

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division**

AUGUST DEKKER, et al.,

Plaintiffs,

v.

SIMONE MARSTILLER, et al.,

Defendants.

Case No. 4:22-cv-00325-RH-MAF

**EXPERT DECLARATION OF DR. JOHANNA OLSON-KENNEDY, M.D.,
M.S.**

I, Johanna Olson-Kennedy, M.D., M.S., hereby declare and state as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have been asked by Plaintiffs' counsel to provide my expert opinion on gender identity; the treatment and diagnosis of gender dysphoria; the Florida Medicaid Generally Accepted Professional Medical Standards (GAPMS) Determination on the Treatment of Gender Dysphoria published by Florida's Agency for Health Care Administration (AHCA) in June 2022, along with its attachments; and Fla. Admin. Code. R. 59G-1.050(7) which prohibits Medicaid coverage of puberty blockers, hormone and hormone antagonists, "sex

reassignment” surgeries, and any other procedures that alter primary or secondary sexual characteristics.

3. I 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. BACKGROUND AND QUALIFICATIONS

4. I received my Doctor of Medicine (M.D.) degree from the Chicago Medical School in 1997. In 2000, I completed my residency in pediatrics at the Children’s Hospital of Orange County, California, and from 2000 to 2003, I was a Fellow in adolescent medicine at the Children’s Hospital of Los Angeles.

5. I have been a licensed physician in California since 2000 and am Double Board Certified by the American Board of Pediatrics in Pediatrics and in Adolescent Medicine. I specialize in the care of transgender youth and gender diverse children, and am currently the Medical Director of the Center for Transyouth Health and Development, in the Division of Adolescent Medicine at the Children’s Hospital in Los Angeles, California. The Center is the largest clinic in the United States for transgender youth and provides gender diverse youth with both medical and mental health services, including consultation for families with gender diverse children and routine use of medications to suppress puberty in peri-pubertal youth (i.e., youth at the onset of puberty), gender-affirming hormone use for

masculinization and feminization, as well as surgical referrals. Under my direction, the Center conducts rigorous research aimed at understanding the experience of gender diversity and gender dysphoria from childhood through early adulthood.

6. Over the course of my work with this population during the past 16 years, I have provided services for approximately 1000 young people and their families, and currently have an active panel of around 650 patients of varying ages, up to 25 years old.

7. I have been awarded research grants to examine the impact of early interventions including puberty-delaying medication (commonly known as puberty blockers) and gender-affirming hormones on the physiological and psychosocial development of gender diverse and transgender youth. I have lectured extensively, across the United States and internationally on the treatment and care of gender diverse children and transgender adolescents, the subjects including pubertal suppression, gender-affirming hormone therapy, transitioning teens and the adolescent experience, age considerations in administering hormones, and the needs, risks, and outcomes of hormonal treatments. I have published numerous articles and chapters, both peer reviewed, and non-peer reviewed, on transgender health-related issues.

8. I am currently the principal investigator on a multisite National Institutes of Health grant to continue, for an additional 5 years, an ongoing study examining the impact of gender-affirming medical care for transgender youth on physiologic and psychological health and well-being. The first five years have already been completed. This is the first study of its kind in the US to determine longitudinal outcomes among this population of vulnerable youth. The study to date has yielded approximately 26 manuscripts.

9. I am an Associate Professor at the Keck School of Medicine at the University of Southern California and attending physician at Children's Hospital of Los Angeles. I have been a member of the World Professional Association for Transgender Health (WPATH) since 2010, and a Board Member of the US Professional Association for Transgender Health (USPATH) since 2017. I was recently appointed to the Executive Board of the USPATH. I am also a member of the Society for Adolescent Health and Medicine and the American Academy of Pediatrics. In addition I am a member of the LGBT Special Interest Group of the Society for Adolescent Health and Development.

10. I am the 2014 Recognition Awardee for the Southern California Regional Chapter of the Society for Adolescent Health and Medicine.

11. In 2019, I was invited by the University of Bristol as a Benjamin Meaker visiting professor, the purpose of which is to bring distinguished researchers from overseas to Bristol in order to enhance the research activity of the university.

12. In preparing this report, I have relied on my training and years of research and clinical experience, as set out in my curriculum vitae, and on the materials listed therein. A true and accurate copy of my curriculum vitae is attached hereto as **Exhibit A**. It documents my education, training, research, and years of experience in this field and includes a list of publications.

13. I have also reviewed the materials listed in the attached bibliography (**Exhibit B**). The sources cited therein are authoritative, scientific peer-reviewed publications. I generally rely on these materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this declaration.

14. In addition, I have reviewed the Florida Medicaid Generally Accepted Professional Medical Standards (GAPMS) Determination on the Treatment of Gender Dysphoria published by Florida's Agency for Health Care Administration (AHCA) in June 2022, along with its attachments, including the "assessments" of Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch (Attachment C), Dr. James Cantor (Attachment D), Dr. Quentin Van Meter (Attachment E), Dr. Patrick

Lappert (Attachment F), and Dr. G. Kevin Donovan (Attachment G) (hereinafter, “GAPMS Memo”); and Fla. Admin. Code. R. 59G-1.050(7) which prohibits Medicaid coverage of puberty blockers, hormone and hormone antagonists, “sex reassignment” surgeries, and any other procedures that alter primary or secondary sexual characteristics. I may rely on these documents, as well as those cited in curriculum vitae and the attached bibliography, as additional support for my opinions.

15. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

Prior Testimony

16. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Fain v. Crouch*, No. 3:20-cv-00740 (S.D. W.Va.); *Kadel v. Folwell*, Case No. 1:19-cv-00272-LCB-LPA (M.D.N.C.); *In the interest of J.A.D.Y. and J.U.D.Y., Children*, Case No. DF-15-09887 (255th Jud. District Ct.,

Dallas Cty., Tex.); and *Paul E. v. Courtney F.*, No. FC2010-051045 (Superior Ct., Maricopa Cty., Ariz.).

Compensation

17. I am being compensated for my work on this matter at a rate of \$200.00 per hour for preparation of declarations and expert reports, as well as any pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

II. EXPERT OPINIONS

A. Gender Identity

18. The term gender identity was originally coined in 1964 by American psychiatrist Robert J. Stoller, a noted psychoanalyst who studied sexual orientation, gender identity, and differences in sexual development. Gender identity is a distinct characteristic and is defined as one's internal sense of being male or female (or rarely, both or neither). It has a strong biological basis. Every person has a gender identity.

19. The concept of gender identity is contemporaneously understood both colloquially and within the domain of science and medicine to denote someone's gender. It is a concept well-understood and accepted in medicine and science.

Indeed, gender identity information is commonly collected and reported on within the context of scientific research. (Clayton, et al., 2016).

20. The term cisgender refers to a person whose gender identity matches their sex assigned at birth. The term transgender refers to a person whose gender identity does not match their sex assigned at birth.

21. Historically, “gender” was equated with a person’s sex assigned at birth, which refers to the sex assigned to a person when they are born, generally based on external genitalia. However, a more contemporary understanding of gender shows that one’s gender identity may differ from one’s sex assigned at birth.

22. While both gender identity and sex are often assumed and treated as binary and oppositional, they are more accurately experienced as along a spectrum. For example, there are multiple sex characteristics, such as genitalia, chromosomal makeup, hormones, and variations in brain structure and function. For some of these characteristics there is significant variance as reflected by the dozens of intersex mechanisms and varying gender identities. Additionally, not all sex characteristics, including gender identity, are always in alignment. Accordingly, the Endocrine Society Guidelines state that, “As these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.”

23. As early as 1966 it has been understood that gender identity cannot be changed. Efforts to do so have been shown to be unsuccessful and harmful.

24. “Conversion” or “reparative” therapy refers to the practice of attempting to change an individual’s sexual orientation and attractions from members of the same sex to those of the opposite sex. A similar model of therapy for individuals with a transgender identity or experience has historically been an approach promoted by some individuals, notwithstanding its ineffectiveness and harmful effects. Accordingly, 20 states and the District of Columbia have banned reparative therapy for youth, and major medical organizations have issued statements deeming the practice to be unethical.

25. A Williams Institute report published in 2018 estimates that just under 700,000 LGBT individuals in the United States have undergone “conversion therapy” at some point in their lifetime, about half of those during adolescence. Because some psychiatrists and sexologists working in the 1960’s and 70’s perpetuated the idea that being transgender was likely the result of a pathological early childhood experience, many professionals and lay community members continue to believe that gender is malleable. Tactics have ranged from simple redirection, thought pattern alteration or hypnosis to aversion techniques including induction of vomiting, nausea, paralysis or electric shocks, have been employed in

order to change the expression, behavior, and assertion of one's authentic gender. (Mallory, et al., 2019). However, multiple studies show that gender identity has a strong biological basis and cannot be changed. As such, reparative therapy is both ineffective and harmful for transgender and gender diverse youth.

B. Gender Dysphoria and its Treatment

26. Gender Dysphoria (GD) is a serious medical condition characterized by distress due to a mismatch between assigned birth sex and a person's internal sense of their gender. GD was formerly categorized as Gender Identity Disorder (GID) but the condition was renamed in May 2013, with the release of the American Psychiatric Association (APA)'s fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). In announcing this change, the APA explained that in addition to the name change, the criteria for the diagnosis were revised "to better characterize the experiences of affected children, adolescents, and adults." The APA further stressed that "gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition."

27. On May 25, 2019, the World Health Assembly approved International Classification of Diseases (ICD) version 11 that had been published by the World Health Organization in 2018. In this newest version of the ICD, all trans-related

diagnostic codes were removed from the chapter “Mental and Behavioral Disorders,” and the code “Gender incongruence” was included in a new chapter “Conditions related to sexual health.” These codes replaced the outdated “Gender Identity Disorder of childhood” (F64.2), “Gender Identity Disorder not otherwise specified” (F64.9), “transsexualism” (F64.0), and “Dual-role transvestism” (F64.1), which perpetuated the idea that patients seeking and undergoing medical interventions for a medical condition are mentally ill. (Suess Schwend, 2020).

28. For a person to be diagnosed with GD, there must be a marked difference between the individual’s expressed/experienced gender and the gender others would assign to the individual, present for at least six months. In children, the desire to be of the other gender must be present and verbalized.¹ The condition must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

29. The World Professional Association of Transgender Health (WPATH) has clear recommendations for the health of transsexual, transgender, and gender non-conforming people in what is now the Standards of Care version 7 (SOC 7). The SOC are based on the best available science and expert professional consensus. They

¹ Notably, the DSM-IV included a separate diagnosis for GID in children, which required the child to display a number of behaviors stereotypical of the non-natal gender. That diagnosis, and its list of behavioral requirements, have been deleted from the DSM-V and replaced by updated and more precise diagnostic criteria.

are currently under revision to create an updated version 8. The WPATH SOC have been endorsed and cited as authoritative by most major medical associations in the United States, including the American Medical Association, the American Psychiatric Association, the American Psychological Association, the Endocrine Society, the Pediatric Endocrine Society, the American College of Physicians, and the American Academy of Family Physicians, among others.

