IN THE EQUALITY COURT OF SOUTH AFRICA

(WESTERN CAPE DIVISION, CAPE TOWN)

CASE NO.: EC 05 /2024

In the matter of :

LS	**First Applicant**
TRIANGLE PROJECT	**Second Applicant**
KS	**Third Applicant**

and

SCHOOL GOVERNING BODY, STELLENBOSH HOËRSKOOL	**First Respondent**
PRINCIPAL, STELLENBOSH HOËRSKOOL	**Second Respondent**
HEAD OF DISCIPLINE, STELLENBOSH HOËRSKOOL	**Third Respondent**
NOMINATED TEACHER, LEARNER SUPPORT STELLENBOSH HOËRSKOOL	**Fourth Respondent**
MEC, EDUCATION WCED	**Fifth Respondent**
HEAD OF DEPARTMENT EDUCATION, WCED	**Sixth Respondent**
CAPE WINELANDS EDUCATION DISTRICT DIRECTOR	**Seventh Respondent**
MINISTER OF BASIC EDUCATION	**Eighth Respondent**

AMICUS CURIAE AFFIDAVIT BY EXPERT: KRISTOPHER E. KALIEBE, M.D.

KK

I the undersigned,

KRISTOPHER EDWARD KALIEBE

do hereby make oath and state that:

1.1. I am a duly qualified and board certified medical practitioner specialising in Psychiatry, Child and Adolescent Psychiatry, and Forensic Psychiatry. I am a professor at the University of South Florida in Tampa, Florida, United States. The full details of my qualifications and experience are set out hereinbelow.

1.2. The facts set out herein fall within my personal knowledge, save where the contrary is expressly stated or appears from the context, and such facts are true and correct.

1.3. I have prepared a report setting out my expert opinion which I believe will be of assistance to this Honourable Court on material issues in the case between the parties referred to in the heading above. My report is incorporated into this affidavit and is structured as follows:

TABLE OF CONTENTS

KK

2. I. BACKGROUND AND QUALIFICATIONS

2.1. I have been retained by the legal representatives of an amicus curiae before this Court in this matter namely **FIRST DO NO HARM SOUTHERN AFRICA** ("FDNHSA") in the above-captioned lawsuit to provide an expert opinion concerning care of patients with gender dysphoria and in particular the process known as social transitioning of children in society in general with particular reference to social transitioning in a school context. I have read the founding papers of the Applicants in this matter as well as the Court order dated the 25th of February 2026 providing for submissions and expert evidence by FDNHSA (which court order is also referred to hereinafter as "the Court order") and express my views on the allegations made by the Applicants to support what is known as "social transitioning" particularly in a school context relating to children suffering from gender dysphoria. I will explore how clinical care has been affected by the lack of an open, scientific dialogue regarding how best to treat gender dysphoric patients. I have reviewed existing literature related to gender dysphoria.

2.2. My opinion will be based primarily on my own experience as a physician, psychiatrist, and professor, as well as the relevant literature in this area. I may

KK

wish to supplement my opinions or the bases for them as new evidence comes to light or new research is published.

2.3. I am qualified to give this declaration, and have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion. I am being compensated at the usual hourly rate charged by a person of my experience and qualifications. Any compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony that I provide.

2.4. I am a professor at the University of South Florida in Tampa, Florida, United States. I am Board Certified in Psychiatry, Child and Adolescent Psychiatry, and Forensic Psychiatry. My clinical work has been primarily in university-based clinics, community clinics, and juvenile corrections.

2.5. I was awarded my medical degree in 1999 and subsequently completed general psychiatry, child and adolescent psychiatry, and forensic psychiatry training. This training includes education in human biology, human sexuality, development, brain functioning, normal development, and psychopathology. Gender dysphoria (then labeled "gender identity disorder") and gender dysphoria treatment were part of my professional training.

2.6. From 2005 to 2016, I was an Assistant Professor at Louisiana State University Health Science Center – New Orleans. I was the training director of the LSU Child Psychiatry Fellowship for 2 years. From 2016 to August 2023, I was an Associate Professor at the University of South Florida, where my clinical roles mainly

included University clinics, working with juvenile corrections and supporting primary care physicians through the Florida Medicaid Psychiatric Medication hotline. I cover psychiatric on-call at Tampa General Hospital. I also practice forensic psychiatry, handling child and adult cases in criminal and civil courts. I was promoted to full professor at the University of South Florida effective August 1, 2023.

2.7. I work in two university-based training clinics. For my entire stay at the University of South Florida, I have supervised a child and adolescent psychiatry clinic, and in January 2023, I added an adult psychiatry resident clinic to my schedule.

2.8. As a supervising physician at the University of South Florida's Outpatient Clinic and Silver Child Development Center, my role is to function as a clinical supervisor and instructor. Psychiatry residents and Child Psychiatry residents serve as the primary patient evaluators and clinicians. I also evaluate new patients directly and then see patients as needed. I oversee the residents' work product and function as the physician of record. In this clinic I evaluate and treat pediatric patients with gender dysphoria. In addition to these direct clinical experiences, my duties at the Silver Child Development Center include training residents regarding the treatment of patients, including those with gender dysphoria.

2.9. Similarly, at the University of South Florida's Outpatient Psychiatry Center, my duties include supervising and instructing psychiatry residents. At this clinic as well, general psychiatry residents serve as the primary patient evaluators and clinicians, and I evaluate new patients directly and see them afterward as needed.

KK

I oversee the residents' work product and function as the physician of record. As part of my role in this clinic, I evaluate and treat adult patients with gender dysphoria.

2.10. At the University of South Florida, I have a small practice of patients with gender dysphoria.

2.11. Within the juvenile justice system, I also evaluate and treat patients with gender dysphoria. And I have been consulted to provide a second opinion and coordinate care regarding a patient with gender dysphoria in the Louisiana juvenile correctional system.

2.12. I have extensive teaching experience, including teaching medical students, general psychiatry residents, child and adolescent psychiatry fellows, and forensic psychiatry fellows. I have years of extensive positive feedback from medical students and psychiatry residents. I have been awarded four resident teaching awards, the latest in June 2025.

2.13. My support of, and attempts to improve, conventional medicine are balanced by a healthy degree of caution. The history of medicine is filled with examples of the harms that can come with unproven, unnecessary, aggressive, or counterproductive interventions. As such, I've presented twice at the Preventing Overdiagnosis conference.

2.14. I am a member of the American Academy of Child and Adolescent Psychiatry, the American Academy of Psychiatry, and the Law, and the American Psychiatric Association. I recently joined Heterodox Academy, and I co-chair their Campus

KW

Community at the University of South Florida. I have been most active in the American Academy of Child and Adolescent Psychiatry (AACAP), which I joined in 2000. I was awarded status as a Distinguished Fellow at AACAP in 2016. I first presented regarding media at the 2004 AACAP annual conference and have now presented at the annual conference 25 times. I served as co-chair of the Media Committee from 2013 to 2021, and was an author on the AACAP's clinical practice guidelines for telepsychiatry. I served as the Liaison from AACAP to the American Academy of Pediatrics from 2016 to 2022. I have also served AACAP in the state affiliates, acting as the Louisiana Council for Child Psychiatry as secretary/treasurer for 4 years and as president for 2 years.

2.15. I have extensive experience in psychotherapy and have received additional training in Cognitive Behavioral Therapy and trauma-focused therapies. I have been providing psychotherapy and teaching psychotherapy to psychiatry trainees throughout my career. I supervise psychiatry residents at the University of South Florida regarding psychotherapy. I created and taught a Cognitive Behavioral Therapy practicum for Louisiana State University residents from 2007 to 2016. I was a member of the Association for Behavioral and Cognitive Therapies from 2004 to 2016. I am a member of Therapy First, an organization devoted to providing psychotherapy to people with gender dysphoria. I lectured on "Group Socialization Theory" at the Therapy First Conference on November 12, 2025.

2.16. I have 5 publications related to gender dysphoria that have been recently published.

KK

2.16.1. AACAP News, with David Atkinson, MD, entitled, *Adolescent Onset Gender Dysphoria, Our Perspective*, 304-05 (Nov/Dec 2023).

2.16.2. Letter to the Editor, The Journal of the American Academy of Psychiatry and the Law, *A reply to Legal, Mental Health, and Societal Considerations Related to Gender Identity and Transsexualism*, Vol 51, (4) 608-09 (2023).

2.16.3. "Letter to the Editor", in response to "A reply to "The present state of housing and treatment of transgender incarcerated persons". J Am Acad Psychiatry Law. 2024, 52 (4) 532

2.16.4. Kozlowska, K., Hunter, P., Clayton, A., **Kaliebe, K.**, & Scher, S. (2025). Obstacles to progress in paediatric gender medicine. European Journal of Developmental Psychology, 1-31.

2.16.5. U.S. Department of Health and Human Services. (2025). Treatment for pediatric gender dysphoria: Review of evidence and best practices (Final peer-reviewed version). Office of Population Affairs.

2.17. I also practice and teach forensic psychiatry.

2.18. A list of my publications and other qualifications and experience is attached to this report as Exhibit "A."

3. II SUMMARY OF MAIN POINTS

KK

3.1. Rules based on biological sex are important components of any school code of conduct, and are not per se unfair discrimination or harmful to mental health.

3.2. **Regarding paragraph 2.1 of the Court order**: I comment on what is in the best interests of children in general from a clinical point of view. In this regard from a clinical point of view the Respondents' maintenance of sex-based uniform, hair, and bathroom policies does not unfairly discriminate against the Applicant, but instead constitutes a justifiable limitation that protects the privacy, safety, dignity, and best interests of the First Applicant ("LS") and all learners by recognising the immutable, material reality of biological sex. Having clear school policies and enforcing reasonable rules are sometimes resented by students or their families, but having these policies are helpful to student mental health. Not enforcing reasonable school policies would likely be detrimental to student mental health.

1.

3.3. **Regarding paragraph 2.1.1 and 2.1.2 of the Court order:** Clinically speaking, sex-based uniform and hair rules serve legitimate pedagogical and safeguarding purposes by promoting order and focus. Schools are reasonable to deny requests for social transition of transgender-identifying students. Social transition is a potent and potentially harmful psychosocial intervention that can increase psychopathology, entrench dysphoria and reduce natural desistance.

3.4. **Regarding paragraph 2.1.3 of the Court order:** Clinically speaking, denying access to opposite-sex bathrooms upholds fair safeguarding based on biological sex differences in privacy and vulnerability; there is not evidence for transgender identifying students that neutral facilities cause harm or that compelled opposite-sex access improves mental health.

3.5. **Regarding paragraph 2.2 of the Court order:** There is no scientifically credible clinical mental health related rationale to amend the Code of Conduct to compel gender-identity-based accommodations such as opposite-sex uniforms, pronouns, or facilities, as this would subordinate the sex-based rights and best interests of the vast majority of learners to a potentially harmful and contested subjective belief in gender identity. This compelled cooperation, replacing sex based rules with a regimen of rules surrounding self-defined gender identity, is without robust evidentiary support that making these changes would be good for the mental health of transgender-identifying students.

3.6. Clinically speaking, the Respondents have fulfilled their duty to act in the best interests of every child by upholding evidence-based, sex-realist policies; granting the relief sought would compel a system detrimental to the long term mental health of the children involved, all without credible medical evidence of improving anyone's mental health. Such a system would also be in opposition to material

KK

reality, which will not be in the long term best interests of the mental health of the children impacted by such a system.

3.7. Humans are a sexually dimorphic species and this is a fundamental fact of human life. There is no medically or psychologically compelling reason to move away from dividing children by biological sex. Gender dysphoric or transgender-identifying minors should not be told that they are the other sex, nor is there a need for them to access services, spaces or privileges reserved for the opposite sex. Transgender identifying students do not need to be given a name in the other biological sex, rather society could make space for their temperaments and behavioral preferences while still acknowledging their biological sex. It is inappropriate to lie to children and pretend or tell them that they are anything other than their biological sex.

3.8. From a clinical psychiatric perspective, the contemporary "transgender child" is an artificial, socially constructed category that is clinically unhelpful and potentially harmful to the individual child by entrenching gender dysphoria, discouraging thorough assessment of comorbidities, and sharply reducing natural desistance rates through social transition, while being developmentally inappropriate for schools as educational rather than therapeutic environments; therefore, elevating transgender status to the status of a protected right entitling special

KK

accommodations, would seriously undermine the ability of a school to act in the best interests of such children, not least of all by depriving such children of sound medical intervention by appropriately trained and experienced people and reinforcing a medical protocol which at this stage simply is not supported by best practice medicine.

3.9. Social-transitioning interventions are not clinically necessary in the school context. Social transitions should be resisted because they are more likely to harm than to help the child.

3.10. Despite claims there is evidence that social transitioning is helpful, these claims have no substantial basis in evidence. There are no school based studies to guide decisions for students expressing transgender identities or gender distress in school settings, so all claims about results of changes in code of conduct are based on theory. But the fact that some social-transitioning items are psychologically pleasing in the short term to children with gender dysphoria does not mean that such interventions are clinically helpful or medically necessary to be provided in the school environment.

3.11. Transfer of natal male youth with gender dysphoria into girl's spaces is unnecessary and inappropriate. Even if it is desired by natal males with transgender identification to be in the girls' categories at school, the benefits are theoretical and must be weighed against the significant costs and harms involved, including the significant harm to the emotional and physical well-being of female students.

