

Human Rights Campaign Response to Amicus Brief of Paul R. McHugh, M.D., et al. in Support of Defendant-Appellee

Paul McHugh, a psychiatrist at Johns Hopkins University, has repeatedly filed amicus briefs in cases concerning the civil rights of lesbian, gay, bisexual, transgender and queer (LGBTQ) people. His investment in these cases is puzzling, because McHugh's research career has never touched on gender identity or sexual orientation, nor does he appear to have clinical experience with LGBTQ patients. Nonetheless, in early 2017, McHugh filed a brief in the Supreme Court of the United States arguing against transgender student Gavin Grimm's right to use gender-appropriate restrooms in his Gloucester, VA high school. Listed as coauthors were diabetes researcher Paul Hruz and biostatistician Lawrence Mayer; like McHugh, neither coauthor appears to have clinical or research experience with transgender children or adults. This lack of expertise may explain why the brief itself is filled with misunderstandings and misstatements about transgender children and teens. Below, we address three primary areas of inaccuracy: unsubstantiated and widely rejected claims about "conversion therapy"; misinformation about gender-affirming care; and crucial school climate research that the brief fails to address.

False Statements About Conversion Therapy

The most concerning section of the brief is the assertion that conversion therapy—that is, a range of practices intended to change a person's sexual orientation or gender identity—is an appropriate response to transgender youth. Every major medical and mental health organization, including the American Medical Association, the American Psychological Association, the American College of Physicians, the American Academy of Pediatrics, the American Psychoanalytic Association, the American School Counselor Association, the American Psychological Association and the National Association of School Psychologists, have explicitly rejected conversion therapy. Not only is there no evidence that these practices work, research clearly shows that they cause long-lasting psychological harm, including the risk of suicide (American Academy of Pediatrics Committee on Adolescence, 2013; American College of Physicians, 2015; American Psychoanalytic Association, 2012; American Psychological Association and National Association of School Psychologists, 2015; American School Counselor Association, 2014). As a result, nine states and the District of Columbia have enacted laws or regulations to protect minors from conversion therapy..

Remarkably, the brief does not cite a single study on the safety or effectiveness of conversion therapy. The only original report cited on the topic describes the approach of controversial practitioner Ken Zucker—but presents no data on the results (Zucker, Wood, Singh, & Bradley, 2012). Indeed, the cited paper admits that "the treatment literature is lacking in terms of rigorous comparative evaluations."

More remarkable still, that lone report directly contradicts the brief's claim that transgender teens like Grimm should be blocked from transitioning, let alone subjected to conversion therapy. Even Zucker, one of the few remaining advocates of conversion therapy on gender-variant children, acknowledges that adolescents' gender identities are generally stable and unchangeable. In the cited article, Zucker and colleagues write that they "...take a very different approach when we work with adolescents...if the clinical consensus is that a particular adolescent is very much likely to persist down a pathway toward hormonal and sex-reassignment surgery, then our therapeutic approach...supports this pathway on the grounds that it will lead to a better psychosocial adaptation and quality of life" (Zucker et al., 2012).

In lieu of evidence that conversion therapy works, the brief relies on figures for how many children with gender dysphoria or nontraditional gender expression (such as masculine girls and feminine boys) no longer have these traits as they get older. What these studies—some of them decades old—tell us is that children who have distress about their gender, or in many cases have *parents* who are worried about their

gender, often do not grow up to be transgender. The studies do not claim to address whether conversion therapy or any other “treatment” affects these traits. To do so, research would need to consider differences between “treated” and “untreated” children in a randomized trial, or conduct an interrupted time series study, in which researchers look for changes based on when treatment began. Simply looking at the long-term outcomes of gender-variant children makes it impossible to distinguish any effects of “treatment” from natural developmental changes. Indeed, many of these studies combine children who received various “treatments” with children who received no conversion therapy at all.