30. The UCSF Center for Excellence in Transgender Care as well as the Endocrine Society have both published comprehensive guidelines for the care of transgender and non-binary individuals that are largely consistent with the WPATH SOC.

31. The GAPMS Memo and some its attached “assessments” discuss a number of approaches to care, though they fail to properly describe them and to discuss their limitations.

32. One of the approaches discussed by Dr. Van Meter is “reparative” or “corrective” therapy. *See* Attachment E to GAPMS Memo, at 6 (“Van Meter”). As discussed above, this so-called “therapy” has proven to be ineffective and harmful, and has been deemed to be unethical.

33. **“Redirection”** – Under this approach, advocated by people like Dr. Van Meter, a mental health therapist would encourage caregivers to use positive

reinforcement to try to “redirect” children toward behavior that is more typical of their birth-designated sex or less gender specific. Underlying this approach is the assumption that a child’s gender identity is malleable through social interventions. The goal of redirection is thus to eliminate gender-diverse desires and expressions over time, and to try to prevent the transgender child from being transgender. This approach is not recommended because negative reinforcement (e.g., shaming the child for gender diverse expression) has substantial negative mental and social health consequences. (Turban and Ehrensaft, 2018; Ehrensaft, 2017). It also ignores that gender identity is innate and cannot be changed.

34. **Wait-and-see** – The wait-and-see approach (also called watchful waiting) involves waiting to see if the child’s gender identity will change as the child gets older. This approach typically recommends that caregivers prohibit a prepubertal social transition, but may allow cross-gender play and clothing within the home or support both masculine and feminine activities as the child explores their interests in other social settings. The wait-and-see approach assumes that gender is binary and becomes fixed at a certain age; it pathologizes gender diversity and fluidity. It is distinguished from following the child’s lead, an affirming approach that allows the child to present in the gender role that feels correct and moves at a pace that is largely directed by the child. This approach ignores evidence

that young children thrive when given permission to live in the gender that is most authentic to them and are at risk for symptomatic behaviors if prevented from doing so. (Ehrensaft, 2017).

35. **Affirmation** - The affirmative approach considers no gender identity outcome: transgender, cisgender, or otherwise, to be preferable. (Turban and Ehrensaft, 2018). It permits a child to explore gender development and self-definition within a safe setting. A fundamental concept of this approach is that gender diversity is not a mental illness. The gender-affirmative model is defined as a method of therapeutic care that includes allowing children to speak for themselves about their self-experienced gender identity and expressions and providing support for them to evolve into their authentic gender selves, no matter at what age. Under this model, a child's self-report is embedded within a collaborative model with the child as subject and the collaborative team including the child, parents, and professionals. Support is not characterized by "encouraging" children or youth to be transgender or not, but rather by allowing children who express a desire to undergo a social transition (which may include changing names, pronouns, clothing, hairstyles, etc.) to do so. **For children who have not yet reached puberty, medical intervention is unnecessary and unwarranted.** After the onset of puberty medical

interventions such as puberty blockers, and later hormones and surgery, may be appropriate.

36. While some argue that gender affirmation leads a child or adolescent down a path of inevitable transgender identity, no such evidence exists, either in the scientific or the clinical setting. To the contrary, studies show that gender identification does not meaningfully differ before and after social transition. (Rae, et al., 2019).

37. Under both the “wait and see” and affirmative care models, as understood in the scientific literature, medical care is recommended following the onset of puberty. (Ehrensaft, 2017).

38. The most effective treatment for adolescents and adults with GD, in terms of both their mental and medical health, contemplates an individualized approach. Medical and surgical treatment interventions are determined by the care team (usually a medical and mental health professional) in collaboration with the patient, and the patient’s family, if the patient is a minor. These medical decisions are made by the care team in conjunction with the patient and, if the patient is a minor, the patient’s family, and consider the patient’s social situation, the level of gender dysphoria, developmental stage, existing medical conditions, and other relevant factors. Sometimes treatment begins with puberty delaying medications

(also referred to as puberty blockers), later followed by gender-affirming hormones. Most youth, and certainly all adults, accessing treatment are already well into or have completed puberty. Gender-affirming genital surgeries are generally sought after hormone treatment and, as described below, whether they are recommended varies based on whether the patient is an adolescent or adult, as well as other factors.

39. *Puberty blockers*: The beginning signs of puberty in transgender youth (the development of breast buds in assigned birth females and increased testicular volume in assigned birth males) is often a painful and sometimes traumatic experience that brings increased body dysphoria and the potential development of a host of comorbidities including depression, anxiety, substance abuse, self-harming behaviors, social isolation, high-risk sexual behaviors, and increased suicidality. Puberty suppression, which involves the administration of gonadotrophin-releasing hormone analogues (GnRHa), essentially pauses puberty, thereby allowing the young person the opportunity to explore gender without having to experience the anxiety and distress associated with developing the undesired secondary sexual characteristics. In addition, for parents/guardians who are uneducated about gender diversity and/or who have only recently become aware of their child's transgender identity, puberty blockers provide additional time and opportunity to integrate this new information into their own experience and to develop skills to support their

child. Puberty suppression also has the benefit of potentially rendering obsolete some gender-affirming surgeries down the line, such as male chest reconstruction, tracheal shave, facial feminization, and vocal cord alteration, which otherwise would be required to correct the initial “incorrect” puberty.

40. Puberty suppression has been used safely for decades in children with other medical conditions, including precocious puberty, and is a reversible intervention. (Mul, et al., 2008). If the medication is discontinued, the young person continues their endogenous puberty. The “Dutch protocol,” developed from a study conducted in the Netherlands and published in 2006, calls for the commencement of puberty blockers for appropriately diagnosed and assessed gender dysphoric youth as early as 12 years of age. (de Vries, et al., 2014). Both the Endocrine Society and the WPATH’s SOC, however, recommend initiation of puberty suppression at the earliest stages of puberty (usually, Tanner 2) (assuming someone has engaged in services before or around this time), regardless of chronological age, in order to avoid the stress and trauma associated with developing secondary sex characteristics of the natal sex.

41. A growing body of evidence demonstrates the positive impact of pubertal suppression in youth with GD on psychological functioning including a decrease in behavioral and emotional problems, a decrease in depressive symptoms,

and improvement in general functioning. (Turban, et al., 2020; de Vries, et al., 2014, Costa et al 2015).

42. Puberty blockers, thus, afford youth the opportunity to undergo a single, congruent pubertal process and avoid many of the surgical interventions previously necessary for assimilation into an authentic gender role. It is a simple reversible intervention that has the capacity to improve health outcomes and save lives. Over the course of my work in the past sixteen years with gender diverse and transgender youth, I have prescribed hormone suppression for over 250 patients. All of those patients have benefitted from putting their endogenous puberty process on pause, even the small handful who discontinued GnRH analogues and went through their endogenous puberty. Many of these young people were able to matriculate back into school environments, begin appropriate peer relationships, and participate meaningfully in therapy and family functions. Children who had contemplated or attempted suicide or self-harm (including cutting and burning) associated with monthly menstruation or the anxiety about their voice dropping were offered respite from those dark places of despair. GnRH analogues for puberty suppression are, in my opinion, a sentinel event in the history of transgender medicine, and have changed the landscape almost as much as the development of synthetic hormones.

43. *Gender-affirming hormones:* Cross-gender or gender-affirming hormone therapy involves administering steroids of the experienced sex (i.e., their gender identity) (estrogen for transfeminine individuals and testosterone for transmasculine individuals). The purpose of this treatment is to attain the appropriate masculinization or feminization of the transgender person to achieve a gender phenotype that matches as closely as possible to their gender identity. Gender-affirming hormone therapy is a partially reversible treatment in that some of the effects produced by the hormones are reversible (e.g., changes in body fat composition, decrease in facial and body hair) while others are irreversible (e.g., deepening of the voice, breast tissue development). Eligibility and medical necessity should be determined case-by-case, based on an assessment of the youth's unique cognitive and emotional maturation and ability to provide a knowing and informed consent. The decision would be made only after a careful review with the youth and parents/guardians of the potential risks and benefits of hormone therapy. The youth's primary care provider, therapist, or another experienced mental health professional can help document and confirm the patient's history of gender dysphoria, the medical necessity of the intervention, and the youth's readiness to transition medically.

44. *Gender-affirming surgeries:* Some transgender individuals need surgical interventions to help bring their phenotype into alignment with their gender. Surgical interventions may include vaginoplasty, tracheal shave, liposuction, breast implants, and orchiectomy for transfeminine individuals and chest reconstruction, hysterectomy, oophorectomy, salpingectomy, construction of a neoscrotum, and metoidioplasty or phalloplasty for transmasculine individuals.

45. The current WPATH SOC recommend that genital surgery – i.e., surgery which will render the individual sterile – not be carried out until the individual reaches the legal age of majority to give consent for medical procedures, while acknowledging that care is individualized. In addition, the Standards recommend that the other surgical interventions (e.g., chest surgery for transgender males and breast augmentation for transgender females) may occur earlier than the legal age of consent, preferably after ample time living in the desired gender role and after one year of hormone therapy. The SOC, however, further recognize that these are individual determinations and that “different approaches may be more suitable, depending on an adolescent’s specific clinical situation and goals for gender identity expression.”

46. Gender-affirming medical interventions are considered medically necessary and are recognized as such by many major professional organizations. The denial of this care results in negative health consequences.

47. There are those (see GAPMS Memo at 12-13) who would make the argument that the recent uptick in youth presenting for services related to GD is the result of “social contagion.” But if social contagion theory applied to gender and gender identity, there would be zero transgender people, because of the consistent exposure to an overwhelming majority of cisgender people. The social contagion argument that is posited by some confuses the relationship between one’s recognition of their gender and their exposure to gender related information and community, particularly with regard to internet activity, asserting that youth are declaring themselves to be transgender or gender diverse because they were exposed to this online, or they have multiple friends who are also experiencing GD. Adolescent development includes finding like groups of peers, which extends to finding friend groups who are also gender diverse. Finally, attributing GD to “social contagion” is a simplistic perspective that discounts that the process of doing something about one’s gender dysphoria is complex and difficult and involves parental consent for minors.

48. There is no scientific evidence that one develops gender dysphoria from being exposed to people with GD. To the contrary, most evidence shows that gender identity has a biological basis (Korpaisarn, et al., 2019; Saraswat, et al., 2015) and is affixed by early childhood (Slaby, et al., 1975).

C. Critiques of the GAPMS Memo and the Attached “Assessments”

49. The GAPMS Memo and the attached assessments contain a number of inaccurate assertions or misrepresentations, in addition to those noted above.

Misunderstandings and Misrepresentations of Desistance

50. The GAPMS Memo falsely states that “the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex and that the puberty suppression can have side effects.” (GAPMS Memo at 14). This is a blatant misrepresentation of the scientific literature. The studies pertaining to desistance upon which the GAPMS Memo relies pertain to *pre-pubertal* youth, not adolescents. In fact, contrary to the GAPMS Memo’s assertion, studies show that if gender dysphoria is present in adolescence, it usually persists (DeVries, et al., 2011).

