IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

BRIANNA BOE, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
UNITED STATES OF AMERICA,	)	
	)	
Intervenor Plaintiff,	)	
	)	
v.	)	Civil Action No. 2:22-cv-184-LCB
	)	
HON. STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama, *et al.*,	)	
	)	
Defendants.	)	

SUPPLEMENTAL EXPERT REPORT OF
JAMES CANTOR, PH.D.

Table of Contents

1. I have previously submitted my report, dated May 19, 2023, as an expert witness in this case ("Cantor Report"). Since that time, substantial additional materials have become available pertinent to my testimony in this case. This supplemental report contains my assessments of these additional materials as they relate to the opinions that I have previously rendered in this case. My updated *curriculum vitae* is provided as Appendix C to this report.

2. These materials include internal documents provided by WPATH under subpoena, which remain under a protective order of the court, and which I discuss in my separate Appendix A. In addition to the WPATH documents, I have reviewed other recently-published materials that are directly relevant to my previously rendered opinions including: new peer-reviewed studies published in the research literature, systematic reviews updating the contents of the scientific literature, and the policy changes and conclusions increasingly offered by international authorities and recognized topic experts.

I. New research, employing methods superior to prior investigations, reports that transition failed to improve mental health indicators.

3. In my previous report, I offered analysis and opinions on the body of research looking at the impact of social transition on desistance (Cantor Report, Section IX.B.) and on suicide and suicidality, particularly in the context of gender dysphoria (Cantor Report, Section X.). Important peer-reviewed publications since the date of my prior report further confirm my conclusions.

A. Morandini et al. (2023): Social transition is not associated with improvement in mental health.

4. Until recently, studies of the social transition of minors used only subjective descriptions of their mental health—either the self-reports of the socially transitioning youth or reports from their parents. Often, these studies relied not merely on self-reports, but on self-

reported retrospective memory—that is, subjects' recollections of how they felt at prior times. Those studies yielded contradictory results: Some reported social transition to be associated with improved mental health and well-being (e.g., Kuvalanka et al. 2017; Olson et al. 2016), and others reported a lack of improvement (e.g., Sievert et al. 2021; Wong et al. 2019).

5. The first study of the mental health impact of social transition based on objective and contemporaneous assessments conducted by professionals has now been published in the peer-reviewed literature: Morandini et al. (2023) is a study by a team of co-authors including one from the gender dysphoria clinic at Vrije University, Amsterdam (a widely recognized source of the most-cited literature in *support* of medical transition of minors). The authors examined "whether children and adolescents diagnosed with gender dysphoria who socially transitioned showed fewer psychological difficulties than those (also with gender dysphoria) who were still living in their birth-assigned gender." (Morandini et al. 2023 at 1052.)

6. The study improves on prior studies in multiple aspects, including the use of objective and comprehensive mental health assessments conducted by professional clinicians instead of only subjective self-reports; having a larger sample for analysis; conducting separate analyses for: i) the prepubescent versus adolescent age youth, ii) the male-to-female versus female-to-male transitioners, and iii) living status (biological sex or adopted gender) versus the names used (birth name versus new name). Ultimately, the analyses identified no significant differences in any of the mental health indicators (mood disorders, anxiety disorders, or suicide attempts).[1]

7. The researchers concluded that, for children and adolescents diagnosed with gender dysphoria:

[1] The study noted a single potential exception among the 12 analyses conducted, suggesting the possibility that, among the male-to-female transitioners, when social transition was defined as living status, the frequency of mood disorders might have been lower. Subsequent analysis, however, suggested that to be a statistically spurious finding, "as more sensitive analyses that treated age as a continuous rather than as a categorical variable, failed to support that finding." (Morandini et al. 2023 at 1053.)

> Overall, there were no significant effects of social transition or name change on mental health status. (Abstract.)
>
> Living in role and birth-assigned gender were not associated with mood, anxiety, or suicide attempts. (at 1052.)
>
> The present findings, although preliminary, suggest that social gender transition is not associated with mental health status in children and adolescents, at least in the short term. These findings are consistent with the only other study that directly compared clinic-referred youth experiencing gender dysphoria who had socially transitioned with those who had not. (at 1058.)

8. In the report of their results, the researchers also warned against over-interpreting or over-simplifying their findings. Although their study represents an improvement on prior studies analyzing social transition, I agree with these researchers' reminder that cross-sectional evidence such as theirs can be superseded in the future by studies using still superior methods, such as randomized, controlled trials (RCTs), as explained in my initial report. (Cantor Report, Section III.C.)

B. Glintborg et al. (2023) and Kaltiala (2023): Two large and relatively high quality studies find no mental health benefit from medicalized transition.

9. In my prior report, I provided analysis on the then-existing cohort studies examining medicalized transition. (Cantor Report, Section XIII.) Since then, two new large and important studies have been published, one out of Denmark (Glintborg et al. 2023), and the other out of Finland (Kaltiala et al. 2023).

10. Each of these studies examined the medical and mental health records of *all* patients within their respective countries who were diagnosed with Gender Identity Disorder (Denmark) or referred to the centralized national gender identity clinics (Finland) across a large number of years (3812 patients across 21 years in Denmark, in Glintborg et al., and 3665 patients across 28 years in Finland in Kaltiala et al.). This method avoided the severe limitations caused by selection bias, as well as the small samples sizes of many studies in this field.

11. Both studies measured mental health of subjects and controls across time based on clinical records. Because of the centralized administration of the Danish and Finnish public healthcare systems, the researchers had a relatively complete medical database available for analysis. This method avoided the limitations associated with self-reports and memory that I have detailed in my prior report (Cantor Report, Section IV.).

12. In both studies, before beginning medicalized transition (with cross-sex hormones) people diagnosed with or referred for gender dysphoria exhibited extremely elevated levels of other mental health issues, consistent with prior studies. Overall, Glintborg et al. found that "[Metrics of poor mental health] were stable after initiation of gender-affirming hormone treatment, without sign of decrease after date of first prescription of gender-affirming hormone." (at 342:2.) Kaltiala et al. similarly found that "the proportion requiring specialist-level psychiatric treatment actually increased more among those who underwent medical GR [gender reassignment]" as compared to otherwise comparable patients who did not, and reported that their "findings . . . do not suggest that medical GR interventions resolve psychiatric morbidity among people experiencing gender distress." (at 6:1.)

13. In Glintborg et al., analyses of the rates of psychiatric diagnoses before versus after medicalized transition revealed: At year one, post-transition rates of psychiatric illness greatly increased beyond their already elevated levels, relative to the non-transsexual control groups. By year five, psychiatric illness rates remained highly elevated, but approximating the level of elevation from before medicalized transition, relative to the control groups. Analyses of the rates of psychiatric medication use found that the gender dysphoric subjects exhibited greater use of psychiatric medication before transition relative to controls, and that this higher reliance on psychiatric medication had increased further one year after transition, and further still by year

five.

14. In Glintborg et al., the people undergoing medicalized transition were age 15 and older (1,142 people under age 18, and 2,670 people age 18 or older). The researchers noted that they conducted their analysis both with and without people under 18, and they found the results not to differ.

15. Consistent with the conclusions in my prior report, these data demonstrated that (1) people with gender dysphoria have extremely elevated rates of other mental health issues, (2) medicalized transition is not followed by improvement in mental health, and (3) in the year after transition, mental health *worsened.* Glintborg et al. noted the possibility that undergoing the mental health assessments required before medicalized transition is what caused the apparent increase in rates of psychiatric illnesses recorded. They did not, however, include the alternative possibility that the increase followed from transitioners' realization that the interventions were not resolving their mental health issues and that the subsequent improvements (when observed at all) followed from the increased use of psychiatric medication they were also receiving to address the psychiatric issues directly.[2]

C. McGregor et al. (in press) compared gender dysphoric youth who did versus did not receive puberty-blockers, but extensive differences between the samples confounded the results.

