SUICIDE, SUICIDALITY, AND PEDIATRIC MEDICAL TRANSITION IN *UNITED STATES V. SKRMETTI* AND BEYOND

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INTRODUCTION

Children and adolescents experiencing gender discordance are a vulnerable population. A part of that vulnerability is expressed in high rates of accompanying mental health diagnoses and symptoms. Among the most frightening mental health issues faced by this population, and by their parents and families, is suicide, and more broadly suicidality, which can be defined as "the risk of suicide, usually indicated by suicidal ideation or intent . . ." or as "suicidal thoughts, plans, gestures, or attempts."[1]

The risks of suicide and suicidality have been repeatedly invoked in defenses of pediatric medical transition and its specific interventions of puberty blockers, cross-sex hormones, and surgery, which are often labeled a part of "gender-affirming care." The message to parents has often been stark, as admonitions such as "[w]ould you rather have a dead daughter or a live son?" warn parents that a failure to consent to and support medical transition risks the death of their child by suicide.[2] The message to society has been similar: medical pediatric transition is necessary to avoid the deaths of vulnerable children and adolescents. These messages have been widespread, delivered in transgender medical clinics,[3] parent support groups,[4] the Harvard Law

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[1] *Suicidality*, AMERICAN PSYCHOLOGICAL ASSOCIATION DICTIONARY, https://dictionary.apa.org/suicidality [https://perma.cc/QA4F-T3UP]; *Student Life*, ANDERSON UNIVERSITY: STUDENT LIFE COUNSELING SERVICES, https://anderson.edu/student-life/counseling/suicidality/#:~:text=What%20is%20Suicidality,plans%2C%20gestures%2C%20or%20attempts [https://perma.cc/PWB7-Z9FM].

[2] Joint Appendix at 905, United States v. Skrmetti, No. 23-477 (Declaration of Chloe Cole) [hereinafter J.A.]; Emily Bazelon, *The Battle Over Gender Therapy*, N.Y. TIMES (Jun. 15, 2022), https://www.nytimes.com/2022/06/15/magazine/gender-therapy.html [https://perma.cc/QS6N-53ZV]; Aron Hirt-Manheimer, *Choosing to Have a Living Daughter*, REFORM JUDAISM (JUNE 4, 2021), https://reformjudaism.org/blog/choosing-have-living-daughter [https://perma.cc/7LM4-PM5F] ("Our only choice was to have a dead son or a living daughter."); Brief of Max Lazarra as *Amicus Curiae* Supporting Respondents at 4, United States v. Skrmetti, No. 23-477, https://www.supremecourt.gov/DocketPDF/23/23-477/328204/20241015112955436_23-477_Amicus%20Brief.pdf [https://perma.cc/7L7S-DL5V] [hereinafter Lazzara Brief].

[3] *See* Bazelon, *supra* note 2; Lazzara Brief, *supra* note 2, at 3–4; J.A. at 905.

[4] *See* Bazelon, *supra* note 2; Lazzara Brief, *supra* note 2, at 4.

Review,[5] the Yale Law School Integrity Project,[6] and in the *United States v. Skrmetti* litigation currently pending before the United States Supreme Court.[7]

Yet, when Justice Alito, in oral argument in *Skrmetti*, questioned whether these admonitions are scientifically grounded, he elicited a partial but significant concession from Chase Strangio, the attorney representing the original plaintiffs who challenged Tennessee's prohibition of pediatric medical transition:

> [T]here is no evidence in some --- in the studies that this treatment reduces completed suicide. And the reason for that is completed suicide, thankfully and admittedly, is rare and we're talking about a very small population of individuals with studies that don't necessarily have completed suicides within them.[8]

The message that actual suicide is "rare" is discordant with the drumbeat of statements and implications that, as stated in the Harvard Law Review in 2021, "access to … gender-affirming healthcare services is essential—even lifesaving—for trans youth."[9] The common claims regarding suicidality and attempts, even when they do not mention completed suicides, have left the impression that pediatric gender transition is necessary to avoid completed suicide. The clarifications that there is a lack of evidence of increased deaths and that completed suicide is "rare" have not generally been provided. Thus, parental, youth, and societal decisions have been influenced by this overriding fear of children and adolescents dying by suicide if they are denied access to pediatric medical transition.

Upon deeper examination, the claims of reduced suicidality, including reduced attempts, from pediatric gender-affirming medical care are also not supported by the available evidence. This essay will make the opposite argument that, over the longer term, medical pediatric transition increases, rather than reduces, risks of suicidality, attempted suicide, and completed suicide.

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[5] *See* Outlawing Trans Youth: State Legislatures and the Battle over Gender-Affirming Healthcare for Minors, 134 HARV. L. REV. 2163, 2167–69 (2021).