3.12. The World Professional Association for Transgender Health (WPATH) document that is labelled "Standards of Care" should neither be treated as authoritative nor be used to determine which interventions are "medically necessary" or clinically appropriate. WPATH is a corrupt organization and most often bases its recommendations on low-quality evidence. WPATH openly engages in political and other advocacy, which undermines any suggestion they should be viewed as neutral arbiters of medical scientific evidence.

KK

4. III OPINION

4.1. In response to the draft order, this expert opinion will be confined to the topics ordered, regarding whether the contested code of conduct is detrimental to mental health, and considerate of the mental health of all children.

4.2. **Regarding paragraph 2.1 of the Court order:** I am of the opinion that these policies are clinically justifiable limitations that serve the best interests of every child. They reflect the immutable, material reality of biological sex, which remains the only fair, verifiable basis for single-sex provisions in schools. Requiring the school to override biological sex in order to "affirm" LS's subjective gender identity would also, clinically speaking, not be in the best interests of other learners who would be forcibly compelled by the school to agree with ideological statements regard theoretical gender identities, use opposite sex pronouns, and immerse themselves in related fictions. In addition, these infringements are in addition to safeguarding issues raised for the girls — whose privacy, dignity, safety, and fair participation in education would be compromised. The elevation of one learner's subjective experience above the objective rights of others will not be good for mental health. Biological sex is a category firmly established through medical science; gender identity is not. Policies that distinguish on the basis of sex for intimate facilities, uniforms, and appearance standards are not arbitrary; they are rooted in physiological differences that are relevant to privacy, vulnerability to harassment, and developmental needs in a school setting. Clinically speaking, the evidence is that such distinctions are all crucial to the long term mental health of all children.

KK

4.3. **Hair and uniform policies (paragraphs 2.1.1 and 2.1.2 of the Court order):**

The school's uniform code and hair-related rules are sex-based for pedagogical and safeguarding reasons. They promote order, reduce distraction, and maintain a clear, consistent environment in which all learners can focus on education rather than contested identity claims. From my clinical experience such codes are in the long term best interests of developing children, which by definition involves wrestling with identity issues. From a mental health point of view, the absence of such clear safeguarding codes in fact may exacerbate and solidify identity struggles into adulthood.

KK

4.4. Allowing LS to wear the opposite sex uniform would not merely "accommodate" LS; it would put the authority of the school behind the idea that LS is in fact the opposite sex. This would pressure the entire school community to treat LS as the opposite sex. This is not a neutral expression of "gender identity"; it is an active clinical intervention placing the student in the role of the opposite sex. That institutional mandate would cause psychological harm by consolidating dysphoria and suppressing exploration of identity. The cross sex role will interfere with mental health by endorsing the reality of a gender identity which is an ideological construct; potentially causing premature closure of identity exploration. This can divert students from exploration of psychological problems and comorbidities (autism, trauma, same-sex attraction, social contagion). Allowing cross sex uniforms would be a signal from the school to students that subjective identity overrides observable reality. Social transition is not benign "recognition" but an intervention with the potential to harm psychological stability, uncertain long-term mental-health outcomes, and the potential to reduce natural desistance rates. No cited study in the Applicants' papers provides robust evidence that such affirmation produces net benefits that outweigh these risks.

4.5. **Regarding paragraph 2.1.3 of the Court order - Bathroom access:** Denying LS access to the girls' bathroom is not exclusion or stigma; it is safeguarding and upholding fair consistent policies, so necessary for the healthy mental development of all children at a school. Biological males and females have materially different privacy needs, vulnerability profiles, and developmental trajectories. Schools' policies should protect all learners. Compelling girls to accept opposite-sex presence in their bathrooms would infringe amongst other things their psychological and physical vulnerability profiles far more directly than requiring LS to use a bathroom consistent with LS's sex.

4.6. The best-interests standard applies to every child. In my clinical opinion, the school respondents properly weighed LS's subjective distress against the privacy, safety, and developmental interests of the broader student body. Evidence from governmental authorities and high-quality systematic review(Cass 2024, HHS Report 2025, Hall et al 2024) conclude that immediate social affirmation is not proven to be in the long-term best interests of gender-distressed children. The school's approach — maintaining sex-based rules while offering counseling and parental involvement— is a sound position for the best interests of LS and other children.

KO

4.7. The First Respondent should not amend the Code of Conduct to mandate gender-identity accommodation. There is no mental health based obligation on the First Respondent to provide "reasonable accommodation" of gender identity and expression in the manner sought by the Applicant. The best interests of the child are paramount, and that paramountcy applies to all children. Amending the Code to compel pronoun use, opposite-sex facility access, or uniform changes based on self-identified gender would subordinate what clinically speaking is in the best interests of the majority to the subjective emotional feelings of a minority who are opting for one specific way of coming to terms with their identity struggle, a struggle pervasive amongst all children. This is not equality; it in effect is compelling all the children present to a greater or lesser extent to become part of a theoretical medical experiment, not supported by best medical evidence.

KK

4.8. The applicants did not provide evidence that compelled affirmation improves outcomes or that sex-based policies cause harm. The high-quality systematic review (Hall et al. 2024) shows the evidence for social transition is weak. The associated Cass Review (2024) concluded that comorbidities must be addressed through exploratory care, not immediate affirmation. In my clinical opinion, schools should not be required to implement policies that lack a sound evidentiary foundation and potentially exacerbate long term mental health struggles. Social transition is not a "basic act of recognition." It is an active psychosocial intervention that can cause harm. Requiring the entire school community to participate in it coerces immersion in fiction. This is neither healthy for LS (who may be steered away from addressing root causes) nor for other learners. It is not in the best interests of the child or the school community.

4.9. The practical consequences of adopting the advocated framework are not "inclusion" but coercion of the entire school community into participation in a contested medical and psychological fiction. This is not good for mental health, **NOR** is medically necessary. It is a short sighted short term policy to appease a child who is presenting with identity issues and thus depriving the child of medically speaking meaningful intervention and help. This obviously can have a profound negative impact on the mental health and development of all the other learners at the school. Of course, it also compromises the school's duty to teach verifiable truth. Such policies are not in the best interests of children.

5. CONFLATION OF GENDER NONCONFORMITY, HOMOSEXUALITY, AND CLINICAL GENDER DYSPHORIA

5.1. A recurring flaw is the blurring of distinct phenomena. Statements treat ordinary gender nonconformity (a boy who likes dolls, a girl who plays rough sports) or same-sex attraction as evidence of a fixed "transgender identity" that schools must immediately affirm. This is not neutral; it is the imposition of a particular ideological model. As a psychiatrist specialising in child and adolescent mental health, I view the contemporary category of the "transgender child" not as a naturally occurring, immutable trait requiring special recognition in schools, but as a socially constructed phenomenon — an instance of Ian Hacking's "making up people" (Hacking, 2007). This category emerged only in the twenty-first century, directly linked to the novel practice of social transition for prepubertal children with gender dysphoria (Byrne & Gorin, 2026). It is created through a social process involving classification ("transgender child"), institutions (e.g., WPATH, AAP), experts, parents, and received opinion about innate gender identity. Transgender-child identities are thereby brought into existence rather than discovered; the children are made, not found (Byrne & Gorin, 2026).

5.2. Clinically, this artificial framing is unhelpful — indeed, often harmful — to the individual child. Gender dysphoria and incongruence in children are highly fluid conditions with historically high rates of natural desistance (60–90%) when managed with watchful waiting and exploration of comorbidities such as autism, trauma, anxiety, depression, or same-sex attraction (Steensma et al., 2013; Singh et al., 2021; Ristori & Steensma, 2016). Social transition functions as an active psychosocial intervention that dramatically increases persistence of dysphoria and steers children toward medical pathways with weak evidence of long-term benefit and potential psychological harms (Cass, 2024b; Hall et al., 2024; Olson et al., 2022; deMayo et al., 2025). Treating "transgender status" as a fixed identity discourages thorough assessment of underlying mental health issues, reinforces distress rather than resolving it, and risks iatrogenic harm by closing off natural developmental trajectories.

5.3. In the school environment, institutionalising this category of transgender through opposite-sex uniforms, bathrooms, pronouns, or formal affirmation is clinically inappropriate. Schools are not therapeutic settings equipped to deliver mental-health interventions, nor would such intervention be good for mental health. Such policies normalise and potentially spread social contagion among vulnerable peers during a developmental window of identity formation (Littman, 2018; Cass, 2024b). They disrupt the learning environment, compromise the psychological safety and privacy of all students (particularly girls), and shift focus from education and evidence-based mental health support to ideological affirmation. This approach contradicts core psychiatric principles of exploratory care, comorbidity treatment, and safeguarding developmental plasticity.

5.4. As a direct clinical consequence, "transgender status" should not be elevated to the status of a protected right in schools. Rights-based demands for special accommodation presuppose a stable, inherent trait analogous to biological sex. The evidence shows the opposite: the category is socially produced, clinically mutable, and best managed through cautious, individualised mental health care rather than environmental reinforcement. Schools best serve children's mental health by maintaining sex-based policies grounded in biological reality while providing compassionate, non-affirming support that keeps options open and addresses root causes.

KK

5.5. The Cass Review (2024) and desistance literature document that the large majority of pre-pubertal children with gender dysphoria desist naturally when given space, support for comorbidities, and no active social transition. Many such children are same-sex attracted; some distress appears linked to homophobia or social contagion, especially the sharp post-2010 rise. By treating any gender-atypical expression as proof of an innate "transgender self" requiring affirmation, the advocated framework pathologises normal variation, creates conflict when reasonable other students and staff will not participate, and steers children toward medical pathways with uncertain benefit and known risk.

5.6. This is not "recognition of diversity." It is a regressive enforcement of sex stereotypes under the guise of liberation: a feminine identifying boy is asking to play as role as if he is "really a girl"; a masculine identifying girl is asking to play the role that she is "really a boy." True acceptance of gender nonconformity would allow children to be feminine boys or masculine girls without demanding that the entire community rewrite biological reality.

6. GENDER IDENTITY AS A WEAK LEGAL CONSTRUCT AND OVERVALUED IDEA

6.1. Gender identity is a relatively recent, subjective, and unfalsifiable legal construct that lacks the empirical robustness required to override long-established institutional policies grounded in biological sex. Unlike sex — which is binary, observable, immutable, and rooted in reproductive anatomy, genetics, and physiology — gender identity is an internal, self-reported feeling that cannot be independently verified or measured. Treating it as a protected characteristic that automatically demands institutional accommodation elevates a contested psychological concept to the status of an objective right, with profound consequences for schools, sports, facilities, and child safeguarding. This elevation is not compelled by equality principles and is incompatible with the clinical best-interests standard.

6.2. The concept of transgender identity functions as a shared **overvalued idea** (Dork et al 2026)— a psychiatric term describing a strongly held, false conviction that is not of delusional intensity but is maintained with disproportionate conviction and is resistant to contrary evidence. Overvalued ideas are well-documented in various psychiatric disorders, including eating disorders, body dysmorphic disorder (BDD), and obsessive-compulsive disorder (OCD). In anorexia nervosa, the patient holds an overvalued idea of being "fat" despite objective emaciation and medical risk (Fairburn, 2008; Garner & Garfinkel, 1980). In BDD, individuals maintain a fixed, exaggerated belief that a minor or imagined physical flaw is grotesque, leading to compulsive behaviours and severe distress despite reassurance (Veale & Neziroglu, 2010; Phillips, 2004). In OCD, overvalued ideas around contamination, harm, or symmetry drive rituals that the individual recognises as excessive yet cannot relinquish (Kozak & Foa, 1994). In no other situation do we believe it is psychologically healthy for clinicians, families or the community to go along with claims of an overvalued belief. Schools should not go along with (and certainly should not be **compelled** to go along with) these beliefs in this circumstance, nor should they believe the claim that having the belief you are the other sex is psychologically healthy and normal.

6.3. Gender dysphoria is the psychiatric disorder that is a frequent outcome of overvalued beliefs regarding the benefits of a transgender identity and the ability to change sex. The belief that one is "trapped in the wrong body" or that subjective identity overrides biological sex is held with high conviction despite clear contrary evidence from genetics, reproductive anatomy, and desistance studies. The Cass Review (2024) documented extremely high rates of comorbidity with autism, trauma, anxiety, depression, and eating disorders in gender-distressed youth, suggesting that gender dysphoria often functions as a maladaptive coping mechanism rather than an innate, immutable trait. Social transition and institutional affirmation may reinforce the overvalued idea in the same way that mirror-checking or weight-checking reinforces BDD or anorexia .

6.4. Treating transgender identity as normal or healthy and requiring schools to override sex-based policies is, clinically speaking, unreasonable and unsupportable. It is not a "right" that automatically trumps material reality, or what is in the best interests of other learners. Schools exist to teach verifiable truth and to safeguard all children. Compelling the entire community to participate in social transition (pronouns, uniforms, bathrooms, sports) coerces immersion in a shared fiction. This is not neutral accommodation; it is an active psychosocial intervention with weak evidence of net benefit and documented risks of consolidating dysphoria, suppressing desistance, and medicalising vulnerable youth.

KR

6.5. Such demands constitute, clinically speaking, special treatment rather than equality and are not supported by the available best evidence. Reasonable accommodation must be supported by the best evidence available. Prioritising an overvalued idea over biological sex, parental rights, and the best interests of every child is neither scientifically justified nor good for mental health. To best facilitate mental health, institutional policy must remain grounded in material reality.

7. HUMANS ARE A SEXUALLY DIMORPHIC SPECIES

7.1. The basic biology of human beings is as a sexually dimorphic species. Biological sex is well-defined in all biological sciences, including medicine (Bhargava 2021). Sex is important in human development and throughout the lifecycle (Archer 2019). Sex is binary and determined at conception, "There are only two sexes, and there can never be more." (Dougan 2025). Biological sex is programmed into every cell in the human body.

