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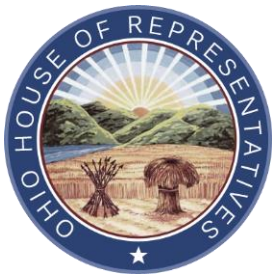

Gary Click
State Representative

Committees
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The SAFE Act

HB 454

Chair Manchester, Vice chair Cutrona, Ranking Member Liston and members of the House Committee on Families, Aging, and Human services, thank you for the opportunity to testify on HB 454, The SAFE Act.

Do you remember what it was like when you were a child? Do you remember the things you were passionate about? Do you remember the things that you just knew were true? Do you remember how obsessed you were with certain things? Were you ever in puppy love? Sometimes, a childhood passion follows you through life, like Neil Armstrong's passion for flight, and you become an astronaut. Yet many other children have started off with that same dream of going to space and found themselves in other happy and successful careers without any regrets.

Childhood is a time of play, imagination, and exploration where we can dream about many futures and try on a few different personalities. How often are we surprised by how someone's life turned out? Sometimes it's for the good and sometimes it's not so good. As children, our lives and our futures are elastic. They are filled with possibilities and opportunities. And sometimes they are filled with difficulties and tragedies, disappointments, and maladies.

As a child with limited life experience, every circumstance seems so immediate and traumatic. This is where the adults come in and add perspective and patience into the equation.

I am honored to serve on this committee with my colleagues because I truly believe that each one of us is here because we genuinely care about the people we serve. We are less driven by ideology than by the reality that there are issues that face people in our communities that have to be addressed at a level that either opens doors or puts a safety net in place to safeguard human rights.

While I was generally aware of this issue, a bill like this was not on my radar when I stepped foot into the legislature. It wasn't until I sat with teary eyed families and medical professionals that I decided to follow up with personal research and accept the challenge to carry this legislation. With your permission, I would like to share with you a few things that I have learned and I know that you will keep an open mind just as I did.

Gender Dysphoria

While you will often hear words like trans, transgender, transman or transwoman, the clinical term is gender dysphoria. It was once regarded as gender identity disorder, but the diagnosis was changed due to lobbying efforts in order to remove the stigmatism of a *disorder*.

Gender Dysphoria is an extreme discomfort with one's sex. Sometimes it is associated with a strong desire to be the opposite sex, but not always. This is why some people today also choose to identify as nonbinary. In fact, people now claim that there are hundreds of sexes and places like Facebook will give you multiple options.

Professional Curiosity

In order to alleviate the stress of gender dysphoria, it would be helpful to understand the cause. This is where we begin to experience conflict and controversy. Clinicians are not in agreement. A number of clinicians have professional curiosity and believe that discovering the origins of the dysphoria are a significant factor in providing an effective professional plan of care.

In contrast, there is increasing societal pressure to simply accept that some people are trans. They were born in the wrong body and affirming care is not just an option but is the **only** option. The pressure for this approach appears to be two-fold. First, there are the activists who attempt to associate and align gender dysphoria with sexual orientation. However, these are two distinct issues, and it is worth noting that there is often significant pushback on this concept from both the LGB community and various factions of the trans community. Identification and orientation are two separate issues.

The second factor is simply the profitability of gender affirming care. A little over a decade ago, it was difficult to discover a gender clinic near you. Today, there are over three hundred gender affirming clinics across the United States. The gender industry is big business.

Gender dysphoria is a real condition and people experiencing gender dysphoria deserve the best care possible. No one asks to be uncomfortable in their own body. Young ladies do not ask to be anorexic. No one chooses to suffer from body dysmorphia or body integrity disorder. Kids who are known as "cutters" do not choose to have an impulse for self-harm and children who experience gender dysphoria do not choose it. We should not stigmatize any of these children and we should have the professional curiosity to conduct sufficient research in order to provide the best care possible.

Causality

There are both known and unknown factors when we explore the causes of gender dysphoria, and we must be both humble and professional enough to distinguish between the two.