Moreover, these studies tell us little about the much smaller set of children whom clinicians actually believe are transgender. Typically, they include very broad groups of children referred for gender concerns; at most, they are limited to those diagnosed with the older (“Gender Identity Disorder”) or newer (“Gender Dysphoria”) psychiatric diagnoses applied to these concerns. Neither of these diagnoses was designed to distinguish transgender from non-transgender children. They include children who are simply non-traditional in their expression and behaviors, as well as children who are uncertain about their gender identity. In contrast, clinicians consider a child likely to be transgender only when they are “insistent, consistent and persistent” about *being* (not simply *wishing they were* or *acting like*) a girl, boy, or some other gender identity. These signs have been established through both clinical experience and empirical research (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Hidalgo et al., 2013; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). The brief misrepresents this crucial difference, claiming that “all competent authorities agree that between 80 and 95 percent of children *who say that they are transgender* naturally come to accept their sex...by late adolescence” (emphasis added). In reality, a child’s self-assertion that they are transgender was not an inclusion criterion for any relevant study. There is no evidence for the claim that most children identified (whether by themselves, their families or clinicians) as transgender would grow up to be non-transgender adults.

Finally, the brief fails to acknowledge, let alone challenge, the professional consensus that conversion therapy leads to psychological harm for both transgender and non-transgender children. Because conversion therapy proponents are so focused on the gender identity, gender expression or sexual orientation of the “treated” children, they rarely report how those children fare psychologically. However, the available evidence is damning. A comprehensive 2009 review and report from the American Psychological Association identified more than 20 harmful outcomes of conversion therapy, including depression, shame, social withdrawal, decreased self-esteem, increased self-hatred, high-risk sexual behaviors and suicidality (American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Focusing specifically on children with gender dysphoria, one study compared psychological symptoms in children from Zucker’s clinic to those at an affirmative program in Washington, D.C., finding that the groups were equally gender-variant yet only the Zucker children had clinical levels of psychopathology (Hill, Menvielle, Sica, & Johnson, 2010). That study cautioned that the differences might be caused by something other than the treatment approach, but it adds to the evidence that children whose gender-related self-expression is discouraged are at high risk of mental health problems. In fact, not only has Zucker reported high levels of psychological difficulties in his own patients, the vignettes he offers about patients’ long-term trajectories suggest ongoing mental health difficulties in both transitioning and non-transitioning patients. These results are in stark contrast to the outcomes for affirmed children and youth, discussed in the following section.

Misinformation About Gender-Affirming Approaches

Although the brief uses the term “affirmance” to refer to gender transition—the social, and sometimes legal or medical, changes that a transgender person makes to reflect their gender identity—gender-affirming approaches are actually much broader. “Affirmative” or “affirming” treatment simply means helping a child explore their gender identity and other gender-related feelings, in a way that supports any gender outcome (Hidalgo et al., 2013). For transgender children, this can include gender transition; for

others, it may mean helping the child develop self-confidence about their masculine or feminine traits and cope with any bullying they may encounter. Research indicates that affirmative treatment may reduce gender-related distress for children who identify with their sex assigned at birth (non-transgender children) as well as for those who do not (transgender children) (Menvielle & Hill, 2010). It is important to understand that affirming care and gender transition are not synonymous. Affirming care can include social and medical gender transition for children and families who pursue it, but equally important are the clinician and family's positive attitude towards gender variance and their openness to a variety of outcomes, including but not limited to transition. These latter factors may be equally important to the child's trajectory, when compared to families and clinicians that permit children to transition yet stigmatize transgender identity or push children toward a specific outcome.

All available evidence indicates that children and adolescents who receive affirming care fare quite well, even when they begin treatment with high levels of psychological distress. Focusing specifically on transgender children (rather than their gender-variant counterparts), there are at least three major studies of mental health outcomes after affirming medical care, each finding mental health identical or near-identical to non-transgender peers:

- A 1997 study of 22 transgender youth who medically transitioned as teenagers found that they were functioning well socially and psychologically, and that none regretted their transition (Cohen-Kettenis and van Goozen, 1997).
- A 2014 study followed adolescents through social and medical gender transition into young adulthood, finding at follow-up that “gender dysphoria had resolved, psychological functioning had steadily improved, and well-being was comparable to same-age peers” (De Vries et al., 2014).
- In a 2015 study that also followed adolescents through transition, both affirmative psychological support and the use of puberty-delaying medication were associated with improved psychological functioning. Teens in that study who received puberty-delaying medication improved to levels indistinguishable from non-transgender, psychologically healthy peers (Costa et al., 2015).