[6] *See* ANNE ALSTOTT, MEREDITHE MCNAMARA ET AL., AN EVIDENCE-BASED CRITIQUE OF THE CASS REVIEW ON GENDER-AFFIRMING CARE FOR ADOLESCENT GENDER DYSPHORIA 38 (2024) https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf [https://perma.cc/B3HK-6MED] (citing Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. Adolescent Health. 643 (Apr. 2022)). The Green study cited by the Integrity Project claims it establishes "less attempted suicide in ages 13-17" for those accessing cross-sex hormones but fails to report the finding that "[f]or youth under age 18, the aOR for seriously considering suicide in the past year did not reach statistical significance (aOR = .74, p = .08)" *Id.* at Table 4. Nor did the Integrity Project discuss the finding, also for those under age 18, that "[t]he pattern of statistical significance for findings related to past-year suicidality was less consistent, which may indicate challenges related to statistical power when examining fairly infrequent outcomes such as suicidal thoughts and behaviors, particularly among smaller subgroups of individuals." *Id.* at 647. The study's claim that suicidal thoughts and behaviors are "fairly infrequent" seems inconsistent with, for example, a claim in the Harvard Law Review that "[M]ore than one-third of transgender high school students attempt suicide in a given year." *Outlawing Trans Youth*, *supra* note 5, at 2163. The Integrity Project thus appeared to follow the unfortunately common pattern of picking out results that support their thesis, while ignoring those that did not—a pattern perhaps repeated in the very study they cited here. At issue still is the reliability of the Green study, which, as a self-reported non-probability study, as the study itself admits, cannot demonstrate causation—meaning it cannot actually prove that the use of cross-sex hormones is responsible for any positive results that appear statistically. *See* Green et al., *supra* note 6, at 648.

[7] *See, e.g.*, Transcript of Oral Argument at 31–33, 39, 48, 87–89, United States v. Skrmetti, No. 23-477.

[8] *Id.* at 88.

[9] *Outlawing Trans Youth*, *supra* note 5, at 2167.

I. WATCHFUL WAITING VERSUS GENDER-AFFIRMING CARE

Much of current gender-affirming medicine in the United States is focused on giving children what they want as quickly as possible. This leads to mantras such as "children know who they are."[10] However, giving children what they want now is not a rational basis for medical interventions with potentially permanent, and certainly long-term, impacts.

The prohibition of pediatric medical transition is consistent with the watchful waiting approach to the care of pediatric gender dysphoria patients. Watchful waiting is not the equivalent of conversion therapy; rather, it involves supportive counseling.[11] It is based on data that most cases of gender dysphoria in children and adolescents, in the process of the individual's development, resolve by adulthood.[12] Watchful waiting was an accepted method of treatment in the field of pediatric transgender medicine in the United States and Canada until ten to fifteen years ago.[13] Variations of watchful waiting are once again a common form of treatment of pediatric gender dysphoria in much of Western Europe, as some countries have determined that the more aggressive medical interventions of puberty blockers, cross-sex hormones, and surgery are not supported by scientific evidence, and hence, these interventions are experimental and should only be employed in exceptional circumstances.[14]

The Standards of Care for the Health of Transgender and Gender Diverse People (8th ed. 2022) [hereinafter SOC-8], issued by the World Professional Association for Transgender Health (WPATH), is one of the documents most relied on by advocates of pediatric gender-affirming care. SOC-8 affirms that "prepubescent children are not eligible for medical intervention" and that "gender trajectories in prepubescent children cannot be predicted and may evolve over time."[15] Hence, even WPATH's current gender-affirming care standards employ something like watchful waiting for prepubescent children.

The claim that gender discordance existing by puberty and early adolescence necessarily reflects a permanent gender identity has been a justification for the aggressive practices of medical

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[10] Ed Yong, *Young Trans Children Know Who They Are*, THE ATLANTIC (Jan. 15, 2019), https://www.theatlantic.com/science/archive/2019/01/young-trans-children-know-who-they-are/580366/ [https://perma.cc/9C3N-Y85B].

[11] J.A. at 443–45, 504.

[12] *Id.*

[13] *See* Bazelon, *supra* note 2; *see generally* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE (7th ed. 2012).

[14] *See* J.A. at 332–43, 582–92; *Children and young people's gender services: implementing the Cass Review recommendations*, NHS ENGLAND (Aug. 7, 2024), https://www.england.nhs.uk/long-read/children-and-young-peoples-gender-services-implementing-the-cass-review-recommendations/ [https://perma.cc/T2B8-P459]; CARE OF CHILDREN AND ADOLESCENTS WITH GENDER DYSPHORIA: SUMMARY OF NATIONAL GUIDELINES, SOCIALSTYRELSEN (Swedish National Board of Health and Welfare) 3 (Dec. 2022) https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf [https://perma.cc/6LJY-9G2P]; Azeen Ghorayshi, *Youth Gender Medications Limited in England, Part of Big Shift in Europe*, N.Y. TIMES (Apr. 9, 2024), https://www.nytimes.com/2024/04/09/health/europe-transgender-youth-hormone-treatments.html [https://perma.cc/7RSX-FG76].