7.2. The term "gender non-conforming" refers to individuals whose behavior, interests or sexual orientation does not align with the traditional sex stereotypes. Being gender non-conforming is not pathological nor does it induce the need for any psychological or medical intervention.

7.3. The term gender identity was introduced in the 1960s when it meant the sense of knowing which sex you belong to, i.e. I'm female or I'm male (Byrne 2023). However, the phrase "gender identity" is currently used differently. An advocacy group, The World Professional Organization for Transgender Health (WPATH) definition is "A person's deeply felt, internal, intrinsic sense of their own gender." This definition refers to the word gender, thus being circular and opaque, and deeply felt" and "intrinsic" does nothing to clarify.

7.4. The term "transgender" is typically explained in terms of gender identity. Transgender people are those who claim they have a gender identity that does not "align with" or "match" their biological sex. Many claim humans can have a gender identity as a man, women or "something else."

7.5. From the United States Department of Health and Human Services report on Gender Dysphoria: "'Assigned sex at birth' is not a harmless euphemism. It suggests an arbitrary decision—not unlike 'assigned seating'—rather than the observation of a characteristic present long before birth, namely the child's sex. Moreover, if the phrase 'assigned sex' were intended merely as a gentler way of referring to sex in conversations with patients and families, one would expect more direct language to be used in the specialty medical literature. In professional contexts, where clarity is paramount, euphemisms are generally avoided." (P32)

7.6. The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) provides that the diagnostic criteria for Gender Dysphoria in adolescents are (1) a "marked incongruence between one's experienced/expressed gender and assigned gender, lasting at least six months, as manifested by at least two of the [identified symptoms]," and (2) "clinically significant distress or impairment in social, occupational, or other important areas of functioning." Gender Dysphoria is a psychiatric disorder, and the official nomenclature regarding this discomfort with sex changed in 2013 from Gender Identity Disorder to Gender Dysphoria in 2013 as the DMS 5th edition was published.

7.7. To add to this confusion, and as detailed by Kathleen Stock, there are different, confusing, and conflicting definitions of the term gender, she roughly describes by these four. (Stock p 37 -40)

7.7.1. **Gender 1 -** The distinction between men and women. In this case, it is clearer to use the term sex. I will not use gender in this sense in this report, I will use the term sex, and occasional use the term biological sex for clarity.

7.7.2. **Gender 2 –** The sexual stereotypes, or sex associated stereotypes. These are patterns of behavior related to the different sexes.

7.7.3. **Gender 3 -** The social role assumed to be assigned to each sex. The roles that men and women tend to take.

KK

7.7.4. **Gender 4** - Gender identity, the private experience of gender role, as seen above.

7.8. From the perspectives of those who have gender related distress and their friends and family, and those who choose to support them, there can be a rational point in immersion in the fiction that people can change sex. For those who have gender-related distress, it can be pleasing when others go along with one's self-concept of being the other sex. This process of presenting as the opposite sex, with the intent of having others go along with the presented sex role, is called "social transition".

7.9. As will be detailed in this report, social transition has unknown and possibly harmful effects on the development of young people and raises concerns on the institutional and legal level. The 2025 report from the United States Department of Health and Human Services note:

> *"Medical providers have a professional duty to apprise their patients of their conditions and the treatment options in language that is accurate, ethically neutral, and in no way misleading. In the case of pediatric gender medicine (PGM), language has distorted the clinical picture, obscuring important distinctions." (P 29).*

7.10. In a similar vein, schools and mental health professionals also have a duty to uphold the truth and use clear and accurate language.

KK

8. WPATH IS AN ADVOCACY ORGANIZATION WHOSE PUBLISHED GUIDELINES DO NOT ESTABLISH "STANDARDS OF CARE."

8.1. Published guidelines from World Professional Association for Transgender Health (WPATH) do not establish a "standards of care." WPATH cannot be depended on to produce balanced scientific and clinically appropriate guidelines, due to the activist orientation of the organization. As such, members of WPATH, and other advocates—which in total comprise a small number of physicians— have been able to leverage moralized claims and low-quality evidence to promote theories about transgender identities and medical interventions for gender dysphoria. There has simultaneously been a silencing and censorship of more balanced and mainstream viewpoints. This scholarly suppression is well documented, and I have experienced it personally.

8.2. It is easy to substantiate claims that WPATH is an advocacy organization. Examining their press releases and policy statements, and the WPATH files, is sufficient to establish this fact. Internal documents released as part of litigation revealed WPATH has engaged in research malfeasance and misleads the public regarding the content of its guidelines. Before that analysis, what follows is some background.

8.3. WPATH is an international, multidisciplinary, professional association whose reported "mission is to promote evidence-based care, education, research, public policy, and respect in transgender health." WPATH Standards of Care (SOC)

KK

documents share some features with what a medical organization would call clinical practice guidelines. The 2011 edition of WPATH's SOC documents are known as SOC-7, and the 2022 version is SOC-8. The authors of SOC-8 state: "The overall goal of SOC-8 is to provide health care professionals (HCPs) with clinical guidance to assist [transgender and gender-diverse] TGD people in accessing safe and effective pathways to achieving lasting personal comfort with their gendered selves with the aim of optimizing their overall physical health, psychological well-being, and self-fulfillment."

8.4. Dahlen et al. reviewed WPATH SOC-7 as part of a systematic review and quality assessment of international clinical practice guidelines for gender minority/trans people. They noted that WPATH SOC-7 "contains no list of key recommendations nor auditable quality standards." (Dahlen et al., 2021.) Among the principal findings was that WPATH SOC-7 "cannot be considered [the] 'gold standard.'" In the review, WPATH scored poorly on editorial independence, applicability, and rigor of development. The reviewers noted that WPATH tended to prioritize stakeholder involvement rather than methodological rigor.

8.5. Among the implications were that "[c]linicians should be made aware that gender minority/trans health [clinical practice guidelines] outside of HIV-related topics are linked to a weak evidence base" and that "[o]rganizations producing guidelines and aspiring to higher-level quality could use more robust methods, handling of competing interests and quality assessment." Yet despite the well-known methodological weakness to SOC-7, WPATH created SOC-8 with many of the

same problems, only selectively using the conventions expected to create a trustworthy clinical practice guideline.

8.6. WPATH SOC-8 obscures the most important element required for a trustworthy clinical practice guideline: the assessment of the strength of the evidence used to make recommendations. Hiding the strength of evidence obscures critical data from those evaluating the evidence base underpinning an organization's recommendations. (Murad 2017.)

8.7. My analysis is supported by the British Medical Journal Investigations Unit's review of the evidence for transgender treatments, including the WPATH SOC-8. (BMJ 2023 p.382.) The British Medical Journal (BMJ) investigators interviewed Gordan Guyatt, M.D., an internationally recognized leader on systematic reviews and, in fact, the co-developer and first author of the original GRADE guidelines. BMJ also interviewed expert Mark Helfand, professor of medical informatics and clinical epidemiology at Oregon Health and Science University. Helfand noted that "WPATH's recommendations lack a grading system to indicate the quality of the evidence—one of several deficiencies."

8.8. This same BMJ article highlighted transparency issues with the guidelines: "Both Guyatt and Helfand noted that a trustworthy guideline would be transparent about all commissioned systematic reviews: how many were done and what the results were." (BMJ 2023 pp.380-82.)

8.9. The Cass Review similarly found "serious questions about the reliability of [WPATH's] current guidelines" (Cass Review at 130). Taylor et al. found they

KK

"lack[ed] developmental rigour and are linked through cosponsorship" with the Endocrine Society's similarly flawed guidelines. "Most guidelines have not followed the international standards for guideline development, and because of this the [Cass Review] could only recommend two guidelines for practice - the Finnish guideline published in 2020 and the Swedish guideline published in 2022." (Cass Review Page 27, Paragraph 45).

8.10. "Previous guidelines relied much more heavily on expert opinion rather than on systematic reviews of the evidence." (Page 132, Chapter 9.33). "[I]nstead of stating that some of its recommendations are based on clinical consensus, WPATH 8 overstates the strength of the evidence in making these recommendations." (Page 132, Paragraph 9.32). "However, none of the WPATH 8 statements in favor of social transition in childhood are supported by the findings of the University of York's systematic review (Hall et al: Social Transition) (Page 163: 12.30).

8.11. While a complete review of SOC-8 is beyond the scope of this report, I must note five major concerns as a mental health professional:

8.11.1. ***First,*** SOC-8 makes no analysis for why it prioritizes gender affirmation of gender identity over affirmation and acceptance of the physical sexed body. For clinicians and psychotherapists, these trade-offs are complex matters and fundamental to treatment. SOC-8 treats the question as though it had a clear answer supported by the evidence: affirmation of self-reported gender identity always. The underlying theory that affirmation of gender identity is preferable to body acceptance runs through the document, and

KK

arises out of ideology rather than evidence. This foundational theoretical claim underpins much of the assessment and treatment recommendations. This fundamental bias makes SOC-8 untrustworthy.

8.11.2. ***Second,*** SOC-8 suggests consumer-driven medical and surgical interventions and deems these medically necessary without adequate supporting evidence. In no other field of medicine does a life-altering intervention become medically necessary based primarily on the desire of the patient. In children and adolescents, this consumer-driven model is particularly inappropriate. If the SOC 8 authors used another metric to gauge medical necessity, they hid how this analysis was done. This claim of automatic medical necessity is especially problematic in the context of patients with significant psychiatric morbidity.

8.11.3. ***Third,*** SOC-8 approached gender incongruence as psychologically healthy, which is accurate when discussing gender non-conformity, but doubtful regarding gender dysphoria/gender incongruence. Ethical medical professionals support gender non-conformity, which can just mean not adhering to sex stereotypes and is often associated with same-sex attraction. There is not enough science to determine whether, and if so in what circumstances, gender incongruence/gender dysphoria may be psychologically healthy. This is a critical point because when adopting the theory that all gender expressions are psychologically healthy, WPATH associates comorbidities, such as suicidality and depression, as being caused by society, rather than individual psychopathology, this is often called the

KK

"minority stress" theory. Later in this document, there will be more discussion of the minority stress theory. Despite minimal supporting evidence WPATH has promoted the concept of "minority stress" as causing co-morbidities, and many practitioners of youth gender medicine appear to believe this "minority stress" theory. These clinicians thus believe it is part of the care to become social change activists, an unfamiliar role for physicians and mental health providers. They attempt to change society to accommodate all gender identities because, in the minority stress theory, society is the source of the pathology. It is not clear that physicians and mental health providers have the wisdom, knowledge, and expertise to change society. When society does change at their request, there is a risk of significant unintended harmful consequences.

8.11.4. As WPATH has a goal to change society, SOC guidelines consistently recommend changes to institutions, such as schools, without a review of the tradeoffs and harms involved. Placing biological males expressing a female gender identity into biological women's spaces, disregards the special needs and circumstance of biological females. As such, the SOC-8 suggestions regarding school neglects honest appraisals, stakeholder input, and nuance required to create a trustworthy recommendation regarding gender transition in schools. As usual, WPATH overstates the benefit of an affirming and medicalized approach and does not adequately review the risks.

8.11.5. ***Fourth***, SOC-8 normalizes self-mutilation via inclusion of "Eunichs" as just another non-binary category without any suggestion that these individuals require mental health assessment before any consideration of chemical or surgical procedures.

8.11.6. ***Fifth***, SOC-8 downplays concerns related to detransitioning. While this topic is explored, SOC-8 is less than upfront, and frequently uses the term "rare", but does not define how they determine what they believe is "rare". As the literature emphasizes, with the recent cohort among a regime of less-restrictive access, the detransition rates is unknown. (Cohn 2023; Jorgensen 2023.) This concern about detransition is especially high in the new cohort of adolescents with gender dysphoria, where no long term data is available and social factors seem to drive the transgender-identity.

8.12. Below will detail policy statements and press releases, but also other episodes I have learned about that have caused me to conclude that WPATH is an untrustworthy source to guide care of gender dysphoric patients.

8.13. The recently released "WPATH files", leaked internal discussions between WPATH members, were published as the WPATH Files by the think tank Environmental Progress (https://environmentalprogress.org/big-news/wpath-files). The site reports: "The WPATH Files reveal that the organization does not meet the standards of evidence-based medicine, and members frequently discuss improvising treatments as they go along. Members are fully aware that children and adolescents cannot comprehend the lifelong consequences of "gender-

affirming care," and in some cases, due to poor health literacy, neither can their parents." My review of the lightly redacted text and the video which confirms this analysis, is available for the public to read. The WPATH files display clinicians who believe they are helping, but who seem so committed to an ideological movement that they have suspended their critical thinking. There is minimal discussion of the tradeoffs involved in youth gender care, and clinical caution is frequently derided as "gatekeeping". Activist members speak freely regarding their disdain for "cis normativity" and the "gender binary", and their belief in patient self-determination regarding surgical body modification, whether or not these modifications relate to gender dysphoria.

8.14. WPATH's November 15th, 2017 WPATH Identity Recognition Statement argued for gender unfettered recognition, even for minors: "WPATH advocates that appropriate gender recognition should be available to transgender youth, including those who are under the age of majority, as well as to individuals who are incarcerated or institutionalized. WPATH recognizes that there is a spectrum of gender identities, and that choices of identity limited to Male or Female may be inadequate to reflect all gender identities." As such WPATH makes clear it seeks to legally prioritize gender self-identification over biological sex, even in children. This is a more permanent and more radical form of social affirmation. WPATH claims, without citation from research, that optimal physical and mental health arise from expression of gender identity. As such WPATH articulates a belief in "transgender youth", as if it is certain the transgender identification is permanent. WPATH omits any analysis whether the more flexible and appropriate language

KK

would be "minors with gender dysphoria" or "youth currently identifying as transgender" to emphasize this is likely a temporary phase.

