

## THE FACTS:

### REBUTTING THE FLORIDA DEPARTMENT OF HEALTH MEMO MISLEADING THE PUBLIC ON THE SCIENCE BEHIND GENDER-AFFIRMING CARE

On April 20, 2022, the Florida Department of Health issued a letter regarding gender-affirming care for transgender youth, joining Texas and Alabama in the effort to politicize age-appropriate, medically-necessary care. The letter recommends against the provision of puberty blockers, gender-affirming hormone therapy, and gender-affirming surgery to transgender youth and adolescents under the age of 18. These guidelines go even further than Texas and Alabama in calls to limit care, recommending against even social transition - that is, allowing transgender youth to use the name, pronouns, and gender presentation that conforms to their identity.

Accompanying this dangerous and life-threatening guidance was a so-called 'fact sheet,' which dismisses a recent explainer by the U.S. Department of Health and Human Services (HHS) on the medical need for gender-affirming care. The Florida Department of Health rejects the science, medicine, and evidence-based approach of the HHS, instead dangerously cherry-picking select research to assert their claims. They present misleading interpretations of study findings, ignore citations where the authors themselves contradict Florida's claims, and exclude important contextual information. Further, they focus on single studies, many with small samples and numerous methodological flaws, to support their assertions of the harms of gender-affirming care. In doing so, they ignore the vast majority of the literature, which has repeatedly found that gender-affirming care carries substantial positive benefits, and minimal harms, for transgender youth.

The reality is, Florida's state mandate takes decisions about their children away from parents, and decisions about their patients away from doctors. Denying transgender youth the ability to transition—be it preventing social transition such as changing their hair, clothes, or pronouns, or denying access to safe, affirming, and age-appropriate medical care such as gender-affirming hormones or puberty blockers—is dangerous, life-threatening, and abusive. Rather than protect trans youth, all it does is aim to push them back into the closet, an approach which is tantamount to state-endorsed conversion therapy. Rather than affirm parental rights, all it does is deny parents the autonomy to make the best decisions for their children to support their development.

Below we refute each of the assertions made by the Florida Department of Health, including highlighting the numerous errors and biases in their fact sheet, by drawing from a large body of scientific, academic, and clinical evidence in support of the provision of gender-affirming care, including social and medical transition.

### Lie #1:

**Detransition rates among youth are extremely high, and thus it is dangerous to allow youth access to therapies they will go on to regret.**

To make this claim, they cite a review article published in [International Review of Psychiatry](#) by Ristori & Steensma (2016), claiming it states that “80%” of those seeking clinical care will lose their desire to identify with the non-birth sex.

### Reality:

**Numerous published studies from more recent years have noted that detransition is, in fact, quite rare – with youth who meet criteria for gender dysphoria, and who undergo social or medical transition, being the most likely to be persistent in their trans identification**

- [Turban et al, 2021](#) used retrospective data from over 17,000 trans identified adults in the United States surveyed on the 2015 USTS and found that only **13.1% had ever detransitioned** at any point in their lives.

And among those who did detransition, it was almost exclusively for external reasons such as pressure/lack of social support from family and loved ones, encountered stigma, and difficulty finding jobs

- 2.4% detransitioned due to “uncertainty or doubt around gender”
- 35.6% detransitioned due to “pressure from a parent”
- 32.6% detransitioned due to “pressure from community or social stigma”
- [Wiepjes, et. al., 2018](#) looked at over 40 years of data from Amsterdam and found that **less than 2% of adolescents** who began puberty suppression stopped treatment, and over 78% who were seen in the gender clinic in adolescence went on to surgically transition

Among all people who transitioned, 0.5%-- a total of 14 people out of almost 6,800--expressed regret

- [Bustos et al, 2021](#), in a systematic review/meta-analysis of 27 studies including over 7,900 transgender patients who underwent gender-affirming surgery (of any type), found that a total of 77 patients--**less than 1% who underwent transmasculine surgeries and 1% who underwent transfeminine surgeries**--had any regret.

It's important to note that regret was tied to a lack of social acceptance for their identity and transition, rather than a changing view of their own identity, or wish they had not received the surgery.

### Reality:

**Ristori & Steensma themselves note that “it seems reasonable to**



**conclude that the persistence of [gender dysphoria] may well be higher” (pg.16) than was reported in their article, due to numerous methodological issues in the studies they cite in their review.**

- Their figure comes from combining the results of 10 studies of 317 people—adding up the number of people who were persistently gender dysphoric across all studies, and dividing it by the number of people included in all studies. However, these studies are not comparable, and by combining them, we lose a lot of nuance
- The studies used to formulate the desistance statistic are themselves riddled with methodological flaws, including, most importantly, that many of the children studied were not gender dysphoric to begin with.

For example, in one of the 10 studies (Drummond et al, 2008) only 15 of 25 girls met the criteria for gender dysphoria at baseline.