16. McGregor et al. (in press), a currently in-press article, purports to show that medicalized transition is associated with better mental health scores, contrary to my conclusions in my prior report. The study identified itself, correctly, as a "retrospective cohort" study. *Retrospective* cohort studies are faster and less expensive to conduct than *prospective* cohort

[2] I also observe a continuing drumbeat of anecdotal reports by detransitioners that medicalized transition did not improve their preexisting mental health problems. See, e.g. the several detransitioners' narratives reported in Pamela Paul, *As kids, they thought they were trans. They no longer do.*, New York Times, February 2, 2022.

studies, but provide less conclusive and more ambiguous results. Prospective studies identify a sample and follow them up again later to analyze what features changed among the participants, whereas retrospective studies select the participants at the end point and then go back to examine hospital or other records to explore what features differed at the beginning.

17. The McGregor study was conducted at the Gender Multispecialty Service (GeMS) program of Boston Children's Hospital. As noted in the study, the GeMS program assesses the mental health of children twice: once, prior to approving them for puberty-blocking medication, and a second time, prior to approving them for cross-sex hormone treatment. Also as noted in the study, adolescents already too old for puberty-blocking medication (i.e., past Tanner Stage 3) receive only the latter assessment.

18. Unfortunately, the analysis conducted and reported by the McGregor team was so flawed as to be meaningless: They compared the 40 children who sought and received puberty-blockers and are now seeking cross-sex hormone treatment (i.e., children who were assessed *and passed* the mental health screening) with the roughly 400 adolescents seeking cross-sex hormones who had not yet been screened for mental health at all. As a result, one cannot validly conclude that the greater mental health scores of the children receiving puberty-blockers were caused by the puberty-blockers. This retrospective study has no means of ruling out the much more logical conclusion that the children who received puberty-blockers only seem mentally healthier because the less healthy ones had already been screened out of that set.

19. Another fatal error of McGregor et al. is that they compared *childhood-onset* gender dysphoria with *adolescent-onset* gender dysphoria. As noted in my prior report, these represent distinct patient populations with distinct features, which McGregor neglected to discuss despite reporting the same distinctions. (Cantor Report, Section IX.C.) As summarized by the

McGregor authors:

> These two groups were significantly different across all assessed demographic domains. The blocker population was significantly younger, more likely to be assigned male at birth, more likely to affirm a female gender, and more likely to identify as white. (McGregor et al. (in press) at 3.)

A comparison across two groups that already differ in so many potentially important ways is necessarily uninformative: As the authors correctly emphasized about their own results, "causation [of the differences in mental health between the two groups] cannot and should not be assumed." (at 5.) Indeed, the authors reported that once they controlled for age, the correlation they report between receiving puberty blockers and lower levels of suicidal thoughts *disappeared* (at 6.). In sum, that the older ROGD group showed poorer mental health than the childhood-onset group is consistent with the ROGD hypothesis presented in my prior report: for at least many cases, ROGD represents an outcome mental health vulnerability.

20. I note that the McGregor et al. authors agree with a critical risk of harm detailed in my initial report—that puberty blockers alone may permanently sterilize a child, stating that "blockade impairs hormone-driven development of the ovaries or testes, and this may substantially reduce *or eliminate* future fertility potential in the absence of experimental options" (at 5, emphasis added.). The reference to "experimental options" is an oblique way of admitting that reliable restoration of fertility after prolonged puberty blockade has not been demonstrated.

D. Thompson et al. (2023): A new systematic review confirms the absence of reliable evidence that medical transition is a safe and beneficial treatment for gender dysphoric adolescents.

21. As indicated in my prior report, *systematic review* is the process employed by Evidence-Based Medicine to prevent the cherry-picking of studies favoring one side of an issue and helping ensure clinical decisions are based on the totality of the evidence. (Cantor Report, Section III.) My prior report cited all the systematic reviews then available from the peer-

reviewed literature and national health care systems that conducted them. (Cantor Report, Section V.)

22. Since then, Thompson et al. (2023) published a new systematic review in the peer-reviewed journal, *PLoS Global Public Health,* spanning the physical and mental health outcomes of puberty-blocking medications, of cross-sex hormone administration, and of surgery (primarily, double mastectomy) in adolescents between ages 12 and 18. The review employed the widely recognized procedures for reducing bias, including: pre-registration (in the publicly available PROSPERO database of systematic reviews) to prevent "publication bias"; explication of its data extraction methods (employing the PRISMA guidelines), to prevent incomplete assessments of studies; full disclosure of inclusion/exclusion criteria and a listing of all the studies included and all the studies excluded (along with specifying which criteria excluded studies failed to meet), to prevent cherry-picking of studies favoring any one conclusion; and a standard criterion-based assessment of the risk of bias posed by each study it included.[3]

23. The Thompson review identified 19 relevant research reports from six countries. Of the 19 studies, five reported on the mental health outcomes (benefits to mental health being the goal of the physical transition). The physical health outcomes assessed were bone density, liver enzymes, haemoglobin, glucose metabolism, lipid profile, and blood pressure—such risks to physical health are among the harms which must be weighed against proven benefits to assess treatment risk:benefit ratios.

24. This systematic review reiterated the conclusions of the prior systematic reviews:

- The evidence base for the outcomes of gender dysphoria treatment in adolescents is lacking. It is impossible from the included data to draw definitive conclusions

[3] Although the most widely used instrument for assessing risk of bias is GRADE, Thompson et al. used the Crowe Critical Appraisal Tool (CCAT, version 1.4). The GRADE method focuses on the research methods used in conducting a study, whereas the CCAT method includes several aspects about the article reporting those findings. Thus, GRADE assessments emphasize the reliability of findings, whereas CCAT assessments also reflect the introduction to and discussions of those results from that study's authors.

regarding the safety of treatment. (at 2.)

- It is clear that we simply do not know enough about the observed phenomenon referred to as AOGD [*adolescent-onset gender dysphoria*], nor do we fully understand the huge increase in numbers of adolescents (and especially NF [*natal females*]) presenting for GD [*gender dysphoria*] intervention in recent years, nor the comorbidities and long-term outcomes. (at 42.)

- [A]s pointed out in the interim report for the Cass review…good quality evidence is most definitely still lacking. (at 42.)

- This review series has highlighted a lack of quality evidence in relation to adolescent GD [*gender dysphoria*] in general: epidemiology, comorbidity, and treatment impact is difficult to robustly assess. Without an improvement in the scientific field, clinicians, parents, and young people are left ill-equipped to make safe and appropriate decisions. (at 43.)

25. Regarding the levels of evidence of the existing research, Thompson et al. noted that no survey studies were of sufficient quality for inclusion, that the pertinent studies are at the "cohort study" level of evidence, and that no randomized controlled trials (RCTs) yet exist. As quoted above, Thompson et al. called for improvement in the science of this question, and included no indication that RCTs could not be conducted.

E. Christensen et al. (2023): A new systematic review confirms my conclusion of insufficient evidence to conclude that medical transition reduces suicide or suicidality.

26. My prior report summarized the existing science on suicide and suicidality. (Cantor Report, Section X.). Since then, Christensen et al. (2023) has conducted the first systematic review of that research, which has now been published in the peer-reviewed journal, *Child Psychiatry & Human Development*, and its results align with the conclusion in my prior report that there is no evidence of sufficient quality to conclude that medicalized transition reduces rates of suicide or suicidality.

27. Christensen et al. reviewed studies of preventing suicide in transgender youth ages 24 and under, including medicalized transition and other interventions (such as crisis intervention or online media). The review followed well-established and high-quality review procedures,

including the PRISMA guidelines for data extraction, and applying a criterion-based assessment of the risk of bias posed by the included studies.

28. In total, Christensen et al. identified 17 studies, eight of which pertained specifically to medicalized transition. These eight yielded only inconsistent results, with some, but not other studies reporting statistically significant differences in rates of suicidality among medically transitioned youth. That review confirmed the summary provided in my prior report and reported that:

- Common flaws that created high risk of bias included self-reporting, lack of controls for comparability, small sample sizes, and lack of generalizability. (at 7.);
- Despite the pressing need for suicide prevention within this population, there has been a lack of high-quality evidence focusing on prevention of suicide amongst transgender youth. (at 7–8.);
- [N]o randomized controlled trials to date investigate the impact of interventions on rates of suicidal ideation and suicide attempt in transgender and gender diverse youth. . . (at 9.);
- [T]he overall quality of evidence is low, and the risk of bias is high. There is an urgent need for high-quality studies of interventions to reduce risk of suicide amongst transgender youth. . . (at 9.).