[15] WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSGENDER AND GENDER DIVERSE PEOPLE at S67 (8th ed. 2022) [hereinafter SOC-8].

transition prior to adulthood. Upon examination, that claim lacks an empirical basis. Hence, watchful waiting until adulthood remains a plausible, and indeed superior, approach.

II. STUDIES OF TRANSGENDER ADULTS IN THE UNITED STATES AND EUROPE FIND ALARMINGLY HIGH RATES OF BOTH SUICIDAL IDEATION AND SUICIDE.

Numerous studies in the United States and Europe over decades have found that transgender adults have very high rates of suicidal ideation and suicide, even in the most accepting societies.[16]

A Swedish population-based matched cohort study covering the period from 1973 to 2003 of those who had undergone sex reassignment surgery found "considerably higher risks for mortality, suicidal behavior and psychiatric morbidity than the general population."[17] "[M]ortality from suicide was much higher in sex-reassigned persons, compared to the matched controls."[18] The raw data shows 10 deaths by suicide among the 324 sex-reassigned persons, whereas there were 5 deaths by suicide for 3240 matched controls: a rate about twenty times higher.[19]

More recently, a large-scale Danish study following nearly seven million people over four decades of health and legal records found that transgender individuals had 7.7 times the rate of suicide attempts, and 3.5 times the rate of deaths by suicide, as compared with the rest of the population.[20] Further, the risk of death by causes other than suicide for the transgender population was nearly double than that for the non-transgender population.[21] As to mental health concerns, nearly 43% of the transgender population had a psychiatric diagnosis, compared with 7% of the general population.[22]

A study examining Veterans Health Administration electronic medical records from 2000 to 2011 through official "gender identity disorder" codes found "the rate of suicide-related events" among transgender VHA veterans "more than 20 times higher than were rates for the general VHA population."[23]

More recently, the Williams Institute at UCLA School of Law in 2019 published the results from the 2015 US Transgender Survey, touted as the "largest survey of transgender people in the US to date"[24] This was an online survey of adults (18 and older) which produced 27,715 respondents; like any online survey, it reflects the limitations of such self-selected, online survey results.[25] In many respects, the sample was not representative of the US population, being much younger,

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[16] *See* J.A. at 398–400.

[17] Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PUB. LIB. SCI. ONE 1, 1 (2011).

[18] *Id.* at 5.

[19] *Id.*

[20] *See* Annette Erlangsen et al., *Transgender Identity and Suicide Attempts and Morality in Denmark*, 329 J. Am. Med. Assoc. 2145, 2145–2153 (2023).

[21] *Id.* at 2150.

[22] *Id.* at 2148.

[23] John R. Blosnich et al., *Prevalence of Gender Identity Disorder and Suicide Risk Among Transgender Veterans Utilizing Veterans Health Administration Care*, 103 AM. J. PUBLIC HEALTH e27, e27 (2013).

[24] Jody L. Herman et al., *Suicide Thoughts and Attempts Among Transgender Adults*, UCLA WILLIAMS INST. 1 (Sept. 2019), https://williamsinstitute.law.ucla.edu/publications/suicidality-transgender-adults/ [https://perma.cc/PKD5-JLVA].

[25] *Id.* at 5.

better educated, and with a higher proportion of white respondents.[26] Obviously, as a survey of the living, it could not identify completed suicides. Nonetheless, it is striking that "transgender adults have a prevalence of past-year ideation that is about twelve times higher, and a prevalence of past-year suicide attempts that is about eighteen times higher, than the general US population."[27] Indeed, 81.7% "reported ever seriously thinking about suicide in their lifetimes, while 48.3[%] had done so in the past year. In regard to suicide attempts, 40.4[%] reported attempting suicide at some point in their lifetimes, and 7.3[%] reported attempting suicide in the past year."[28]

SOC-8 also acknowledges that "[s]ome studies have shown a higher prevalence" of depression, anxiety, and suicidality "than in the general population, *particularly in those requiring medically necessary gender-affirming medical treatment*."[29] SOC-8 and others hypothesize that these much higher rates of suicidality stem from discrimination and minority stress.[30]

But evidence shows that neither discrimination nor minority stress is, in general, associated with completed suicides.[31] For example, as to race, the suicide rate for Black males in the United States was considerably lower in 1950, under the conditions of state-approved segregation, than it was in 2018 (7.5 versus 11.6 per 100,000).[32] The rates of suicide for white males from 1950 to 2018 have been two to three times higher than for Black males.[33] The rates of suicide for males are consistently more than three times the rate for females.[34] Thus, as to completed suicides, white males, often considered the privileged majority, have had, under very different social conditions as to race and gender as have existed from 1950 to the present, by far higher rates of suicide than groups living under minority stress and even state-approved forms of discrimination.