51. To be sure, there are a significant number of *pre-pubertal* children who demonstrate an interest or preference for clothing, toys, and games that are stereotypically of interest to members of the “other” gender. Some of these children

are transgender and some are not. It is the study of such *pre-pubertal* children that has created confusion about the persistence of gender dysphoria into adolescence and adulthood. Specifically, the *pre-pubertal* children who were the subject of research endeavors in the late 20th century included both children who are transgender and children who are not, i.e., those that would have met current criteria for a diagnosis of “Gender Dysphoria in Children” and those who would be considered “sub-threshold” for this diagnosis.

52. At the time of these studies, the diagnosis of “Gender Dysphoria in Children” did not exist and therefore the study subjects did not need to meet criteria B, which is “the presence of clinically significant distress associated with the condition.” In addition, the criteria for the then-used “gender identity disorder in children” diagnosis did not require a child to have “a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender),” which the current “Gender Dysphoria in Children” diagnosis requires.

53. Thus, given the broader criteria used at the time, it is unsurprising that some of the research undertaken toward the end of the 20th century demonstrated that most children who exhibited gender-nonconforming behavior did not go on to have a transgender identity in adolescence. Yet, notwithstanding its inapplicability

and faulty underpinnings, this “evidence” has been used to argue against gender affirmation for children and adolescents.

54. What is more, these arguments about desistance in *pre-pubertal* children are wholly irrelevant to the question of coverage and provision of medical care as treatment for GD. That is because research to date shows that if transgender identification persists into adolescence, then desistance is incredibly rare, and no medical or surgical treatments are recommended for *pre-pubertal* children.

55. Additionally, no studies have ever demonstrated that gender affirmation in childhood “leads to” a child being transgender who otherwise might not have been. Studies have demonstrated that the majority of youth whose GD and cross-gender identity continue to be present, or those whose GD emerges in adolescence, are highly unlikely to identify and live as cisgender individuals. Youth with GD, particularly those who are unaffirmed and denied care, are at high risk for depression, anxiety, isolation, self-harm and suicidality at the onset of puberty-related changes that feel wrong to them.

The Myth of Social Contagion and Rapid-Onset Gender Dysphoria (ROGD)

56. The GAPMS memo asserts that gender-affirming care should not be provided because the causes of GD are uncertain. It suggests that “exposure to ‘social and peer contagion’” accounts for the rise in numbers of adolescents who

identify as transgender, pointing to research that has identified so-called “rapid-onset gender dysphoria” (ROGD). (GAPMS Memo at 12-13; see also Cantor ¶ 48-49). However, ROGD is not a diagnosis recognized by any medical or scientific institution, and there is no scientific evidence in support of it.

57. The concept of ROGD originated from a single article authored by Lisa Littman (Littman, 2018), a researcher who had no experience in the field of gender medicine, transgender issues, or gender dysphoria, prior to the publication of her article.

58. Littman’s article was heavily criticized for its flawed methodology, potential for bias, and overrepresentation of its findings (see, e.g., Brandelli Costa, 2019; Restar, 2019). For example, Littman’s study was based solely on “parent observations and interpretations.” But parental reports are not necessarily a reliable basis for understanding a particular youth’s experience with their gender, let alone whether the youth has gender dysphoria (see, e.g., Kennedy, 2022; Brandelli Costa, 2019). Moreover, most of the parents who participated in the study were recruited from websites targeted to parents likely to question their child’s gender self-identification and the current best health care approaches. In addition, the study also failed to collect data from the adolescents and young adults (AYAs) or clinicians,

which would have been necessary in order to come up with and validate ROGD as a new phenomenon.

59. Following the numerous critiques of the Littman study, the journal that published the study retracted it, ordered a post-publication review, and republished the article with a correction notice (Littman, 2019), along with an apology (Heber, 2019).

60. The correction notice acknowledged, among other things, that:
- a. “there is some information about the AYAs that the parents would not have access to and the answers might reflect parent perspectives” and that “consideration of what information parents may or may not have access to is an important element of the findings”;
 - b. “the study’s output was hypothesis-generating rather than hypothesis-testing”;
 - c. “three of the sites that posted recruitment information expressed cautious or negative views about medical and surgical interventions for gender dysphoric adolescents and young adults and cautious or negative views about categorizing gender dysphoric youth as transgender”; and

d. “There is expected variation in how objective parents can be about their own children” and that the “descriptive study was not designed to explore or measure the objectivity of participants.”

61. Thus, the correction notice ultimately acknowledged that the study “does not validate the phenomenon” of ROGD and that the term ROGD “should not be used in a way to imply that it explains the experiences of all gender dysphoric youth nor should it be used to stigmatize vulnerable individuals.” In the end, aside from the correction notice, the journal that published the study issued an apology “for oversights that occurred during the original assessment of the study” (Heber, 2019).

62. What is more, since the publication of the Littman article, new studies have been published that dispel the notion of ROGD or that social contagion contributes to the development of gender dysphoria (Bauer, et al., 2022; Turban, et al., 2022). To date, no study has been published that validates or proves the hypothesis of ROGD presented by the Littman study. Indeed, Lisa Littman herself said at the GenSpect 2021 Conference that ROGD was not a new phenomenon, but rather a re-naming of late onset GD.

63. The GAPMS Memo, Dr. Cantor, and Dr. Van Meter incorrectly allege that an increase in numbers of youth presenting for care related to GD provides

support for the social contagion theory. (See GAPMS Memo at 12-13; Van Meter at 9-10). For one, varying estimates of prevalence are the result of inconsistent measures of transgender populations. Some studies have assessed the fraction of a population which had received the DSM-IV diagnosis of GID or the ICD 10 diagnosis of transsexualism, both of which were limited to clinical populations who sought a binary transition (male-to-female or female-to-male). For example, the prevalence reported in DSM-5 (0.005–0.014% for birth-assigned males; 0.002–0.003% for birth-assigned females) are based on people who received a diagnosis of GID or transsexualism and were seeking hormone treatment and surgery from gender specialty clinics, and, therefore, do not reflect the prevalence of all individuals with gender dysphoria or who identify as transgender. Other studies have reported on those who self-identified as transgender or gender incongruent and found that measuring self-identity yields much higher numbers. In 2016, data from the Center for Disease Control’s Behavioral Risk Factor Surveillance System suggested that 0.6% of U.S. adults identify as transgender, double the estimate utilizing data from the previous decade. (Byne, et al., 2018). Ultimately, there is nothing surprising about the fact that more transgender people have begun identifying themselves to others as societal stigma has started to abate, and nothing about that lends support to the “social contagion” theory.

Dr. Cantor's False Assertion of Transition-on-Demand

64. In his “assessment,” Dr. Cantor, a psychologist with no clinical experience in treating gender dysphoria in minors and no experience monitoring patients receiving drug treatments for gender dysphoria, states that “transition-on-demand” increases the probability of unnecessary transition and unnecessary medical risks. (Cantor ¶ 21).

65. His claim is wholly divorced from the reality of care for transgender people. First, like all health care, gender-affirming care for every transgender person is individualized. There simply is no one specific route.

66. Second, Dr. Cantor inaccurately assumes that every transgender person wants and receives rapid access to services. For most transgender individuals seeking care, nothing about their process has been rapid, even when they are young. Most individuals with gender dysphoria have engaged in a long, arduous and private process of understanding their gender to be different from the one assumed at birth. Dr. Cantor gives no credibility to transgender patients regarding their right to bodily autonomy nor their capacity to make sound and informed decisions.

67. Finally, Dr. Cantor is wrong to assert that affirmation “increases the probability of unnecessary transition and unnecessary medical risks.” (Cantor ¶ 21). There is no evidence to support the notion that affirmation of gender in pre-pubertal

children, or at any age, leads to transition. Medical interventions are not recommended and are not appropriate for pre-pubertal children. If one's gender could be impacted by the role of rearing, there would be few transgender people who transition in adulthood, as most were reared in the gender role that corresponded with their sex assigned at birth. It is not logical to think that while we have been epically failing at convincing transgender people to be cisgender that we would be able to make someone who is cisgender into someone who is transgender, a directionality that may correspond with higher rates of discrimination, harassment, and even violence. There is no data to support any such notion that children who are socially transitioned in a pre-pubertal time period who then go on to embrace their assumed gender at birth are damaged. I know several such young people who are healthy and happy.

The Quality of the Evidence and Lack of Randomized Controlled Trials

68. The care of transgender individuals has a long history. As with all medical care, there is a range of quality in the existing data regarding the treatment of gender dysphoria (see UCSF Guidelines), and there is certainly a need for additional studies of a longitudinal nature. But again, that is true with most medical care.

69. Between 1963 and 1979, over 20 university-based gender identity clinics opened in the United States. These clinics provided interdisciplinary care that included psychiatrists and other mental health professionals and played an important role in the provision of medical services to transgender people and in promoting research to improve their care. The majority of these clinics closed following a 1981 decision of the U.S. Department of Health and Human Services (HHS) that labeled sex reassignment surgery as experimental, in large part due to advocacy by Dr. Paul McHugh.² That decision was overturned by HHS in 2014 in a determination that concluded that the 1981 decision was “unreasonable and contrary to contemporary science and medical standards of care.” (Byne, et al., 2018).

70. Over the last four decades: research has continued to occur in the United States and internationally; WPATH (formerly the Henry Benjamin International Gender Dysphoria Association) published the first iteration of the Standards of Care in 1979, which is now in its 7th version and for which the 8th version is in development; the DSM and ICD stopped classifying transgender identification as a mental disorder; the American Psychological Association and Endocrine Society, as well as other medical organizations, adopted clinical guidelines consistent with the WPATH Standards of Care; and dozens of

² In this way, Dr. McHugh actively attempted to suppress the research that he complains is lacking in this field of care.

interdisciplinary gender clinics associated with research institutions and teaching hospitals have been providing gender-affirming care for transgender youth and adults across the United States.

71. Drs. Brignardello-Petersen and Wiercioch repeatedly refer to an apparent lack of data comparing treated vs. untreated individuals with gender dysphoria. Their report continually places emphasis on data that they rated as “low certainty” based on GRADE criteria. These observations about the data do not mean that gender-affirming care is experimental or investigational.

72. One of the intrinsic elements of rating the quality of evidence is the study design. Randomized controlled trials (RCTs) are considered the highest quality in the grading of evidence. Many of the research studies on gender-affirming care get a “low quality” grade due to the lack of RCTs.

73. But it is well-established that utilizing an untreated control group is unethical in this context – gender-affirming medical interventions have been used for decades, resulting in a vast amount of clinical knowledge about their efficacy. That said, we have a large de facto group of untreated individuals with gender dysphoria who experience significant psychiatric symptoms because of widespread barriers to access to care.

74. Clinicians who are competent in the care of transgender individuals practice according to a “first do no harm” ethic which understands that doing nothing is not a neutral option for those with gender dysphoria. Multiple studies have demonstrated the safety of gender-affirming hormones, and a growing body of evidence does the same with regards to the safety of GnRH analogues. (Kuper, et al., 2020; Chew, et al., 2018; Colton-Meier, et al., 2011). The same is true with regards to surgery. (Marano, et al., 2021; Olson-Kennedy, et al., 2018; Murad, et al., 2010; Smith, et al., 2005; Pfafflin & Junge, 1998).