8.15. There are calls for censorships and ideological hegemony at the US Professional Association for Transgender Health (USPATH) and which is the regional affiliate for the larger WPATH). Zander Keig, a longstanding WPATH member and former chair of the USPATH advocacy committee, discussed on a public podcast that he received a call from Dr. Joshua Safer, a WPATH board member, former president of USPATH, and an author of the 2017 Endocrine Society Guideline. (Heterodorx podcast at 39:40-41:00 (Apr. 22, 2023), perma.cc/PB6A-K3VF.) According to Keig, who spoke about the episode publicly, Keig had agreed to be an advisor to the Gender Dysphoria Alliance, an organization composed of transgender people, detransitioners, and researchers that is "committed to thoughtful and respectful dialogue" and hearing from multiple perspectives regarding gender dysphoria. (April 22, 2023 Heterodorx podcast at 39:40-41:00.) Presumably because the Gender Dysphoria Alliance is not unquestioningly "affirming" in all circumstances, Dr. Safer asked Keig to resign from USPATH, or threatened to remove him as chair of the USPATH advocacy committee, because he was advising the Gender Dysphoria Alliance. Keig also stated that Dr. Safer suggested that he (Keig) lie about the reasons for resigning.

8.16. Keig's experience is illuminating on multiple grounds. First, silencing a member of USPATH and cleansing USPATH leadership of dissenters brings into question the ethics and scientific integrity of Dr. Safer. This is made more concerning because Dr. Safer was an author of the Endocrine Society Clinical

FK

Practice Guidelines (co-authored with WPATH) and other scientific research articles promoting transgender care. Second, as in this episode Dr. Safer appears to be representing the USPATH board, this shows an institutional problem. WPATH and USPATH claim to be open to scientific exchange and diversity of thought, but their leaders risk termination if they are affiliated with a more open minded and less politicized group, such as the Gender Dysphoria Alliance.

8.17. WPATH has become an uncomfortable place for clinicians or researchers whose data or perspectives do not support a narrow ideological viewpoint. (Ciszek 2021.) In 2016, for instance, renowned psychologist Kenneth Zucker had his USPATH conference presentation successfully drowned out by protestors because his research suggested that affirmation-only therapy could cause gender dysphoric children to "persist" when they would otherwise have their gender dysphoria "desist." After shutting down Dr. Zucker's panel, the activists made demands to the USPATH board, which subsequently removed Dr. Zucker from an upcoming panel and apologized to the activists (rather than Dr. Zucker) for allowing Dr. Zucker to attend the conference. The USPATH board thus rewarded the activists who silenced scholarly debate. When prominent international experts are expelled because their data and analysis does not please WPATH's vocal activists, WPATH cannot be considered a professional or scientific organization. This is a prime example of "internal" scholarly suppression and is perhaps the most dangerous type of censorship. Internal suppression occurs when censorship arises within organizations.

8.18. By removing Zucker, WPATH surely applied pressure to silence others within WPATH with similar data or viewpoints. This directly enforced WPATH's dogmatic groupthink regarding a fundamental underpinning of youth gender medicine, the assumption that youth gender dysphoria continues into adulthood. As noted in a recent paper, when adults "hastily collude in their use of trans-identification template" not only is this affirmation at odds with longstanding knowledge regarding adolescent development, it can cause iatrogenic harm. (Korte, 2023)

8.19. Even prominent leaders at USPATH/WPATH, like Laura Edwards-Leeper and Erica Anderson, have acknowledged that, as they titled their Washington Post article, "The Mental Health Establishment is Failing Trans Kids." This failure is in large part due to a move away from clinically sound careful practice. USPATH and WPATH responded to the article by releasing an October 12, 2022 joint statement condemning "the use of the lay press ... as a forum for the scientific debate." The board of USPATH then privately censured Anderson, who later resigned as president. Rather than respond to alarming reports of poor care by two experienced clinicians with a call for an investigation of the facts, WPATH/USPATH chose to attempt to silence concerns and punish clinician urging caution.

8.20. This public excoriation displays why Anderson and Edwards-Leeper went to the press: they cannot speak openly at WPATH. If these experts believed WPATH was open to reform from within, involving the lay press would not be necessary. WPATH leadership's response displays it is an organization more

KK

concerned about reputation management than following up on member concerns about patient safety. Curiously, they stated: "USPATH and WPATH oppose the use of the lay press, either impartial or of any political slant or viewpoint, as a forum for the scientific debate of these issues, or the politicization of these issues in any way." This was a strange statement for a politicized organization who has made efforts to suppress the viewpoints of clinicians and researchers, such as Kenneth Zucker, Lisa Littman, and Michael Bailey.

8.21. This episode with Anderson and Edwards-Leeper should be considered another effort aimed toward "internal suppression." Again, internal suppression is the most dangerous form of suppression of scholarship because it foments groupthink and thus may sanctify misinformation as evidence-based or expert opinion. In the case of WPATH, this groupthink recommends clinical practice that does not reflect the evidence base and has the potential to cause harm.

8.22. Yet WPATH also attempts to disrupt the academic scholarly exchange. A September 4, 2018 press release on the behalf of the WPATH global board of directors attacked the term ROGD, Rapid onset Gender Dysphoria. Lisa Littman's data and analysis had caused such a panic at WPATH, that the organization felt compelled to attack this term. Interestingly, WPATH did not address any of the facts leading to the term, but rather stoked fear that somehow this term may cause "absolute conclusions" about causative factors related to the increase in adolescent onset of gender dysphoria without previous history of childhood gender dysphoria. They attempt to squash any skepticism that might prevent youth declaring a transgender status from having a medical pathway and they

declared that gender identity be honored. Hypocritically, WPATH claims it encourages academics freedom. Thankfully they did confirm that gender identity development is not fully understood by anyone, which includes WPATH members who create their guidelines.

8.23. Similarly on November 22, 2022 USPATH and WPATH responded to the New York Times article "*They Paused Puberty, But Is There a Cost?*" published on November 14, 2022. As such, USPATH and WPATH waged a public relations war to undermine evenhanded reporting, falsely claiming that the New York Times spread misinformation by questioning the many unknowns and allowing experts to voice their opinions. USPATH and WPATH claim that only clinicians already professionally and personally identified with gender affirming medicine can interpret research in this population. Rather, those who already have their income and prestige attached to this care are the most biased.

8.24. WPATH's press release spreads misinformation by reiterating their favorite speculative narrative about risks: "Any such risk must also be taken into context with the substantial benefits of treatment, and harms of not accessing such treatment, including high rates of mental health disorders and suicidality." They systematically misrepresent the evidence. WPATH, by May of 2022, was already aware their own systematic review did not support claims that affirming treatments are life-saving.

8.25. "WPATH Statement on Yogyakarta Principles plus 10 and Healthcare Delivery" (July 29, 2019), perma.cc/T5ZJ-ENYT: "The Board of Directors of the

World Professional Association for Transgender Health (WPATH) recognizes the Yogyakarta Principles plus 10 as operational policy guidelines that governments should follow in order to ensure the health and rights of all persons under internationally accepted human rights declarations. In states and under laws that are in conflict with the Yogyakarta Principles plus 10, WPATH recommends that health professionals work within existing regulations and available mechanisms to advance the health and rights of all people in ways that move treatment closer to that advocated by the Yogyakarta Principles plus 10, with the primary objective of the immediate best interests of the patient or client."

8.26. For background, **The Yogyakarta Principles** is a document about human rights in the areas of sexual orientation and gender identity. It includes much common sense and humane principles geared at accepting and promoting the welfare of gender-nonconforming individuals. But it also suggests a complete overhaul of sex- and gender-related legal frameworks without discussion or apparent consideration of any trade-offs and harms that may come from such adoption. WPATH endorsement of Yogyakarta Principles plus 10 (perma.cc/PN2R-QN6B) regarding healthcare delivery reveals an underlying stance geared toward toppling long-established law based on biological sex without regard to collateral damage that may occur when strident ideological stances interact with reality.

8.27. WPATH's endorsement of this wide scope of legal principles shows that this organization comes from a fundamental civil rights ideology, rather than a clinical or scientific approach. WPATH's broad rights-based philosophical underpinnings

KK

conflict with a nuanced science-based discussion of practical matters, such as whether biological males who identify as female should play on female sports teams or school should divide pupils by biological sex or self-identified gender. Such an absolutist rights-based viewpoint also distorts dialogue about how to best promote the health and well-being of gender nonconforming children and adolescents by prioritizing a child's likely fluid gender self-identification as more important than their biological sex.

8.28. Principle 31 calls for a "right to legal recognition without reference to ... sex, gender, sexual orientation, gender identity, gender expression or sex characteristics." And Principle 3 states that "States shall ... [e]nsure that all persons are accorded legal capacity in civil matters, without discrimination on the basis of sexual orientation or gender identity, and the opportunity to exercise that capacity, including equal rights to conclude contracts, and to administer, own, acquire (including through inheritance), manage, enjoy and dispose of property" and shall "[t]ake all necessary legislative, administrative and other measures to fully respect and legally recognise each person's self-defined gender identity."

8.29. It is easy to grant that sexual orientation and gender identity should not prevent individuals from work or business. Yet calls for all levels of government and legal systems to pretend that biological sex is not a primary factor of human life is an entirely different matter. Gender self-identification has the potential for causing significant harm, especially as related to child, adolescents and to women-only spaces. WPATH wants to abolish biological sex, and instead use gender self-identification, commencing with social transitioning (as is the demand

KK

of LS in the present matter) to guide and determine policy. This radical overhaul of society is an experiment with significant potential medical and psychological harms.

8.30. "World Professional Association for Transgender Health (WPATH) Board of Directors and Ethics Committee Statement Opposing Legislation that Endangers Health" (Aug. 3, 2020), perma.cc/CG74-UP2K: Again, in this press release, WPATH "condemns" a ruling it disagrees with. WPATH claims that the U.S. Department of Health and Human Services rule denied "civil rights protections" and frames the rule as "permit[ting] hostile health care providers ... to discriminate." WPATH chooses to neglect any discussion regarding debates over the quality of care, medical necessity and cost, and seeks to circumvent this via demands of government fiat to provide this care.

8.31. "WPATH Identity Recognition Statement" (Nov. 15, 2017), perma.cc/8CWR-JG5Y: WPATH claims, without citation from research, that optimal physical and mental health arise from expression of gender identity. It claims this leads to the conclusion that identity documents should not have biological sex, but rather should have gender identity. WPATH further claims there should be no barriers from the medical community to access gender recognition. WPATH opposes all limits such as waiting periods or time periods living as their self-identified gender. WPATH "recognizes that, for optimal physical and mental health, persons must be able to freely express their gender identity, whether or not that identity conforms to the expectations of others."

8.32. Furthermore, WPATH has mismanaged conflicts of interest. The authors of SOC-8 had conflicts of interest that violated guidelines with which WPATH claimed to comply. Managing both financial and intellectual conflicts of interests is particularly important when guidelines rely heavily on expert consensus. The chair for guideline panels and other panel members should be free of significant conflicts and conflicted members should constitute no more than a minority of any guideline development group. It appears that virtually all authors of the SOC-8 had both financial and intellectual conflicts of interest because they made part of their living off of providing pediatric medical transition and they had already publicly advocated for pediatric medical transition. SOC-8's final COI statement reads as follows: *Conflict of interests [sic] were reviewed as part of the selection process for committee members and at the end of the process before publication. No conflicts of interest were deemed significant or consequential.* There are serious questions regarding the accuracy of this statement. While there were conflicts throughout the SOC-8 authorship, the conflicts were most glaring at the top, where Eli Coleman, the chair of the SOC-8 committee and first author of SOC 8 was employed by the University of Minnesota which received substantial financial commitments from the Tawani Foundation directly supporting his work. (Boe v. Marshall, No. 2:22-cv-00184: 700-3 (2024, p. 239).) The Tawani Foundation is chaired by Jennifer Pritzker, a philanthropist and advocate for transgender issues. Tawani also was the primary funder for the SOC-8. Coleman admitted under deposition that there was essentially no screening of authors regarding conflicts of interest and conflicts of interest were an afterthought, as

they were not presented until at least six months after members had already been selected (Boe v. Marshall, No. 2:22-cv-00184: 700-3 (2024, pp. 219–222).

8.33. Some recent articles expose what has occurred at WPATH. This comes after the release of documents in a legal case in Alabama (*Boe v. Marshall*):

8.33.1. Pamela Paul, New York Times, *Why is the US still pretending we know gender-affirming care works?* (July 12, 2024): *"Recently released emails show the WPATH leaders told researchers that their work should 'not negatively affect the provision of transgender health care in the broadest sense.'"*

8.33.2. The Economist, *Research into trans medicine has been manipulated* (June 27, 2024):

> *"Court documents recently released as part of the discovery process in a case involving youth gender medicine in Alabama reveal that wpath's claim was built on shaky foundations. The documents show that the organisation's leaders interfered with the production of systematic reviews that it had commissioned from the Johns Hopkins University Evidence-Based Practice Centre (epc) in 2018."*
>
> *"After wpath leaders saw two manuscripts submitted for review in July 2020, however, the parties' disagreements flared up again. In August the wpath executive committee wrote to Ms. Robinson [Associate Professor at Johns Hopkins] that wpath*

KK

had 'many concerns' about these papers, and that it was implementing a new policy in which wpath would have authority to influence the epc team's output—including the power to nip papers in the bud on the basis of their conclusions."

