction" while ignoring "overall measure of well-being." In fact, the Hayes Directory found that the "overall individual well-being is unknown." *See id.*

In conclusion, relevant to the Court's present concern, the AMA's suggestion that gender identity should be read into sex protections in furtherance of treatments goals for those suffering from gender dysphoria is misplaced. Given that the stated goal of transitioning people with gender dysphoria to their identified gender is to improve their overall well-being, altering a person's body, sometimes

permanently, should not be done without solid scientific evidence of its benefits. Since the known studies only measure self-reported satisfaction with the aesthetic result, and not improved quality of life, mental state, or overall well-being, these procedures should not be recommended treatment.

B. There is Insufficient Scientific Evidence to Support Treating Gender Dysphoric Children as if They are the Opposite Sex.

While this case involves an adult in the context of Title VII, Title IX, applicable to educational institutions, borrows interpretations from Title VII. If this Court, for policy reasons, were to redefine sex to mean gender identity, that definition will impact children in educational settings. Indeed, such an interpretation has been used to force some schools to open privacy facilities to the opposite sex. Such an approach not only subjects students to sexual harassment through the systematic loss of bodily privacy, but such treatment is actually contraindicated for those children who suffer from gender dysphoria.

1. Gender Dysphoric Children Suffer from a Psychological Disorder that Can Be Resolved through Therapy in Many Cases.

Gender dysphoric children subjectively feel they are the opposite sex based on what they think it is like to be the opposite sex. *See* American Psychiatric Association, *Diagnostic & Statistical Manual of Mental Disorders* (*DSM-5*) 452 (5th ed. 2013). Other than in this area, children who have persistent

beliefs that do not conform with reality are not encouraged to persist in those beliefs. *See* Cretella, *supra* (listing similar conditions); Anne Lawrence, *Clinical and Theoretical Parallels Between Desire for Limb Amputation and Gender Identity Disorder*, 35 Archives of Sexual Behavior 263-78 (2006) (comparing gender dysphoria and body integrity identity disorder). In the same way, counselors should assess and guide those with gender dysphoria in ways that permit them to work out their conflicts and correct their false assumptions.

Until recently when ideological imperatives took the place of scientific evidence, this is precisely what was done for gender dysphoric children. Dr. Kenneth Zucker, a leading authority on gender dysphoria, successfully helped children through psychosocial treatments like talk therapy, organized play dates, and family counseling. *See* Cretella, *supra*, at 51; Zucker, *supra*, 369-97. A follow-up study revealed that only three of twenty-five female children continued to struggle with gender dysphoria. Kelley D. Drummond et al., *A Follow-up Study of Girls with Gender Identity Disorder*, 44 Developmental Psychology 34-45 (2008).

2. Gender Affirmation and Medical Intervention for Gender Dysphoric Children is Not Helpful, and Can be Harmful.

In contrast to the belief that we and our children are best served by observing and cooperating with our observable biological reality, the AMA and the APA say that children who suffer from gender dysphoria can relieve that dysphoria through social

transition, puberty blockers, cross-sex hormones, and eventually surgically altering sex-based anatomy to look like that of the opposite sex. This progression, however, is unhelpful since children who identify with the opposite sex but who are allowed to go through puberty without puberty blockers and cross-sex hormones cease identifying with the opposite sex 70% to 98% of the time for males and 50% to 88% of the time for females. *See DSM-5*, at 455.

Conversely, when children are encouraged to progress through social transition to puberty blockers, they tend to persist with their dysphoria. Yet no longitudinal, controlled studies support gender-affirming treatments for gender dysphoria. *See* Cretella, *supra*, at 52. The problem is that while some persons who go through all these stages may report satisfaction with an eventual surgery,[21] they may still suffer the same morbidities and experience startlingly high rates of suicide and attempted suicide. *See* Public Discourse, *supra*.

Not only does the progression from affirmation to surgery result in increased psychological problems, but the evidence is insufficient to suggest that each step along the way is safe and efficacious. While affirming a child's gender identity may appear a compassionate way to help a child during a painful and confusing experience, it is not.

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[21] *See, e.g.*, Annelou L.C. de Vries et al., Y*oung Adult Psychological Outcomes After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696-704 (2014). However, long-term effects were not evaluated, and the study was not properly controlled.

> There is an obvious self-fulfilling nature to encouraging young [gender dysphoric] children to impersonate the opposite sex and then institute pubertal suppression. . . . All of his same-sex peers develop into young men, his opposite sex friends develop into young women, but he remains a pre-pubertal boy. He will be left psycho-socially isolated and alone.

American College of Pediatricians, *Gender Ideology Harms Children*, Sept. 2017.

Repetition affects the structure and function of the brain through what is called neuroplasticity. Thus, children who are encouraged to live as the opposite sex may be increasingly unable to live as their own sex. *See* Cretella, *supra*, at 53. As a result, some children who would otherwise overcome their gender dysphoria may be unable to do so.