75. In addition, RCTs are ill-suited to studying the effects of gender-affirming interventions on psychological wellbeing and quality of life of trans people. Adequate masking, adherence, and generalizability are severely impeded in trans care, thereby negating the superior scientific value of RCTs.

76. Gender-affirming interventions have physiologically evident effects, making it impossible to mask RCTs. The purpose of puberty blockers, hormone therapy, and transition-related surgeries is to inhibit or produce visible bodily changes.

77. In an RCT, adolescents who are on puberty blockers would notice that their endogenous pubertal development had stopped, whereas those not on puberty blockers will notice that they had not. Hormonal suppression is achieved around four

weeks after treatment is initiated, but it may take multiple months before participants notice that pubertal development has ceased.

78. Similarly, transgender people given hormone therapy would notice bodily changes from taking estrogen or testosterone, whereas trans people in the control arm would notice no such changes. The onset of visible effects from hormone therapy varies from person-to-person. The first changes typically appear between one and six months of initiation, whereas other desired changes may not begin for up to a year.

79. Although it may take some time before participants are able to ascertain which treatment arm they were allocated to due to the delayed effect of puberty blockers and the progressive effect of and hormone therapy, large-scale unmasking is inevitable. Because the physiological changes are the primary purpose of gender-affirming care, meaningful effects on psychological wellbeing and quality of life are not expected until unmasking occurs. As such, while RCTs can be utilized to examine the effects of gender-affirming care on physiology, using RCTs to measure the effect of gender-affirming care on psychological wellbeing and quality of life would be inappropriate.

80. Unmasking an RCT of gender-affirming care would lead to non-compliance, cross-over, and response bias in the control arm of the study.

Transgender people with gender dysphoria who pursue gender-affirming care are typically insistent and persistent in seeking the interventions. They are not ambivalent as to whether they are assigned to the intervention or control arm of the study. Upon realizing that they are in the control arm due to physiological effects or lack thereof, a large proportion of the study participants would likely withdraw from the study or pursue alternative sources of gender-affirming interventions.

81. Withdrawing from the study and noncompliance with the study protocol is most likely among people who have alternative means of securing gender-affirming care and who experience more severe bodily gender dysphoria, raising grave concerns of systematic bias. Gender-affirming interventions can be obtained from parents, peers, illicit or unauthorized sources, other providers within or outside of the health care system, and through medication-sharing with participants from the active arm of the study. Some of these options are associated with elevated safety risks, giving rise to additional ethical concerns about the use of RCTs. Intentional withdrawal with the goal of forcing the study to end is also possible. Resentment towards researchers for not allowing all participants to receive gender-affirming interventions may also increase the risk of response bias compared to observational studies, and the experimental design may motivate youths to engage

in self-harm or suicidal behavior to influence the study results, aggravating scientific and ethical concerns.

82. Given that withdrawal rates could be high enough for studies to be terminated before they are concluded, RCTs may prove impossible to conduct altogether. The likelihood of withdrawal, non-adherence, and response bias in the context of trans care undermines RCTs' ability to detect true associations and avoid specious associations between the intervention and the outcomes.

83. Many disciplines and areas of research rely on observational studies because RCTs are considered impracticable or unethical. This is especially common when studying the mental health outcomes of physiologically evident interventions due to the impossibility of masking, and when studying the outcomes of highly desired interventions due to the risks of de-randomization. Psychological and psychosocial interventions are most commonly studied using observational methodologies, and many research questions remain unstudied with RCTs.

84. Thus, while the GAPMS Memo correctly notes that “[p]resently, no RCTs that evaluate puberty suppression as a method to treat gender dysphoria are available,” the lack of RCTs is easily understood considering the above observations about RCTs in this context. (See GAPMS Memo at 15). And, the GAPMS Memo fails to mention is that “[d]espite GnRH analogue treatment being used in precocious

puberty for more than 20 years, there are no randomized controlled trials to evaluate the effect of GnRHa on a final height compared with untreated controls.” (Mul, et al., 2008).

85. In addition, the GAPMS Memo’s focus on RCTs reveals AHCA’s fundamental misunderstanding of “evidence-based medicine.” (GAPMS Memo at 9).

86. Evidence-based medicine, which originated in the second half of the 19th Century, means the conscientious, explicit, judicious, and reasonable use of current best evidence in making decisions about the care of individual patients. Since its inception, evidence-based medicine has included an element of clinician expertise. Indeed, the modern understanding of evidence-based medicine is a systematic approach to clinical problem solving which allows the integration of the best available research evidence with *clinical expertise and patient values*. (Masic, et al., 2018).

87. Contemporaneous evidence-based medicine is defined by the *integration of clinical knowledge and skills* with the best critically-appraised-evidence available *as well as patient values and preferences in order to make a clinical decision*. The research literature is continually growing as new discoveries unravel.

88. The GAPMS Memo assigns no value to clinician expertise, experience, and skill, nor to the desires of the individual seeking services. In fact, the GAPMS Memo repeatedly and broadly asserts that recommendations for treatment of GD by well-established professional associations do not rely on evidence-based medicine, but rather on the recommendations outlined by WPATH, the Endocrine Society or others. But these two organizations not only examine best available evidence, but the guidelines and standards of care are updated by clinicians and scientists at the top of the field.

The Use of “Off-Label” Medications

89. Both the GAPMS Memo and Dr. Van Meter repeatedly express concern that the U.S. Food and Drug Administration (FDA) has not approved puberty blockers or hormone therapy for the treatment of gender dysphoria. (See, e.g., GAPMS Memo at 8, 19; Van Meter at 8). Indeed, Dr. Van Meter asserts that the mere use of these medications “off-label” amounts to “uncontrolled, non-consentable experimentation on children.” (Van Meter at 8). These concerns are misleading and false.

90. The use of “off-label” medications is extremely common across all fields in medicine and there are many medications that are used “off-label” in the pediatric population. Most of the therapies prescribed to children are on an off-label

or unlicensed basis. (Allen, et al., 2018). Common medications that are used “off-label” in pediatrics include antibiotics, antihistamines, and antidepressants. That is because the majority of drugs prescribed have not been tested in children and safety and efficacy of children’s medicines are frequently supported by low quality evidence. This is explained by the lack of clinical research in this population, caused by ethical, scientific, and technical issues, as well as commercial priorities.

91. “From the FDA perspective, once the FDA approves a drug, healthcare providers generally may prescribe the drug for an unapproved use when they judge that it is medically appropriate for their patient.” (FDA, 2018). Indeed, for over 40 years, the FDA has informed the medical community that “once a [drug] product has been approved . . . , a physician may prescribe it for uses or in treatment regimens of patient populations that are not included in approved labeling.” (FDA, 1994). Accordingly, the American Academy of Pediatrics has stated that “off-label use of medications is neither experimentation nor research.” (Fratarelli, et al., 2014). Thus, “[t]he administration of an approved drug for a use that is not approved by the FDA is not considered research and does not warrant special consent or review if it is deemed to be in the individual patient’s best interests.”

Concerns about the Diagnosis of Gender Dysphoria and the Use of Self-Reports

92. The GAPMS Memo and Dr. Cantor criticize that the diagnosis of gender dysphoria is based, at least in part, on a patient's self-report. (GAPMS Memo at 19, 24, 28; Cantor ¶¶ 42, 49). This critique demonstrates a fundamental misunderstanding of how gender-affirming care is provided.

93. While we have continued to attain a greater understanding about the etiology of gender incongruence, patients do not self-diagnose, as Dr. Cantor suggests. (Cantor ¶¶ 42, 49). However, it is not unusual or extraordinary in medicine for a provider to consider patients' reports of their symptoms as part of the medical assessment. Much like the diagnosis of many clinical conditions, providers rely on self-report to ascertain accurate diagnoses. Consider the diagnosis of chronic fatigue. The diagnostic criteria for this diagnosis include the following: fatigue so severe that it interferes with the ability to engage in pre-illness activities; of new or definite onset (not lifelong); not substantially alleviated by rest; worsened by physical, mental or emotional exertion. Like gender dysphoria, these diagnostic criteria are a subjective telling of an individual's personal experience. It is incumbent upon providers of gender-affirming care to acquire skills that help them ascertain many details about their patient's gender experience including but not limited to the history, developmental trajectory, and expectations regarding treatment options.

94. The provision of gender-affirming care occurs in multi-disciplinary settings, and indeed, the WPATH SOC recommend such an approach. (Chen, et al., 2016; Coleman, et al., 2012). The multiple health providers involved, from various fields, are well trained to conduct clinical interviews and to assess a patient's report to determine whether they meet the diagnostic criteria for GD.

Particular Concerns about the Use of Puberty Delaying Medications

95. The GAPMS Memo and Dr. Cantor allege that the provision of puberty delaying medications for the treatment of gender dysphoria are not effective. This is not true.

96. A substantial body of evidence shows that gender-affirming medical interventions improve mental health outcomes for transgender persons with gender dysphoria, who, without treatment, experience higher levels of depression, anxiety, and suicidality. While each of these studies—as with all studies in medicine—has strengths and limitations, and no one study design can answer all questions regarding an intervention. Taken together, these studies indicate that gender-affirming medical care improves mental health for adolescents who require such care.

97. Keeping this in mind, peer-reviewed cross-sectional and longitudinal studies have found that pubertal suppression is associated with a range of improved mental health outcomes for transgender adolescents, including statistically

significant improvements in internalizing psychopathology (e.g., anxiety and depression), externalizing psychopathology (e.g., disruptive behaviors), global functioning, and suicidality. (e.g., Tordoff, et al., 2022; Turban, et al., 2020; van der Miesen, et al., 2020; Achille, et al., 2020; de Vries, et al., 2014; de Vries, et al., 2011).

98. For example, in the realm of cross-sectional studies, Turban et al. *Pediatrics* 2020 found that, after controlling for a range of other variables, those who accessed pubertal suppression had lower odds of lifetime suicidal ideation than those who desired but were unable to access this intervention during adolescence. A similar study by van der Miesen et al. in the *Journal of Adolescent Health* compared 272 adolescents who had not yet received pubertal suppression with 178 adolescents who had been treated with pubertal suppression. Those who had received pubertal suppression had statistically significant lower “internalizing psychopathology” scores (a measure of anxiety and depression). Longitudinal studies have yielded similar results; for example, de Vries et al. in the *Journal of Sexual Medicine* found statistically significant improvements in symptoms of depression and general functioning following pubertal suppression for adolescents with gender dysphoria.

99. The GAPMS Memo, as well as the “assessments” by Dr. Brignardello-Petersen and Dr. Wiercioch and by Dr. Cantor, emphasize the possible risks and side

effects associated with the provision of gender-affirming care. Every single medication, however, has potential negative side effects, in addition to the possibility of new side effects that have not been historically documented. This is one of the reasons that evidence-based medicine relies heavily on experienced clinicians to exercise their expertise and judgement.

100. The risks associated with the provision of GnRH analogues are comparable when used for transgender and non-transgender patients alike. For example, many of the side effects and risks associated with the provision of GnRH analogues have been well-studied with regards to the use of these medications for the treatment of central precocious puberty (CPP) (Eugster, 2019).

