**Testimony of Psychologist Ann E. Gillies Ph.D.,
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Senator Carney, Representative Moonen and members of the Joint Standing Committee on Judiciary:

This testimony is in opposition to L.D. 1735.

As of 2016, fewer than one in 10,000 adult natal males and one in 30,000 adult natal females experienced Gender Dysphoria.1

Despite this fact, there has been an exponential rise in referral rates of children and adolescents to gender clinics world-wide, since 2009.

The United Kingdom’s Tavistock Clinic which saw an explosion of referrals, is now closing after an investigation into the use of puberty blockers and cross-sex hormones that found the current model of care is ***not a safe or viable long-term option.*** 2

“***The current evidence does not support informed decision making and safe practice in children.”***3 There are approximately 1,000 lawsuits currently pending4

United Kingdom National Institute for Health and Care Excellence (N.I.C.E) evidence review states:

“Any ***potential benefits of gender-affirming hormones must be weighed*** against the largely ***unknown long-term safety profile*** of these treatments in children and adolescents with gender dysphoria.”5

*This isn’t the only gender clinic revising its standards of care. Sweden, Finland, Australia and now Norway have followed suit, after finding that the risks of puberty-suppressing and gender-affirming hormonal treatment currently outweigh the possible benefits.[[1]](#footnote-1)*

An Archive of Diseases in Childhood letter referred to puberty-blocker treatment as **“*a momentous step in the dark***.”[[2]](#footnote-2)

Gender-dysphoric children present with ***3-5 pre-existing*** mental health concerns. The majority have an “***existing diagnosis of an autism spectrum condition***” (ASC), or are likely to obtain one.[[3]](#footnote-3) They present with a history of self-harm, suicidal ideation, somatic symptom disorders, ADHD, oppositional defiance, and conduct problems.[[4]](#footnote-4)

What these children need is not to be fast-tracked into cross-sex medicalization, but to receive psychological care for their pre-existing traumas and co-morbidities.

Thank you for listening. Please vote ought not to pass on LD 1735.

1 Zucker, KJ, et al. Gender Dysphoria in Adults. Annu. Rev. Clin. Psychol. 2016. 12:217–47.)(P.217.)
2 https://www.bbc.com/news/uk-62335665
3 https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2019/RCGP-transgender-careposition-statement-june-2019.ashx?la=en [“15.” C. Heneghan, T. Jefferson, ‘Genderaffirming hormone in children and adolescents; BMJ EBM, 25 February 2019. ]
4 IBID
5 https://arms.nice.org.uk/resources/hub/1070871/attachment and <https://arms.nice.org.uk/resources/hub/1070905/attachment>

1. The Swedish National Council for Medical Ethics. https://www.transgendertrend.com/wp-content/uploads/2019/04/SMER-National-Council-for-Medical-Ethics-directive-March-2019.pdf [↑](#footnote-ref-1)
2. Referencing: (Richards C, Maxwell J, McCune N. Use of puberty blockers for gender dysphoria: a momentous step in the dark. Archives of Disease in Childhood 2019;104:611-612.) [↑](#footnote-ref-2)
3. Clarke, Anna Churcher, and Anastassis Spiliadis. “‘Taking the Lid off the Box’: The Value of Extended Clinical Assessment for Adolescents Presenting with Gender Identity Difficulties.” Clinical Child Psychology and Psychiatry, vol. 24, no. 2, 2019, pp. 338–3 52., doi:10.1177/1359104518825288 [↑](#footnote-ref-3)
4. Russell DH, Hoq M, Coghill D, Pang KC. Prevalence of Mental Health Problems in Transgender Children Aged 9 to 10 Years in the US, 2018. JAMA Netw Open. 2022;5(7):e2223389. doi:10.1001/jamanetworkopen.2022.23389 [↑](#footnote-ref-4)