Representatives Nosse, Goodwin, Nelson, Bowman, Conrad Dexter, Javadi, Morgan, Pham, and Tran,

I am a therapist with 10 years of clinical experience. I am also a woman who has had an abortion, and supports other women's right to choose. Fifteen years ago, in my own recovery, I began the WikiHow article "How to Recover From an Abortion[1]," which has since been edited by dozens of contributors and viewed tens of thousands of times. I have counseled others with respect for their choices as they faced difficult decisions to keep or terminate pregnancies, and I have been with them every step of the way.

I was also once a troubled adolescent who became sexually active at a young age, and got taken advantage of by older men who did not have my best interest at heart. I have provided counseling to adolescent girls who have been sexually abused and exploited, and to adult women who suffered similar experiences in their youth.

I have counseled people who have considered, received, and had major health issues following various forms of "gender affirming healthcare."

I support a woman's right to choose, and after having studied HB 2002, I urge you to vote NO on this bill.

I urge you to follow the money and consider about who stands to benefit from this legislation. When I read it, I do not see any vulnerable people that stand to benefit. Rather, I see three profiteers: child sex traffickers, and others involved in the sexual exploitation of vulnerable young people; Big Pharma; and the fertility industry.

HB 2002 seems to rely on three dangerous and unfounded presuppositions, which I will address one by one.

Dangerous and unfounded presupposition #1:
If a girl under the age of 15 is sexually active, and doesn't want her parents to know, it is truly better for her parents not to know.

Based on lived experience, professional experience, and depth study of human development, I cannot support this idea. I have never met a woman that had sex prior to the age of 15 and did not deeply regret it, or was not at least left deeply confused as to what she truly wanted, and what the other person's motives were. Have *you* ever met a woman that had sex at age 12, or 13, or 14, in the context of a safe and loving relationship, and was in no way harmed, physically or psychologically, by the experience?

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[1] https://www.wikihow.com/Recover-from-an-Abortion

When I was 14 years old, I was groomed and molested by a 31-year-old man. He was the cool guy who worked at the place where I took guitar lessons and showed me all his punk rock paraphernalia.

I thought I was in love, and I was naive enough to believe he truly loved me. Little did I know, he was a heroin addict and a pedophile who was cheating on his girlfriend. Did I mention I was 14 and he was 31?

At 14, I wouldn't have wanted my mother to know. If asked, I would have told anyone, "my mother would kill me!" My mother would not, in fact, have killed me. Hyperbole is the language of adolescence. My mother would have been extremely upset, and rightly so. Looking back, although I would have been humiliated and likely been punished in some way as well, my life absolutely would have been better off had my mother had found out exactly what was happening. Perhaps I would have finally gotten the help I so clearly needed. Perhaps justice would have been served, and he would have been prevented from going on to do the same to other girls, which — given his position as the cool punk rock guitar teacher at the music center down the street from the high school — he certainly must have done.

Sometimes it seems it's even worse for today's girls. Children are exposed to exponentially more pornography than they were even two decades ago when I was a teen, and at younger ages, and the nature of that pornography is more violent, twisted, and deranged than ever before. It's sad but not surprising that a quarter of 17-year-old women have been choked[2]. Indeed, I have heard stories in my counseling practice of young women being choked on the first date, or at the first kiss — destroying their self-esteem, sense of romance, safety, and vision for long term relational happiness. Another rampant problem facing today's teen girls occurs when perpetrators groom victims into sharing nudes, or pressure them into being filmed during sexual acts (or film them unwittingly). These materials then become collateral that can be used to effectively hold girls hostage and pressure them into enduring all sorts of other humiliating abuses.

Oregon is already a hotbed for child sex trafficking. Do we really want to make it even easier for these criminals to cover their tracks?

The abuse I suffered at the age of 14 fortunately did not lead to an unwanted pregnancy. But let's imagine for a moment what life might be like for the thousands of girls who do find themselves in this position.

Who brings them to the clinic?
Who pays for any associated costs?

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[2] https://link.springer.com/article/10.1007/s10508-022-02347-y
https://academic.oup.com/jsm/article-abstract/18/6/1024/6956008?redirectedFrom=fulltext&login=false

Who hides the evidence?

If you have been considering voting yes on this bill — do you think these girls, seeking contraceptives and abortions at ages 14 or 13 or 12, have safe, caring, loving boyfriends? Do you assume these boyfriends are healthier people for them to be attached to than their own parents are?