29. My own summary of the available science was that "No methodologically sound studies have provided meaningful evidence that medical transition reduces suicidality." (Cantor Report, ¶ 148.) Christensen et al., after conducting a formal systematic review, reached the same conclusion: "It is yet largely unproven what the effect of such interventions may be on rates of suicidal ideation and attempt—let alone completion—amongst transgender and gender-diverse youth" (Christensen et al. 2023 at 9.). The objective research evidence simply does not support claims that medicalized transition represents a "life-saving" procedure.

30. Importantly, of the 17 studies included in this review, only two existed before 2019.[4] That is, both the Endocrine Society guidelines (published in 2017) and the AAP policy (published in 2018) lack the benefit of the relevant studies nearly entirely. The published systematic review conducted by WPATH (i.e., Baker et al. 2021) cited zero of these 17 studies.

31. Moreover, Christensen et al. reiterated the fact that there have been no RCT studies, and called for high quality studies to be conducted (without any indication that it would be unethical to conduct such RCTs). (Christensen et al. 2023 at 9.).

II. Multiple new detransition studies confirm features consistent with the hypothesis that ROGD is largely a social contagion phenomenon.

32. As indicated in my previous report, respected national health care systems of several countries have warned of the risk that medical transition of minors can lead to detransition and severe regret due to irreversible physical harms. (Cantor Report, Section V.) Because detransition (1) can occur several years after transition, (2) is not typically reported to the clinic that provided transition (Littman (2021)), (3) thus cannot be distinguished by the clinic from dropping out of a clinical study for other reasons, and (4) is not systematically tracked by any centralized database in the U.S., reliable knowledge about the features and frequencies of detransition cannot develop at the same rate as other aspects of study. The scientific study of detransition has only just begun, with even the Version 8 of WPATH's Standards of Care (SOC-8) noting that basic information about detransition remains unknown (SOC-8 at S77.). In this situation, it is unjustified and misleading to claim that the paucity of evidence suggests that rates

[4] Namely:
Lytle, M. C., Silenzio, V., Homan, C. M., Schneider, P., & Caine, E. D. (2018). Suicidal and help-seeking behaviors among youth in an online lesbian, gay, bisexual, transgender, queer, and questioning social network. *Journal of Homosexuality, 65,* 1916–1933.
Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018) Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behavior among transgender youth. *Journal of Adolescent Health, 63,* 503–505.

of detransition are low, rather than merely reflecting the difficulty of data collection and as a result the greater the time that will be required for such research to be completed.

33. Scientific interest in this issue is extremely high, and evidence is only now beginning to accumulate. In the comparatively short time since my previous report, many new studies of detransition have appeared in the peer-reviewed literature:

Littman, L., O'Malley, S., Kerschner, H., & Bailey, J. M. (2023). Detransition and desistance among previously trans-identified young adults. *Archives of Sexual Behavior*. doi: 10.1007/s10508-023-02716-1

MacKinnon, K. R., Gould, W. A., Enxuga, G., Kia, H., Abramovich, A., Lam, J. S. H., & Ross, L. E. (2023). Exploring the gender care experiences and perspectives of individuals who discontinued their transition or detransitioned in Canada. *PlosONE.* doi: 10.1371/journal.pone.0293868

MacKinnon, K. R., Kia, H., Gould, W. A., Ross, L. E., Abramovich, A., Enxuga, G., & Lam, J. S. H. (in press). A typology of pathways to detransition: Considerations for care practice with transgender and gender diverse people who stop or reverse their gender transition. *Psychology of Sexual Orientation and Gender Diversity.* doi: 10.1037/sgd0000678

Sanders, T., du Plessis, C., Mullens, A. B., & Brömdal, A. (2023). Navigating detransition borders: An exploration of social media narratives. *Archives of Sexual Behavior, 52,* 1061–1072.

Sansfaçon, A. P., Gelly, M. A., Gravel, R., Medico, D., Baril, A., Susset, F., & Paradis, A. (2023). A nuanced look into youth journeys of gender transition and detransition. *Infant and Child Development, 32,* e2402.

Sansfaçon, A. P., Gravel, É., Gelly, M., Planchat, T., Paradis, A., & Medico, D. (in press) A retrospective analysis of the gender trajectories of youth who have discontinued a transition. *International Journal of Transgender Health.* doi: 10.1080/26895269.2023.2279272

These empirical studies have employed a range of techniques to examine detransitioners' characteristics, including semi-structured interviews, thematic analysis of social media sites, and quantitative surveys using independently validated instruments.

34. The most scientifically rigorous of these is Littman et al. (2023). To recruit detransitioners to participate in this peer-reviewed study, the researchers noted that "Efforts were made to reach communities with differing perspectives about gender dysphoria, desistance,

transition, and detransition" (at 60.). The study's sample consisted of individuals 91% of whom were biologically female, ranging in age from 18 to 33 years (mean of 24.9 years), and 81% white. The majority of participants described themselves as politically liberal (68%), non-religious (82%), and supportive of gay marriage rights (86%) and transgender rights (91%).

35. The results of this quantitative, peer-reviewed study confirmed the conclusions of the qualitative studies interviewing detransitioners and prior survey studies: The majority of the detransitioners reported that the phenomenon referred to as rapid onset gender dysphoria (ROGD) correctly describe their experience (53%), with 23% indicating they did not know, and 24% reporting it did not. Co-morbid psychiatric diagnoses were acknowledged by the majority, consistent with prior studies. Self-harm was extremely prevalent in the sample before and during their period of transgender identification, 71% and 64% respectively. Interestingly (and urgently calling for further research), self-reported self harm dropped radically to 23% among this sample after they detransitioned and returned to a gender identity aligned with their biological sex.

36. The study results also supported the social contagion hypothesis of ROGD:

> Participants in the current study were asked if, at the time of transgender identification, they belonged to a friendship group where one or more members of the group became transgender-identified around the same time. The majority (60.3%) answered in the affirmative (with 24.4% referring to offline friendship groups, 14.1% referring to online friendship groups, and 21.8% referring to both). More than a third of participants responded that the majority of their offline and online friends became transgender-identified (34.6% and 38.5%, respectively) and participants acknowledged that their offline and online friendship groups engaged in mocking people who were not transgender-identified (42.3% and 41.0%, respectively). (Littman et al. 2023 at 68.)

It bears emphasizing this finding that more than a third of these (overwhelmingly female) respondents reported that "the *majority*" of their friends at some point became transgender-identified. In my opinion, this finding is entirely inconsistent with claims that transgender

identity is innate and immutable, like sexual orientation, rather than influenced by social and psychological factors.

37. Importantly, study participants were asked about the informed consent procedures they received from the clinicians providing the medicalized transition services. The majority (61.5%) reported receiving hormonal treatments from clinicians using only the informed consent, rather than a gate-keeping model, and, although they received some information, the results indicated that:

> 66.7% felt they were inadequately informed about risks and 31.3% felt this about benefits. Only one participant (2.1%) reported that a clinician provided information about treatment alternatives to cross-sex hormones . . . 75.0% of participants reported that they received inadequate information about these alternatives, [and fewer than] one-tenth (8.3%) of participants indicated that they were informed by their clinician about the lack of long-term studies about natal females with late-onset gender dysphoria. Similarly, only 12.5% were informed that the risks, benefits, and outcomes for medical transition of late-onset gender dysphoric youth have not been well studied. (Littman et al. 2023, at 70–71.)

III. New epidemiological evidence supports the hypothesis that ROGD is merely one symptom of a wide pattern of sharp declines in the mental health of especially female adolescents, corresponding with the increased social pressures introduced by social media in the smartphones era.

38. As noted in my previous report, the peer-reviewed evidence repeatedly differentiates between the previous, well-established types of gender dysphoria (childhood-onset gender dysphoria and adult-onset gender dysphoria; see Cantor Report, Sections IX.A. & IX.B.), and the only recently observed pattern of adolescent-onset or rapid-onset gender dysphoria (ROGD; see Cantor Report, Sections IX.C.).[5] Some advocates reject the social contagion explanation of the sudden epidemiological change, citing political, social, and therapeutic implications they claim

[5] One of the peer-reviewed sources I cited was Diaz and Bailey (year), published in *Archives of Sexual Behavior.* After my report was submitted, that article was republished as:

Diaz, S. & Bailey, J. M. (2023). Rapid-onset gender dysphoria: Parent reports on 1,655 possible cases. *Journal of Open Inquiry in the Behavioral Sciences.* doi: 10.58408/issn.2992-9253.2023.01.01.00000012

follow from that conclusion (see Section XI.B. below); however no other interpretation has been offered that is capable of explaining the evidence.