In 5 of the studies, which relied on the same population of 55 children from the 1960s and 70s, youth were also enrolled based on a wide range of characteristics at baseline, such as cross-gendering, “preference for girl playmates”, and “feminine gestures.

- 5 studies focus on the same 55 children, recruited in the 1960s. Almost a third of the sample (99 children) were recruited prior to 2000.
- Steensma, writing with Cohen-Kettenis in 2018, notes that the DSM V provided more stringent criteria to define gender dysphoria. Studies conducted on youth who transitioned prior to 2013 (when DSM V went into use)--which includes the vast majority of studies included in this review--may thus include youth with a much wider range of symptoms of gender dysphoria, which could include those more likely to detransition/desist in their treatment.

As they note *“we expect that future follow-up studies using the new diagnostic criteria may find higher persistence rates and hopefully shed more light on developmental routes of gender variant and transgender children.”* (p.226)

- There were inconsistencies in the definition of detransition vs. persistence used across studies, with some focusing on stopping treatment and others focusing on change in gender dysphoria scores, making results non-comparable.
- Some of the ‘treatment’ programs respondents underwent before being assessed for detransition vs. persistence were also closer to conversion therapy programs than gender-affirming programs.

In the 5 studies which focused on a total of 55 children from the 1960s and 70s, the treatment provided was not gender-affirming care, but rather “psychoanalytically oriented psychotherapy” which was more akin to conversion therapy, focused on discouraging gender atypical behavior and desires.



- There were inconsistencies in timing of follow-up, which also suppressed the results when averaged across all 10 studies – when considering persistence/desistance across longer time periods, we see much more consistency.

In the very same article from IRP article themselves acknowledge that *“the more intense GD is in childhood, and the more cross-gendered behaviour is reported by parents or through self-report, the higher the chance that the GD persists...A social transition in childhood, especially in natal boys, and verbal identification with the desired/experienced gender was predictive for the persistence of GD.”* (pg. 16)

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### **Lie #2:**

**There is no evidence to support the positive impact of gender-affirming medical care for transgender youth**

### **Reality #2:**

**There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for transender youth—including in some of the very studies they cite.**

- Green and colleagues immediately follow their assertion that “causation cannot be inferred” by noting their findings replicate those from longitudinal, retrospective, and prospective studies that receipt of gender-affirming care is associated with positive mental health benefits. Thus, by contextualizing their findings with other studies that utilize “repeated measures designs...it appears likely that receipt of GAHT may lead to reduced levels of depression and suicidality.” (pg.648)
- Chew and colleagues note that receipt of puberty blockers had numerous positive psychosocial impacts, including “significant improvements in multiple psychological measures, including global functioning, depression, and overall behavioral and/or emotional problems” (pg 14).

It was not that hormone therapy (e.g.Progestin, Antiandrogens, Estrogen, and Testosterone) had negative impacts, but rather that, at the time of the review, no studies had examined associations between hormones and psychosocial outcomes. But that is no longer the case.

Since Chew, et al., was published, numerous studies have specifically reported on positive association between receipt of gender-affirming hormones and positive psychosocial outcomes. For example

- Allen et al., 2019 a prospective, longitudinal study following 47 youth who received gender-affirming hormones (GAH), found that suicidality was significantly lower, and general well-being was significantly higher, at conclusion of treatment

- Tordoff et al, 2022, a prospective study of transgender and non-binary youth age 13-20, found that those who received gender-affirming care (including both puberty blockers and gender-affirming hormones) were 60% less likely to report moderate/severe depression, and 73% less likely to report suicidal thoughts at the end of the 1-year study, compared with those who did not receive gender-affirming treatment
- Notably, at the end of the study, 37% of those receiving gender-affirming care reported suicidal/self-harm thoughts, compared with 83% of those who did not receive gender-affirming care
- Turban et al, 2022 looked at retrospective data from almost 22,000 transgender adults who reported ever wanting gender-affirming hormones (GAH). Compared with those who were never able to obtain GAH, those who did reported significantly lower rates of prior-year suicidality in adulthood. Associations were strongest for those who were able to access GAH earlier in life
  - Accessed GAH in early adolescence = 60% reduction in suicidality in adulthood
  - Accessed GAH in late adolescence = 50% reduction in suicidality in adulthood
  - Accessed GAH in adulthood = 20% reduction in suicidality in adulthood
- Despite the Florida DoH's claims that "a small study on 44 patients in the United Kingdom failed to show any psychological benefit to puberty blockers on children aged 12 to 15." In fact, this statement is based on the finding that scores on some metrics remained unchanged/stable, NOT that scores worsened. In addition, the study findings included numerous benefits.

The authors note that the lack of change is actually an improvement, as "the lack of change in an outcome that normally worsens [self-harm and psychological functioning] in early adolescence may reflect a beneficial change in trajectory for that outcome, i.e. that GnRHa treatment reduced this normative worsening of problems." (pg.20)

On many other metrics of psychological and physical health, "most participants reported positive or a mix of positive-negative changes in their life" (pg 13). This includes higher ratings of happiness, lower to no side effects, increased social acceptance, and improved psychological well-being.