If so, what is your evidence base for those beliefs? And how does a girl with abusive parents end up with such a wonderful boyfriend? If a girl really came from such a damaged family that we couldn't trust her parents not to harm her if they found out she were sexually active, wouldn't we expect to see her manifest this dysfunction by choosing unsafe, exploitative partners who cared for her even less? Isn't that (sadly) how things tend to go?

I think it's far more likely that the people driving these girls to these appointments are perpetrators of child sex trafficking, or otherwise up to no good. Looking at the data on sexual trends among youth (eg, studies like this one by Herbenik et al[3]) would sadly seem to support my concerns.

These laws help predators cover their tracks, while keeping crucial knowledge about girls' wellbeing away from the adults in their lives who are *far more likely* to love, care for, and want to protect them: their parents.

I support a woman's right to choose. But I do not trust an adolescent girl's judgment on whether she is prepared to have sex, with whom, how her parents might react, whether these reactions are justified, and what kind of parental reaction or involvement is ultimately best for her long term welfare.

Dangerous and unfounded presupposition #2:
Barring exceptional circumstances, most people over the age of 15 are capable of consenting to voluntary sterilization with little likelihood of regret or complication.

Again: where is the evidence base?

This bill implies that barring various vaguely-specified exceptions, people over 15 are generally capable of consenting to sterilization. *What?*

Before proceeding with a "yes" vote on this bill, I implore you to look at the literature, or look at your own life and the lives of people you know, and point to the evidence base that suggests

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[3] https://academic.oup.com/jsm/article-abstract/18/6/1024/6956008?redirectedFrom=fulltext&login=false

that what a person imagines for his or her reproductive future at age 16, or 20, or even 29, has a robust predictive capacity for the decisions he or she will ultimately want to make.

Put more plainly, allow me to state the obvious: we have *all* known people, or *been* people, who swore up and down they did not want children, right up until the point where suddenly they did. There is no evidence to suggest that this has somehow suddenly, fundamentally changed in recent years.

I say this as someone who has always leaned toward not wanting my own biological children, and whose position on that has remained fairly steady (though not without its ups and downs). And I say this as the partner of someone who got a vasectomy after having had his two children. My position on this matter is not extreme; I have little in common with my Catholic grandmother, who had five children and probably never touched a contraceptive. Yes, some of us do know early that we don't want children, and maintain that position; but many others will change in ways they could never have predicted. And yes, some individuals and families do benefit from sterilizing procedures, albeit usually later in life and often only after having had the number of children they feel comfortable supporting. But *of course* there need to be boundaries and safeguards in place around any life-altering, irreversible medical decision. And there is simply no precedent nor evidence base for making lifelong infertility an easy, accessible, affordable option for so many people, so early in life.

Indeed, infertility itself is a health risk. I have counseled grieving mothers of stillborn babies, and women who could not conceive though they desperately wanted a family. The depression they face is difficult to describe, and places such patients at higher risk of suicide. It is well established in the literature on suicide that responsibility to loved ones is among the greatest protective factors.

Furthermore, it is well established that people change far more during the course of their 20's than they would predict at the beginning of that decade[4].

There is simply no justification, whether scientific or philosophical, for the idea of sterilizing young people.

And I've barely touched on the health risks of early sterilization, but it's not insignificant that sterilizing procedures that remove hormone-producing gonads, such as hysterectomy and orchiectomy, increase the likelihood of early dementia[5]. Hormones play many important roles throughout the body, and removing the body's ability to naturally produce hormones creates a

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[4] Source: *The Defining Decade: Why your Twenties matter — and how to make the most of them now*, by Meg Jay

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3702015/
https://oncology.medicinematters.com/androgen-deprivation-therapy/prostate-cancer/gnrh-agonists--orchiectomy-linked-to-increased-risk-for-non-alzh/16426728

cascade of problems for all systems of the body, extending beyond the scope of what I am able to write for you today.

But the sterilization clauses in this bill are *saying the quiet part out loud*. Let's be real: for every individual under 30 seeking a vasectomy or hysterectomy for the sole purpose of permanently preventing conception, a great many more are seeking "gender-affirming care," which results in lifelong sterility as a secondary or tertiary effect. Which brings us to this bill's dangerous presupposition #3:

Dangerous and unfounded presupposition #3:
So-called "gender affirming care" is safe, effective, and medically necessary.