101. Given that puberty blockers are reversible, permanent sterility is not a side effect. There is no data to support that patients who have been treated with blockers for central precocious puberty are “sterilized” following its use. To the contrary, information regarding long-term outcomes of patients treated with GnRH analogues with respect to gonadal function are reassuring. In fact, some studies have shown that assigned males had normal sperm function following treatment and cisgender women treated as children did not need assisted reproductive techniques.

102. In addition, while during the course of treatment with pubertal delaying medication, there is some loss in bone density, which is a side effect that we discuss

with all patients and their families, studies show that with removal of the blocking agent or addition of gender affirming hormone therapy, bone mineral density begins to improve (Vlot, et al., 2017; Klink, et al., 2015). Studies regarding the use of GnRH analogues for the treatment of CPP document that following cessation of therapy with puberty delaying medications bone mineral accrual appears to be within the normal range compared with population norms (Eugster, 2019). Indeed, patients treated with pubertal suppression for CPP are on pubertal blockades without affirming hormones for longer periods of time than patients treated with puberty blockers for the treatment of gender dysphoria and the same risks are present.

Particular Concerns about the Use of Cross-Sex Hormones

103. The claim that treating gender dysphoria with medically supervised and recommended hormone treatment is particularly risky or causes serious mental health effects is not supported by data.

104. Peer-reviewed research studies have found improved mental health outcomes following gender-affirming hormone treatment (*e.g.*, estrogen or testosterone) for individuals with gender dysphoria, including adolescents (see, *e.g.*, Achille, et al., 2020; de Lara, et al., 2020; Grannis, et al., 2021; de Lara, et al., 2020; Allen, et al., 2019). These include statistically significant improvements in internalizing psychopathology (*e.g.*, anxiety and depression), general well-being,

and suicidality. For example, Allen et al. followed a cohort of 47 adolescents with gender dysphoria, and found statistically significant improvements in general well-being and suicidality, as measured by the National Institutes of Health “Ask Suicide Screening Questions” instrument.

105. The use of hormones for the treatment of gender dysphoria, like all medical treatment, can cause side effects, but all mental health and mood-related effects are better managed in the population of gender dysphoric patients who are under ongoing supervision and treatment by mental health providers. By contrast, other diagnoses do not require the ongoing support of mental health providers while on these treatments. In fact, this treatment monitoring in persons with gender dysphoria would actually be considered a safer protocol than those used for individuals receiving hormone therapy to treat other diagnoses.

106. What is more, the side effects and risks associated with these treatments are not unique to transgender individuals placed on these therapies.

107. Fertility preservation is offered to all transgender patients prior to the initiation of gender affirming hormones. However, data shows that treatment with testosterone is not sterilizing (Yaish, 2021). And many transgender men become pregnant on their own.

108. It is also important to note that when these risks are reported, they are rare risks. They are also the risks associated with these hormones whether they are endogenous or exogenous. While starting a transgender individual with gender dysphoria on these medications can raise their risk, their risk profile remains similar to their cisgender counterparts. Many times, the lipid profiles, hematologic profiles, and findings are equivalent to that of the gender these individuals identify with, as opposed to that of their sex they were born.

109. Overall, as a physician that treats many conditions, treatment for gender dysphoria is in no way the riskiest or potentially harmful. Insulin, if used inappropriately, can cause death. Some endocrine patients may require pituitary surgeries or adrenal tumor removals. The postoperative management of these individuals is crucial to their care and avoidance of severe complications that could result in mortality.

The Misconceived Notion that Psychotherapy Alone Is Sufficient for the Treatment of Gender Dysphoria

110. Dr. Cantor describes several studies and claims that because the study subjects who were recipients of both gender-affirming hormones or puberty blockers, on the one hand, and psychotherapy, on the other hand, demonstrated improvements in mental health, that the medical interventions could not be differentiated as responsible for the improvement. (Cantor ¶¶ 40-41).

111. Historically the psychotherapy professional world advocated for a “therapy only” model to address gender dysphoria. As early as the 1920’s and 1930’s it became evident to the preeminent scholars in the field that gender dysphoria (named something else at that time) was refractory to psychotherapy. As noted in 1966 in Harry Benjamin’s *The Transsexual Phenomenon*, “Allegedly, transsexualism, although basically a psychiatric condition, is paradoxically resistant to psychiatric help.” In this statement, Harry Benjamin acknowledges that psychiatric intervention cannot alter people’s gender, nor does it lead to a diminishing of the distress that arises from gender incongruence. There has been an abundance of opportunity to demonstrate unequivocally that gender dysphoria is best treated with psychotherapy alone, and yet it never has been. To suggest this is now an appropriate approach simply because transgender people are coming out at younger ages is illogical.

III. CONCLUSION

112. Gender-affirming medical and surgical care is effective, beneficial, and necessary for transgender people suffering with gender dysphoria, including transgender youth after the onset of puberty. It is well documented and studied, through years of clinical experience, observational scientific studies, and even some

longitudinal studies. It is also the accepted standard of care by all major medical organizations in the United States.

113. The denial of gender-affirming care, on the other hand, is harmful to transgender people. It exacerbates their dysphoria and may cause anxiety, depression, and suicidality, among other harms.

114. The GAPMS memo is misguided and informed by individuals with no experience or knowledge base regarding the provision of gender-affirming care, not to mention well-documented biases against transgender people and/or the provision of gender-affirming care. The report leans heavily on manuscripts that are not contemporaneous with our modern understanding of gender identity and gender dysphoria, demonstrated by outdated and incorrect terminology.

115. While data may be described as weak due to the lack of randomized controlled trials, many disciplines and areas of research rely on observational studies because RCTs are considered impracticable or unethical. This is especially common when studying the mental health outcomes of physiologically evident interventions due to the impossibility of masking, and when studying the outcomes of highly desired interventions due to the risks of de-randomization. Psychological and psychosocial interventions are most commonly studied using observational methodologies, and many research questions remain unstudied with RCTs.

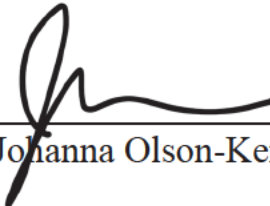
116. Finally, the reports completely overlook bodily autonomy. Given the repeated conflation of children and adolescents, it is not surprising that the “assessments” relied upon by the GAPMS Memo and the GAPMS Memo itself view adolescents as too immature to understand their own gender. However, many studies have demonstrated that cisgender children as young as age 2 know their gender. Denying medical care to adolescent youth with gender dysphoria is an act of acquiescence to the fear of what is not understood.

117. I do not disagree that, as with every field of medicine, there is more to learn in the field of transgender youth care. That is why I became an investigator. However, there is room to provide gender-affirming medical interventions in a thoughtful manner that extrapolates from relevant fields of science and medicine, existing data and clinical expertise while simultaneously carrying out necessary investigations.

118. The denial of much needed care only serves to harm transgender people.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and corrected.

Executed this 11th day of September 2022.



Johanna Olson-Kennedy, M.D., M.S.

EXHIBIT A
Curriculum Vitae

CURRICULUM VITAE
JOHANNA OLSON-KENNEDY MS, MD
AUGUST 30, 2022

PERSONAL INFORMATION:

Work
5000 Sunset Blvd. 4 th Floor Los Angeles, CA 90027
Phone: 323-361-3128
Fax: 323-953-8116
Work Email: jolson@chla.usc.edu

EDUCATION AND PROFESSIONAL APPOINTMENTS**EDUCATION:**

<i>Year</i>	<i>Degree, Field, Institution, City</i>
1992	BA, Mammalian Physiology, UC San Diego, San Diego
1993	MS, Animal Physiology, The Chicago Medical School, Chicago
1997	MD, Medical Doctor, The Chicago Medical School, Chicago
2015	MS, Clinical and Biomedical Investigations in Translational Science, USC, Los Angeles

POST-GRADUATE TRAINING:

<i>Year-Year</i>	<i>Training Type, Field, Mentor, Department, Institution, City</i>
1997 - 1998	Internship, Pediatrics, Children's Hospital Orange County, Orange
1998 - 2000	Residency, Pediatrics, Antonio Arrieta, Children's Hospital Orange County, Orange
2000 - 2003	Fellowship, Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles
2012 - 2015	Master's Degree, Clinical and Biomedical Investigations in Translational Science, USC

ACADEMIC APPOINTMENTS:

<i>Year-Year</i>	<i>Appointment</i>	<i>Department, Institution, City, Country</i>
2006 - 2016	Assistant Professor of Clinical Pediatrics	Division of Adolescent Medicine, Children's Hospital Los Angeles/USC Keck School of Medicine, Los Angeles, USA
2016 - Present	Associate Professor of Clinical Pediatrics	Division of Adolescent Medicine, Children's Hospital Los Angeles/USC Keck School of Medicine, Los Angeles, USA

CLINICAL/ADMINISTRATIVE APPOINTMENTS:

2008 - 2012	Fellowship Director	Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, USA
2012 - present	Medical Director	The Center for Transyouth Health and Development, Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, USA

2021 - present	Clinical consultant	Santa Barbara Neighborhood Clinics
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LICENSURE, CERTIFICATIONS**LICENSURE:**

<i>Year</i>	<i>License number, State, Status</i>
2000	A-67352, California, Active

BOARD CERTIFICATION OR ELIGIBILITY:

<i>Year</i>	<i>Board, State, Status</i>
2001, 2009, 2015	Pediatrics, California, active

SPECIALTY CERTIFICATION:

<i>Year</i>	<i>Specialty Certification, Status</i>
2003, 2013	Adolescent Medicine, California, active

HONORS, AWARDS:

<i>Year</i>	<i>Description</i>	<i>Awarding agency, address, city</i>
2009	Health Care Advocacy Champion	Democratic Advocates for Disability Issues, Los Angeles
2010	Clinical Research Academic Career Development Award	Saban Research Center TSRI Program: Community Health Outcomes and Intervention, Los Angeles
2012	Extraordinary Service Award	Equality California, 202 W 1st St., Suite 3-0130, Los Angeles
2013	Top Doctor	Castle Connolly
2014	Anne Marie Staas Ally Award	Stonewall Democratic Club; 1049 Havenhurst Drive #325, West Hollywood
2014	Top Doctor	Castle Connolly
2014	Recognition Award for Outstanding, Compassionate and Innovative Service	SoCal Society for Adolescent Health and Medicine Regional Chapter, Los Angeles
2015	The Champion Award	The Division of Adolescent Medicine; CHAMPION FUND 5000 Sunset Blvd. Los Angeles
2016	America's Most Honored Professional's – Top 10%	America's Most Honored Professional's
2016	Regional Top Doctor	Castle Connolly
2017	Exceptional Women in Medicine	Castle Connolly
2017	Regional Top Doctor	Castle Connolly
2017	America's Most Honored Professional's – Top 5%	America's Most Honored Professional's
2018	Regional Top Doctor	Castle Connolly
2019	Benjamin Meaker Visiting Professorship	University of Bristol, Bristol UK
2019	Regional Top Doctor	Castle Connolly
2019	L.A's Top Docs	Los Angeles Magazine
2019	Top Docs	Pasadena Health
2019	America's Most Honored Professional's – Top 1%	America's Most Honored Professional's
2020	Regional Top Doctor	Castle Connolly
2020	Southern California Top Doc	Castle Connolly