Hence, suicide rates do not correlate with minority status or a lived experience of discrimination. Indeed, the Danish study of very high rates of suicides and attempted suicide comes from one of the most LGBTQ + friendly nations in Europe and, indeed, the world.[35] This is not to say that no discrimination exists, but rather to emphasize that discrimination may not be the most important factor as to suicide rates.

Thus, while anti-discrimination efforts are valuable in themselves, they cannot resolve the much higher rates of suicide and suicidality for transgender adults.

The very high rates of suicide and suicidality for adult transgender persons suggests that the representation commonly made to pediatric patients and their parents, that medical transition

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[26] *Id.* at 10–11.

[27] *Id.* at 1.

[28] *Id.*

[29] SOC-8 at S171 (emphasis added).

[30] *Id.*; *see also* Herman, *supra* note 24, at 2.

[31] J.A. at 396–97.

[32] *National Center for Health Statistics*, CENTERS FOR DISEASE CONTROL AND PREVENTION (2019), https://www.cdc.gov/nchs/data/hus/2019/009-508.pdf [https://perma.cc/HH57-37CD].

[33] *Id.*

[34] *Id.*

[35] *See* Erlangsen, *supra* note 20; *Denmark – a very LGBT+ friendly country*, DENMARK, https://denmark.dk/society-and-business/denmark-a-very-lgbt-friendly-country [https://perma.cc/3CZP-Q684].

will permanently resolve mental health issues and distress and save those patients from suicide and suicidality, is false.

III. THE WEIGHT OF MEDICAL RESEARCH INDICATES THAT PEDIATRIC MEDICAL TRANSITION DOES NOT REDUCE SUICIDE OR SUICIDALITY, AND MAY EVEN INCREASE PEDIATRIC SUICIDE AND SUICIDALITY; FURTHER, PROHIBITIONS OF PEDIATRIC MEDICAL TRANSITION DO NOT INCREASE SUICIDE.

On July 19, 2024, Professor Louis Appleby, University of Manchester, Department of Health and Social Care adviser on suicide prevention, posted on an official UK government site an independent report, titled, "Review of suicides and gender dysphoria at the Tavistock and Portman NHS Foundation Trust."[36] This independent report was in response to online claims "that there has been a large rise in suicide by current and recent patients of the Gender Identity Development Service (GIDS) service at the Tavistock since an earlier restriction of puberty-blocking drugs that followed a High Court decision in a case (Bell v Tavistock) in December 2020."[37] Professor Appleby indicated:

> In this period of 6 years the data show a total of 12 suicides: 6 in the under 18s, 6 in those 18 and above. In the 3 years leading up to 2020-21, there were 5 suicides, compared to 7 in the 3 years after. This is essentially no difference, taking account of expected fluctuations in small numbers, and would not reach statistical significance. In the under 18s specifically, there were 3 suicides before and 3 after 2020-21.[38]

Beyond finding no statistically significant differences in completed suicides before and after the British Court had limited access to puberty blockers, Professor Appleby stressed the inability to attribute suicide to this single factor, given the complexities of the lives of those involved:

> Alongside the figures, there is a summary of the problems faced by the young people who died. These include mental illness, traumatic experiences, family disruption and being in care or under children's services."[39]

As previously noted, Justice Alito cited page 195 of the Cass Report, which states:

> Tragically deaths by suicide in trans people of all ages continue to be above the national average, but there is no evidence that gender affirming care reduce this.[40]

The Cass Report also noted that "children and young people with gender dysphoria are at an increased risk of suicide, but suicide risk appears to be comparable to other young people with a similar range of mental health and psychosocial challenges. Some clinicians feel under

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[36] Louise Appleby, *Review of Suicides and Gender Dysphoria at the Tavistock and Portman NHS Foundation Trust: Independent Report*, UK NATIONAL HEALTH SERVICE (Jul. 19, 2024), https://www.gov.uk/government/publications/review-of-suicides-and-gender-dysphoria-at-the-tavistock-and-portman-nhs-foundation-trust/review-of-suicides-and-gender-dysphoria-at-the-tavistock-and-portman-nhs-foundation-trust-independent-report [https://perma.cc/3Z2X-22NT].

[37] *Id.*

[38] *Id.*

[39] *Id.*

[40] Cass, *Independent review of gender identity services for children and young people: Final report* at 195, ¶ 16.22 (2024) https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf [https://perma.cc/3EA6-3ACG] [hereinafter Cass Report].

pressure to support a medical pathway based on widespread reporting that gender-affirming treatment reduces suicide risk. This conclusion was not supported by the University of York's systematic review."[41]

One of the difficulties with the assumption that medical transition reduces suicide and suicidality is the "co-concurring mental health problems" that are common with gender-discordant children and adolescents.[42] Hence, reducing gender discordance may not, in itself, address these co-concurring mental health issues. Further, it is unclear whether the very high rates of suicidality are from "the inherent distress from the gender dysphoria," the co-occurring mental health issues, or other issues.[43]