I have given you this testimony before (when discussing HB 2458) and I will repeat it as many times as I have to:

There is no consensus in the medical or mental health field that so-called "gender affirming care" is safe, effective, or medically necessary.

This is the biggest lie of our times, it is destroying the lives of countless people, and just because it is being perpetuated by people in positions of power, such as Rachel Levine, does not make it true.

Indeed, you will hear more testimony against HB 2002 from my colleague Julia Mason, MD, who can attest to the internal controversy within the field of pediatric medicine. If I recall her story correctly, although a demand for a systematic review of the evidence supporting "gender affirming care" made it into the top 5 most popular threads within the American Academy of Pediatrics' online community in 2021, this thread and the discussion it called for were silenced by the AAP.

I implore you to listen to Dr. Mason's experiences, as well as the stories of 6 detransitioners who were harmed by "gender affirming care," and perspectives from a dozen other experts (including myself), in our film, *Affirmation Generation*. You can watch this film for free online by visiting our website at affirmationgenerationmovie.com and clicking on the Vimeo link, or go directly to https://vimeo.com/800032857.

Every day, I hear from more and more concerned therapists that are witnessing the madness in the rush to "affirm," and worried for the fallout. This is not a left vs right, gay vs straight, or atheist vs Christian issue. I hear from therapists all around the country, and even the world; from all over the political spectrum; gay and straight alike. I have heard from a liberal lesbian Oregonian therapist whose heart was touched by the stories of detransitioned clients; an elderly British psychoanalyst who first began seeing patients with tremendous regret about these life-altering procedures back in the early 90's; and so many people in between.

Even members of the trans community are sounding the alarm. I recently heard from a 70 year old trans woman by the name of Sarah Jane who is a long time personal friend of Representative Nosse. Sarah is as aghast as the rest of my community about the 4,000% increase in adolescent girls presenting to gender clinics in the past decade. Sarah and I discussed this bill on my YouTube channel. Please listen to our conversation here: https://www.youtube.com/watch?v=vOqAtDDUf9M&t=100s

Now, proponents of this bill might argue that there are safeguards in place. After all, the language in this bill does specify that the care must be deemed "medically necessary" by a medical or behavioral health care provider. Surely that means we can trust their judgment, right?

Not so fast.

Amongst many who have not been following this issue closely, there is a widespread misunderstanding that those who provide "gender affirming care" follow a regimented screening, assessment, and counseling process to ensure that only people who are "truly trans" (a highly contested and poorly defined phrase), or are truly "likely to benefit benefit," or have no co-morbidities that could render this type of "treatment" contraindicated, will go on to complete the process.

If that's you, may I present to you Exhibit A: *The Gender Affirmative Letter Access Project*[6]. This is only one of many such resources led by providers who believe, as the title of this article cited as a resource by the GALAP claims, "Gatekeeping hormone replacement therapy for transgender patients is dehumanizing."[7]

In our documentary, *Affirmation Generation*, Dr. Julia Mason shared her observation that every time she referred a child to a gender clinic for further evaluation of their gender-related concerns, the clinic "affirmed" the child and proceeded to recommend medicalization. This has been my observation as well, and that of thousands of other pediatricians and therapists.

If you listen to the stories of detransitioners, such as those featured in our film, the overwhelming experience is that they were immediately "affirmed" by medical providers and therapists, while their comorbidities were either ignored, overlooked, downplayed, or framed as secondary to their gender dysphoria, on the dangerous and unfounded assumption that jumping to medicalizing the dysphoria would somehow miraculously resolve their underlying

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[6] https://thegalap.org/

[7] https://www.florenceashley.com/uploads/1/2/4/4/124439164/jme_gatekeeping_and_hormone_replacement_therapy_revised_online.pdf?fbclid=IwAR2fbUYMlDbgW8kV73bTfPbrWMut5TR_a-heXFVhIzbgn9gt9LdBXWod-QM

issues. In the words of Abel Garcia, “she told me she did not want me to gate-keep me on anything, and she had my letter to transition right away.”

I don’t just *suspect* this is the policy, based on other people’s anecdotes. I *know* it to be the new “standard of care” being taught to therapists and imposed on clinics, because I’ve been to the trainings where it was taught. I practiced this way for years, in good faith, from 2016 to 2020, as my concerns that this might not be the best way to help people secretly mounted. I finally reached the point where I decided I had to change course and learn more in 2020, when I came across the stories of detransitioners. Ever since then, I have been studying, befriending, learning from, amplifying, and counseling detransitioners.