Puberty blockers pose other health risks. For example, they impair bone growth, decrease bone accretion, interfere with brain development, and impair fertility.[22] *See* Cretella, *supra*, at 53.

Rather than encouraging the progression through these stages, children would be better served at the very first stage by not encouraging

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[22] "There is a significant lack of robust, comprehensive evidence around the outcomes, side effects and unintended consequences of [puberty blockers and cross-sex hormones] for people with gender dysphoria, particularly children and young people, which prevents [General Practitioners] from helping patients and their families in making an informed decision." The Royal College of General Practitioners, *supra*, at 5.

their belief that they are the opposite sex. If they are allowed to progress through puberty, the issues of gender dysphoria naturally resolves the vast majority of the time. Therefore, a more cautious approach, supplemented by individual or family psychotherapy would be most compassionate. In short, the notion that science requires gender affirmation, and thus for policy reasons gender identity should be read into the word "sex" is misplaced.

III. Protocols Calling for Social Affirmation, Hormone Treatment, and Sex Reassignment Surgery are a Reflection of Ideology and Activism, Not Evidence-Based Medicine.[23]

We should treat everyone with dignity and respect, but there is significant disagreement in the particulars of what is helpful to those identifying as transgender and what should be asked of others in the process. Though some research has been conducted regarding treatment of those who identify as transgender, when "research touches on controversial themes, it is particularly important to be clear about precisely what science has and has not shown." *See* New Atlantis, *supra*, at 114.

As discussed above, the existing studies on treatment of and outcomes for transgender persons are poor support for gender affirmation or the

[23] The APA's claim that gender identity discrimination, as a matter of science, is sex discrimination, *see* APA Br. at 4, is equally ideology, not science.

progression to medication or surgery,[24] yet the large medical associations like the AMA and APA ardently endorse these practices. Unfortunately, ideology rather than science is driving the support. And since dissent is systematically eliminated and those who disagree are loudly condemned, the kind of research necessary to inform the public debate is not occurring.

"Consensus" in the scientific community is more contrived than scientific. "Mainstream clinicians and scientists who consider gender discordance to be a mental disorder have been deliberately excluded in the makeup of the steering committees of academic and medical professional societies which are promulgating guidelines that were previously unheard of." *Id*. For instance, when the Endocrine Society created its guidelines, "the panel selected included only those who supported the emerging practices and attempts by many of the endocrinologists present to raise concerns were muted." Ryan T. Anderson, *When Harry Became Sally: Responding to the Transgender Moment* 112-13 (Encounter Books 2018).

The American Psychiatric Association, in the most recent edition of *DSM*, removed gender identity disorder and replaced it with gender dysphoria.

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[24] In fact, of the Endocrine Society's twenty-two recommendations on how to treat gender dysphoric people, "only three were supported by scientific proof. [And] [t]hese three warned of potential adverse effects of hormonal manipulation." Decl. of Quentin L. Van Meter, M.D., Ex. I in Resp. to Opp'n. for Mot. for Prelim. Inj. at 14, *United States of America v. State of North Carolina*, No. 16-425 (M.D.N.C., dismissed April 14, 2017).

"Changes in diagnostic nomenclature in this area were not initiated through the result of scientific information but rather the result of cultural changes fueling political interest groups within professional organizations." Decl. Josephson, *supra*, at 6. Naturally, considering identity with the opposite sex to be a mental disorder is incompatible with social affirmation. Therefore, the nomenclature was changed so that only the anxiety caused by the incongruity between sex and identification is considered to be a disorder.

Yet, since we would neither affirm a person who believed themselves disabled when they have a fully functional body nor suggest surgeries to disable such persons to conform their bodies to their beliefs, we should carefully consider the approach we take concerning persons' subjective beliefs about their sex. Indeed, if something conflicts with our understanding of biological facts, is inconsistently applied, and defies common sense, we should demand more evidence to suggest that these factors are all pointing the wrong direction. The support for gender affirmation, medications, and surgery come from testimonials, but that is not evidence. It would be akin to asking consumers if they are satisfied with their vehicles, and publishing those testimonies, claiming it to be evidence of quality or reliability. It is not as if we do not know how to get good data, such as with control studies, but we refuse to conduct good science or follow the science — and that has everything to do with activism and ideology — not good medicine.

As confirmation of the power of activism over science, those who follow the science are often shut down. Consider Lisa Littman, Assistant Professor of the Practice of Behavioral and Social Sciences at Brown University, who coined the phrase "rapid onset gender dysphoria." She made the observation based on various parental reports that those who identify as transgender during or after puberty appear to have underlying and preexisting psychiatric conditions, and she called for more research. After members of the transgender community criticized the research, Brown quickly distanced itself. And ultimately, she lost a consulting job due to the research.[25] Jeffrey S. Flier, M.D., former dean of Harvard Medical School, wrote, "I have never once seen a comparable reaction from a journal within days of publishing a paper that the journal already had subjected to peer review, accepted and published. One can only assume that the response was in large measure due to the intense lobbying the journal received. . . ."[26]

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[25] Jonathan Kay, *An Interview with Lisa Littman, Who Coined the Term 'Rapid Onset Gender Dysphoria,'* Quillette, March 19, 2019. https://quillette.com/2019/03/19/an-interview-with-lisa-littman-who-coined-the-term-rapid-onset-gender-dysphoria/.