"Ms. Robinson protested that the new policy did not reflect the contract she had signed and violated basic principles of unfettered scientific inquiry she had emphasised repeatedly in her dealings with wpath. The Hopkins team published only one paper after wpath implemented its new policy: a 2021 meta-analysis on the effects of hormone therapy on transgender people. Among the recently released court documents is a wpath checklist confirming that an individual from wpath was involved 'in the design, drafting of the article and final approval of [that] article'. (The article itself explicitly claims the opposite.) Now, more than six years after signing the agreement, the epc team does not appear to have published anything else, despite having provided wpath with the material for six systematic reviews, according to the documents."

8.33.3. Benjamin Ryan, NY Sun, *'Damning' Information About Trans Medical Group Expected to Reach Supreme Court, as Justices Consider Challenge to Ban on Gender Treatments for Minors* (July 10, 2024):

"The unsealed documents indicate Wpath leadership caved to political pressure from outside groups and quietly crafted its pediatric guidelines with the intent of influencing public policy. Wpath leadership also balked at the potential publication of research findings the organization had commissioned that its leadership believed might negatively impact access to gender-transition treatment."

""According to unsealed internal communications, WPATH also wielded a heavy hand after it in 2018 commissioned from evidence-based medicine experts at Johns Hopkins University a series of systematic literature reviews—the gold standard of scientific evidence—regarding various facets of trans medical care. After some of the Hopkins teams' findings raised concerns among WPATH leadership that they might 'negatively affect the provision of transgender health care,' WPATH compromised the independence of the Hopkins researchers. This included asserting the final say on the publication of any systematic reviews. To date, just two reviews have been published."

"The Cantor report [an expert report submitted in the Alabama litigation] further found that WPATH leaders crafted the language of its medical guidelines for the express purpose of influencing insurance coverage, policy, and litigation, which, according to Dr. Cantor, in at least some points, came 'even at the expense of scientific accuracy.' He also found that Wpath coordinated on the

draft with the ACLU, which is behind many of the suits against state bans of such treatment."

8.34. WPATH internal documents clearly show that WPATH is an advocacy organization and not a scientific one. This scandal is detailed in Kozlowska et al, 2025. *"It has recently become clear, however, that WPATH speaks of evidence-based medicine but does not practice it."* (p 6 Kozlowska 2025).

8.35. "The organization's efforts to suppress evidence – dating back to 2018 – were revealed via WPATH internal documents". (Kozlowska 2025 p 6). WPATH policy permitted the use/publication of data only if "the intention [is] to use the Data for the benefit of advancing transgender health in a positive manner". (Boe v. Marshall, Case No. 2:22-cv-00184, in the United States District Court for the Middle District of Alabama (hereinafter "Boe v. Marshall"), Document 560-17, p. 76).

8.36. WPATH required the researchers both (a) submit the prospective publication to WPATH for its review and approval and then, in direct contradiction, (b) assert that the researchers are "solely responsible for the content of the manuscript, and the manuscript does not necessarily reflect the view of WPATH" (Boe v. Marshall, Doc. 560-17, p.78- 79).

8.37. "This dual, mutually inconsistent requirement inescapably compromises the integrity of the researchers and also violates the conditions for the development of clinical practice guidelines." (p 7 Kozlowska 2025).

KK

8.38. At its core, WPATH's deception involved pressuring the Johns Hopkins researchers to emphasize positive data and downplay negative data. Results of this distortion of research occurred in the Abstract of the Baker 2021 systematic review, which contains narrative elements that overstate the strength of evidence. Abstracts are extremely important because most readers only read the Abstract, as they trust that the narrative in the abstract is reflected in the data of the paper. Even worse, WPATH stopped the publication of the vast majority of systematic reviews it commissioned. By burying these reviews, WPATH chose to hide the weakness of the evidence rather than be honest with professionals, the public, and worst of all, patients with Gender Dysphoria considering medical treatments with lifelong body changes and potentially severe side effects.

8.39. *"This process failure has wide-ranging implications since many countries, professional organizations, and clinicians have considered WPATH guidelines to be evidence- based and a rock-solid foundation for designing their own guidelines"*. (P 7 Kozlowska 2025) The repeated citing of WPATH guidelines in other guidelines, by institutions, and by clinicians, shows a direct link between WPATH's malfeasances and widespread inappropriate clinical treatment of Gender Dysphoria.

8.40. "Many professional organizations and government health authorities that published position statements or guidelines in support of GAT have not amended their positions or guidelines even though systematic reviews and population-

KK

based studies have yielded evidence that undercuts earlier, pro-GAT claims." (P. 10 Kozlowska 2025)

8.41. "This process of doubling down by 'trusted' organizations – and failing to offer guidelines in line with existing research – undercuts the foundation for gender medicine's chain of trust. Clinicians can no longer blindly trust either the position statements put out by their organizations or the clinical guidelines published by WPATH. Likewise, patients and their families can no longer remain confident that the GAT offered by their clinicians reflects current medical standards." (P. 11 Kozlowska 2025)

CONCLUSION ON WPATH AND USPATH

8.42. Based on these accounts, and others, I conclude that USPATH and WPATH are not trustworthy science-based organizations. They do not prioritize the best evidence and safeguarding patients, but instead express politically oriented advocacy.

8.43. Again, I am not alone. In 2020, for example, the United States Department of Health and Human Services declined to "take a definitive view on any of the medical questions raised" "about treatments for gender dysphoria" because there was a "lack of high-quality scientific evidence supporting" the interventions and explained that the public "relied on the conclusions of an advocacy group (WPATH) rather than on independent scientific fact-finding." *Nondiscrimination in*

Health & Health Education Programs or Activities, 85 Fed. Reg. 37,160, 37,186-98 (June 19, 2020).

9. "GENDER AFFIRMING" TREATMENT, INCLUDING SOCIAL TRANSITION, HAVE NOT BEEN SHOWN TO BE SAFE, EFFECTIVE, CLINICALLY INDICATED, OR MEDICALLY NECESSARY.

9.1. Neither Gender dysphoria (GD) itself, nor what is the best psychotherapeutic or medical approach is well understood. This is especially true in children and adolescents. My review of the research concludes that the evidence base for gender dysphoria treatments is mixed, overestimates harms, and is generally low quality. Below I provide details for this assessment.

9.2. The World Health Organization (WHO) on January 15, 2024, confirmed that "the evidence base for children and adolescents is limited and variable regarding the longer-term outcomes of gender affirming care for children and adolescents." (WHO FAQ, p.3).

9.3. Until recently, affirming treatment for youth with gender dysphoria has been exceedingly rare; therefore, nominal long-term data exist. It is especially challenging to evaluate this evidence base due to changing definitions and epidemiology. Advocates of gender affirming treatments point to short-term improvements observed in some studies. It is very possible that many of these improvements are placebo effects (Clayton 2022). Placebo effects are positive

changes based on expectations. Placebo effects are routinely seen in other treatments, such as pills for depression

9.4. Recent research from Finland, involving the largest and most detailed data set ever published, actually shows a worsening of young people's mental health after gender transition (Ruuska et al., 2026). While these patients did have hormone and surgical treatment, it is possible that much of this worsening is due to social transition. Based on the best currently available evidence, mental health is not improved by these social transitions, and since mental health improvement is the presumed justification for gender affirmation, it would be unethical to continue to recommend this path. Insufficient data is available to make a confident proclamation regarding the risks and benefits of social transition for any particular individual.

9.5. WPATH's and other associations (such as PATHSA) portray affirmative treatments for gender dysphoric or transgender identifying youth as both effective and virtuous. This false narrative has had a chilling effect on scholarly dialogue regarding gender dysphoria in the medical community. This framework brands those who disagree regarding the evidence base as morally inferior and biased. Through mechanisms I will describe below, moralization has been counter-productive to developing trustworthy science and has contributed to the spread of misinformation regarding transgender identities and treatment approaches to gender dysphoria.

KK

9.6. Prudent physicians generally avoid being part of a partisan and moralized debate, and do not want to be harassed by gender activists. (Evans 2021.) As mentioned earlier, the highly politicized dialogue regarding the issue of transgender care mirrors a larger phenomenon within the academic community. On many complex and divisive issues within academia, there has been a push from activist individuals and groups demanding conformity of opinion with narrow, highly moralized viewpoints. (Bindewald 2021.) The example of gender dysphoria shows that academic medicine has not been immune to this same phenomenon.

9.7. This suppression of gender transition research is part of a well-established pattern of placing data or logic questioning the dogma regarding the effectiveness of gender transitions into the category of "Unassailable Ideas" (Redstone and Villasenor 2020). The ideology surrounding Gender Dysphoria treatments fulfills all three of Redstone and Villasenor's criteria for being an "unassailable idea." Promoting gender transitions fits the pattern of what is popular in academia and among elites, following the themes of: 1) Anything that undermines traditional frameworks is automatically good; 2) Discrimination is the cause of unequal outcomes; and 3) Identity is more important than other factors. (Redstone and Villasenor 2020, p. 10 - 14).

9.8. Pressures to make social transition the correct response to transgender identities essentially push all parties involved to adopt a simple framework. All-or-nothing rhetoric can be an effective technique to rally support around a political cause. Yet social transition of transgender identifying young people and the treatment of gender dysphoria has complex ethical, legal, social, and clinical tradeoffs.

9.9. Within psychiatry and medicine, we as practitioners face enormous suffering. Gender non-conforming patients do, at times, face harassment and discrimination. Transgender -identifying students have high rates of depression, anxiety, and self-harm. Schools, their staff, and mental health professionals want to help. Those who propose social transition as a solution to this suffering hope to relieve suffering. Yet false hope, especially when mixed with false theories, can cause suffering.

9.10. All humans, including physicians, tend to find arguments in favor of conclusions we want to believe, and this bias is known as motivated reasoning or confirmation bias. (Peters 2020.) Supporters of gender affirming approaches want to believe they have found an ethical and evidence-based solution. This motivated reasoning explains the strong divergence between the enthusiastic support for gender affirming treatments and the relatively weak evidence base and logical inconsistencies.

10. SOCIAL-TRANSITIONING INTERVENTIONS ARE NOT CLINICALLY INDICATED IN THE SCHOOL CONTEXT.

10.1. A common refrain in this field is that the science is settled when it comes to how to help transgender identifying young people and that the "gender-affirming" model of care is the best, most effective, and most ethical approach (Abbruzzese et al, 2023, p. 673). In fact, studies have shown that its promises are largely

KK

illusory and that the affirmative-care model is not evidence based (McDeavitt, Cohn, & Kulatunga-Moruzi, 2025).

10.2. Social transitioning is a life-altering psychosocial intervention without proven benefits. Social transitioning involves immersing a person in the idea that they embody a sex different from their natal sex. It typically involves adopting a different name, going by different pronouns, and adopting superficial attributes associated with the opposite sex, like clothes, hairstyles, makeup, etc. Although most commonly this encompasses a binary social transition (identifying and living as the opposite sex), it may also encompass adopting a non-binary identity.

10.3. There is a dearth of studies on social transitioning and what studies do exist largely rely on low-quality studies and come to contradictory results. Overall, these studies fail to show that social transitioning is beneficial.

10.4. The 2023 study by James S. Morandini et al. examined whether social transition and name change was associated with mental health outcomes in a study of 645 children and adolescents (aged 4–17) referred to the UK's GIDS with gender dysphoria. Using clinician-rated measures of mood/anxiety difficulties and past suicide attempts, the researchers found overall, "no significant effects of social transition or name change on mental health status." (p. 1045).

10.5. Morandini's study is consistent with Sievert et al.'s (2021) study—"the only other study that directly compared clinic-referred youth experiencing gender dysphoria who had socially transitioned with those who had not" (Morandini, 2023, p. 1058). Sievert et al. examined the psychological functioning in a clinical sample

of 54 German children (aged 5–11) diagnosed with gender dysphoria and found that the degree of social transition (e.g., changes in name, pronouns, clothing) did not significantly predict better outcomes on the Child Behavior Checklist, whereas poor peer relations and worse family functioning were strong predictors of impaired psychological health.

10.6. Similarly, Wong et al. (2019) compared psychosocial wellbeing (using the Child Behavior Checklist) between socially transitioned transgender children and gender-variant children with similar levels of gender variance (who identified with their natal sex). They found little evidence that social transition status was associated with differences in internalizing or externalizing problems, with peer relations emerging as a more relevant factor for psychological challenges in the non-transitioned group. Wong et al. found that psychosocial challenges for socially transitioned youth were similar to those of their peers.

10.7. England's National Health Service commissioned a systematic review (Hall et al., 2024) on the social transitioning of children and adolescents by the University of York as part of the Cass Review. This is, to date, the most comprehensive review of the evidence on this topic. This systematic review revealed an "absence of robust evidence of the benefits or harms of social transition for children and adolescents" (Hall et al., 2024, p. 1). The evidence is "limited, [and] low quality" because most studies were "cross-sectional with non-representative samples and lack an appropriate comparator group" (Hall et al., 2024, p. 6).

KK

10.8. To be sure, some studies have suggested that social transitioning has positive effects (Durwood et al., 2017; Olson et al., 2016). These were covered in Hall et al. (2024). Without diving into the flaws in these studies, they are highly privileged, selected samples that cannot be seen as representative of wider transgender identifying population.

10.9. Also important is the lack of evidence "that *not* allowing a child to socially transition may in itself be harmful." This is "not supported from the findings of [the Hall et al.] systematic review" (Hall et al., 2024, p. 6).