2020	Southern California Top Doctors	
2020	L.A's Top Docs	Los Angeles Magazine
2020	America's Most Honored Professional's – Top 1%	America's Most Honored
2021	Southern California Top Doc	Castle Connolly
2021	America's Most Honored Doctors – Top 1%	America's Most Honored
2021	Top Doctors	Castle Connolly
2022	America's Most Honored Doctors – Top 1%	America's Most Honored
2022	Top Doctors	Castle Connolly

TEACHING**DIDACTIC TEACHING:***Keck School of Medicine at USC*

<i>Year-Year</i>	<i>Course Name</i>	<i>Units/Hrs</i>	<i>Role</i>
2019	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth	One hour	Curriculum development and delivery
2020, 2021, 2022	Approach to the Care of Gender Non-conforming Children and Transgender Youth	One hour	Curriculum development and delivery

CalState Fullerton

<i>Year-Year</i>	<i>Course Name</i>	<i>Units/Hrs</i>	<i>Role</i>
2017	Gender Nonconforming and Transgender Youth	One hour	Curriculum development and delivery

UNDERGRADUATE, GRADUATE AND MEDICAL STUDENT (OR OTHER) MENTORSHIP:

<i>Year-Year</i>	<i>Trainee Name</i>	<i>Trainee Type</i>	<i>Dissertation/Thesis/Project Title</i>
2015 - 2016	David Lyons	MD	Transgender Youth Clinical Clerkship
2016 - 2019	Jonathan Warus	MD	Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts
2019 - 2021	Laer Streeter	MD	Comparison of Histrelin Implants
2020 - Present	Richard Mateo Mora	MD	Fertility Preservation Among Transgender Women
2022	Avery Everhart	PhD	Incomplete Data & Insufficient Methods: Transgender Population Health Research in the US

GRADUATE STUDENT THESIS, EXAM AND DISSERTATION COMMITTEES:

<i>Year-Year</i>	<i>Trainee Name</i>	<i>Committee Type</i>	<i>Student Department</i>
2022	Avery Everhart	Dissertation	Social Work

POSTGRADUATE MENTORSHIP:

<i>Year-Year</i>	<i>Trainee Name</i>	<i>If past trainee, current position and location</i>
2012-2013	Lisa Simons, MD	Clinical Instructor – Lurie Children’s Hospital
2013	Shelley Aggarwal, MD	Clinical Instructor – Stanford University School of Medicine
2014	Julie Spencer, MD	Adolescent Medicine Provider Kaiser Hospital
2014-2015	Michael Haymer, MD	Program Director, Psychiatry Department UCLA
2015-2017	Patrick Shepherd, MD	CHLA Endocrinology Fellow
2015-2018	Jonathan Warus, MD	Faculty, CHLA/USC Keck School of Medicine
2015-2020	Shannon Dunlap, PhD	Postdoctoral Scholar - Research Associate, University of Southern California, Suzanne Dworak-Peck School of Social Work
2020-Present	Marianela Gomez-Rincon, MD	Adolescent Medicine Fellow
2020-Present	Jonathan Warus, MD	CHLA, Assistant Professor of Clinical Pediatrics
2022	Emmett Henderson, PhD, MS	USC Suzanne Dworak-Peck School of Social Work Senior mentor K99; USC

MENTORSHIP OF FACULTY:

<i>Year-Year</i>	<i>Mentee Name</i>	<i>Mentee Department</i>
2021 - present	Jonathan Warus, MD	Division of Adolescent Medicine, CHLA
2022	Brigid Conn, PhD	Clinical Psychologist, CHLA

SERVICE**DEPARTMENT SERVICE:**

<i>Year-Year</i>	<i>Position, Committee</i>	<i>Organization/Institution</i>
2010-2015	Secretary, The CHAMPION Fund Executive Board	The Division of Adolescent Medicine, Children’s Hospital Los Angeles

HOSPITAL OR MEDICAL GROUP SERVICE:

<i>Year-Year</i>	<i>Position, Committee</i>	<i>Organization/Institution</i>
2021 - present	Committee Member	SOGI work group, CHLA

PROFESSIONAL SERVICE:

<i>Year-Year</i>	<i>Position, Committee</i>	<i>Organization/Institution</i>
2012-present	Member, LGBT Special Interest Group	Society for Adolescent Health and Medicine
2022	Secretary, Executive Board of Directors	US Professional Association of Transgender Health

CONSULTANTSHIPS AND ADVISORY BOARDS:

<i>Year</i>	<i>Position, Board</i>	<i>Organization/Hospital/School, Institution</i>
2010-2017	Member, Advisory Board	Transyouth Family Allies
2017-present	Member, National Medical Committee	Planned Parenthood
2017 - Present	Board Member	US Professional Association of Transgender Health
2021	Expert Panelist	Robert Wood Johnson Foundation - National Commission on Data Transformation for Health Equity
2021	Member, Advisory Board	The National LGBTQIA+ Health Education Center

PROFESSIONAL SOCIETY MEMBERSHIPS:

<i>Year- Year</i>	<i>Society</i>
2003 - present	Society for Adolescent Health and Medicine
2005 - present	American Academy of Pediatrics
2006 - 2011	Los Angeles Pediatric Society (Past president 2010)
2010 - present	Professional Association for Transgender Health
2014 - present	Society for Pediatric Research
2017 - present	US Professional Association for Transgender Health

MAJOR LEADERSHIP POSITIONS: (E.G., DEAN, CHAIR, INSTITUTE DIRECTOR, HOSPITAL ADMINISTRATION, ETC.)**RESEARCH AND SCHOLARSHIP****EDITORSHIPS AND EDITORIAL BOARDS:**

<i>Year-Year</i>	<i>Position</i>	<i>Journal/Board Name</i>
2015 - present	Associate Editor	Journal of Transgender Health

MANUSCRIPT REVIEW:

<i>Year-Year</i>	<i>Journal</i>
2014 - present	Pediatrics
2014 - present	Journal of Adolescent Health
2014 - present	LGBT Health
2014 - present	International Journal of Transgenderism
2015 - present	Journal of Transgender Health
2018 - present	Clinical Child Psychology and Psychiatry
2018 - present	Journal of Sexual Medicine
2018 - present	Journal of Transgender Health
2021 - present	JAMA Peds

GRANT REVIEWS:

<i>Year</i>	<i>Description</i>	<i>Awarding agency, City, State, Country</i>
2017	Cognition and Perception Study Section	National Institutes of Health, Bethesda, Maryland, USA
2017	Neurological, Aging and Musculoskeletal Epidemiology Study Section	National Institutes of Health, Bethesda, Maryland, USA
2018	Social Psychology, Personality and Interpersonal Processes Study Section	National Institutes of Health, Bethesda, Maryland, USA
2018	Neurological, Aging and Musculoskeletal Epidemiology Study Section	National Institutes of Health, Bethesda, Maryland, USA
2019	Special Emphasis Panel Review of Research Conference (R13) Grants	National Institutes of Health, Bethesda, Maryland, USA
2019	The Einstein Foundation Award for Promoting Quality in Research	Einstein Foundation, Berlin
2020	Biobehavioral and Behavioral Sciences Study Section	National Institutes of Health, Bethesda, Maryland, USA
2021	Social Psychology, Personality and Interpersonal Processes Study Section	National Institutes of Health, Bethesda, Maryland, USA

MAJOR AREAS OF RESEARCH INTEREST

Research Areas
1. Transgender and non-binary children, adolescents and young adults
2. HIV medication adherence

GRANT SUPPORT - CURRENT:

<i>Grant No. (PI)2R01HD082554-06A1 (Olson-Kennedy)</i>	<i>Dates of Award: 2021-2026</i>
<i>Agency: NICHD</i>	<i>Percent Effort 25%</i>
<i>Title: The Impact of Early Medical Treatment in Transgender Youth</i>	
<i>Description: This is the continuations of a multicenter study, the first of its kind in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.</i>	
<i>Role: Principle Investigator</i>	
<i>Total Direct Costs: \$4,918,586</i>	

<i>Grant No. 1R01HD097122-01 (Hidalgo)</i>	<i>Dates of Award: 2019-2024</i>
<i>Agency: NICHD</i>	<i>Percent Effort 2.5%</i>
<i>Title: A Longitudinal Study of Gender Nonconformity in Prepubescent Children</i>	
<i>Description: The purpose of this study is to establish a national cohort of prepubertal transgender/gender nonconforming (TGNC) children (and their parents), and longitudinally observe this cohort to expand the body of empirical knowledge pertaining to gender development and cognition in TGNC children, their mental health symptomology and functioning over time, and how family-initiated social gender transition may predict or alleviate mental health symptoms and/or diagnoses.</i>	
<i>Role: Site PI</i>	
<i>Total Direct Costs: \$2,884,950</i>	

GRANT SUPPORT - PAST:

<i>Grant No. (PI)</i> 1R01HD082554-01A1		<i>Dates of Award:</i> 2015-2020
<i>Agency:</i> NICHD		<i>Percent Effort</i> 45%
<i>Title:</i> The Impact of Early Medical Treatment in Transgender Youth		
<i>Description:</i> This is a multicenter study, the first of its kind in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.		
<i>Role:</i> Principle Investigator		
<i>Total Direct Costs:</i> \$4,631,970		
<i>Grant No. (COI)</i> R01AI128796-01		<i>Dates of Award:</i> 2/24/17-1/31/18
<i>Agency:</i> NIAID		<i>Percent Effort:</i> 5%
<i>Title:</i> Maturation, Infectibility and Trauma Contributes to HIV Susceptibility in Adolescents		
<i>Description:</i> This proposal explores the overarching hypothesis that fluctuations in sex steroid levels and mucosal trauma (sexual activity) are key determinants of mucosal immune activation and epithelial integrity, and that microbial communities are central to these processes. We will pursue this hypothesis by examining longitudinal changes in the anogenital microbiome as well as protein expression at these mucosal sites during sexual maturation (cisgender youth) and in hormonally-controlled sexual maturation (transgender youth). Associations between sex steroid levels, microbial community composition, mucosal trauma, and vaginal proteins will be determined and modeled.		
<i>Role:</i> Co-Investigator		
<i>Total Direct Costs:</i> \$44,816		

<i>Grant No. (PI)</i> U01HD040463		<i>Dates of Award</i> 2006 – 2016
<i>Agency:</i> NIH/NICHD		<i>Percent Effort:</i> 10%
<i>Title:</i> Adolescent Medicine Trials Network for HIV/AIDS		
<i>Description:</i> Adolescent Medicine Trials Network for HIV/AIDS		
<i>Role:</i> Co-Investigator		
<i>Total Direct Costs:</i> 2,225,674		