In addition, there are at least two studies indicating that transgender children and teens do well when parents support and affirm their identities:

- In a 2012 study of transgender youth (ages 16 to 24), those with supportive families were 69 percent less likely to be depressed and 93 percent less likely to have attempted suicide in the past year (Travers, Bauer, Pyne, Bradley, Gale, & Papadimitriou, 2012).
- A 2016 study of socially affirmed transgender children 12 years and younger found that they were no different from non-transgender controls on depression symptoms, and had only marginally more anxiety symptoms (Olson, Durwood, DeMeules, & McLaughlin, 2016).

These studies show none of the dire outcomes the brief poses as consequences of gender transition. The reality of affirming care differs dramatically from the brief's dour predictions of “comparatively poor health outcomes” (20), lower life satisfaction (20), a lack of “social rehabilitation” (21), and an overall lack of benefits from transition.

The first and most important reason for the discrepancy is that none of these three handpicked studies was designed to determine whether gender transition improves transgender patients' mental or physical health. The “poor health outcomes” and “lower life satisfaction” studies simply compared post-transition adults to non-transgender adults. This tells us nothing about how transition affected the transgender adults. Rather, research indicates that transgender people—like other minority groups—are at risk for health problems to the extent that they face social stigma, discrimination, and violence (Bariola et al., 2015; Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Budge, Adelson, & Howard, 2013; Clements-Nolle, Marx, & Katz, 2006; Nuttbrock et al., 2010; Perez-Brumer, Hatzenbuehler, Oldenburg, & Bockting, 2015). These are harms in which discriminatory school practices, like the ones at stake in the

Grimm case, play a causal role. The brief thus misleads readers and the Court when it suggests that transition, rather than prejudice, causes health disparities. Indeed, it fails to mention that patients in the second study “reported anecdotally that their quality of life is better now than before [gender-confirming surgeries]” (Kuhn et al., 2009), while the authors of the first study called for “improved psychiatric and somatic care after sex reassignment” rather than questioning the value of gender transition (Dhejne et al., 2011). Of the studies cited, only the “social rehabilitation” study compared the well-being of transgender people who received medical transition services to those who did not. Evidently, according to the study text, “social rehabilitation” refers to job and education levels, residential stability, and “gender-appropriate cohabitation or marriage”¹ (Meyer & Reter, 1979). These are not the outcomes we would expect from gender-confirming surgeries, which are intended primarily to improve mental health—perhaps what is meant by the authors’ remark that patients found treatment “subjectively satisfying.”

Second, while a 2010 systematic review identified 28 studies of outcomes after gender transition (Murad et al., 2010), and additional research has since been conducted, the brief highlights research only on people who transitioned at least fourteen years ago—and as early as the 1960s. While long-term follow-up is valuable, both the quality of care and the social context have shifted dramatically over the past half-century. It is extremely misleading to focus exclusively on a previous generation of transgender adults in predicting the life courses of today’s transgender teens, especially when a great deal of newer data are available. Indeed, the 2010 systematic review found that gender transition that includes hormone therapy “likely improves gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life” (Murad et al., 2010).

Not only does the brief selectively highlight old data that suit its agenda, it focuses on outcomes for those who transition as adults, while the Grimm case concerns children and teens who transition. Considering the consistently positive outcomes observed in studies of young people who receive affirming care, age at transition may well predict better outcomes. Yet the brief acknowledges only one of several outcome studies on transgender children or adolescents, relegating it to a footnote—perhaps because its positive findings do not suit the authors’ goals.