10.10. Other studies similarly support this conclusion. A related scoping review by Conabere et al. (2025) examined how social transition is defined and measured in studies of transgender youth under 18, finding significant variability, oversimplification, and inconsistency in definitions/measures, limiting comparability and understanding of its impacts.

10.11. In short, there is no high-quality evidence that social transition improves psychosocial functioning, and the *body of evidence* suggests there is no benefit.

10.12. Social transition is theorized to be helpful as it appears empathetic to gender distressed individuals by allowing them to live as if they were the other sex. However, social transition is a controversial process that, while desired by some young people, can cause harm. There are also many reasons to believe social transitioning is harmful or iatrogenic (where medical treatment causes the disease or illness) (Zucker, 2020).

KK

10.13. As previously discussed, most instances of gender dysphoria in young people will naturally resolve itself (Zucker, 2018; Cantor, 2019; Singh et al., 2021). Yet social transition in children and adolescents appears to prolong transgender identification and continue gender dysphoria (Zucker, 2020; Olson et al., 2022). Because social transition involves the idea that a biological male or female internally embody the opposite sex, there is a plausible risk that it reduces a person's capacity to recognize or admit the factual nature of their biological sex. In other words, socially transitioning a young person may alter their psychosexual and personal development and engrain continued body-related distress. Their identity becomes "locked in" (Zucker, 2020; Olson et al., 2022).

10.14. "Gender-affirmative psychotherapy seems to collude with primitive defences that keep the individual in a frozen psychological state" (van Zyl, 2024, p. 172). Resolution of gender-related distress is aided when it is not affirmed, and when the individual is not enveloped in ideologies that normalize or encourage gender-related distress (van Zyl, 2024; Hutchinson, 2025).

10.15. Even Dutch researchers, who pioneered pediatric interventions for gender-related distress, recommend against ("a cautious attitude") early social transition because of how difficult it can be for those who would like to "return" to their natal sex and "the unpredictability of their child's psychosexual outcome" (Steensma et al., 2011, p. 16). In particular, some girls who desisted experienced "great trouble when they wanted to return to the female gender role," making "social steps long before puberty ... hard to reverse" (Steensma et al., 2011, p. 16).

10.16. There is strong evidence that this altered trajectory and prolonged transgender-identification widens the pathway to medicalization involving puberty blockers, hormones, and eventually surgery (Zucker, 2020). A quantitative follow-up by Steensma et al. (2013) of 127 Dutch youth found that childhood social transition was a strong predictor of persistence into adolescence, directly linking it to a greater likelihood of seeking medical transition. Similarly, Olson et al., (2022) tracked 317 socially transitioned U.S. youth (ages 3–12 at transition) over 5 years, reporting 94% persistence in transgender identity, with the majority advancing to puberty blockers or hormones as they reached adolescence.

10.17. Hall et al., (2024) synthesized these and other studies, concluding that earlier social transition is associated with higher persistence rates and a greater tendency to proceed to medical pathways, emphasizing that prolonged transgender identification (often entrenched by social transition) shifts trajectories away from natural desistance (historically 60–90% without intervention) toward endocrine and even surgical interventions. The Endocrine Society guidelines have similarly noted that social transition contributes to persistence, increasing risks of medical escalation without robust predictors for individual outcomes (Hembree et al., 2017).

10.18. Thus, social transition could be thought of as a risk factor for initiation into the medicalized pathway, a pathway that the majority of children will otherwise avoid. This means that social transitioning increases the likelihood of prolonged gender dysphoria and later sex trait modification via pharmaceuticals or surgery with all of the attendant risks of harm and lifelong medical dependency, and

unknown psychological, functional, and psychosexual outcomes (discussed further below).

10.19. As noted by Zucker regarding social transition in children, "if one conceptualizes gender social transition as a type of psychosocial treatment, it should come as no surprise that the rate of gender dysphoria persistence will be much higher as these children are followed into their adolescence and young adulthood .... If this is, in fact, the case, one might ask why would one recommend a first-line treatment that is, in effect, iatrogenic [illness cause by treatment]" (Zucker, 2020 p. 37).

10.20. As noted in the Cass Review, social transition is described as a significant psychosocial intervention that requires caution. This caution is all the more acute considering the high rates of children whose gender-related distress naturally resolves alongside with the lack of evidence that transitioning in any form (social, pharmaceutical, or surgical) leads to any discernible benefits.

10.21. This is not to say that gender non-conformity or sexual orientation can be changed. Sexual orientation and sex-trait expression (such as more masculine females, and more feminine males) is likely to persist in many individuals. Yet distress regarding sex traits or sexual orientation can, and does, resolve. Not fitting sex stereotypes can be difficult for young people. Part of personal growth and identity development during adolescence is learning to accept yourself. This natural process is being distorted by the rush to label young people transgender before they have even finished their process of psychosexual development.

10.22. Especially concerning in a school environment is that social transition is an attempt to force others to go along with something they understand is not accurate and may be unhealthy. When people reasonably raise questions or resist saying things they do not believe are true, then interpersonal conflict increases which is not good for the mental health of the children at the school. Social transition policies in schools involve compelled speech—requiring teachers, staff and other students to affirm beliefs or use language they do not genuinely hold. Compelled speech is not good for student's mental health. In the context of high school social transition policies—such as mandatory pronoun usage or compelled affirmation of gender identities—this same universal concern applies. Such obligations can penalize students or staff for refusing to express contested views about sex and identity, transforming schools into environments of enforced orthodoxy rather than places of genuine inquiry and respect for differing beliefs. This recognition underscores why compelled speech is not merely inappropriate but fundamentally incompatible with a healthy school environment and the proper mental health development of children.

10.23. The available evidence indicates that social transition undermines an individual's desire to participate in psychotherapy to explore why they have their body-related distress. The social transition process thereby undermines the exploration and self-reflection that can lead to relief of the gender-related distress. Again, while social transition might decrease transgender identifying students' discomfort in the short term, it ultimately may cause long-term harms, including

KK

the continuation of gender dysphoria. Social transition may entrench gender dysphoria by creating external commitments (e.g., name changes, pronouns and self-presentation) that make reversing the transition socially and psychologically costly. This is important as identity development is occurring in students, and schools are responsible for fostering healthy identity development.

10.24. It should also be noted the "concept creep" (Haslam 2016) that has occurred in this context, when "medically necessary" has now left the realm of treatments for cancer, cardiovascular disease, or even clear cases of mental illness, but now is including participating in an unfalsifiable identity claim. The claim of a "right" to social transition is rather forcing others to go along with a self-assigned label steeped in contested and ideological concepts. "Concept creep" is the principle that psychological and psychosocial concepts start with a valid narrow idea, like harm, bullying, violence, or abuse and these words are stretched beyond their original meaning as they are applied in new contexts and also with less extreme forms. For example, what was considered "trauma", "violence", "bullying" or "abuse" in the past has, in certain contexts, now includes normal interpersonal conflict or mild unintentional injury. These new uses of the terms, in this case the term "rights", are empowered in such a way to create over-sensitivity, fear of any power imbalance or normal slights and now raises everyday differences of opinion or commonplace boundaries or rules into "trauma". This concept creep can arise out of desires to help and improve circumstances but in the end enfeebles those who are susceptible to believe narratives of harm, oppression and injustice. In my opinion facilitating such concept creep by facilitating social transitioning, is not in

the long term best interests for the mental health of all the children involved, including those being compelled to use speech not in line with objective reality.

10.25. Similarly, when it comes to social transition, the concept of "rights" and "medical necessity," by some opinions, has now crept into choosing hair color, clothes, or having others address you in the manner you prefer. These are not medical necessity issues or rights. Are we to believe the students with transgender identities, with the necessary counselling and support, cannot cope with routine experiences that are the expression of the material reality of their sex. These unnecessary entitlements are not in the best interest of transgender-identifying children and in my opinion and experience should be avoided.

10.26. Social transitioning for gender dysphoria in school settings has not been studied to examine the outcomes of social transition, including tradeoffs, costs, and treatment effects (Social transition is considered a psychosocial treatment). This context is generally a data free zone.

10.27. It is unnecessary and inappropriate for schools to transfer biological males to female spaces and vice versa. This includes youth with gender dysphoria. Most importantly, there is no evidence to show that providing gender dysphoric youth with cross-sex spaces would benefit these youth. Even if it is desired by youth with gender dysphoria to be designated as the other sex and placed in cross sex spaces, it is not appropriate for schools to go along with these students' desires. As mentioned earlier, most youth with gender dysphoria, when followed over time, desist. This argues against obliging schools to go along with what is most likely a

KW

phase of life in a vulnerable and mentally ill youth. If there is any individual benefits to the gender dysphoric youth, these benefits must be weighed against the significant costs and harms involved. These costs and harms come in many forms.

10.28. To begin with, once a single youth expressing gender dysphoria is awarded access to a cross-sex spaces, then others who claim cross sex gender identity would have the right to seek transfer. As the most violent acts are committed by males and the vast majority of sex offenders are male, this would put males in spaces with females. This could significantly harm the emotional and physical well-being of female students. Even the presence of a single male body in such close quarters can be triggering for female victims of sexual abuse. As girls and adolescent females with gender dysphoria do have high rates of sexual trauma, placing these vulnerable children and young women with biological males for "treatment" is misguided. Any discussion of rights must include the rights of women and girls to same sex spaces.

11. GENDER IDENTITY LACKS A BIOLOGICAL BASIS.

11.1. The Applicants appear to be claiming that gender identity has a biological basis. This can only be accurate in the most reductionist framework, and that all human experiences are on some level biological. The limited available twin studies show that environment and development factors are more influential than genetics, as monozygotic twins concordance rate is below 50%. (Karamanis

KW

2022; Heylens 2012.) Furthermore, the genetic or other biological links also may not relate to gender dysphoria but same-sex attraction or other confounding variables, and any biological link could be quite small.

11.2. Furthermore, gender identity changes in individuals and in populations over time. Thus, environmental influences must play a sizable role, such as generational factors, ideology, and cultural influence. This is demonstrated by the recently observed massive increase in transgender-identification and gender dysphoria in the Western World.

11.3. Neither brain scans nor any other method has found a biological basis to gender dysphoria. Any claims of biological basis are conjecture. (Levin 2023; Boucher 2020.)

12. THE MINORITY STRESS THEORY IS NOT CONSISTENT WITH AVAILABLE EVIDENCE.

12.1. The applicants invoke the concept of minority stress. The theory of minority stress fails to explain the high rates of psychiatric illness or neurodivergent characteristics in transgender identifying adolescents. The original minority stress model (Meyer, 2003) was created to explain high rates of mental illness in same sex attracted adults. Here I refer to as minority stress theory, because it is being applied to a new population: transgender young people.

KK

"The foundation of minority stress theory lies in the hypothesis that sexual minority health disparities are produced by excess exposure to social stress faced by sexual minority populations due to their stigmatized social status (relative to heterosexual populations). Since its introduction, which focused on sexual minorities, minority stress theory has been expanded to include gender minorities in particular describing the role of gender non-affirmation as a stressor for transgender and nonbinary people." (Frost & Meyer, 2023, p. 1).

12.2. Meyer's concept of minority stress has some, but limited, empirical support regarding same-sex attracted adults, particularly in past unwelcoming environments. But putting aside concerns about its validity as to sexual minorities (see below), it has achieved popularity outside its original context as a tool for promoting affirmation of gender identity. "The minority stress perspective, which views social conditions as the source of morbidity and distress for minority persons, advances an ideological agenda that promotes social change toward a more egalitarian society" (Meyer, 2005, p. 52).

12.3. Hendricks and Testa (2012) proposed the gender minority stress and resilience model as an extension of Meyer's minority stress theory. This framework has not been validated in transgender-identified people, especially in children and adolescents. More consistent with the available data is that high rates of psychiatric comorbidities are present *before* the advent of gender dysphoria (Littman, 2018; Diaz & Bailey, 2023b; Becerra-Culqui et al., 2018).

KK

12.4. Minority stress is a poor fit when it is applied to transgender-identifying youth because it purports to explain their symptoms and problems as results of victimization, lack of affirmation, and rejection without disentangling cause and effect. The existing evidence is largely from cross-sectional studies using convenience samples that fail to adequately distinguish minority stress from the direct effects of gender dysphoria, psychosocial factors, and pre-existing psychopathology. It assumes that the symptoms, such as depression or anxiety, are a consequence of the transgender identity, rather than the transgender identity being an outgrowth of the symptoms. And the theory conveniently always points in one direction: affirmation and unquestioningly agreeing with the young person's narrative.

12.5. There are many reasons to doubt whether minority stress accurately reflects how psychiatric issues begin in transgender-identifying populations. Multiple Western industrialized societies experienced a wave of explosion of gender dysphoria among adolescents with high rates of comorbidities, suggesting that other factors are at play. After all, there is greater societal acceptance and awareness of gender nonconformity today than in the past. But the fact that mental health has simultaneously deteriorated among the fastest-growing transgender-identifying cohort contradicts minority stress theory. As noted by Meyer et al. (2021):

> "Our findings are clearly inconsistent with the hypothesis. We started our hypothesis from a theoretical perspective that suggests that as social conditions improve, exposure to minority stressors and mental health

KK

problems would decrease. Our hypothesis was optimistic, but we were not blind to evidence to the contrary. (p. 13)."