<i>Grant No. (PI)</i> SC CTSI 8KL2TR000131		<i>Dates of Award:</i> 2012-2014
<i>Agency:</i> KL2 Mentored Career Research Development Program of the Center for Education, Training and Career Development		<i>Percent Effort:</i> 37.5%
<i>Title:</i> The Impact of Hormone Blockers on the Physiologic and Psychosocial Development of Gender Non-Conforming Peri-Pubertal Youth		
<i>Description:</i> This study aimed to understand the impact of puberty blocking medications on mental health and physiologic parameters in peri-pubertal transgender youth.		
<i>Role:</i> Principal Investigator		
<i>Total Direct Costs:</i> 191,525		

Invited Lectures, Symposia, keynote addresses

<i>Date</i>	<i>Type</i>	<i>Title, Location</i>
2014	Invited Lecture	Transgender Youth; Needs, Risks, Outcomes and the Role of the System, Including Permanency and Inclusion for Our Youth, Administrative Office of the Courts, Center for Families and Children, San Diego, California
2015	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Lopez Family Foundation Special Lecture for Puerto Rico and Panama, Lopez Family Foundation, Children's Hospital Los Angeles, Los Angeles, California
2015	Symposium	Transgender Youth – An Overview of Medical and Mental Health Needs of Gender Non-Conforming Children and Transgender Adolescents, Public Child Welfare Training Academy, Academy for Professional Excellence at San Diego State University School of Social Work, San Diego, California
2015	Invited Lecture	Meeting the Needs of Transgender Adolescents; 1 st Annual Southern California LGBT Health Symposium; USC/UCLA, Los Angeles, California
2015	Symposium	Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; GetReal California's Initiative; "Integrating Sexual Orientation, Gender Identity, and Expression (SOGIE) into California's Child Welfare System," Oakland, California
2016	Invited Symposium	Caring for Gender Nonconforming and Transgender Youth; Idyllwild, California
2016	Educational symposium	Gender 101: A Primer; Vista Mar, California
2016	Invited Lecture	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach, California Association of Marriage and Family Therapists, Los Angeles, California
2016	Invited Lecture	Caring for Gender Nonconforming Children and Transgender Youth, California Psychological Association, Continuing Education Institute, Irvine, California
2016	Invited Lecture	Health Issues Related to Transgender Youth; LA City Health Commission, Los Angeles, California
2016	Invited Lecture	Caring for Gender Nonconforming and Transgender Youth, Medical Directors 12th Annual Update on Reproductive Health and Medical Leadership, Planned Parenthood, Steamboat Springs, Colorado
2016	Invited Lecture	Caring For Transgender Teens, UCLA Meet the Professor, Los Angeles, CA
2017	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Santa Barbara, CA
2017	Invited Lecture	Healthcare for TGNC Youth, Expanding Competency for LGBT Youth in the System, Washington DC
2017	Invited Lecture	Gender Non-conforming and Transgender Children and Youth; Center for Early Education, West Hollywood, CA
2017	Invited Lecture	Rethinking Gender, University of Massachusetts, Annual Convocation Welcome Luncheon, Worcester, MA

2017	Invited Lecture	Gender Non-Conforming Children and Transgender Youth, Board of Behavioral Sciences, Orange, CA
2017	Invited Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, Santa Monica Rape Treatment Center, Santa Monica, CA
2017	Invited Lecture	Transgender Youth Care in the New Millennium, USC Law and Global Health Initiative, Los Angeles, CA
2018	Invited Lecture	Supporting Gender Diverse and Transgender Youth: A Deeper Look at Gender Dysphoria, Studio City, CA
2018	Invited Lecture	Working with Trans and Gender Non-Conforming Youth, Children's Hospital Orange County, CA
2018	Invited Lecture	Caring for gender Non-conforming and Transgender Youth and Young Adults, Ascend Residential, Encino CA
2018	Invited Lecture	Caring for gender Non-conforming and Transgender Youth and Young Adults, California State University Northridge, Northridge, CA
2018	Invited Lecture	Gender Dysphoria; School Nurse Organization of Idaho Annual Conference, Idaho
2018	Invited Lecture	Gender and What You Should Know, Archer School for Girls, Brentwood, CA
2018	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Oceanside, CA
2018	Invited Lecture	Gender Dysphoria: Beyond the Diagnosis, Advance LA, Los Angeles, CA
2018	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Andrology Society of America Clinical Symposium, Portland, OR
2018	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Los Angeles, CA
2018	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Center for Early Education, Los Angeles, CA
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Cal State Los Angeles, California
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Claremont Colleges, California
2019	Symposium	TransYouth Care; Flagstaff, AZ
2019	Invited Lecture	Transgender and Gender Non-conforming Youth, Ascend Residential Treatment, Utah
2019	Invited Lecture	Gender Diverse and Transgender Youth; What Pediatricians Should Know, Common Problems in Pediatrics Conference, Utah AAP, Utah
2019	Invited Lecture	Gender Diverse and Transgender Youth; What Pediatricians Should Know, Common Problems in Pediatrics Conference, Utah AAP, Utah
2019	Invited Lecture	Caring for Gender Diverse and Transgender Youth, Grand Rounds, UCLA Olive View, CA
2019	Invited Lecture	Caring for Gender Diverse and Transgender Youth, Grand Rounds, Good Samaritan, CA
2019	Invited Lecture	Puberty Suppression in Youth with Gender Dysphoria, Fenway Trans Health Program, Boston
2019	Invited Lecture	Recognizing the Needs of Transgender Youth, California Department of Corrections and Rehabilitation, Ventura, CA
2019	Invited Lecture	Gender Dysphoria; Beyond the Diagnosis, Gender Education Demystification Symposium, GA

2019	Invited Lecture	Caring for Gender Nonconforming and Transgender Youth, Los Angeles Superior Court/Los Angeles Bar Association Training, CA
2019	Invited Lecture	Supporting Gender Diverse and Transgender Youth; A Deeper Look at Gender Dysphoria, Oakwood School, CA
2020	Symposium	Trans Youth Care, Chico Transgender Week, Virtual Presentation
2020	Invited Lecture	Gender Nonconforming and Transgender Youth, Novartis, Virtual Presentation
2020	Invited Lecture	Advanced Hormones; More than Just T and E, CHLA, Virtual Presentation
2020	Invited Lecture	Video Telehealth and Transgender Youth, Telehealth Best Practices for the Trans Community, The Central Texas Transgender Health Coalition, Virtual Presentation
2020	Invited Lecture	Gear Talk, Transforming Families, Virtual Lecture
2020	Invited Lecture	Tips for Parenting a Trans or Gender Diverse Youth, Models of Pride, Virtual Presentation
2020	Invited Lecture	Caring for Gender Diverse and Transgender Youth, LGBTQ+ Clinical Academy, Palo Alto University, Virtual presentation
2020	Invited Lecture	USC Medical School, Los Angeles, CA
2020	Invited Lecture	Medical Interventions for transgender youth, Cal State Los Angeles, Los Angeles
2020	Plenary Session	Understanding Issues Involving Gender Non-Conforming and Transgender Individuals Coming to a Courtroom Near You, Mid-Winter Workshop for Judges of the Ninth Circuit, Palm Springs, CA
2021	Invited Lecture	Gender Affirmation through a Social Justice Lens; Center for Gender Equity in Medicine and Science (GEMS) at Keck School of Medicine, Los Angeles
2021	Invited Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Providence Medical Group – South Bay Pediatrics (Torrance, San Pedro, Redondo Beach), virtual lecture
2021	Invited Lecture	Caring for Gender Diverse and Transgender Youth. SLO Acceptance, Cal Poly, Virtual Presentation
2022	Invited Lecture	Transgender and Non-binary children and youth, Board of Behavioral Sciences
2022	Invited Lecture	Gender Affirmation through a Social Justice Lens; University of Arizona Health Sciences LGBTQ+ Symposium & Health Fair
2022	Invited Lecture	Gender Dysphoria in Children, Adolescents and Young Adults, MedLambda and PsychSIG Keck USC School of Medicine, Virtual Lecture
2022	Invited Lecture	Caring for Transgender and Gender Nonconforming Youth, Presbyterian Healthcare Services, New Mexico, Virtual lecture
2022	Invited Lecture	Transgender and Non-Binary Youth, Rogers Behavioral Health, Virtual Lecture

Invited Grand Rounds, CME Lectures

<i>Date</i>	<i>Type</i>	<i>Title, Location</i>
2014	Grand Rounds	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach; Seattle Children's Hospital, Seattle, Washington

2014	CME lecture	Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; Eisenhower Medical Center Transgender Health Symposium, Palm Springs, California
2014	Grand Rounds	Toddlers to Teens: Comprehensive Health Care for the Transgender Child, Cultural Psychiatry Lecture Series, University of Iowa Carver College of Medicine, Iowa City, Iowa
2014	Grand Rounds	Caring for Gender Non-conforming Children and Teens in the New Millennium; A Multidisciplinary Team Approach, Children's Hospital Los Angeles, Los Angeles, California
2014	CME lecture	Difficult Cases, Gender Spectrum Family Conference, Gender Spectrum, Moraga, California
2014	CME lecture	Difficult Cases, Gender Spectrum Family Conference, Gender Spectrum, Moraga, California
2014	CME lecture	Cross-sex Hormones for Teenagers, How Young is Too Young? Philadelphia Trans Health Conference, Philadelphia, Pennsylvania
2014	CME lecture	Pediatric Update, Philadelphia Trans Health Conference, Philadelphia, Pennsylvania
2015	Grand Rounds	Caring for Gender Nonconforming and Transgender Youth, Stanford Division of Adolescent Medicine, Palo Alto, CA
2015	CME Educational Lecture	The Transgender Experience, St. Joseph's Providence, Burbank, CA
2015	CME Educational Lecture	Update on the Transgender Patient for the PCP, St. Joseph's Providence, Burbank, CA
2015	CME Educational Lecture	Caring for Gender Non-Conforming Children and Transgender Teens, Providence Tarzana, CA
2015	Grand Rounds	Caring for Gender Nonconforming and Transgender Youth, University of Southern California, Los Angeles, California
2015	Grand Rounds	Puberty Blockers and Cross Sex Hormones, Pediatric Endocrinology, Children's Hospital Los Angeles, Los Angeles, California
2015	CME lecture	Youth and Hormones, 2015 Gender Expansion Conference, University of Montana, Missoula Montana
2015	CME lecture	Transyouth Healthcare, 2015 Gender Expansion Conference, University of Montana, Missoula Montana
2015	CME lecture	Supporting Transgender Youth, Southern Oregon University Student Health and Wellness Center Workshop, Southern Oregon University, Ashland, Oregon
2015	PCS Grand Rounds	Caring for Gender Nonconforming Children and Transgender Youth, Children's Hospital Los Angeles, Los Angeles, California
2015	CME lecture	Medical Care for Gender Non-Conforming Children, Transgender Adolescents and Young Adults in the New Millennium, Continuing Medical Education of Southern Oregon, Medford, Oregon
2015	Grand Rounds	Medical Care for Gender Non-Conforming Children and Transgender Youth, Olive View Medical Center-UCLA, Sylmar, California
2015	Grand Rounds	Caring for Gender Non-conforming Children and Transgender Teens, Harbor-UCLA Department of Pediatrics, Torrance, California