So there is a circular logic to this bill. On the one hand, the bill states that medical or behavioral health professionals must endorse “gender affirming care” as “medically necessary” for a patient in order for insurance to be required to cover it. On the other hand, an important fact is left un-stated:

We now have a large cohort of medical and behavioral health professionals who are deeply bought into the following ideas:
-anyone who says they are trans, must be trans;
-this is something only an individual can know about themself, and it should always be honored;
-it’s transphobic to assume that identifying as trans could be a phase, or attributable to trauma, social influence, or untreated mental health conditions;
-such patients will benefit from “gender affirming care,” and are unlikely to regret it;
-such patients should always be affirmed, not questioned, by their healthcare providers;
-any questioning on the part of a healthcare provider, evaluation for other reasons for gender dysphoria, or proposal of treatments besides affirmation and transition, are “conversion therapy;”
-and the role of the professional should be to rubber-stamp, reduce barriers, and ease access to these life-altering procedures, not “gate-keep.”

In practice, this means that the proposed legislation, as currently worded, sets up a system in which providers who share these beliefs, which are abundant in Oregon, will happily usher anyone through this irreversible process of social affirmation and medical transition, without any safeguards in place.

Again, there is no evidence base to support these assumptions. Let’s take them one at a time:

-anyone who says they are trans must be trans

This first claim falls flat on its face. How does it account for detransitioners and desisters? People will say to them, “you were never really trans.” What an ostentatious claim to make. Detransitioners believed they were trans so ardently that they made life-altering decisions.

Furthermore, those two statements cannot be true at the same time. We cannot both live in a world in which anyone who says they are trans, is trans; and a world in which those who believed they were trans, but then changed their minds, never really were trans.

-this is something only an individual can know about themself, and it should always be honored

Today's treatment of gender issues conflates matters of identity with matters of healthcare — a combination that obscures clear reasoning. In this case, the logic goes that an individual's inner sense of identity ought not be debated. While there are interesting philosophical, ethical, and psychological debates to be had over that concept, the implication doesn't stop there when we conflate identity with healthcare, because what proceeds from that is that, based on this subjective sense of identity, a certain *diagnosis and treatment* should be provided. Therefore, according to this logic, the individual's subjective sense of identity should determine not only how they are viewed and treated socially, but also how their healthcare providers should treat them.

But this is not how healthcare providers treat other conditions. We do not allow our patients to self-diagnose and we certainly do not base treatment decisions off of their self-diagnoses. If a patient wants antibiotics for a viral condition, or bariatric surgery though she's anorexic, or an inpatient mental health hospitalization for mere anxiety in the absence of psychosis or suicidal ideation, her doctor not only *may* decline based on his professional judgment, but is actually morally and legally obliged to do so, no matter how much this disappoints or angers the patient. Failure to do so would constitute malpractice.

-it's transphobic to assume that identifying as trans could be a phase, or attributable to trauma, social influence, or untreated mental health conditions

Whether or not anything is "transphobic" does not concern me because I have been called that slur hundreds of times in response to my efforts to protect vulnerable people from making irreversible decisions that place them at high risk of regret, chronic pain, disability, infertility, sexual dysfunction, depression, PTSD, and suicide. I do not care what names people call me in an effort to discredit and intimidate me. But I understand this word still has influence over some people.

Nonetheless, we have abundant evidence that identifying as trans is absolutely a phase for some people, and can in many cases be attributable to trauma, social influence, or untreated mental health conditions. I could write an entire book just on this statement alone, but let's start with the fact that gender dysphoria has a natural desistance rate of 80-90% if left untreated (medically). In other words, *it is a phase.* I am of the bafflingly controversial opinion that that's a good thing. Why? Because it means that in the majority of cases, the discomfort

young people feel with their "gender incongruence" will fade away as they enter adulthood, find their place in society, and come to terms with their sexuality, and these individuals can go on to live happy, healthy lives without requiring ongoing medical assistance with their "gender." Many will grow up to be gay or lesbian, while others will go on to have their own biological children. Big Pharma and Big Fertility need not get involved with these individuals' independent lives.