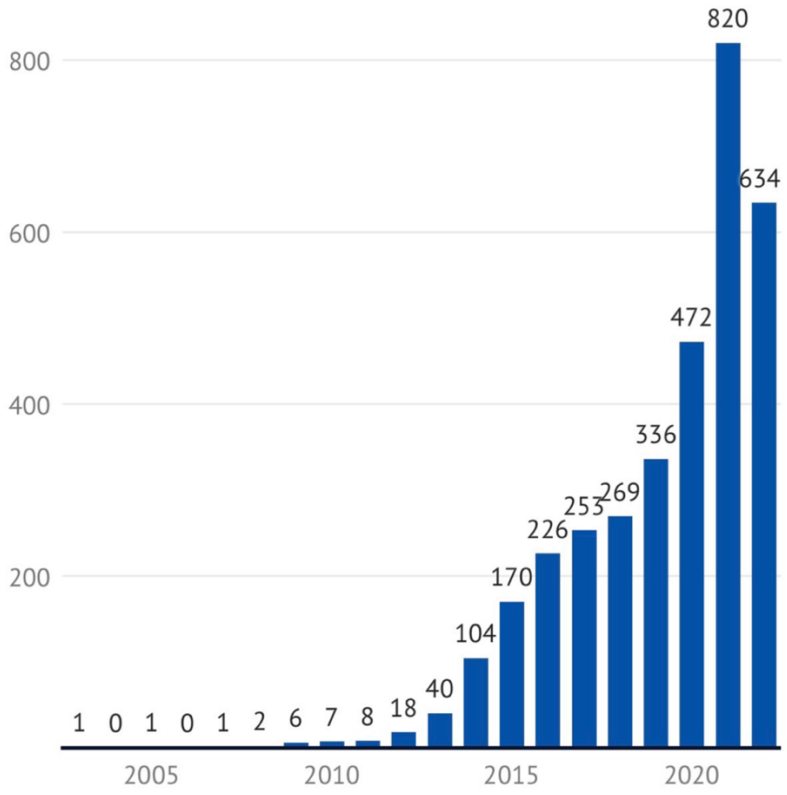
39. Since the preparation of my prior report, highly relevant new evidence has been reported by multiple, highly reliable sources (including national surveys), that endorse the patterns predicted by the social contagion explanation. Large quantities of mental health data have been produced recently due to the interest in investigating the impact of COVID on public mental health. What this research has repeatedly revealed is that, although there have been some decreases in mental health indicators during the COVID era, the major decline began nearly a decade before the COVID era (Villas-Boas et al. 2023) and instead corresponds with the new ubiquity of smartphones and social media among adolescents.

40. As demonstrated by the following sources, each of these exponential changes has occurred simultaneously and primarily within the same demographic group outlined in my prior report: adolescent, biological females, with psychosocial vulnerabilities making them more susceptible to social influence. Neither the claims of sexual minority stress nor any other hypothesis apart from the new influence of smartphones and social media predicts or provides any explanation for these several concurrent and ubiquitous patterns, below.

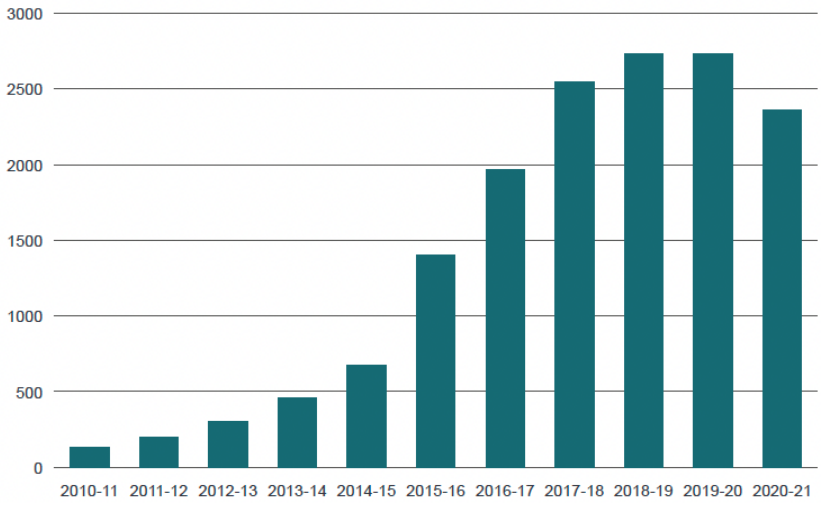
A. Additional data show an exponential increase in gender dysphoria referrals coincident with the wide uptake of social media.

41. First, evidence from additional sources simply confirms the presence and timing of the exponential increases in numbers of reported cases of gender dysphoria throughout the industrialized world, as already noted in my previous report.

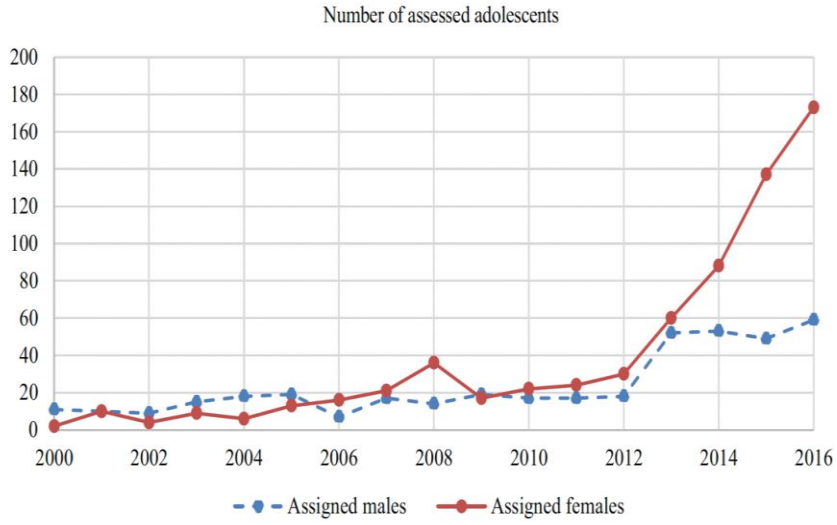
42. **Australia**: The Royal Children's Hospital gender service reports the following data on referrals to its gender service, with an exponential rise beginning in 2011–2012. (Bachelard 2023.)



43. **United Kingdom**: In her interim report, Dr. Cass provides the following data on referrals for gender dysphoria in the U.K., following almost exactly the same timing and curve. (Cass 2022 at 34.)

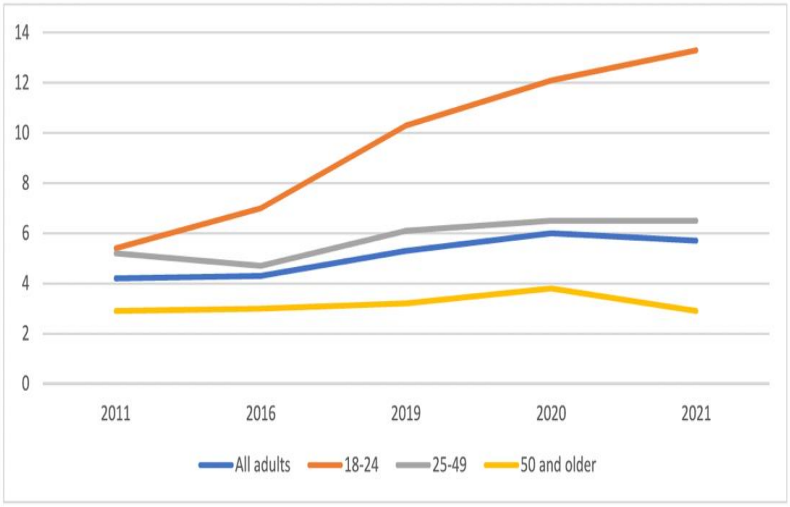


44. **The Netherlands:** Data from the Netherlands shows the same pattern and timing and breaks out the fact that the phenomenon is primarily affecting biological females. (Arnoldussen 2020.)