There are studies that indicate an extraordinarily high suicide or suicidality rates for those undergoing pediatric medical transition. One of the earliest studies of suicide came from the Netherlands. In a 1988 study of 141 patients who had undergone sex reassignment surgery, three patients committed suicide post-transition, and sixteen attempted suicide, within two to five years of starting transition.[44] By contrast, the Dutch suicide rate has varied from a high of around 14.4 per 100,000 annual suicides in the early 1980s to around 11 per 100,000 in more recent years. Thus, the three suicides out of 141 patients over a maximum of five years is exceptionally high, with an equivalent rate of at least 425 suicides per 100,000.[45]

The Cass Report discussed a paper from a Belgium gender clinic which had reported five deaths from suicide among 177 adolescents aged 12–18, where all five had commenced cross-sex hormones.[46] This again is an extraordinarily high rate of suicide for adolescents undergoing medical transition.

These high rates of suicide and suicidality for some who undergo medical transition could occur in part because medical gender transition is commonly initiated too early and aggressively in a vulnerable population with concurring mental health issues. The false prognosis of the permanence of gender discordance and gender identity in adolescence leads to the prescribing of unnecessary and even harmful treatments in a population that includes many who, in the context of watchful waiting, would have resolved their gender discordance without undergoing the complicated medical and personal pathway of transition. An ideologically-driven medical practice leads to severe violations of the "first, do not harm" principle of bioethics.

Particularly in the United States, the development of the science is distorted by a strong bias toward the affirmation of gender-affirming care. For example, the New York Times reported that Dr. Johanna Olson-Kennedy, an "advocate of adolescent gender treatments," had withheld publication of a study on the impact of puberty blockers, because the data did not support her initial

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[41] *Id.*, at 186, ¶ 15.36.

[42] *Id.*, at 186, ¶ 15.37.

[43] *Id.*

[44] *See generally* Bram Kuiper & Peggy T. Cohen-Kettenis, *Sex reassignment surgery: A study of 141 Dutch transsexuals*, 17 ARCHIVES SEXUAL BEHAV. 439 (1988).

[45] *1,894 suicides in 2016*, CENTRAAL BURAEU VOOR DE STATISTIEK (June 28, 2017) https://www.cbs.nl/en-gb/news/2017/26/1-894-suicides-in-2016 [https://perma.cc/W6L2-SELH].

[46] Cass Report, at 186, ¶ 15.41 (citing Gaia Van Cauwenberg et al., *Ten years of experience in counseling gender diverse youth in Flanders, Belgium. A clinical overview*, 33 INTL. J. IMPOTENCE RSCH. 671 (2021)).

hypothesis that puberty blockers would improve mental health.[47] She blamed her decision on a concern that her work would be "weaponized" by opponents of pediatric medical transition, saying that the work "has to be exactly on point, clear and concise:" meaning that she would not publish data that contradicted her belief in the efficacy of pediatric medical transition.[48] The actual results were that a quarter of the adolescents were "depressed or suicidal" before treatment, with no apparent improvements from that data two years later after puberty blockers.[49]

Like others, Dr. Olson-Kennedy relied on her clinical experiences in touting the efficacy of medical gender transition, viewing such clinical experience as more reliable than medical research studies.[50] However, the legal regime for approval and use of medications in the United States presupposes that human subjects research in the form of clinical trials is superior to physicians' experiences in treating patients, as to determining the safety and efficacy of medications. Hence, the FDA usually requires multiple levels of human clinical trials for drug approval, and double blinded placebo trials are considered the gold standard, as they screen out the bias of physicians and patients toward believing in the efficacy of medical treatments.[51] The FDA has not yet approved any medications for the purposes of gender affirming care of medical gender transition. Hence, such treatments are currently "off-label," protected by the rule that once the FDA approves a medication for a specific condition and population, physicians are permitted to prescribe such medications for a different purpose and population.[52] The issues of physician bias and susceptibility to marketing incentives are particularly concerning in off-label use.[53] The issue of physician bias is particularly concerning where there are strong ideological elements involved, as there are in the area of gender-affirming care, which is linked to contentious understandings of gender and sex which go far beyond the medical treatment of persons experiencing gender discordance.[54]

The Cass report noted a clinical consideration which could explain the perception of efficacy: "a short-term boost in mental wellbeing is to be expected when sex hormones are introduced," which for those taking testosterone would produce "body changes in line with their identified gender within a few months. The start of long anticipated physical changes would be expected to improve mood, at least in the short term, and it is perhaps surprising that there is not a greater

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[47] Azeen Ghorayshi, *U.S. Study on Puberty Blockers Goes Unpublished because of Politics, Doctor Says*, N.Y. TIMES (Oct. 23, 2024), https://www.nytimes.com/2024/10/23/science/puberty-blockers-olson-kennedy.html [https://perma.cc/DD7M-JG85].