While scientists are still searching, there are no known biological causes for gender dysphoria. It is not uncommon to hear the myth of girl's brains in boy's bodies and vice versa. However, this is scientifically measurable and is conclusive. Neurologists have done the research. Our brains match our bodies one hundred percent of the time.

The nearest exception relates to individuals with DSD (disorder of sexual development), formerly known as intersexed.[1] DSD falls into two distinct categories. The first is based on chromosomal anomalies. Males possess XY chromosomes. Females possess XX chromosomes. Individuals with mismatched chromosomes are intersexed. Another cause of DSD relates to virilization in the womb. Over exposure to testosterone by females or under exposure by males may disrupt the appropriate development of the genitals. These individuals are distinct from those who are experiencing gender dysphoria and are exempt from any provisions of the SAFE Act.[2]

Comorbidities

While there are no known physiological causes of gender dysphoria, there are many known comorbidities. The comorbidities are not the same for each person. While some individual may not have known comorbidities, multiple mental health factors are documented to be primary factors for gender dysphoria.[3]

Children experiencing gender dysphoria and known to also experience anxiety, depression, suicidal ideations, autism, schizophrenia, low self-esteem, bullying and more. In some rare instances, the mental health factors may not be their own but in fact the result of Fictitious Disorder in Another (FDIA), formerly known as Munchausen Syndrome.[4] [5] Amber Bingle presented on gender dysphoria on a Ted Talk and proclaimed that her daughter told her that she was a boy from "literally from the womb."[6]

Perhaps the most heartbreaking contributing factor is sexual abuse. When a child's innocence is ripped away from them involuntarily, their minds devise all kinds of ways to escape and to protect themselves. Gender dysphoria is often a complicated mechanism of mental escape and self-defense.

This is where we see unfortunate bias come in and why it is important for the legislature to intervene on the behalf of adolescents. According to one of the leading advocacy organizations, affirming the child's desired sex should take precedence over all other comorbidities.[7]

The mental health concern may not subside until the dysphoria is addressed, as it is the underlying factor for some teens. It is common with non-binary and transgender youth for the mental health issues to be driven by the gender issue. Once the gender issue is dealt with and congruence measures have begun, the co-occuring phychological issues often lessen or resolve."[8]

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[1] The term hermaphrodite, though recognizable by many, is considered offensive and has fallen out of use.
[2] Lines 190-205.
[3] While some activists shun the idea that a mental health disorder may be responsible for their gender dysphoria, others readily acknowledge mental health factors. It should be noted that discussions of mental health do not carry negative connotations. Mental health is not necessarily the same as a mental disability and should not carry negative implications. In fact, it seems evident that many individuals experiencing gender dysphoria possess above average intelligence which is often revealed in their accomplishments.
[4] https://www.gaylawnet.com/laws/cases/2011-CA-001568-ME.pdf
[5] https://www.supremecourt.ohio.gov/rod/docs/pdf/7/2007/2007-Ohio-1394.pdf
[6] https://youtu.be/t_gCASi58Ps?t=663
[7] Brill, Stephanie; Kenney, Lisa. The Transgender Teen (p. 179). Cleis Press. Kindle Edition.
[8] Brill, Stephanie; Kenney, Lisa. The Transgender Teen (p. 220). Cleis Press

It shouldn't require an advanced education to recognize that prescribing puberty blockers and cross sex hormones and placing a child on a path to surgical intervention should not be the first or preferred course of intervention.

Gender Affirmation Therapy

Reasonable people should be concerned with any approach that is based on intimidation, fear, manipulation, and isolation rather than education, information and patience. This is what we discover in the gender affirming model. Transition is almost always the exclusive goal. Anything less is aggressively attacked with misinformation and intimidation.

"Would you prefer a living son or a dead daughter?"

This is a standard question presented to concerned parents in an initial meeting with a therapist. We know this not only because parents and children report it but because many therapists are not shy about it. Listen to this father recount his experience.