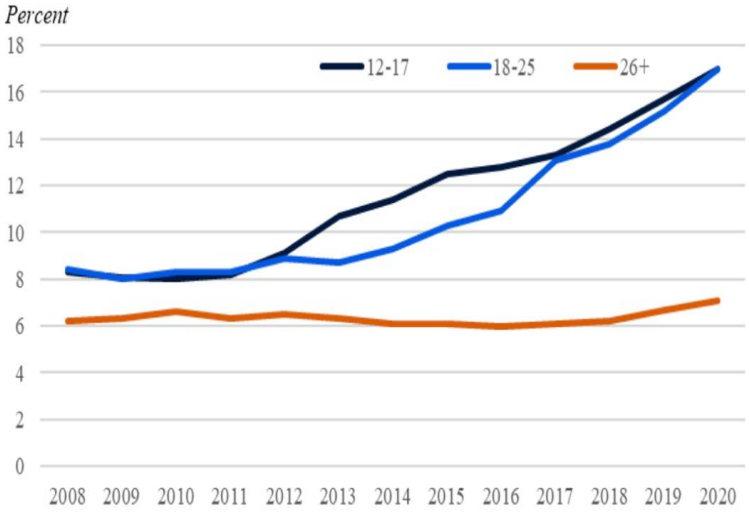


B. Additional data also show a sharp increase in mental health conditions broadly among teens occurred concurrent with the wide uptake of social media.

45. Brunette et al. (2023) plotted data from U.S. National Survey on Drug Use and Health demonstrating that increases in depression began at the same time and occurred among younger rather than older adults:



46. Data from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA 2022) likewise show the rapid rise in depressive episodes, more than doubling, accompanying the social media age, and mostly affecting youth under 25:



C. The post-2011 crisis in mental health, like the explosion of gender dysphoria referrals, has been a largely female phenomenon.

47. The sudden and dramatic increases in depression primarily occurred among biologically *female* adolescents. The U.S. Centers for Disease Control and Prevention (CDC) released the results of its biannual *Youth Risk Behavior Survey* (CDC 2023). The report confirmed that mental health and suicidal thoughts and behaviors worsened significantly between 2011 and 2021. It also found these problems primarily affecting biological females, noting:

> Across almost all measures of substance use, experiences of violence, mental health, and suicidal thoughts and behaviors, female students are faring more poorly than male students. These differences, and the rates at which female students are reporting such negative experiences, are stark. […] In 2021, almost 60% of female students experienced persistent feelings of sadness or hopelessness during the past year and nearly 25% made a suicide plan. (CDC 2023 at 2.)

48. Twenge (2022) showed an exponential increase in major depression rates among U.S. adolescents (ages 12–17) beginning in 2011, as reported by the U.S. National Study of Drug Use and Health, illustrating again this to be primarily among females:

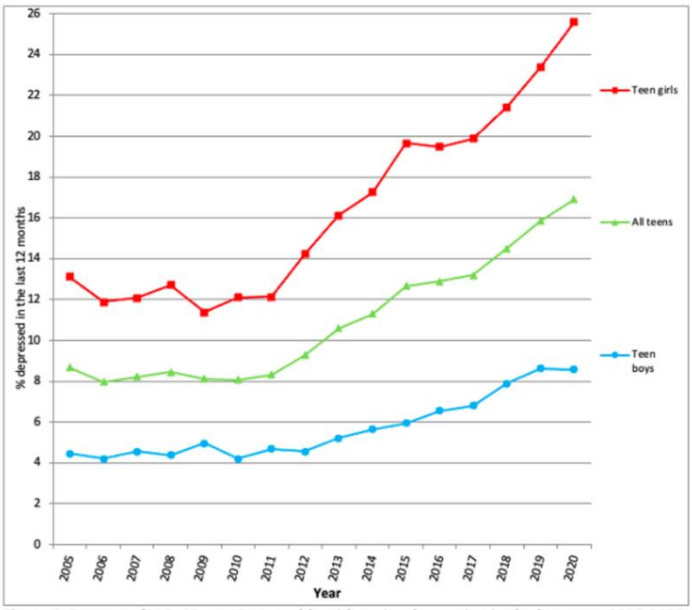


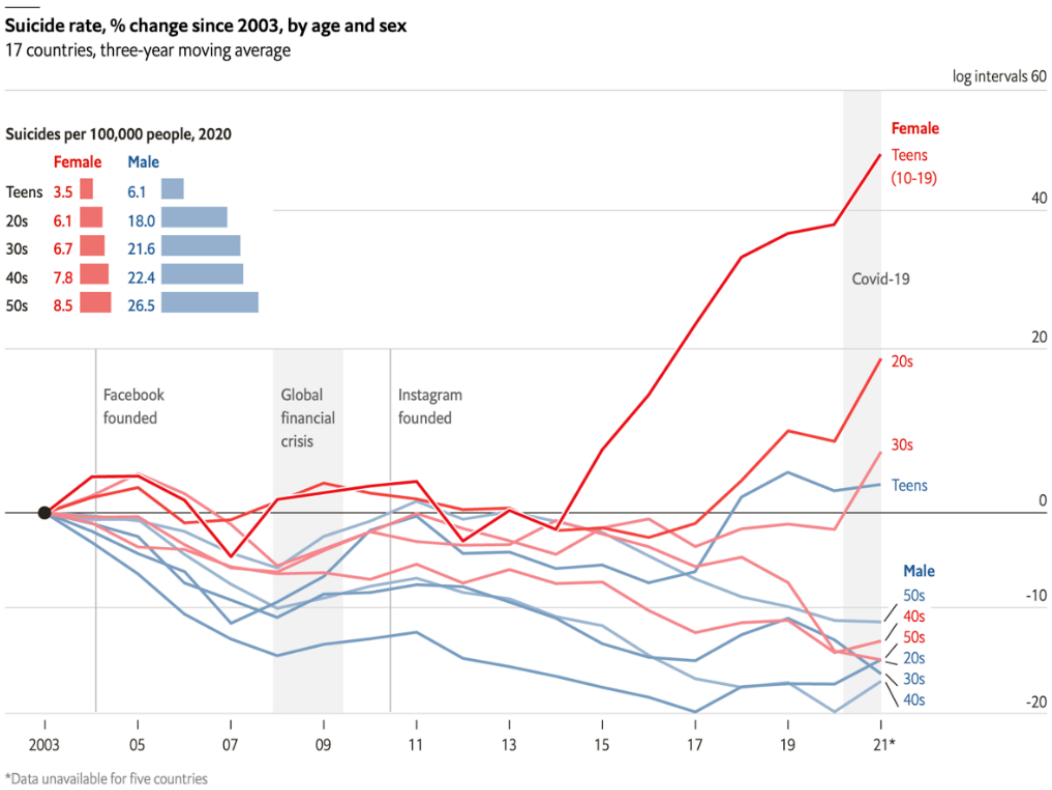
Figure 2: Percent of U.S. 12- to 17-year-olds with major depression in the last year, 2005-2020
Source: National Study of Drug Use and Health. NOTE: Depression assessed using DSM criteria.

(Twenge 2022 at 3.)

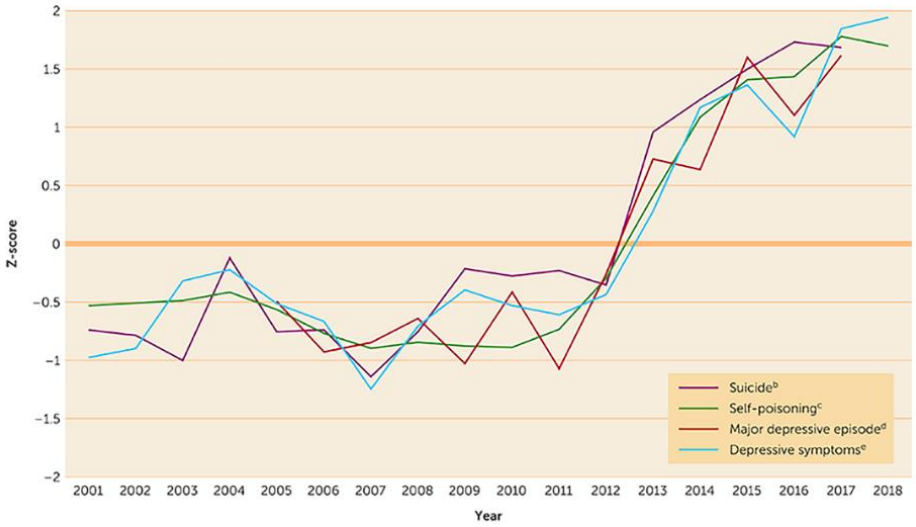
49. Tragically, the same pattern extends beyond depression and mental health to actual completed suicide. While suicide rates for most groups have fallen or remained constant since 2011, completed suicide rates for adolescent girls instead have skyrocketed:

> Suicide rates have been falling overall, but girls—who kill themselves less often than other groups—are an exception. Among girls aged 10–19, suicide rates rose from an average of 3.0 per 100,000 people in 2003 to 3.5 per 100,000 in 2020. The rate among boys, although higher at 6.1 per 100,000 population, has barely changed. (Economist 2023.)