[48] *Id.*

[49] *Id.*

[50] *Id.*

[51] *See* Gail A. Van Norman, Drugs, *Devices, and the FDA: Part 1: An Overview of Approval Processes for Drugs*, 25 J. AM. COLL. CARDIOLOGY: BASIC TRANSL. SCI. 170, 170–72 (2016).

[52] Lars Noah, *Preempting Red State Restrictions on the Use of FDA-Approved Drugs in Gender-Affirming Care?*, 2024 UTAH L. REV. 833, 836–42 (2024).

[53] *See generally* Gail A. Van Norman, *Off-Label Use vs Off-Label Marketing of Drugs: Part 1: Off-Label Use—Patient Harms and Prescriber Responsibilities*, 8 J. AM. COLL. CARDIOLOGY: BASIC TRANSL. SCI. 224 (2023).

[54] *See, e.g.*, Mahmoud v. Taylor, No. 24-297 (pending United States Supreme Court case regarding parental religious liberty as to lack of notice and opt-out for public school LGBTQ+ curriculum and teaching for K–5 children); Department of Education v. Louisiana, 603 U.S. ___ (2024) (Supreme Court denied a petition for a partial stay by the Biden Administration, leaving in place a preliminary injunction blocking the Department of Education from implementing a rule that would expand the definition of sex discrimination under Title IX to include sexual orientation and gender identity).

effect." Hence, longer-term objective studies are required.[55] Thus, clinicians and researchers may be seeing some short-term improvements in mood when gender-discordant patients experience initial success in achieving their transition, which they have been told will have enormous benefit for them, without actually reducing statistically the incidence of suicide and attempted suicide.

IV. RESEARCH ON SUICIDE ATTEMPTS AND ESPECIALLY ON SUICIDAL IDEATION CANNOT PREDICT ACTUAL SUICIDE RATES AND MAY OVERSTATE THE RISKS OF ACTUAL SUICIDE.

Advocates of gender-affirming care for children often use studies of attempts and ideation as support for the claim that pediatric medical transition reduces the risk of completed suicide. But suicide is rare even among those who attempt suicide. In the United States, in 2022, about 49,000 people died by suicide, 1.6 million attempted suicide, 3.8 million made a plan for suicide, and 13.2 million seriously considered suicide.[56] Thus, about 3% of those who attempt suicide die, and the proportions are much lower for other categories of suicidality.[57]

Further, groups differ on the percent of attempts that lead to death or actual suicide; thus, females attempt suicide at substantially higher rates than males, even though males have a much higher suicide rate.[58]

Suicide attempts, and suicidal ideation, indicate substantial distress and are of course of substantial concern. However, the huge and varied gap between suicide itself, and the varied forms of suicidality, *demonstrates that research on those steps short of actual suicide cannot necessarily predict suicide rates*. This is particularly important because the purported risk of a dead child has been used in manipulative ways to obtain consents to treatment and to promote pediatric medical transition.

V. ABUNDANT EVIDENCE SUPPORTS HIGH RATES OF DESISTANCE AND RESOLUTION OF GENDER DYSPHORIA.

Given the extremely high rates of suicide and suicidality in the adult transgender population, the possibility of desistance of gender dysphoria under a watchful waiting approach is particularly significant. Those who through the course of childhood and adolescence resolve gender dysphoria may avoid a lifetime of very high rates of suicide, attempted suicide, and suicidal ideation. This is not intended to denigrate the reality that transgender adults may have a rich and fulfilling life, but it is to consider the impacts on suicide and suicidality of unnecessarily directing minors toward medical gender transition.

Early treatment protocols for gender dysphoria were statistically focused primarily on early-onset gender dysphoria, beginning as early as the toddler years, and most often involving

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[55] Cass Report, at 185, ¶ 15.27; *see also* Cass Report at 184, ¶ 15.26.

[56] *Suicide Data and Statistics*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Oct. 29, 2024), https://www.cdc.gov/suicide/facts/data.html#:~:text=Suicide%20deaths%2C%20plans%2C%20and%20attempts%20in%20the%20United%20States&text=1%20death%20every%2011%20minutes,made%20a%20plan%20for%20suicide [https://perma.cc/CRL3-2NRD].

[57] *Id.*

[58] *Id.*

biological males with a female gender identity. The experience with this population is that the dysphoria for most resolves by puberty in the context of a supportive "watchful waiting" protocol.[59]

In more recent years there has been a very sharp increase in minors presenting with gender dysphoria.[60] Unlike the past dominant cohort, most have been biological females, and most have been presenting near, at, or after puberty, rather than early in childhood. This is not controversial: SOC-8 refers to "the exponential growth in adolescent referral rates" and notes that "adolescents assigned female at birth . . . initiating care 2.5–7.1 times more frequently as compared to adolescents who are assigned male at birth."[61] SOC-8 also acknowledges a "phenomenon occurring in clinical practice is the increased number of adolescents seeking care who have not seemingly experienced, expressed, (or experienced and expressed) gender diversity during their childhood years."[62] Many have pre-existing mental health concerns.[63]