[26] *As a Former Dean of Harvard Medical School, I Question Brown's Failure to Defend Lisa Littman*, Quillette, August 31, 2018. https://quillette.com/2018/08/31/as-a-former-dean-of-harvard-medical-school-i-question-browns-failure-to-defend-lisa-littman/. This type of intolerance to following the science within academic communities is not unique. Fifty-four academics in the UK wrote:

> We are also concerned about the suppression of proper academic analysis and discussion of the

Similarly, Dr. Kenneth Zucker, a leading expert on gender dysphoria in children, who headed the Child Youth and Family Gender Identity Clinic in Toronto, was removed from his clinic on baseless charges and the clinic shut down.[27] Zucker helped to write the "standards of care" guidelines for the WPATH and led the group that developed criteria for gender dysphoria used in DSM-5. *See id.* But as others increasingly pushed gender affirmation and social transition, Zucker's clinic continued to be cautious, suggesting that it was better to "help children feel comfortable in their own bodies," since it recognized the malleable nature of gender identity in children and the likelihood that it will resolve. *See id.* Activists saw this as a rejection of children's gender identities. As a result, the parent

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> social phenomenon of transgenderism, and its multiple causes and effects. Members of our group have experienced campus protests, calls for dismissal in the press, harassment, foiled plots to bring about dismissal, no-platforming, and attempts to censor academic research and publications. Such attacks are out of line with the ordinary reception of critical ideas in the academy, where it is normally accepted that disagreement is reasonable and even productive.

Professor Kathleen Stock, et al., *Academics are being harassed over their research into transgender issues,* The Guardian, October 16, 2018. https://www.theguardian.com/society/2018/oct/16/academics-are-being-harassed-over-their-research-into-transgender-issues.

[27] *See* Jesse Singal, *How the Fight Over Transgender Kids Got a Leading Sex Researcher Fired*, The Cut, February 7, 2016. https://www.thecut.com/2016/02/fight-over-trans-kids-got-a-researcher-fired.html#.

organization running the gender identity clinic interviewed activists and clinicians critical of the clinic and fired Zucker and shut down the clinic based on false claims. *See id*. Yet for the many families who benefited from Zucker's work and others who would benefit, "a sustained campaign of political pressure" took away their options to find help feeling comfortable with their own bodies. *Id*.

This, of course, was not the first time science took the back seat in the practice of medicine. Trendy diagnoses and treatments have lead us astray in the past. *See* Paul McHugh, *Try to Remember: Psychiatry's Clash Over Meaning, Memory, and Mind*, (Dana Press 2008).[28] The practices of eliciting alternative personalities from patients[29] as well as lobotomy[30] had many testimonials about their benefits to patients, but testimonials do not form the substance of evidence-based medicine. Thus we should be especially

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[28] The hystero-epilepsy phenomena of the late 19th century, where patients with neurosis took up the epilepsy symptoms of those they were around, taught us that those with a neurosis "can easily take up what their doctors believe — especially if told that the ideas will help them recover." *Id*. at 61.

[29] *Id*. at 12.

[30] The practice of lobotomy was advanced because of testimonials as it "sometimes provided genuine relief to people who . . . were able to be aware of their situations, even to compare them with the past and say how much better they were." Janet Sternburg, *White Matter: A Memoir of Family and Medicine*, chap. 16 (Hawthorne Books 2014). In the three years following Egas Moniz's Nobel Prize in 1949 for his discovery of the usefulness of lobotomy, more people were lobotomized in the three following years than in the previous fourteen years. *See id.* at chap. 6. But looking back we recognize that clinical practice should have been based on evidence, not testimonials.

cautious when activism or ideology has the upper hand over science.[31] Ultimately, poor science exacerbated the suffering of those treated by lobotomy or diagnosed with multiple-personality disorders in the past, *see id.*, and appears to be doing the same with those suffering from gender dysphoria today.

CONCLUSION

As a matter of science, sex and gender identity are so distinct that gender identity cannot properly be read into or replace sex. And with regard to the underlying policy question, there is no reliable evidence that gender affirmation — understood as asking or requiring persons to affirm others' beliefs that they are the opposite sex — is efficacious.

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[31] The recovered memory phenomenon "gained broad support not only from individual psycho-therapists but also from . . . citadels of authority. And yet the idea rested on claims unsupported by evidence, on speculation unrestrained by caution, and on the trust in authority that leads patients to accept suggestion." *Try to Remember*, *supra*, 1-2. "Psychiatric journals did nothing to interrupt what their editors believed was a kindly intended treatment for traumatically abused people and thus beyond criticism." *Id.* at 21.

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