Changes in suicide rates, by biological sex and age group. (Economist 2023.)



50. Twenge (2020) compared multiple indicators of poor mental health among U.S. girls and young women across 2001–2018, again illustrating the dramatic worsening beginning in 2011. "In most cases, the increases in indicators of poor mental health have been larger among girls and young women than among boys and young men" (Twenge 2020 at 19.). These findings confirm the patterns I have previously identified.



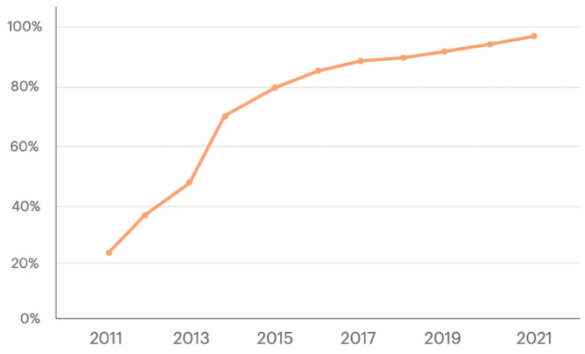
D. The 2011 onset of increased mental health problems and increased gender dysphoria referrals has been recognized as co-occurring with the uptake of smartphones among adolescents.

51. New reports increasingly recognize social media and smartphone usage as the common link behind the proliferation of mental health disorders among adolescents (Brunette et al. 2023; Haltigan et al. 2023), including the recent health advisory by the American Psychological Association on social media use among adolescents (APA (2023).). The APA advisory concluded:

> Research suggests that using social media for social comparisons related to physical appearance, as well as excessive attention to and behaviors related to one's own photos and feedback on those photos, are related to poorer body image, disordered eating, and depressive symptoms, *particularly among girls.* (APA 2023 at 8, emphasis added.)

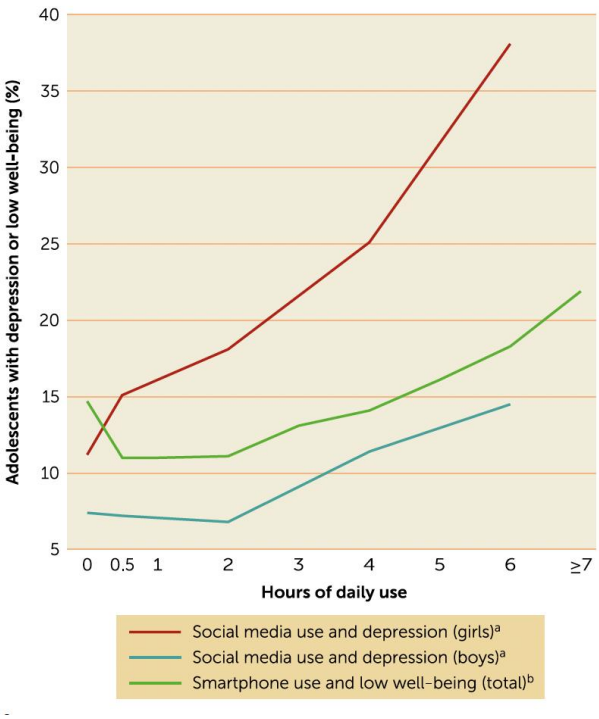
These conclusions further confirm the conclusions of systematic review associating smartphone usage and poorer mental health (Sohn et al. 2019).

52. The timing of the increase in gender dysphoria referrals exactly correspond with the penetration of smartphones and social media into adolescent lives: Data published by Pew Research illustrates that the rates of smartphone usage among teenagers also began its dramatic rise in 2011−2012:



(Lebrow 2022.)

53. Twenge (2020) documents that it is precisely the heavy users of social media who are most likely to report being depressed, feeling unhappy, or exhibiting suicidality. Again, the association is, by far, most striking for adolescent girls:



(Twenge 2020 at 22.)

54. In their peer-reviewed, nation-wide analysis of Finland's centralized gender identity services (GIS), Kaltiala et al. observed:

> The increase in all the younger people contacting GIS and in psychiatric needs among them have taken place simultaneously with the emergence of the widely recognized crisis in mental health among adolescents and young adults throughout the Western world [44, 45], largely associated with the increasing use of social media [44–46]. Social influences that reduce stigma and barriers to care for people suffering from incongruence between their sexed body and lived gender experience likely improve mental health in this group and social media may offer invaluable support and belongingness that buffers against minority stress. However, social media influences may also result in adolescent and emerging adult females – who present particularly frequently with identity confusion [47] – seeking for a solution to their distress through GR [11] and overshadow the need for psychiatric treatment. (Kaltiala et al. 2023 at 6.)

The sources cited by Kaltiala et al. in this paragraph are:

> 11: Marchiano, L. (2017). Outbreak: On transgender teens and psychic epidemics. *Psychological Perspectives, 60,* 345–366.

44: Twenge, J. M. (2020). Increases in depression, self-harm, and suicide among U.S. adolescents after 2012 and links to technology use: Possible mechanisms. *Psychiatric Research and Clinical Practice, 2,* 19–25.

45: Krokstad, S., Weiss, D. A., Krokstad, M. A., Rangul, V., Kvaløy, K., Ingul, J. M., Bjerkeset, O., Twenge, J., & Sund, E. R. (2022). Divergent decennial trends in mental health according to age reveal poorer mental health for young people: Repeated cross-sectional population-based surveys from the HUNT Study, Norway. *BMJ Open, 12,* e057654.

46: Abbasi, J. (2023). Surgeon general sounds the alarm on social media use and youth mental health crisis. *JAMA, 330,* 11–12.

47: Bogaerts, A., Claes, L., Buelens, T., Verschueren, M., Palmeroni, N., , Bastiaens T., & Luyckx, K. (2021). Identity synthesis and confusion in early to late adolescents: Age trends, gender differences, and associations with depressive symptoms. *Journal of Adolescence, 87,* 106–116.

IV. New studies on risks of harm corroborate the dangers posed to children and adolescents by medicalized transition.

55. As I outlined in my prior report, an analysis of the safety and/or efficacy of any particular approach requires a balancing of the probable benefits in light of probable risks. (Cantor Report, Section V.A.) My prior report also detailed both the known and the potential, but largely unstudied, harms associated with administration of puberty blockers and cross-sex hormones to children and adolescents, one of which is irreversible sterilization. (Cantor Report, Section XIV.)

56. Since I prepared my report, a systematic review of the research studying the desire of transgender individuals to become biological parents has now been completed and published, information relevant to the possibility that medical transition will later be perceived by the patient as having inflicted severe harm. Stolk et al. (2023) reviewed of a total of 76 individual studies. The review found that that the majority of adults undergoing medicalized transition desired to become parents in the future; however, fertility preservation utilization rates were nonetheless low. That disconnect obviously leaves large room for future regret and harm.

57. By contrast, Stolk et al. found that among transgender adolescents, only a minority

stated a desire to become biological parents in the future. Stolk et al. did not however, find any study that measured by how such desires *change* over time, once those who transition as adolescents mature into adult life. The much greater levels of desire to become a parent reported by transgender adults suggests the hypothesis that this desire increases as one enters and lives adult life, although a longitudinal study would be necessary to conclude this with confidence. Also not included in Stolk et al. was information comparing levels of asserted desire to be a parent in the future among *non*-transgender adolescents with asserted desire on the part of non-transgender adults. Such a comparison that might give critical insight into the general stability (or lack of stability) of such desires across time and maturation.