Recent studies of this apparently late-onset group have also found very high rates of desistance. A German study published in 2024 noted: "The diagnostic persistence over the 5-year follow-up period of less than 50% in all age groups is in line with the literature and presumably reflects the fluidity of the concept of gender identity in childhood and adolescence . . . ."[64] A secondary analysis of records from the US Military Healthcare System found a four year gender-affirming hormone continuation rate of 70.2%, meaning that nearly 30% had discontinued.[65] A Dutch study of gender non-contentedness in adolescence and early adulthood concluded: "Gender non-contentedness, while being relatively common during early adolescence, in general decreases with age and appears to be associated with a poorer self-concept and mental health throughout development."[66] These studies are consistent with other research indicating a high rate of desistance.[67]

On the other hand, there is evidence that social and medical pediatric gender-affirming care may extend the period of gender discordance between biological sex and gender identity.[68] As these mostly do not involve long-term studies, there remains uncertainty as to how long.

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[59] J.A. at 650–55; *see also* James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46 J. OF SEX & MARTIAL THERAPY 307, 307–13 (2020); Jiska Ristori & Thomas D. Steensma, *Gender Dysphoria in Childhood*, 28 INT'L REV. OF PSYCHIATRY 13, 18–22 (2016); Kenneth J. Zucker, *The Myth of Persistence: Response to "A Critical Commentary on Follow-up Studies and 'Desistance' Theories about Transgender and Non-conforming Children" by Temple Newhook et al.*, 19 INT'L J. OF TRANSGENDERISM 231, 231–45 (2018).

[60] SOC-8 at S43.

[61] *Id.*

[62] *Id.* at S44–45.

[63] Rittakerttu Kaltiala-Heino et al., *Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development*, 9 CHILD & ADOLESCENT PSYCHIATRY & MENTAL HEALTH 1, 5 (2015).

[64] Christian J. Bachmann et al., *Gender Identity Disorders Among Young People in Germany: Prevalence and Trends, 2013-2022*, 121 DTSCH ARZTEBLATT INTL. 370, 370–71 (2024).

[65] Christina M. Roberts et al., *Continuation of Gender-affirming Hormones Among Transgender Adolescents and Adults*, 107 J. CLINICAL ENDOCRINOLOGY & METABOLISM e3937, e3939 (2022).

[66] Pien Rawee et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 ARCHIVES SEXUAL BEHAV. 1813, 1813 (2024).

[67] J.A. at 652–55.

[68] J.A. at 635–41, 651, 655–660.

VI. MANY US PRACTITIONERS OF GENDER-AFFIRMING CARE FAIL TO CARRY OUT COMPREHENSIVE PSYCHOSOCIAL ASSESSMENTS PRIOR TO COMMENCING MEDICAL TRANSITION.

Many who practice pediatric gender-affirming care do not even attempt to assess or predict long-term gender identity and do not regularly conduct comprehensive psychosocial assessments, as these are perceived as needless barriers to care. The goal instead is to proceed as rapidly as possible with medical intervention, based on the view that "any delay in treatment prolongs a child's distress and puts them at risk of self-harm."[69]

For example, Dr. Colt St. Amand, a listed co-author of SOC-8 and a WPATH certified practitioner and mentor, was quoted as follows by the New York Times in June 2022:

> St. Amand thinks the purpose of assessment is not to determine the basis of a kid's gender identity. "That just reeks of some old kind of conversion-therapy-type things . . . . I think what we've seen historically in trans care is an overfocus on assessing identity . . . . People are who they say they are, and they may develop and change, and all are normal and OK. So I am less concerned with certainty around identity, and more concerned with hearing the person's embodiment goals. Do they want to have a deep voice? Do you want to have breasts? You know, what do you want for your body?"[70]

Thus, St. Amand does not attempt to "shield teenagers from taking medication with effects they might later decide they didn't want . . . . If the drugs don't suit them . . . they can simply stop."[71]

Another prominent advocate of gender-affirming care negatively characterized assessments of long-term gender identity as "singling out trans kids, and specifically with a mental-health provider, not medical staff, to interrogate, to go down this comprehensive inquisition of their gender."[72]

Thus, the provision of professional mental health assessment is characterized as a barrier and burden rather than a positive provision of care. Other critics called such limits "abusive" and "unethical" and as undermining patient autonomy.[73]

These negative views of assessment were elicited in response to an earlier draft of SOC-8, which for pediatric patients recommended "several years" of persistently identifying with another gender and a requirement of a comprehensive diagnostic assessment prior to commencing medical transition.[74] These requirements are minimized in the final draft; for example, gender incongruence should be "marked and sustained" prior to commencing gender-affirming medical care, but no particular period of time is indicated.[75] Thus, the SOC-8 final standards were significantly influenced by advocacy and ideology.