"The pediatrician said if I didn't affirm my daughter's identity, and I didn't get her the help that she needed, and she killed herself, I was going to feel awfully guilty—right in front of my daughter."[9]

Gender affirmation therapy begins with the misconceptions surrounding gender and sex. The word gender was originally a linguistic term rather than a description of one's inner feelings and sexual identity. Historically, however, gender is synonymous with sex and used additionally as a function of grammar to indicate if words are masculine or feminine.[10]

Only in recent history has gender come to represent an inner identity separate from one's sex.[11] Without any evidence to sustain this theory, it has become vogue to speak of an individual's gender identity as a tangible reality that exists outside of one's sex. This is an ideological system of belief that is unverifiable by means of scientific evidence. Yet without the backing of science, activists and even some clinicians suggest that gender affirmation, meaning hormone blockers, opposite sex hormones and ultimately surgical intervention is the preferred if not only legitimate course of action.

Although this is undoubtedly a significant movement, it is by no means a consensus movement among professionals. It is in fact an ideological movement that is opposed by leading professionals who are willing to brave the onslaught of activist opposition and misinformation.

Gender affirmation therapy does not affirm an individual's gender but rather affirms their dysphoria, kicking the can down the road and leaving grave consequences to be dealt with later.

Watchful Waiting

Leading professionals from varied backgrounds advocate for watchful waiting as the safest, most comprehensive, and least intrusive means of therapy.

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[9] https://www.cnsnews.com/commentary/jared-eckert/gender-affirming-health-care-children-exposed-new-documentary

[10] http://webstersdictionary1828.com/Dictionary/gender

[11] Dr. John Money and his now debunked social experiments are credited with the change in the definition of gender, so called discovery of a gender identity and the introduction of the phrases assigned male at birth (AMAB) and assigned female at birth (AFAB).

Dr. Kenneth Zucker is widely recognized as the foremost authority on gender dysphoria. He was the chair of the committee that wrote the guidelines for gender identity disorder in the DSM IV and gender dysphoria in the DSM V. Dr. Zucker has both practiced and advised watchful waiting as the best practice for children experiencing gender dysphoria.[12]

Dr. Stephen Levine was the chair of the fifth edition of the World Professional Association of Transsexual Health (WPATH). He has experience in providing care for transgender individuals and advocates for watchful waiting.

Dr. James Cantor is a neurologist specializing in the field of sexology.[13] He is an advocate for the transgender community and the author of the *Transsexual Bill of Rights*.[14] Not only is Dr. Cantor a strong advocate for watchful waiting, but he has also authored a blistering rebuke of the American Academy of Pediatrics recommendations for gender affirming care.[15]

Dr. Debra Soh is also a neurologist specializing in the field of sexology. She is also a fierce advocate for LGBTQ rights. Dr. Soh is the author of a book entitled, *The End of Gender*. She advocates for people to be able to both transition and to be respected. However, she does not believe that remaining faithful to the science of sex conflicts with an individual's ability to enjoy sexual freedom. Because youth are incapable of fully comprehending the long-term consequences of transition, she advocates for watchful waiting.[16]

Dr. Lisa Littman is a physician and researcher who discovered the phenomenon of Rapid Onset Gender Dysphoria (ROGD).[17] ROGD describes adolescents with no prior symptoms of gender dysphoria who suddenly announce a trans identity as part of a social contagion. This is often tracked to the influence of social media along with a desire to fit into a group or escape an adverse experience. Dr. Littman's initial peer reviewed research was vigorously attacked by activists but ultimately withstood a second round of peer review. Abigail Shrier picked up on this research and added her own personal investigation to produce a book entitled, *Irreversible Damage*.[18] This book documents personal accounts of adolescents and their families who have coped with ROGD.

Stella O'Malley and Sasha Ayad are gender specialists who also produce the *Gender: A Wider Lens Podcast*.[19] They regularly interview newsmakers and specialists who work in the field of gender. Stella herself was a child who experienced gender dysphoria. They advocate for watchful waiting.

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[12] Activists once falsely accused Dr. Zucker of practicing conversion therapy simply because he rejected the gender affirmation model. When a new administration took over, the activists voices prevailed, the institute agreed with their accusations, and he lost his job. However, Dr. Zucker prevailed in a lawsuit, the institute apologized and Dr. Zucker was award nearly a half million-dollar settlement.