58. Notably, Stolk et al. recognize that cross-sex hormone treatment beginning at Tanner Stage 2 ends the possibility of future fertility. The review noted also that WPATH guidelines include no procedures that would prevent this effective sterilization. Rather, WPATH guidelines include only the recommendation that individuals undergoing medicalized transition receive counseling about that loss of capacity for biological children. Neither the review nor WPATH provides any indication of how effective such counseling can be with, for example, a 10-year-old or prepubescent child making the irreversible decision never to become a biological parent. No evidence or methodology exists for validating whether any consent or assent obtained from such a child could be meaningfully informed.

V. Evidence-based medicine warns against strong recommendations based on low quality evidence.

59. In his declaration, Dr. Antommaria did not contest that the evidence cited in support of the medicalized transition of minors was of low quality; however, Dr. Antommaria asserted that it is standard practice for clinical guidelines to issue strong recommendations on the basis of

only low quality evidence. (Antommaria Report at 11–15.) New documentation, including peer-reviewed publications and the now identified sources of WPATH's procedures, indicate instead that recommendation strength being discordant with evidence strength conflicts with evidence-based medicine. First, Chapter 14 of WHO (2014) is titled "*Strong recommendations when the evidence is low quality,*" and makes this principle explicit:

> GRADE guidance *warns against discordant recommendations* because when either the benefits or harms of an intervention are uncertain, one cannot be confident that an intervention does more good than harm. Strong recommendations are directives that are meant to be followed by all or almost all guideline users and under all or almost all foreseeable circumstances. […] Because of this, discordant recommendations may entrench practices whose benefit is uncertain. For instance, a discordant recommendation may lead the users of a WHO guideline to carry out interventions that are detrimental individually or collectively or to waste scarce resources on ineffective interventions. (WHO 2014 at 170–71, emphasis added.)

60. A new peer-reviewed article, published in *BMC Medical Research Methodology,* compared quality of evidence with strength of recommendations for all the National Clinical Guidelines (NCGs) of Ireland after 2019, when that country's national health care system adopted the GRADE approach to evidence-based medicine—Chong et al. (2023). Chong et al. first summarized the basic principle behind evidence-based medicine:

> 1) Strong recommendations confirm confidence that the desirable effects outweigh the undesired consequences and 2) conditional/weak recommendations are made when there is uncertainty regarding potential harms or disadvantages. […] For the development of trustworthy guidelines there should be concordance between the quality (certainty) of the evidence and the strength of the recommendations. (Chong et al. 2023 at 2.)

61. Moreover, when there is only low quality evidence to support a treatment that risks harm, the primary recommendations are recommendations *against* that treatment, not *for* it, as Dr. Antommaria misleadingly insinuates. Dr. Antommaria fails to disclose how many of the strong recommendations based on weak evidence he cited were strong recommendations *against*

the procedure because of the weak evidence, rather than *for* the procedure *despite* only weak evidence.

62. As Chong et al. noted: When the evidence of benefit is of low or very low quality, but the evidence of harm is high or moderate, then the recommendation is a strong recommendation *against* the treatment, and when the evidence shows that two treatments have potentially equivalent effectiveness but that one clearly poses less risk (such as with psychotherapy versus medicalized transition), then the recommendation is a strong recommendation *against* the higher risk treatment. (Chong et al. 2023 at 3.)

63. WHO (2014) provides the same instructions:

> When guideline development groups are confident that the desirable consequences (benefits) of an intervention outweigh its undesirable consequences (risks or harms), they will likely issue a strong recommendation in favour of the intervention; when they are confident that the opposite is true, they issue a strong recommendation against the intervention. In cases in which the balance between desirable and undesirable consequences is less certain, the guideline development group will issue a conditional recommendation. (WHO 2014 at 169.)

For example, when there is only low or very low quality evidence of benefit (such as with mental health benefits from medicalized transition), but high or moderate level evidence of harm (such as with the sterilization from cross-sex hormones administered to prepubescent reproductive organs), the proper application of the principles of GRADE as clearly set out in these sources yields a strong recommendation *against* the intervention, not for it.

64. Both Chong et al. (2023) and WHO (2014) do identify five situations which represent exceptions to the concordance principle, in which strong recommendations may be appropriate despite low quality evidence. These give situations are listed below. Notably, four of them are recommendations *against* the treatment:

Situations in which a strong recommendation may be indicated despite low quality evidence.

Situation	Evidence Quality		Recommendation
	Benefits	Harms	
Uncertain benefit, certain harm	Low or very low	High or moderate	Strong recommendation *against* the more harmful/costly option
Potentially equivalent options, one clearly less risky or costly than the other	Low or very low	High or moderate	Strong recommendation *against* the more harmful/costly option
High confidence in benefits being similar, but one option potentially more risky/costly	High or moderate	Low or very low	Strong recommendation *against* the potentially more harmful/costly option
Potential catastrophic harm	Immaterial (very low to high)	Low or very low	Strong recommendation *against* the more harmful/costly option
Life-threatening emergency	Low or very low	Immaterial (very low to high)	Strong recommendation in favor of the intervention

65. A "life-threatening situation" is one for which it is well documented that death would result in very substantial proportion of the affected individuals. WHO (2014) offers as an example that, as multidrug resistant tuberculosis so often results in death, it is acceptable to recommend a fluoroquinolone, despite the evidence of its lesser generally effectiveness and greater toxicity than front-line treatment. (WHO 2014 at 172.) As the science I have reviewed makes very clear, it is not possible to assert that a child or adolescent presenting at gender clinic presents a comparable "life-threatening situation." Nor does any responsible voice (nor even WPATH) assert that the risks posed by administering puberty blockers or cross-sex hormones to

minors are "immaterial." In short, the *only* situation in which the principles of evidence-based medicine permit a strong recommendation based on low quality evidence does not apply.

VI. New studies and statements from medical associations and respected international experts confirm the lack of professional consensus and lack of science supporting the medicalized transition of minors.

66. In my prior report, I cited extensive evidence that claims of a "medical consensus" in favor of medicalized transition of children (often supported by nothing more than pointing to "guidelines" published by professional interest groups) are demonstrably false. (Cantor Report, Section II.F.) Since then, new studies, as well as statements from a variety of medical associations, have further endorsed that conclusion.

A. The World Health Organization (WHO) has removed children and adolescents from its upcoming guidelines on transgender health, making explicit this was because of the lack of evidence.

67. WHO (2014) explicitly identifies its methods as scientific and evidence-based:

> [I]n its normative and standard-setting work, WHO is and will remain a science- and evidence-based organization with a focus on public health. Guidelines are the fundamental means through which the Organization fulfils its technical leadership in health […] WHO's legitimacy and technical authority lie in its rigorous adherence to the systematic use of evidence as the basis for all policies. (WHO 2014 at 1.)

WPATH explicitly names WHO as one of the sources upon which it relied for its methodology in producing SOC-8—see Section VII. below. SOC-8 also employs the WHO diagnostic system (ICD-11) instead of the APA system (DSM-5-TR). Despite WPATH's consistent endorsement of WHO standards, however, WHO itself has come to the opposite conclusion of WPATH on the application of these standards to transgender children and adolescents.

68. On 18 December 2023, the World Health Organization announced the development of a guideline on the health of transgender and gender diverse people, including the provision of gender-affirming care. (WHO 2023.) On 15 January 2024, WHO announced that the guideline

would pertain only to adults (WHO 2024a), stating in a published "FAQ" that the reason for excluding minors was specifically because of the insufficient and inconsistent evidence:

> Why will the guideline only cover adults and not also children or adolescents?
>
> The scope will cover adults only and not address the needs of children and adolescents, because on review, the evidence base for children and adolescents is limited and variable regarding the longer-term outcomes of gender affirming care for children and adolescents. (WHO 2024b at 3.)

B. The *UK Council for Psychotherapy* has now issued official guidance regarding (what it termed) gender critical views and to emphasize that exploratory therapy must not be conflated with conversion therapy.