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[69] Robin Respaut et al., *Why Detransitioners are Crucial to the Science of Gender Care*, REUTERS (Dec. 22, 2022), https://www.reuters.com/investigates/special-report/usa-transyouth-outcomes/ [https://perma.cc/ZP7T-GEZP].

[70] Bazelon, *supra* note 2.

[71] *Id.*

[72] *Id.*

[73] *Id.*

[74] *Id.*

[75] SOC-8,at S32, S48.

VII. ACCORDING TO SOC-8 COMMENCING MEDICAL TRANSITION WITHOUT COMPREHENSIVE ASSESSMENTS AMOUNTS TO PRACTICE WITHOUT EMPIRICAL SUPPORT AND MAY NOT BE IN THE LONG-TERM BEST INTERESTS OF THE PATIENT

The final SOC-8 standards did adhere to the recommendation of a "comprehensive biopsychosocial assessment of adolescents," despite the pushback against assessment as a "harmful assertion of psychogatekeeping."[76] SOC-8 warned:

> There are no studies of the long-term outcomes of gender-related medical treatment for youth who have not undergone a comprehensive assessment. Treatment in this context (e.g., with limited or no assessment) has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time.[77]

SOC-8 further noted that findings of "low regret can only currently be applied to youth who have demonstrated sustained gender incongruence and gender-related needs over time as established through a comprehensive and iterative assessment."[78]

SOC-8 relies entirely on Dutch studies and protocols as an evidentiary basis for gender-affirming care in adolescence. Yet, even those American clinics that conduct interdisciplinary assessments generally do not follow the much more extensive Dutch protocols. Thus, Reuters interviewed staff at eighteen gender clinics across the United States and found that "None described anything like the months-long assessments [Dutch clinicians] adopted in their research."[79] Indeed, seven of the eighteen clinics "are comfortable prescribing puberty blockers or hormones based on the first visit, depending on the age of the child."[80]

Further, nothing prevents practitioners who disagree with the need to conduct a "comprehensive biopsychosocial assessment" (or who simply lack the resources to carry such an assessment) from ignoring the SOC-8 recommendations. Those recommendations have no binding authority.

Thus, many practitioners in the United States lack an evidence-based medical justification for their protocols with minors—even according to the assessment of that evidence by SOC-8. These clinics are prescribing medical interventions with life-long consequences on a highly vulnerable pediatric population, without an evidentiary basis for their protocols.

The lack of an evidentiary basis for the actual practice of pediatric medical gender transition in the United States has important implications for the intertwined issues of mental health, suicidality, and suicide. Without reliable long-term data about the psychological impact of pediatric gender transition, there is no way to justify the claim that such care reduces suicide, suicidality, or even assists mental health, on a long-term basis.

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[76] *Id.* at S48; Bazelon, *supra* note 2.

[77] SOC-8 at S51.

[78] *Id.* at S61.

[79] Chad Terhune et al., *As More Transgender Children Seek Medical Care, Families Confront Many Unknowns*, REUTERS (Oct. 6, 2022), https://www.reuters.com/investigates/special-report/usa-transyouth-care/ [https://perma.cc/WA6E-T4YE].

[80] *Id.*

CONCLUSION

The messages of pediatric medical transition advocates have been stark: If you are experiencing gender dysphoria/discordance, you are permanently transgender. You will experience great distress, and be in serious risk of suicide, until and unless you undergo medical transition. Your mental health issues will be resolved, or at least significantly alleviated, only when you medically transition. These messages claim to be based on listening to pediatric patients but are actually a recruitment into an ideology. These messages claim to be based on evidence, but in actuality, most of the claims lack the kind of quality evidence generally required in medical care.

By contrast, watchful waiting protocols may affirm the reality of the *experience of gender dysphoria/discordance*, but do not immediately ascribe a permanent transgender identity to that experience. Patients and parents can be told that the child or adolescent may be transgender, but there are also other possibilities, given the diverse possibilities as to gender identity and sexual orientation. Hence, the goal of treatment would be to accompany the patient and build resilience through what may be a journey of many years as to gender identity and sexual orientation. Mental health issues and diagnoses are to be treated as issues of their own and are not assumed to be resolvable through medical transition. Medical interventions, which risk physical health complications and infertility and may prematurely cement gender identity, are deferred to avoid unnecessary suffering.

The current state of evidence indicates that watchful waiting protocols, properly implemented, are much more likely, over the long term, to reduce suicide and suicidality for the highly vulnerable population of children and adolescents experiencing gender discordance, as compared to the intrusive and aggressive practices of pediatric medical transition.

If the United States Supreme Court in *Skrmetti* upholds Tennessee's prohibition of pediatric medical transition, it will not need to have resolved these complex and evolving issues of medical practice for a highly vulnerable population, but rather will have left room for others, including states, to develop public policy over time. On the other hand, if the Court invalidates Tennessee's law, it will have created a constitutional straight jacket which will make the Court itself responsible for harms to this vulnerable population.