2015	CME lecture	Caring for Gender Non-conforming Children and Teens in the New Millennium, Healthcare Partners Pediatric Town Hall Meeting, Healthcare Partners CME, Glendale, California
2016	Pediatric Grand Rounds	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth; Children's Hospital Los Angeles, Los Angeles, California
2016	Endocrine Grand Rounds	Approach to Care of Gender Non-Conforming Children and Transgender Adolescents; Cedars Sinai Hospital, Los Angeles, California
2016	Pediatric Grand Rounds	Care of Gender Non-Conforming Children and Transgender Adolescents in the New Millennium, Stanford Lucille Packard Children's Hospital, Palo Alto, California
2016	Pediatric Update	Caring for Gender Variant Children and Adolescents, St. Louis, Missouri
2016	Grand Rounds	Care of Gender Non-Conforming Children and Transgender Adolescents in the New Millennium, St. Jude's Grand Rounds, Memphis, Tennessee
2016	CME Educational Lecture	Transgender and Gender Non-Conforming Youth: Innovative Approaches to Care in 2016; Integrating Substance Use, Mental Health, and Primary Care Services: Courageous and Compassionate Care, Los Angeles, California
2016	CME; professional conference	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach, Arizona Psychiatric Society, Tempe, Arizona
2016	CME/Educational Symposium	Caring for Gender Nonconforming and Transgender Youth, San Diego, California
2016	CME/CEU Educational Training	Medical Interventions for Transgender Youth and Young Adults, San Diego State University, San Diego, California
2016	Grand Rounds	Caring for Gender Nonconforming Children and Transgender Youth, Mt. Sinai Hospital, Pediatric Grand Rounds George J. Ginandes Lecture, New York, New York
2016	CME Educational Lecture	The Transgender Experience, Providence Tarzana, CA
2017	CME Educational Seminar	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, San Diego, CA
2017	CME Educational Seminar	The Care of Gender Non-Conforming children and Transgender Youth; Orange County Health Care Agency, Orange County, CA
2017	CME Educational Lecture	Rethinking Gender, Adolescent Grand Rounds, Children's Hospital Los Angeles, Los Angeles, CA
2017	CME Educational Lecture	Gender Non-Conforming Children and Transgender Youth, Pasadena CA
2017	CME Educational Lecture	Gender Non-Conforming and Transgender Children and Adolescents, Developmental Pediatrics continuing education lecture, Children's Hospital Los Angeles, CA

2017	CME Educational Lecture	Care of Gender Non-Conforming Children and Transgender Adolescents, Lopez Family Foundation Educational Lecture, Los Angeles, CA
2017	CME Educational Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, USC Keck School of Medicine Reproductive Health, Los Angeles, CA
2017	CME Educational Seminar	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, San Diego, CA
2018	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Glendale Unified School District, CA
2018	CME Educational Lecture	Caring for Gender Non-Conforming Children and Transgender Youth, CME by the Sea, CA
2018	CME Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Austin, TX
2018	CME Educational Lecture	Approach to the Care of Gender Non-Conforming Children and Transgender Youth, Desert Oasis Healthcare, Palm Desert, CA
2018	CME Workshop	Mental and Medical Healthcare for Transgender Adolescents, California Association of Marriage and Family Therapists, Garden Grove, CA
2018	CME Educational Lecture	Approach to the Care of Gender Non-Conforming Children and Transgender Youth, Keck School of Medicine, Los Angeles, CA
2018	Grand Rounds	Caring for Gender Non-Conforming Children and Transgender Adolescents, Primary Children's Hospital, Salt Lake City, UT
2018	CME Educational Lecture	Caring for Transgender Youth, Chico Trans Week, Chico, CA
2018	CME Educational Lecture	Rethinking Gender, UCSD Medical School, San Diego, CA
2018	CME Educational Lecture	Rethinking Gender, UCLA Medical School, Los Angeles, CA
2019	Symposium	Recognizing the Needs of Transgender Youth, California Department of Corrections and Rehabilitation, Stockton, CA
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Cal State Los Angeles, California
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Claremont Colleges, California
2019	CME Lecture	Gender Diverse and Transgender Youth, Harbor UCLA Medical Center Grand Rounds, Torrance, CA
2019	CME Lecture	Gender Dysphoria – Beyond the Diagnosis, Gender Odyssey San Diego, San Diego, CA
2019	Grand Rounds	Transgender Youth; What's New in 2019?, Children's Hospital Los Angeles, CA

2019	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Children's Hospital Orange County, CA
2019	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Stanislaus County Behavioral Health and Recovery Services, CA
2019	CME Educational Lecture	Rethinking Gender, Olive View Medical Center Grand Rounds, CA
2020	CME Lecture	Gender Affirmation Through a Social Justice Lens, SAHM Conference, Virtual Presentation
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, AAP Conference, Virtual Lecture
2020	CME Lecture	Conversations with LGBTQ youth; the role of the pediatrician, AAP Conference, Virtual Lecture
2020	Grand Rounds	Creating Affirming Environments for Trans and Gender Diverse Patients, USC OB/Gyn Grand Rounds, Virtual Presentation
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Resident Lecture, CHLA
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Facey Medical Group, Los Angeles, CA
2020	Plenary Lecture	Reframing Gender Dysphoria, LEAH Conference, Los Angeles, CA
2020	CME Lecture	Gender Affirming Care for Pre and Peri-pubertal Trans and Gender Diverse Youth, LEAH Conference, Los Angeles, CA
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Division of Endocrinology, USC, Los Angeles, CA
2021	CME Lecture	Transitioning: From Invalidation and Trauma to Gender Affirming Care; Department of Anesthesiology at CHLA
2021	CME Lecture	Transitioning from Invalidation and Trauma to Gender Affirming Care; ACCM Grand Rounds, Children's Hospital Los Angeles, Virtual presentation
2021	CME Symposium	TransYouth Care; Transfamily Support San Diego, Virtual Symposium
2021	Symposium	TransYouth Care for Parents; Santa Clara, CA
2022	CME Lecture	Gender affirming medical interventions; An Evolving landscape, Critical Issues in Child and Adolescent Mental Health Conference, San Diego, California
2022	CME Symposium	TransYouth Care for Mental Health Providers; Santa Clara, CA
2022	CME Symposium	TransYouth Care; Transfamily Support San Diego, Virtual Symposium

International Lectures

<i>Date</i>	<i>Type</i>	<i>Title, Location</i>
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2013	Keynote	Caring for Gender Non-conforming Children and Adolescents in the New Millennium, Vancouver, Canada
2016	CME; professional conference	Social Transitions in Pre-pubertal Children; What do we know? World Professional Association of Transgender Health, Amsterdam, The Netherlands
2016	CME; professional conference	Beyond Male and Female; Approach to Youth with Non-Binary Gender Identities, World Professional Association of Transgender Health, Amsterdam, The Netherlands
2016	CME; professional conference	Workgroup on Gender Nonconforming/Transgender Youth: Biopsychosocial Outcomes and Development of Gender Identity, World Professional Association of Transgedner Health, Amsterdam, The Netherlands
2017	Invited Lecture	Gender Dysphoria, Beyond the Diagnosis, Pink Competency, Oslo Norway
2017	Invited Lecture	Caring for Gender Non-Conforming Children and Transgender Adolescents: A United States Perspective, Pink Competency, Oslo Norway
2017	Invited Lecture	Caring for Gender Non-conforming and Transgender youth and Young Adults, Diverse Families Forum: The Importance of Family Support in The Trans And LGBT Children, Organized by COPRED and The International Association Of Families For Diversity (FDS), Mexico City, Mexico
2018	Invited Lecture	Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults: Comparison of Nonsurgical and Postsurgical Cohorts, Buenos Aires, Argentina
2018	Invited Lecture	Transgender Youth and Gender Affirming Hormones; A 6-8 year follow-up, Buenos Aires, Argentina
2018	Invited Lecture	Transyouth Care – An NIH Multisite Study About the Impact of Early Medical Treatment in Transgender Youth in the US, Buenos Aires, Argentina
2018	Invited Lecture	Uso de Hormonas Reafirmantes de Genero en Adolescentes Transgenero, Trans Amor Congreso Nacional de Transexualidad Juvenil y Infantes, Monterey, Mexico
2018	Invited Lecture	Bloqueadores de la Pubertad, Trans Amor Congreso Nacional de Transexualidad Juvenil y Infantes, Monterey, Mexico
2018	CME Educational Lecture	Puberty Blockers and Gender Affirming Hormones for Transgender Youth: What Do We Know, and What Have We Learned, Pediatric Academic Societies, Toronto, Canada
2018	Keynote	Transgender Youth Care, SickKids, Toronto, Canada
2019	Invited Lecture	Hormonas que Affirman el Genero pasa Juventud y Adultos Menores Trans, Transformando Desde el Amor y Las Familias, Colombia
2019	Invited Lecture	Infancia Trans y da Genero Diverso, Transformando Desde el Amor y Las Familias, Colombia
2019	Invited Lecture	Transgender Youth: Medical and Mental Health Needs, Bristol, United Kingdom
2019	Invited Lecture	Rethinking Gender, University of Bristol, United Kingdom

2019	CME; professional conference	Male Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults, European Professional Association of Transgender Health, Rome Italy
2019	CME; professional conference	Transgender Youth and Gender Affirming Hormones; 5-7 Year Follow Up, European Professional Association of Transgender Health, Rome Italy
2019	CME Educational Lecture	Gender Dysphoria; Beyond the Diagnosis, European Professional Association of Transgender Health, Rome Italy
2021	CME; professional conference	Advances and Challenges in the Care of Transgender/Gender Diverse Youth; USPATH Conference, Virtual presentation
2022	Plenary Session	The Landscape of Gender Affirming Care for Youth in the US, AusPATH, Virtual

Keynote/Plenary Presentations

<i>Date</i>	<i>Type</i>	<i>Title, Location</i>
2015	Keynote	The Future of Trans Care in the New Millennium, Gender Infinity Conference, Houston, Texas
2016	Plenary Session	Caring for Trans Youth and Gender Non-Conforming Children, Transgender Spectrum Conference, St. Louis, Missouri
2018	Keynote	Future Directions, USPATH, Washington DC
2019	Keynote	Gender Dysphoria; A Deeper Dive Beyond the Diagnosis, Inaugural LGBTQ summit, Santa Clara CA
2022	Keynote	Gender Affirmation Through a Social Justice Lens, Indiana University School of Medicine

PUBLICATIONS:

* INDICATES TRAINEES

** INDICATE YOURSELF AS CO-FIRST OR CO-CORRESPONDING OR SENIOR AUTHORS

REFEREED JOURNAL ARTICLES:

1. Belzer M, Sanchez K, **Olson J**, Jacobs AM, Tucker D. Advance supply of emergency contraception: a randomized trial in adolescent mothers. *J Pediatr Adolesc Gynecol*. 2005 Oct;18(5):347-54. PubMed PMID: 16202939.
2. Puccio JA, Belzer M, **Olson J**, Martinez M, Salata C, Tucker D, Tanaka D. The use of cell phone reminder calls for assisting HIV-infected adolescents and young adults to adhere to highly active antiretroviral therapy: a pilot study. *AIDS Patient Care STDS*. 2006 Jun;20(6):438-44. PubMed PMID: 16789857.
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