For others, it is clearly socially mediated. Please watch our film to hear directly from physician and researcher Lisa Littman, regarding her findings on Rapid Onset Gender Dysphoria. Activists will try to discredit the notion of ROGD, and attribute the 40x increase in adolescent females seeking medical transition to nothing more than increased societal acceptance of trans people. But as a representative of the people of our state, I hope you will do better by the us than to allow your curiosity, attention, and research to be directed by one very loud special interest group that wishes to silence debate over a complex issue with a single, overly simplistic narrative.

And gender dysphoria can absolutely be a symptom of untreated, underlying conditions. We know it is over-represented in those with autism, complex trauma, a history of adoption or foster care, internalized homophobia, sexual abuse, body dysmorphia, OCD, and eating disorders. Many detransitioners will attest to this, and as a therapist it is not difficult for me to explain the psychological mechanisms by which a person can develop the habit of fixating on a single explanation (eg. "my gender dysphoria") for a complex issue (why I feel so bad), especially when that one explanation gives them a direction to move toward that they believe will provide them relief (in this case, affirmation and medicalization).

-such patients will benefit from "gender affirming care," and are unlikely to regret it

Proponents of this belief frequently downplay the rate of detransition, when much is unknown but the evidence we do have suggest it is much higher than they'd like to believe.

We actually have no way of predicting the long term outcomes for a given patient. If we did, we would not be in this mess. By all means, ask the most adamantly pro-trans person you know how they would go about predicting whether a given trans-identified young person is likely to be happy long term post-transition, or whether they might regret it or detransition. No one has an answer to this question.

What we do know about the rate of detransition includes the fact that only a quarter of the 100 detransitioners Lisa Littman surveyed in 2021 even told their former medical providers that they had discontinued care[8]. And in 2022, Roberts et al found that after 4 years, only 70% of patients

[8] https://pubmed.ncbi.nlm.nih.gov/34665380/

prescribed a "gender affirming" hormone regimen were still taking those hormones.[9] A study of gender dysphoric children which began when the children were between the ages of 5-12 and followed up when they were 16-28 found that gender dysphoria did not persist in the majority of cases, but that it was more likely to persist in those who turned out to be same-sex attracted, suggesting that societal gender norms and internalized homophobia play a role in persistence of gender dysphoria[10].

Combine these data points with the exponential rise in gender transition, at earlier and earlier ages, with fewer and fewer checks and balances, and it's fair to assume that the rates of detransition and regret are going to be much, much higher than any trans rights activists would like you to believe.

-such patients should always be affirmed, not questioned, by their healthcare providers;
-any questioning on the part of a healthcare provider, evaluation for other reasons for gender dysphoria, or proposal of treatments besides affirmation and transition, are "conversion therapy"

I have heard far too many stories now of patients who went to therapists asking whether there might be any other reasons for their gender dysphoria besides "being trans," or any other treatment pathways besides social affirmation and medical transition, and were met with the response that to explore that question would constitute "conversion therapy." No other pathways were available to them besides "gender affirming therapy" that led them down an irreversible medical pathway they now suffer consequences of daily. This is a massive dereliction of duty, and it has created tragedies that would have been avoidable.

Of course there are many reasons that a person may have come to the conclusion that they are trans, or have gender dysphoria, as the best way they presently have of conceptualizing their distress. *Of course* non-invasive treatment modalities should be explored before those that have lifelong consequences and create permanent dependence on Big Pharma and Big Fertility. But these modalities are not available so long as the contested phrase "sexual orientation and gender identity change efforts" is conflated with "conversion therapy" and both are made illegal, as I have testified about before.

In case I did not make this clear enough in my testimony against OR HB 2458, "gender identity change efforts" is a murky and poorly defined term. While I understand laws like those were not *intended* to prohibit exploration, I implore you to listen to my feedback, as someone with boots-on-the-ground, lived experience counseling families, about the *impact* of such unclear legislation. Please take this to heart:

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[9] https://pubmed.ncbi.nlm.nih.gov/35452119/

[10] https://pubmed.ncbi.nlm.nih.gov/18981931/

Therapists are agreeable, conscientious people who have oftentimes gotten ourselves into tens if not hundreds of thousands of dollars worth of debt in order to get our graduate degrees, after which we worked thousands of unpaid or poorly-paid internship/trainee hours before finally obtaining our licenses. We love our careers and have built our lives, identities, reputations, financial security, and family decisions based on those hard-earned licenses. Our graduate instructors and postgraduate supervisors put the fear of God into us with regard to how devastating it would be to face threats against our licenses. In general, most therapists have two greatest fears: one, that a patient of ours will complete suicide; and two, that we will face a threat to our license.