Finally, the brief’s claims about the medical risks of gender transition are dubious. Like all medical interventions, treatments that can be part of gender transition have positive and negative effects; patients and clinicians weigh these risks and benefits when deciding how to proceed. We do not ostracize those who take oral contraceptives, for instance, just because they come with certain risks. Yet, when it comes to hormone therapy and surgery, the brief describes comparable effects in a confusing and inflammatory way. It states, for instance, that medications used to pause puberty “decrease bone accretion” and “prevent full organization and maturation of the brain.” Indeed: these are processes that take place during puberty, and that occur for transgender children once they either stop treatment or (more commonly) begin gender-affirming hormone therapy (Delemarre-van de Waal & Cohen-Kettenis, 2006; Vlot et al., 2017). We are not aware of any evidence that puberty-delaying drugs used according to protocol impair brain development, a claim not justified in the article the brief cites. Potential adverse effects of hormone therapy, such as elevated HDL cholesterol, are monitored as for non-transgender patients: with regular blood tests and in light of personal or family medical history. If problems arise, they are addressed as with any other patient, with familiar treatments like diet, exercise and statin drugs (Feldman & Deutsch, 2016). Finally, despite the brief’s implication that hormone therapy puts transgender women at risk for breast cancer, available research shows low rates comparable to those among non-transgender men (Feldman & Deutsch, 2016).

Silence on School Policy Research

As discussed earlier, stigma, discrimination and violence predict mental and physical health risks for

¹ Based on the outdated assumption that transgender women ought to partner with men, and vice versa.

transgender youth and adults. In fact, there is some evidence that the relationship between victimization and psychological distress is strongest for younger transgender people (Nuttbrock et al., 2010). Research has even shown that state-level policies predict better or worse health outcomes, suggesting that policies at various levels might either abet or prevent individual discrimination, or directly affect health and well-being (Perez-Brumer et al., 2015).

This area of research, conspicuously absent from the brief, is crucial for understanding the issues at stake in this case. Particularly relevant are two studies on the relationship between school facility policies and mental health. In one study, transgender people who were barred from gender-appropriate restrooms and housing during college were more likely to have attempted suicide, even after controlling for whether they were harassed on campus. The risk was 32 percent greater for those denied access to bathrooms, and 54 percent greater for those denied access to housing (Seelman, 2016). In a second study, transgender students who felt safe accessing school restrooms were more likely to feel safe at school overall, achieved better grades, and had higher self-esteem (Wernick, Kulick, & Chin, 2017). These experiences are very common: a 2015 survey found that 60 percent of transgender students had been required to use a school bathroom or locker room that didn't match their gender identity, and nearly 70 percent of transgender students avoided bathrooms and locker rooms because they felt unsafe or uncomfortable there (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016).

Though the brief presents no evidence of health disparities between affirmed transgender young people and their non-transgender counterparts, those disparities do exist for the transgender youth population as a whole—and this research suggests that they may be explained, in large part, by stigmatizing school policies like the one the brief defends.

Conclusion

Simply being a medical doctor or researcher does not make someone an authority on transgender children. In the United States alone, dozens of experts have dedicated their careers to the health of transgender children and adolescents, drawing on clinical experience and a growing body of evidence to guide children and families. In contrast, Paul McHugh and his coauthors boast a total of zero peer-reviewed research articles on transgender people of any age. It is not clear that they have so much as met a transgender child.

Neither do the brief's authors back their outdated, misleading and often false claims with references to legitimate research. Instead, they promote the thoroughly rejected practice of conversion therapy without citing a single study on its risks or so-called benefits—yet ignore or criticize actual research on the mental health benefits of affirming care. In another sign of their inexperience, McHugh and his coauthors gloss over the critical distinction between teenagers like Gavin Grimm and younger transgender children, unable to name a single gender identity expert who promotes conversion therapy for transgender teens. Finally, the authors completely ignore all studies on the Grimm case's actual subject: policies and practices that either affirm or stigmatize transgender students and community members. This research consistently supports the fact that stigmatizing anti-transgender policies, like the one Gavin endured at his school, very likely cause mental health problems and even suicide attempts. In contrast, transgender children and youth whose communities support them are far more likely to grow up safe, happy and healthy.

Unscientific claims by biased non-experts put transgender children and youth at risk. As the well-being of these young people is increasingly put up for legal and public debate, the Human Rights Campaign strongly encourages decisions based on research and clinical experience—and urges decision-makers to reject claims not backed by sound sources or relevant expertise.

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