12.6. Minority stress theory makes for a convenient, simplistic picture: lack of affirmation leads to symptoms, more affirmation reduces symptoms. But there are other potential explanations for the high level of psychiatric issues in the adolescent-onset cohort. Scholars like Bailey (2020) have questioned this theory. As noted by Zucker et al. (2016),

> "Meta-analytic reviews ... demonstrate that perceived prejudice and discrimination are associated with an increased prevalence of mental health problems in minority groups," but the "direction of effect cannot be conclusively determined (i.e., whether prejudice and discrimination lead to a greater likelihood of developing mental health problems, or whether mental health problems lead to a greater likelihood of experiencing—or perceiving— prejudice and discrimination)" (p. 230).

12.7. This is especially true when transgender identifying people place demands upon others for compelled speech and participation in narratives at odds with reality.

12.8. Another possibility is that another unknown variable or rejection sensitivity has a significant contribution to the observed increased psychological problems observed in these populations. Rejection sensitivity, as described by Feinstein (2020) and Gao et al. (2017) could plausibly contribute to elevated internalizing symptoms (anxiety, depression, suicidality) in transgender-identifying youth and may play a partial causal role by amplifying perceived rejection and internalized

distress. As noted by Mays & Cochrane (2001, p. 1874) "Psychiatric morbidity may, in fact, generate a tendency to perceive higher levels of discrimination or may disrupt social functioning, resulting in more negative experiences." As noted above, the recent explosion of adolescent-onset gender dysphoria suggests that psychiatric issues come before, not after an adolescent youth's transgender identification.

12.9. In the absence of hard evidence proving or disproving these alternative, plausible explanations, it would be clinically inappropriate and unethical to create a model of care centered on minority stress theory.

13. IV CONCLUSION

13.1. Viewed from a medical and clinical best evidence perspective, the school respondents have not unfairly discriminated against LS. They have fulfilled their duty to balance out what is in the best interests of all the children involved, including LS's best interests. The relief sought would require the school to abandon material reality, compel ideological conformity, and subordinate what is in the best interests of the majority (and indeed of LS as well) to an ideological construct. Such an order would be contrary to the best available research and medical evidence.

13.2. It is scientific and medical consensus that students with transgender identities typically also have a mix of anxiety, depression, self-harm, personality disorders, neurodevelopmental disorders, and trauma-related symptoms. These

mental health problems generally pre-date the development of a transgender identity. Since the co-morbidities pre-date the transgender identity, the theory of minority stress causing the mental health problems is inconsistent with the data. Yet despite this, clinicians who believe in the minority stress theory continue attempts to force changes in society rather than treating the patient's original mental health concerns. Forcing changes in school policy is a prime example and is misguided, likely harmful to all involved, and anti-scientific.

13.3. The mental health and medical system has a long history of spurts of overdiagnosis and overtreatment. Many of our interventions such as frontal lobotomies were celebrated at the time. Eventually society sees the harm, pushes back, and the medical profession eventually reforms. The American opiate epidemic was ushered in by "expert" physicians who proposed that physicians need more compassion because "pain is the 5th vital sign." (Mandell 2016; Adams 2016.) This turned out to be a large-scale social disaster instigated in large part by the medical community. Too much compassion and patient-driven care, when combined with zealous physicians, does cause harm.

13.4. Based on long-term data in Sweden, cross-sex interventions have not been shown to be lifesaving. Even WPATH's own commissioned systematic review admits the evidence does not exist to support the claim that gender affirming treatments are "life-saving" (Baker 2021). We do not have convincing data that affirmative treatments reduce suicidality, and based on one of our most highly-resourced and controlled studies, we should be concerned that it could increase suicide. (Chen 2023.)

KK

13.5. When claims are made that there exists a scientific and medical consensus supporting social transition for youth with gender dysphoria, these claims rest on the assertions of a small group of physicians who are already personally and professionally invested in the gender affirming approach, commencing with social transitioning. Short term social factors around social transition can also explain much of these short term positive effects in a cohort of youth with documented social struggles. For adolescent-onset gender dysphoria, transgender identification may be mostly about finding social support. Yet gender non-conforming youth can be supported without undergoing social transition.

13.6. Children and adolescents are considered a vulnerable population. This is precisely why they need added protections to provide for them, including those voicing a transgender identity, the right social support and limits. Those charged with administering schools should be skeptical, cautious and guard against activist pushed social transition "treatments" in the school setting. For those reasons and the others cited above, social affirmation in school settings is clinically unwise, is not medically necessary or indeed the standard of care.

14.

V References

1 Abbruzzese, E., Levine, S. B., & Mason, J. W. (2023). The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies-and research that has followed. Journal of Sex & Marital Therapy, 49(6), 673–699. https://doi.org/10.1080/0092623X.2022.2150346

2 Adams, J., Bledsoe, G. H., & Armstrong, J. H. (2016). Are pain management questions in patient satisfaction surveys driving the opioid epidemic?. American journal of public health, 106(6), 985.

3 Anderson, E. & Edwards-Leeper, L., The mental health establishment is failing trans kids, Wash. Post, Nov. 24, 2021.

4 Archer J. (2019). The reality and evolutionary significance of human psychological sex differences. Biological Reviews of the Cambridge Philosophical Society, 94(4), 1381–1415. https://doi.org/10.1111/brv.12507

5 Bachmann, C. J., Golub, Y., Holstiege, J., & Hoffmann, F. (2024). Gender Identity Disorders Among Young People in Germany: Prevalence and Trends, 2013-2022. Deutsches Arzteblatt International, 121(11), 370–371. https://doi.org/10.3238/arztebl.m2024.0098

6 Bailey Retraction Note (2023). Retraction Note: Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. Springer Nature. Retrieved from https://link.springer.com/article/10.1007/s10508-023-02576-9.

7 Bailey, J.M., Why is my gender research being cancelled? UnHerd, May 16, 2023, https://unherd.com/2023/05/why-is-my-gender-research-being-cancelled/.

8 Bailey, Michael J. (2020). The minority stress model deserves reconsideration, not just extension. Archives of Sexual Behavior, 49(7), 2265-2268.

KK

9 Baker, K. et al. (2021). Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review. Journal of Endocrine Society, Volume 5, Issue 4, April 2021.

10 Baxendale, S. (2024). The impact of suppressing puberty on neuropsychological function: A review. Acta Paediatrica, apa.17150. https://doi.org/10.1111/apa.17150

11 Becerra-Culqui, T. A., Liu, Y., Nash, R., Cromwell, L., Flanders, W. D., Getahun, D., Giammattei, S. V., Hunkeler, E. M., Lash, T. L., Millman, A. E., Quinn, V. P., Robinson, B., Roblin, D., Silverberg, M. J., Tangpricha, V., & Goodman, M. (2018). Mental health of transgender and gender nonconforming youth compared with their peers. Pediatrics, 141(5), Article e20173845. https://doi.org/10.1542/peds.2017-3845

12 Bhargava, A., Arnold, A. P., Bangasser, D. A., Denton, K. M., Gupta, A., Hilliard Krause, L. M., Mayer, E. A., McCarthy, M., Miller, W. L., Raznahan, A., & Verma, R. (2021). Considering Sex as a Biological Variable in Basic and Clinical Studies: An Endocrine Society Scientific Statement. Endocrine reviews, 42(3), 219–258. https://doi.org/10.1210/endrev/bnaa034

13 Bindewald, B., & Hawkins, J. (2021). Speech and inquiry in public institutions of higher education: Navigating ethical and epistemological challenges. Educational Philosophy and Theory, 53(11), 1074-1085.

14 Boucher FJO, Chinnah TI. Gender Dysphoria: A Review Investigating the Relationship Between Genetic Influences and Brain Development. Adolesc Health Med Ther. 2020 Aug 5;11:89-99. doi: 10.2147/AHMT.S259168. PMID: 32801984; PMCID: PMC7415463.

15 Block J. Gender dysphoria in young people is rising-and so is professional disagreement. BMJ. 2023 Feb 23;380:382. doi: 10.1136/bmj.p382. PMID: 36822640.

16 Boe v. Marshall, documents available at: https://www.alabamaag.gov/boe-v-marshall/

KK

17 Bränström, R., & Pachankis, J. E. (2020). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study. American journal of psychiatry, 177(8), 727-734.

18 Byrne A. (2023). The Origin of "Gender Identity". Archives of Sexual Behavior, 52(7), 2709–2711. https://doi.org/10.1007/s10508-023-02628-0

19 Byrne, A. (2025). How Many Sexes? How Many Genders? Archives of Sexual Behavior, 54(10), 3803–3804 (2025). https://doi.org/10.1007/s10508-025-03209-z

20 Byrne, A. (2023). Trouble with Gender: Sex Facts, Gender Fictions. Polity Press.

21 Byrne, A.; Gorin, M. Trans Kids and "Making Up People" Journal of Controversial Ideas 2026, 6(1), 9; doi:10.63466/jci06010009.

22 Cantor J. M. (2019). Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. Journal of sex & marital therapy, 46(4), 307–313. https://doi.org/10.1080/0092623X.2019.1698481

23 Cass, H. (2022a). The Cass Review: Independent review of gender identity services for children and young people Interim report. National Health Service (NHS), UK. https://cass.independent-review.uk/publications/interim-report/

24 Cass, H. (2022b). Independent Review of Gender Identity Services for Children and Young People – Further Advice. National Health Services (NHS), UK.

25 Cass, H. (2024). The Cass Review: Independent review of gender identity services for children and young people: Final Report. National Health Service (NHS), UK.https://cass.independentreview.uk/home/publications/final-report/

26 Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., ... & Olson-Kennedy, J. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. New England Journal of Medicine, 388(3), 240-250.

27 Ciszek, E., Mocarski, R., Price, S., & Almeida, E. (2021). Discursive stickiness: Affective institutional texts and activist resistance. Public Relations Inquiry, 10(3), 295-310.

KF

28 Clayton, A. (2022). Gender-affirming treatment of gender dysphoria in youth: A perfect storm environment for the placebo effect—the Implications for research and clinical practice. Archives of Sexual Behavior, 1-12.

29 Cohn, J. (2023). The Detransition Rate Is Unknown. Archives of Sexual Behavior, 1-16. Cosentino, C. E., Meyer-Bahlburg, H. F., Alpert, J. L., & Gaines, R. (1993). Cross-gender behavior and gender conflict in sexually abused girls. Journal of the American Academy of Child & Adolescent Psychiatry, 32(5), 940-947.

30 Conabere, W., Lami, F., Andrews, H., Skarlatos, M., Pace, C. C., Buckingham, P., Hay, S., De Ieso, T., Pang, K. C., & Tollit, M. A. (2025). Operationalising social transition in trans and gender diverse youth: a scoping review of definitions and measures. EClinicalMedicine, 91, Article 103720. https://doi.org/10.1016/j.eclinm.2025.103720

31 D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. Archives of Sexual Behavior, 50(1), 7-16.

32 Dahlen, S., Connolly, D., Arif, I., Junejo, M. H., Bewley, S., & Meads, C. (2021). International clinical practice guidelines for gender minority/trans people: Systematic review and quality assessment. BMJ open, 11(4), e048943.

33 Demayo, B. E., Gallagher, N. M., Leshin, R. A., & Olson, K. R. (2025). Stability and change in gender identity and sexual orientation across childhood and adolescence. Monographs of the Society for Research in Child Development, 90(1-3), 7-172.

34 Diaz, S., & Bailey, J. M. (2023). Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. Archives of Sexual Behavior, 52(3), 1031–1043. https://doi.org/10.1007/s10508-023-02576-9 (Retraction published Archives of Sexual Behavior. 2023 Nov;52(8):3577. doi: 10.1007/s10508-023-02635-1.)

35 Diaz, S., & Bailey, J. M. (2023b). Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. Journal of Open Inquiry in the Behavioral Sciences, 3(4). https:/doi.org/10.58408/issn.2992-9253.2023.01.01.00000012.

KK

36 Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. PLoS One. 2011;6(2):e16885.

37 Dougan, F.S. There Are Only Two Sexes and There Can Never Be More. Archives of Sexual Behavior, 54, 3815-3820 (2025). https://doi.org/10.1007/s10508-025-03311-2

38 Dork, J., Dimenstein, E., Burns, L., & Demshuk, M. (2026). Overvalued Ideas: Conceptual Analysis and Literature Review. Behavioral Sciences, 16(5), 708.

39 Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental Health and Self-Worth in Socially Transitioned Transgender Youth. Journal of the American Academy of Child and Adolescent Psychiatry, 56(2), 116–123.e2. https://doi.org/10.1016/j.jaac.2016.10.016

40 Evans, M. (2021). Freedom to think: the need for thorough assessment and treatment of gender dysphoric children. BJPsych bulletin, 45(5), 285-290.

41 Fairburn, C. G. (2008). Cognitive behavior therapy and eating disorders. Guilford Press.

42 Feinstein, B. A. (2020). The rejection sensitivity model as a framework for understanding sexual minority mental health. Archives of Sexual Behavior, 49(7), 2247–2256. https://doi.org/10.1007/s10508-019-01572-8

43 Frost, D. M., & Meyer, I. H. (2023). Minority stress theory: Application, critique, and continued relevance. Current Opinion in Psychology, 101579.

44 Frost, D. M., & Meyer, I. H. (2023). Minority stress theory: Application, critique, and continued relevance. Current Opinion in Psychology, 51, Article 101579. https://doi.org/10.1016/j.copsyc.2023.101579

45 Furlong, Y., & Janca, A. (2022). Epidemiology of personality disorders in individuals with gender dysphoria. Current Opinion in Psychiatry, 35(1), 78-82.