- Of note, the authors also found that any adverse events were rare, "minor and anticipated," and included mild headaches, mild fatigue, and hot flashes). Side effects diminished over time and had largely resolved by the end of follow-up (at 2-3 years post-enrollment).



- Further, there were minimal adverse physiological changes who were still growing, “height growth continued,” subjects retained “normal liver and renal function through treatment” (pg. 18), and bone-mass density continued to increase as well, albeit at a slightly lower rate than in same-age peers.

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### Lie #3:

**Providing gender-affirming care for transgender youth means providing them harmful and irreversible surgeries and medical therapies, which carry significant short- and long-term health risk**

### Reality #3:

**Gender-affirming medical care for transgender youth and adolescents under the age of 18 is largely concentrated to gender-affirming hormones and puberty blockers, many of which have been safely used with cisgender youth for decades, and which have similar safe and positive efficacy among transgender youth.**

- Editorial published in The Lancet Child & Adolescent Health: *“This stance wilfully ignores decades of use of and research about puberty blockers and hormone therapy: a collective enterprise of evidence-based medicine culminating in guidelines from medical associations...Puberty blockers are falsely claimed to cause infertility and to be irreversible, despite no substantiated evidence.”*
- Endocrine Society: *“Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/ gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains.”*
- The Florida chapter of the American Academy of Pediatrics issued their own statement immediately condemning these guidelines, noting that *“appropriate gender-affirming care, conducted in close coordination with pediatricians and parents, is safe and effective for treating patients experiencing gender dysphoria,”*
- **The Florida Department of Health re-cites Green et al., 2022 in their ‘fact sheet’ to claim a link between receipt of gender affirming care and economic hardship. However, this is a misleading claim at best, and a willful misinterpretation at worst, of what the authors found.**

They are drawing a causal conclusion from a study that they explicitly dinged just one page earlier for its non-causal design

- Socioeconomic status was not a study outcome that followed receipt of gender-affirming care. Instead, it was a self-reported demographic

measure, included to identify any group differences that need to be controlled for in analytic models.

- Implying that socioeconomic status was the result of GAHT ignores that we do not know temporality—it could be that youth from lower SES backgrounds are more able to access GAHT, since they qualify for public insurance, which covers GAHT in most states.
- The Florida Health Department also ignores the most crucial nuance of this finding—namely that the group who received GAHT was significantly older than the group who did not, with the majority of those in the receipt group being age 18+ (19.9 in receipt group vs. 16.9 in non-receipt group). Thus the lower SES of the receipt group may be attributable to their older age and living independently.
- Further confirming this finding is the fact that when results were restricted to respondents aged 13-17—aka those largely living with their parents—there was no difference in household SES between the two groups.

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#### Lie #4:

**The new Florida guidelines go beyond those in any other state in banning social transition—which is often a change as simple as changing their hair or name—based on the reports of a study that found “transitioning socially is beneficial for children with GD could not be supported from the present result.”**

#### Reality #4:

**This attempt to ban social transition is based on a misleading interpretation of the null results of a single, small, study. In fact, in the very same sentence the Florida Department of Health cites, the study authors go on to immediately state “*supporting this step may still be considered in individual cases and together with the whole family.*” (p.92)**

- The study, conducted among 54 children in Germany, did not find any harms of social transition. Instead, it found that, in statistical models, peer and family support were significantly predictive of better psychological functioning (defined as a combination of both internal mental distress and external problem behavior), whereas social transition was associated with better psychological functioning, but not statistically significantly.

The authors conclusion, rather than recommend against social transition, was that “*transitioning socially **should not only be viewed as a form of treatment**, but can be understood as a possibility for children to explore their own individual developmental pathways.*” (p.92)



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- **In contrast to the single finding cited by Florida, multiple additional studies have repeatedly found numerous mental health benefits associated with social transition, particularly when affirmed.**

Other studies have found that socially transitioned transgender youth who are supported and affirmed in their identities had levels of depression and self-worth equivalent to that seen in the general population, and only mildly higher levels of anxiety than controls—essentially overcoming mental health disparities typically seen among transgender youth relative to cisgender peers.

Having just one additional adult in their life who support their identity and social transition can substantially lower the risk for suicide.

- **The single most important thing parents, caregivers, and teachers can do to support and protect the transgender and non-binary youth in their lives is to help them to live authentically—including through allowing and affirming their decision to socially transition.**

- Transgender youth, as with transgender adults, do best when they are able to live as their true selves, including using the name, pronouns, and outward presentation that match their identity. In banning this—a form of gender-affirming care—the state removes a significant and critical lifeline for transgender youth.

For transgender youth, being able to use their chosen name can substantially improve positive mental health outcomes, while lowering risk for depression.