[13] www.sexologytoday.com

[14] http://www.jamescantor.org/bill-of-rights.html

[15] http://www.jamescantor.org/uploads/6/2/9/3/62939641/cantor_fact-check_of_aap.pdf

[16] https://www.drdebrasoh.com/book

[17] https://littmanresearch.com/

[18] https://www.amazon.com/Irreversible-Damage-Transgender-Seducing-Daughters/dp/1684510317

[19] https://podcasts.google.com/search/Gender%3A%20A%20Wider%20Lens%20Podcast

These are just a few of the leading professionals who advocate for watchful waiting as the safest most appropriate therapy for children and adolescents experiencing gender dysphoria.

Watchful waiting is the nonjudgmental therapy that focuses on the individual rather than an ideology. The therapist neither affirms nor disaffirms the child's feelings but rather listens and learns. The therapist allows the child to describe themselves and why they feel certain ways.

Throughout this process, the counselor is better able to discover why a child is uncomfortable in their own body. It is possible that throughout the process, a child may persist and choose to later transition. It is also possible to discover that a child has been bullied for being a tomgirl or an effeminate male but is not truly transgender. Sexual abuse may be uncovered. It could be that someone said he was a girl because he played with dolls or that she is a boy because she likes cars and trucks. Sexual stereotypes such as these can be misleading. If we travel back a century ago, pink was considered a masculine color and blue feminine. These preferences are poor standards by which to diagnose a child with gender dysphoria.

Watchful waiting allows children to work through their issues without committing them to long-term, high risk medical interventions. The science tells us that between 85-95% children with gender dysphoria will desist after experiencing puberty. There is no need to rush these children into a choice that they may or may not regret.[20]

Even leading therapists who do not advocate for watchful waiting have to acknowledge the risk of instant affirmation.

> Gradually throughout adolescence, teens learn greater self-control. However, before that occurs, especially in early and middle adolescence, they tend to engage in risky behaviors as they are more focused on immediate gratification. As their brains develop the ability to think through the potential consequences of their actions, teens frequently act in ways that can jeopardize their social, physical, sexual, and emotional safety. As they mature, they are more able to synchronize their behaviors with the increased recognition of potential negative impacts of impulsive decisions, as well as to align their actions with the emerging awareness of their long-term goals.[21]

Risk Factors

Dr. Quentin L. Van Meter, president of the American College of Pediatrics, warns that "The grave side effects of transgendering include, but are not limited to, sterility, sexual dysfunction, blood clots, strokes, cardiac disease, osteoporosis, malignancy, and persistently elevated rates of suicide. Children and teens do not have the cognitive capacity to fully comprehend these risks."[22]

The manufacturers own warning label describes the approved uses of Lupron as treatment for prostate cancer in men, fibroids and endometriosis in women, and central precocious puberty children. Use for

[20] Thomas McCabe is grateful for waiting to transition till adulthood. This provided ample opportunity for the development of the frontal lobe and greater access to reasoning prior to transition. https://www.youtube.com/watch?v=-3XW0RVZA1Q&t=45s

[21] Brill, Stephanie; Kenney, Lisa. The Transgender Teen (p. 112). Cleis Press. Kindle Edition.

[22] https://acpeds.org/press/american-college-of-pediatricians-urges-surgeon-general-to-investigate-medical-transgendering-of-children

gender dysphoria is not recommended and used only off label. Even under its recommended use, the manufacturer warns against using for more than a year and lists serious side effects including: loss of bone mineral density, convulsions, clinical depression, nervousness, anxiety, insomnia, and more. [23]

It is no wonder that a man with the impressive resume of Dr. Joseph Zanga opposes medical interventions in adolescents. Dr. Zanga has served as the Pediatric Department Chair, Loyola Chicago Stritch School of Medicine and Assistant Dean, Brody School of Medicine, East Carolina University President of the American Academy of Pediatrics, and President of the American College of Pediatricians. In his article entitled, *Affirming Sex Change in Kids Violates " First, Do No Harm,"* he writes:

> Puberty is a normal, natural occurrence. Puberty blocking drugs create an abnormal condition that arrests children's brain development as well as their physical sex characteristics. When combined with or followed by cross-sex hormones, they often result in permanent sterility. Cross-sex hormones in and of themselves are associated with debilitating health risks including heart attacks, stroke, diabetes, cancers and more. In addition, rates of suicide are nearly twenty times greater among adults who've used cross-sex hormones and have undergone sex reassignment surgery, even in Sweden which is among the most transgender affirming countries.[24]

Due to the severe and extreme consequences of medicalized treatment for gender dysphoria, the American College of Pediatricians regards these interventions as nothing less than child abuse. [25]

Suicide by the Numbers

Suicide narratives are a consistent part of storytelling frequently used by advocates of affirming ideology. Why wouldn't they use them? They are effective. But do they tell the whole story? You will hear people say things like affirming care saved my life or my child's life. We should not assume that they are being disingenuous or even that this is false. But neither should we assume that this tells the whole story. There is a short version and a long version

Activist organizations such as the Trevor Project are very forceful with this narrative. You should not be surprised when opponents of this bill advise you that affirming care is lifesaving care. However, as compelling their narrative may be, it is not beyond scrutiny. Convenience samples, incomplete data factoring in comorbidities, and self-fulfilling storylines will dress out a self-diagnostic survey primarily addressing suicidal ideations.

Although these suicidal ideations should be taken seriously, studies reveal that any relief provided by medicalized treatment is temporary at best. The elevated suicide risk of individuals who have transitioned tops the charts at twenty times the average rate of suicide.[26] When we measure these

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[23] https://tinyurl.com/hdana2rt
[24] https://tinyurl.com/2mz84vdj
[25] https://tinyurl.com/45erfkt7
[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3043071/

numbers, we are no longer talking about ideations or even attempts and hospitalizations but rather completed suicides.

If we are genuinely as concerned about life saving treatment and reducing the risk of suicide, we must listen to the professionals and look beyond the short-term self-reporting and consider the long-term measurable statistics.

Dr. Stephen Levine reports of a man who sat with a gun to his head and said that he was either going to take his life or become a woman. With Dr. Levine's assistance, he became a woman. After a few years into the transition, he took a knife to his jugular vein. Fortunately, he survived. In therapy, he was angry with Dr. Levine for not digging deeper into his issues. After what seemed like a successful recovery, they jointly published an article entitled Increasingly Ruth outlining his progress into become her. Afterwards, Ruth committed suicide.[27]

Research indicates that so-called gender affirming care does not alleviate suicide risk, it just delays and deepens the risk. Individuals who have completed their transition are nearly twenty times more likely to succeed in taking their lives.[28]

Reversing Trends

Sweden is one of the most progressive and tolerant nations in the world and the home of the Karolinska Institute and the Dutch Protocol for gender affirmation. Following a high court ruling in the UK the Dutch Protocol has been shut down.

> The Karolinska Hospital's new policies echo a growing international concern over the proliferation of medical interventions that have a low certainty of benefits, while carrying a significant potential for medical harm. The latest policy issued by the Karolinska cites the UK NICE evidence review, which found the risk / benefit ratio of hormonal interventions for minors highly uncertain; the 2020 UK judicial review, which highlighted the overarching ethical problems with the practice of medical "affirmation" of minors; as well as Sweden's own Health and Technology Assessment (SBU) evidence review conducted in 2019, which found a lack of evidence for medical treatments, and a lack of explanation for the sharp increase in the numbers of adolescents presenting with gender dysphoria in recent years.[29]

This decision followed the highly publicized case of Keira Bell in Great Britain. Keira sued the Tavistock for the gender affirming treatment she received as a child. Keira was a tomboy. When her mother introduced her to the idea of being trans she thought maybe that was the answer. After all, she was attracted to females. Treatment began with puberty blockers, progressed to testosterone and ultimately a double mastectomy. Today, she lives with a deep bass voice, a five-o-clock shadow, a flat chest, and deep regret. She fears that she will never be able to conceive and wishes she had been challenged

[27] https://tinyurl.com/cwux3wxv
[28] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885
[29] https://segm.org/Sweden_ends_use_of_Dutch_protocol

rather than affirmed. Keira won her lawsuit and the high court ruled that a three-judge panel must approve medically affirming care in the future.[30] [31] [32] [33]

Walt Heyer was among the first to receive so-called gender affirming care before it was ever called gender affirming care. After living for eight years as Laura, he discovered that he had been misdiagnosed. He has written multiple books and now manages the website sexchangeregret.org, where he counsels those who have come to regret their so-called gender affirmation.