46 Garner, D. M., & Garfinkel, P. E. (1980). Socio-cultural factors in the development of anorexia nervosa. Psychological Medicine, 10(4), 647–656. https://doi.org/10.1017/S0033291700054945

47 Gao, S., Assink, M., Cipriani, A., & Lin, K. (2017). Associations between rejection sensitivity and mental health outcomes: A meta-analytic review. Clinical Psychology Review, 57, 59–74. https://doi.org/10.1016/j.cpr.2017.08.007

48 Gillespie, C., Murphy, M., & Joyce, M. (2022). Dialectical Behavior Therapy for Individuals with Borderline Personality Disorder: A Systematic Review of Outcomes After One Year of Follow-Up. Journal of Personality Disorders, 36(4), 431-454.

49 Griffin, L., Clyde, K., Byng, R., & Bewley, S. (2021). Sex, gender and gender identity: a re-evaluation of the evidence. BJPsych Bulletin, 45(5), 291-299.

50 Hacking, I. (2007). Kinds of people: Moving targets. Proceedings of the British Academy, 151, 285–318.Hakeem, A. (2012). Psychotherapy for gender identity disorders. Advances in psychiatric treatment, 18(1), 17-24.

51 Hall, R., Taylor, J., Hewitt, C. E., Heathcote, C., Jarvis, S. W., Langton, T., & Fraser, L. (2024). Impact of social transition in relation to gender for children and adolescents: a systematic review. Archives of disease in childhood, 109(Suppl 2), s12–s18. https://doi.org/10.1136/archdischild-2023-326112

52 Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. Professional Psychology: Research and Practice, 43(5), 460–467. https://doi.org/10.1037/a0029597

53 Heylens, G., De Cuypere, G., Zucker, K. J., Schelfaut, C., Elaut, E., Vanden Bossche, H., ... & T'Sjoen, G. (2012). Gender identity disorder in twins: a review of the case report literature. The Journal of Sexual Medicine, 9(3), 751-757.

54 Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, T. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/ gender-incongruent persons: An Endocrine

Society clinical practice guideline. Journal of Clinical Endocrinology & Metabolism, 102, 3869–3903.

55 Heterodorx, Incorrigible? with Zander Keig, Apr. 21, 2023 (minute 39:40-41:00),

56 https://podcasters.spotify.com/pod/show/heterodorx/episodes/Incorrigible--with-Zander-Keig

57 e22qhr3/a-a9n76p3.

58 Hutchinson, A., Midgen, M., & Spiliadis, A. (2020). In Support of Research Into Rapid-Onset Gender Dysphoria. Archives of Sexual Behavior, 49(1), 79–80. https://doi.org/10.1007/s10508-019-01517-9

59 Hutchinson, A. (2025). Cass informed psychotherapy for gender distressed youth. European Journal of Developmental Psychology, 1–19. https://doi.org/10.1080/17405629.2025.2540809. Epub 2025 Jul 30

60 Jorgensen SCJ. Transition Regret and Detransition: Meanings and Uncertainties. Arch Sex Behav. 2023 Jul;52(5):2173-2184.

61 Karamanis, G., Karalexi, M., White, R., Frisell, T., Isaksson, J., Skalkidou, A., & Papadopoulos, F. C. (2022). Gender dysphoria in twins: a register-based population study. Scientific Reports, 12(1), 13439.

62 Korte, A., & Gille, G. (2023). Wahlverwandtschaften? Trans-Identifizierung und Anorexia nervosa als maladaptive Lösungsversuche für Entwicklungskonflikte in der weiblichen Adoleszenz. Sexuologie, 30.

63 Kohls, G., & Roessner, V. (2022). Editorial Perspective: Medical body modification in youth with gender dysphoria or body dysmorphic disorder–is current practice coherent and evidence-based?. Journal of Child Psychology and Psychiatry.

64 Kozak, M. J., & Foa, E. B. (1994). Obsessions, overvalued ideas, and delusions in obsessive-compulsive disorder. Behaviour Research and Therapy, 32(3), 343–353. https://doi.org/10.1016/0005-7967(94)90132-5

65 Kozlowska, K., Hunter, P., Clayton, A., Kaliebe, K., & Scher, S. (2025). Obstacles to progress in paediatric gender medicine. European Journal of Developmental Psychology, 1-31. https://doi.org/10.1080/17405629.2025.2546574

66 Lam, J. S. H., Abramovich, A., Victor, J. C., Zaheer, J., & Kurdyak, P. (2022). Characteristics of transgender individuals with emergency department visits and hospitalizations for mental health. Psychiatric Services, 73(7), 722-729.

67 Landén, M. (2024). Puberty suppression of children with gender dysphoria: Urgent call for research. Acta Paediatrica, apa.17189.

68 Levin, R. N., Erickson-Schroth, L., Mak, K., & Edmiston, E. K. (2023). Biological studies of transgender identity: A critical review.

69 Littman, L. (2018). Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. / Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLoS ONE, 13(8), Article e0202330. https://doi.org/10.1371/journal.pone.0202330

70 Littman, L. (2019). "Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria": Correction. PLoS ONE, 14(3), Article e0214157. https://doi.org/10.1371/journal.pone.0214157

71 Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. Archives of Sexual Behavior, 50(8), 3353-3369.

72 Mandell, B. F. (2016). The fifth vital sign: A complex story of politics and patient care. Cleveland Clinic journal of medicine, 83(6), 400-401.

73 Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. American Journal of Public Health, 91(11), 1869–1876. https://doi.org/10.2105/AJPH.91.11.1869

KK

74 McDeavitt, K., Cohn, J. & Kulatunga-Moruzi, C. (2025). Pediatric Gender Affirming Care is Not Evidence-based. Current Sexual Health Reports, 17(12). https://doi.org/10.1007/s11930-025-00404-w

75 McPherson, S., & Freedman, D. E. (2023). Psychological outcomes of 12-15 year olds with gender dysphoria receiving pubertal suppression: assessing reliable change and recovery. medRxiv, 2023-05. Meyer I. H. (1995). Minority stress and mental health in gay men. Journal of health and social behavior, 36(1), 38–56.

76 Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychological bulletin, 129(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

77 Meyer, I. H., Russell, S. T., Hammack, P. L., Frost, D. M., & Wilson, B. D. M. (2021). Minority stress, distress, and suicide attempts in three cohorts of sexual minority adults: A U.S. probability sample. PloS one, 16(3), e0246827. https://doi.org/10.1371/journal.pone.0246827

78 Morandini, J. S., Kelly, A., de Graaf, N. M., Malouf, P., Guerin, E., Dar-Nimrod, I., & Carmichael, P. (2023). Is social gender transition associated with mental health status in children and adolescents with Gender Dysphoria? Archives of Sexual Behavior, 52, 1045–1060. https://doi.org/10.1007/s10508-023-02588-5

79 Murad, M. H. (2017, March). Clinical practice guidelines: a primer on development and dissemination. In Mayo Clinic Proceedings (Vol. 92, No. 3, pp. 423-433). Elsevier.

80 Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental Health of Transgender Children Who Are Supported in Their Identities. Pediatrics, 137(3), Article e20153223. https://doi.org/10.1542/peds.2015-3223

81 Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender Identity 5 Years After Social Transition. Pediatrics, 150(2), Article e2021056082. https://doi.org/10.1542/peds.2021-056082

82 Passos, T.S., Teixeira, M.S. & Almeida-Santos, M.A. Quality of Life After Gender Affirmation Surgery: a Systematic Review and Network Meta-analysis. Sex Res Soc Policy 17, 252–262 (2020), https://doi.org/10.1007/s13178-019-00394-0.

83 Peters, U. (2020). What is the function of confirmation bias?. Erkenntnis, 1-26.

84 Phillips, K. A. (2004). Body dysmorphic disorder: Recognizing and treating imagined ugliness. World Psychiatry, 3(1), 12–17.

85 Rachel N. Levin, Laura Erickson-Schroth, Kristie Mak & E. Kale Edmiston (2023) Biological studies of transgender identity: A critical review, Journal of Gay & Lesbian Mental Health, 27:3, 254-283, DOI: 10.1080/19359705.2022.2127042.Redstone, I., & Villasenor, J. (2020). Unassailable ideas: how unwritten rules and social media shape discourse in American higher education. Oxford University Press.

86 Ristori, J., & Steensma, T. D. (2016). Gender dysphoria in childhood. International Review of Psychiatry, 28(1), 13-20.

87 Ruuska, S. M., Tuisku, K., Holttinen, T., & Kaltiala, R. (2026). Psychiatric Morbidity Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996–2019: A Register Study. Acta Paediatrica.

88 Sievert, E. D., Schweizer, K., Barkmann, C., Fahrenkrug, S., & Becker-Hebly, I. (2021). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with gender dysphoria. Clinical Child Psychology and Psychiatry, 26(1), 79–95. https://doi.org/10.1177/1359104520964530

89 Singer, J., Pilgrim, D., Hakeem, A. et al. Constraints on Free Academic and Professional Debate in the UK About Sex and Gender. Arch Sex Behav 52, 2269-2279 (2023). https://doi.org/10.1007/s10508-023-02687-3.

90 Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. Frontiers in Psychiatry, 12, 632784. https://doi.org/10.3389/fpsyt.2021.632784

91 Soldati, L., Hasler, R., Recordon, N., Clement, M., Köhl, J., & Perroud, N. (2022). Gender dysphoria and dissociative identity disorder: a case report and review of literature. Sexual Medicine, 10(5), 100553.

KK

92 Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clinical child Psychology and Psychiatry, 16(4), 499–516. https://doi.org/10.1177/1359104510378303

93 Steensma, T. D., Kreukels, B. P., de Vries, A. L., & Cohen-Kettenis, P. T. (2013). Gender identity development in adolescence. Hormones and Behavior, 64(2), 288–297. https://doi.org/10.1016/j.yhbeh.2013.02.020

94 Steensma, T. D., & Cohen-Kettenis, P. T. (2018). A critical commentary on "A critical commentary on follow-up studies and 'desistence' theories about transgender and gender non-conforming children." International Journal of Transgenderism, 19(2), 225–230. https://doi.org/10.1080/15532739.2018.1468292

95 Stock, K. (2021). Material Girls: Why Reality Matters for Feminism. Fleet.

96 U.S. Department of Health, Education, and Welfare (DHEW), & National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (NCPHSBBR) (2014). The Belmont Report. Ethical principles and guidelines for the protection of human subjects of research. The Journal of the American College of Dentists, 81(3), 4–13. https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html

97 U.S. Department of Health and Human Services (HHS) (2025a). Treatment for pediatric gender dysphoria: Review of evidence and best practices. https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf

98 U.S. Department of Health and Human Services (HHS) (2025b). Supplement to Treatment for Pediatric Gender Dysphoria Review of Evidence and Best Practices. https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report-supplement.pdf

99 U.S. Department of Health and Human Services (HHS) (2025c). Appendix 4: Overview of Systematic Reviews. https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report-appendix.pdf

100 USPATH & WPATH, Joint Letter from USPATH and WPATH (Oct. 12, 2021)

KK

101 https://www.wpath.org/media/cms/Documents/Public%20Policies/2021/Joint%20WPATH%20USPATH%20Letter%20Dated%20Oct%2012%202021.pdf.

102 van Zyl, J. (2024). Formulating gender dysphoria as an affective-perceptual disturbance involving the body. Psychodynamic Practice, 31(2), 160-176. https://doi.org/10.1080/14753634.2024.2371655

103 Veale, D., & Neziroglu, F. (2010). Body dysmorphic disorder: A treatment manual. Wiley-Blackwell.

104 Vogt, K. S., & Norman, P. (2019). Is mentalization-based therapy effective in treating the symptoms of borderline personality disorder? A systematic review. Psychology and Psychotherapy: Theory, Research and Practice, 92(4), 441-464.

105 Wong W. I., van der Miesen A. I. R., Li T. G. F., MacMullin L. N., VanderLaan D. P. (2019). Childhood Social Gender Transition and Psychosocial Well-Being: A Comparison to Cisgender Gender-Variant Children. Clinical Practice in Pediatric Psychology, 7(3):241–253. https://doi.org/10.1037/cpp0000295

106 World Association of Medical Editors. (2009). Conflict of interest in peer-reviewed medical journals: a policy statement of the World Association of Medical Editors (WAME). Journal of Child Neurology, 24(10), 1321–1323. https://doi.org/10.1177/0883073809345928

107 Zucker, K. J., Lawrence, A. A., & Kreukels, B. P. (2016). Gender dysphoria in adults. Annual Review of Clinical Psychology, 12, 217–247.

108 Zucker, K. J. (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. (2018). International Journal of Transgenderism, 19(2), 231–245. https://doi.org/10.1080/15532739.2018.1468293

109 Zucker, K. J. (2019). Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues. Archives of Sexual Behavior, 48(7), 1983–1992. https://doi.org/10.1007/s10508-019-01518-8

110 Zucker K. J. (2020). Debate: Different strokes for different folks. Child and Adolescent Mental Health, 25(1), 36–37. https://doi.org/10.1111/camh.12330

Kristopher Kaliebe, MD

DEPONENT SIGNATURE

Signed and sworn/affirmed to before me at _____ on this _____day of

2026, the deponent having acknowledged that he knows and understands the contents of this affidavit; which is deposed to in accordance with the regulations governing the administration of an oath as more fully set out in Government Notice R1258 of 21 July 1972, as amended by Government Notice 1648 dated 19 August 1977 and Government Notice 903 dated 10 July 1998.

Commissioner of Oaths:

_____

Signature

Full names: _____

KK

Status: _____

Street address: _____

I declare, pursuant to 28 U.S.C. §1746, under penalty of perjury that the foregoing is true and correct.

Executed this 28 day of May 2026.

Kristopher E Kaliebe

Kristopher E. Kaliebe, M.D.