So as it turns out, laws banning "gender identity change efforts" are enough to frighten most therapists not only out of *actually* "efforting to change" someone's gender identity, but also out of *anything that could be construed as such,* for fear that it would be alleged. And if we are afraid to risk the faintest allegation of "gender identity change efforts," what this means in practice is that we are afraid to question our patients' narratives of what it means to be trans; to disagree with their self-diagnosis of gender dysphoria, or to propose treatment alternatives to gender dysphoria besides those our patients may already be determined to pursue, no matter how excessive, invasive, costly, extreme, or developmentally inappropriate those treatments may strike us; to use our patients' birth names and biology based pronouns; or to suggest that non-invasive treatment of underlying mental health issues, or exploration of root causes of gender dysphoria, would be a preferable option.

This is why I, sadly, can no longer work with adolescent girls — a population dear to my heart, for which I was once quite well suited. Many troubled adolescent girls now present with the belief that they are boys, or some other gender identity. If such a girl were to present herself to me, I would be unable to practice the most basic principles of Person-Centered Therapy[11], which require that I, the therapist, be *genuine* toward my client. I cannot genuinely, in good faith, collude with my naive young patient's self-diagnosis and tell her I see her as a boy, because I do not. I see her as a girl, and no matter how boyishly she dresses, I see what she has in common with innumerable girls who've been coming to therapy for decades before her: she is struggling to accept her developing body, grappling with unwanted sexual attention, and looking for a way to fit in with her peers. In today's climate, *that* girl, with those normal struggles of teenage girlhood, believes she is trans.

-and the role of the professional should be to rubber-stamp, reduce barriers, and ease access to these life-altering procedures, not "gate-keep."

Again, this is not how we conceive of the role of the therapist or medical professional when it comes to any other issue. Our role is absolutely to gate-keep, if you must call it that. We have a professional duty of care to use our clinical skills to evaluate the patient's condition and suggest

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[11] https://www.goodtherapy.org/learn-about-therapy/types/person-centered

minimally invasive, medically necessary treatments. Right now our field is starkly divided between those who believe these life-altering, sterilizing, and oftentimes in practice debilitating (yes, major disability inducing) “treatments” are medically necessary for any patient that *wants* them, and those of us who object to such ludicrous notions.

HB 2002 proposes that people as young as 15, fully ten years prior to the completion of normal brain development at age 25, can be permanently sterilized through “gender affirming care” that lacks an evidence base and is correlated with a 19x increase in risk of suicide[12]. It further proposes that medical insurance plans should cover these “treatments” and deliberately disregard the cosmetic nature of procedures such as electrolysis, tracheal shave, and facial surgeries.

I know detransitioned women who cannot get insurance coverage to help undo the damaging effects of the “gender affirming care” they received at little to no cost in the past. I know women who shave their unwanted facial hair multiple times a day while struggling to save up for electrolysis out of pocket. I know women who live with constant throat pain, who have lost their singing voices, who cannot get coverage or even treatment recommendations to help with this, and who have no money for vocal training to try to help regain some of the femininity they regret losing from their voices. I know women asking their friends to help crowdfund the money for “reconstruction” of the breasts they have lost (spoiler alert and sad truth: actual breasts lost to elective double mastectomies cannot be reconstructed, as mammary glands have been lost forever; only cosmetic facsimiles of them can).

How is this an acceptable situation to put vulnerable people in? How can anyone with a conscience proceed with the idea that we should fund cosmetic procedures as a treatment for gender dysphoria as though they are “medically necessary,” while functionally disincentivizing therapists from providing any non-invasive options to resolve psychological distress in gender dysphoric patients, while dismissing and denying and refusing to help with the experiences of the exponentially growing population of people who feel they have been harmed by this approach?

With Sweden, Finland, and the UK all changing their approach[13] and different states passing legislation for and against “gender affirming care” at whiplash-inducing speed, now is not the time to increase ease of access.

Please, let’s work together on a saner approach. Vote no on HB 2002.

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[12] https://www.researchgate.net/publication/291340368_Gender_Dysphoria_in_Adults, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885

[13] https://www.city-journal.org/yes-europe-is-restricting-gender-affirming-care