A simple YouTube search of detransition will quickly reveal that neither Walt nor Keira is not alone.[34] The overwhelming abundance of detransitioners testify to the fact that children are not able to give informed consent. Neither parents, therapists nor physicians can accurately determine which children with gender dysphoria will desist and which will persist.

According to Dr. Lisa Littman's research, the average age of detransition is around twenty-four years of age.[35] Ironically, this is the same time at which the prefrontal cortex responsible for reasoning and judgement is fully developed. Some might argue that the age of eighteen is still too young. I argue that it is at least beyond reasonable.

Informed Consent

I thank you for your patient consideration thus far. Because this issue is so complex and the consequences are so great, a paragraph or two would not suffice. In truth, we have barely scratched the surface. However, I am confident that future witnesses and greater dialogue will fill in the gaps. And so I will conclude my testimony drawing your attention to the basic and fundamental principle of law known as informed consent.

The purpose of this bill is not nor has ever been to make a moral judgement or as some have alleged, to deny anyone healthcare or civil rights. It has been to ensure that children receive appropriate, ethical and safe healthcare as well as to protect their right to make these choices until the time that they are able to legally and rationally consider the risks and rewards. This bill will ensure increased satisfaction among those who do choose to transition and decreased dissatisfaction by reducing the number of individuals who will transition without informed consent.

"The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice."[36]

It is indisputable that children under the age of eighteen do not scientifically possess the reasoning faculties to engage in informed consent. This is why it is unlawful for them to purchase alcohol,

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[30] https://www.persuasion.community/p/keira-bell-my-story
[31] https://quillette.com/2020/12/18/like-it-or-not-keira-bell-has-opened-up-a-real-conversation-about-gender-dysphoria/
[32] https://www.youtube.com/watch?v=V8P8RJwVrZQ
[33] https://www.youtube.com/watch?v=0A6dFxAf8wY
[34] https://www.youtube.com/results?search_query=detransition
[35] https://tinyurl.com/zu6tm8x8
[36] Canterbury v. Spence, 1972

cigarettes, or participate in gaming related activities. A child under the age of thirteen cannot consent to sex. A minor over the age of thirteen may not consent to sex with an adult. Children under the age of sixteen may not donate blood, even with parental consent.

Generally speaking, minors who commit crimes are protected from lifelong consequences and their records are expunged because science recognizes that their brains are not fully developed.

Minors cannot be held liable for contracts because the "purpose of the rule of law is to protect minors whose 'mind and judgement are immature and need to be sheltered from their own imprudence and folly.'"[37]

Minors may not vote, hold office, marry, buy or possess firearms, or even play bingo. If a child cannot donate blood or play bingo in Ohio, is it reasonable to allow them to consent to medicalized treatment that leads to sterilization and other long term health risks?

The SAFE Act is common sense legislation designed to ensure that children and adolescents receive only the best and safest healthcare and guarantees that their rights to choose are preserved for that time in life when they are best able to provide informed consent. I urge a yes vote on the SAFE Act and invite you to join me in keeping Ohio's youth SAFE!

Thank you, Madame Chair Manchester for allowing hearings on this vital topic. I look forward to further discussions, listening to opposition and proponent testimony in the near future. I feel confident that objective minds will conclude that this is not only the most caring and compassionate course but that it is also the only responsible course of action to provide the most holistic and safe care for gender dysphoric children in Ohio.

At this time, I will be happy to answer any of your questions.

[37] Bramley's Water Conditioning v. Hagen, 27 Ohio app3d 300 (11th Dist. Ct. App. 1985) (Citing Mestezko v. Elf Motor Co., 119 Ohio St. 575, 581-582 (1929).