69. The *United Kingdom Council for Psychotherapy* (UKCP) is the national registering body for psychotherapists in the UK, comprising 80 member organizations. It is the primary organization in that country for the education, training, accreditation, and regulation for psychotherapy and psychotherapeutic counselling. After the submission of my prior report, that body issued a statement explaining its guidance for psychotherapy with gender dysphoric minors:

> Psychotherapists and psychotherapeutic counsellors who hold [gender critical] views are likely to believe that the clinically most appropriate approach to working therapeutically with individuals who present with gender dysphoria, particularly children and young people, is exploratory therapy, rather than medicalised interventions such as puberty blockers, cross-sex hormones or reassignment surgery. […] Exploratory therapy should not in any circumstances be confused with conversion therapy, which seeks to change or deny a person's sexual orientation and/or gender identity. (UKCP 2023.)

The statement quoted the Chair of the UKCP, Dr. Christian Buckland, saying:

> The UKCP continues to recognise the fact that there are different professional beliefs on many differing topics within the psychotherapeutic community. […] Medical interventions can potentially be irreversible, and there are risks associated with all medical treatments. Therefore, it is imperative that all underlying aspects to someone's dysphoria are given the attention and exploration they deserve through professional psychotherapies, in order that the overall risks can be appropriately assessed prior to considering medical intervention. (UKCP 2023.)

70. Thus, the UKCP statement directly contradicts the plaintiffs' experts' claims, but further confirms and reiterates the contents of my prior report, including the lack of professional consensus over treatment models (Cantor Report, ¶¶ 34–37), erroneous misuse of the term "conversion therapy" (Cantor Report, ¶ 301), and the risks associated with medicalized transition (Cantor Report, Section XIV.).

C. A new survey of endocrinologists who prescribe gender-affirming hormone treatment demonstrates split opinion, not consensus.

71. A new study surveying board-certified endocrinologists who prescribe gender-affirming hormone treatment (GAHT) to adults found that "GAHT can and is currently being prescribed in large numbers without a prerequisite of psychosocial evaluation from a MHP [mental health provider]." (Bisno et al. 2023 at 469.) Bisno et al. noted that this *lack* of thorough evaluation is consistent with guidelines published by special interest groups with a financial interest in administrating that therapy:

> The Endocrine Society published guidelines in 2017 recommending *against* an obligatory psychosocial evaluation, which was affirmed in the recently published World Professional Association for Transgender Health Standards of Care Version 8 from 2022. (Bisno et al. 2023 at 465.)

By contrast, however, Bisno et al. found that "42.9% of the respondents reported that their practice required documentation of a psychosocial evaluation from a mental health professional before initiating GAHT." The authors concluded that, despite the Endocrine Society and WPATH guidelines, "Endocrinologists who prescribe GAHT are divided about requiring a baseline psychosocial evaluation before prescribing GAHT." (Bisno et al. 2023 at 465.)

72. The fact that almost half of the surveyed physicians reported using clinical criteria *tighter* than those of WPATH and the Endocrine Society indicates their belief that those guidelines provide insufficient protection against harm.

73. The authors of Bisno et al. reported reasons given by some doctors who agreed with the WPATH/Endocrine Society advocacy to remove any requirement for a psychosocial evaluation before prescribing puberty blockers or cross-sex hormones. Interestingly, the reasons tgiven do not reflect evidence-based conclusions about benefits, harms, or risks from medical transition. Rather, the reasons were:

- **Access**: Too "few MHPs [mental health providers] are training in gender-affirming health care" (at 466.) which made it "challenging to find a MHP" (at 467.);
- **Cost**: Too few MHPs "participate in any insurance plan," while "up to 40% of the transgender population is publicly insured or uninsured" (at 467.); and
- **Advocacy goals**: Dispensing with a mental health evaluation would "minimize the association of transgender identity with mental illness" (at 469.).

These reasons do not reflect principles of evidence-based medicine. Rather, they serve to increase potential patients' ability to obtain and afford the services of these endocrinologists. Indeed, these motivations represent the very kinds of conflict of interest that both IoM (2011) and WHO (2014) warn about and seek to guard against—see Section VII.A. below.

D. The American Academy of Pediatrics (AAP) now acknowledges that its 2018 policy statement on gender dysphoric children was not based on a systematic review of the relevant research.

74. As noted in my prior report (Cantor Report, Section XVI.D.) and detailed in my peer-reviewed fact-check (Cantor 2020), the AAP's policy statement on transgender youth misrepresented and directly contradicted the contents of the then-available scientific literature. Neither AAP nor the sole author of its policy statement (Rafferty et al. 2018) conducted either a systematic review or even a competent narrative review of the relevant science. In the several years since that time, AAP has produced no correction or other response to the numerous, documented errors that statement contained.

75. Since the submission of my prior report, AAP Board of Directors has reaffirmed that

same 2018 policy. (Wyckoff 2023.) Remarkably, the AAP did so still without conducting a systematic (or any other) review of the now much expanded relevant science. This is despite: (1) the long list of factual errors I and others had already documented regarding the scientific assertions contained in the policy, (2) the hundreds of relevant peer-reviewed studies published only after that 2018 policy, and (3) the systematic reviews from all over the world that also became available only after 2018, unanimously contradicting the very basis of that policy.

76. The statement AAP made in announcing the policy reaffirmation in its journal, *Pediatrics,* included the assertion by the AAP CEO that the "policy authors and AAP leadership are confident the principles presented in the original policy [Rafferty et al. (2018)] remain in the best interest of children." (Wyckoff 2023.) The principles that the public expects and assumes, however, are the principles of evidence-based medicine, and the principles of evidence-based medicine require a systematic review, which the AAP has neglected to perform, now twice. Additionally, unlike in 2018, there now exist systematic reviews already available from multiple authorities that *do* adhere to the principles of evidence-based medicine, but the AAP has entirely disregarded those available resources.

77. The AAP's announcement did include a statement that it intends to conduct a systematic review in the future, only *after* reaffirming its policy. Such a cart-before-the-horse strategy is clearly positioned to facilitate reaching a predetermined conclusion. Indeed, the AAP statement did not acknowledge any scientific need for a systematic review, and instead highlighted "the board's concerns about restrictions to access to health care with bans on gender-affirming care." As noted in earlier in this report, such declarations from professional guilds represent a conflict of interest—see Section VII.A below. Because of the financial incentives to physicians providing these services, patients' "access to health care" is indistinguishable from

AAP's access to its customer market.

E. New statements from respected international experts increasingly warn of dangers of excessive medicalization and discourage medical transition of children.

78. My prior declaration identified multiple international health care systems reversing their policies that had initially facilitated the medicalized transition of minors. (Cantor Report, Section II.) The international recognition that the earlier policies fail to reflect the medical science and have not been shown to benefit children continues to grow with the still-increasing evidence. It is evident that the U.S. medical policies are growing increasingly isolated from the international medical and scientific consensus in light of the scientific evidence.

79. In a recent open letter in the *Wall Street Journal*, 21 scientists and clinicians from nine countries, all experts in caring for gender dysphoric youth, issued a warning to the U.S. that "Youth gender transition is pushed without evidence: Psychotherapy, not hormones and surgery, is increasingly the first line of treatment abroad." (Kaltiala, Takala, et al. 2023.) The authors emphasized:

> The politicization of transgender healthcare in the U.S. is unfortunate. The way to combat it is for medical societies to align their recommendations with the best available evidence—rather than exaggerating the benefits and minimizing the risks. (Kaltiala, Takala, et al. 2023.)

80. One of the authors of this open letter, Dr. Riittakerttu Kaltiala, is the chief psychiatrist in the department of adolescent psychiatry at the Tempere University Hospital, one of the leading teaching hospitals in Finland. She served as the head of Finland's national pediatric gender program, which began with, and for several years followed, the "Dutch protocol" which includes prescribing puberty blockers for some exceptional gender dysphoric children, starting at age 12. (Cantor Report, Section XVI.A.) Dr. Kaltiala is now, however, vocally advocating against these hormonal interventions which she says "interrupt and disrupt [the] crucial

psychological and physical developmental stage" of puberty. In her recently published essay entitled "Gender-affirming care is dangerous," she recounts that—as her clinic tracked their patients— "the young people we were treating were not thriving. Instead, their lives were deteriorating . . . they were doing worse" and that "some previous patients started to come back to tell us they now regretted their transition." (Kaltiala 2023.) Dr. Kaltiala states that "the [evidentiary] foundation on which the Dutch protocol was based is crumbling," and that "regret is far more widespread" than commonly acknowledged. "For example, one new study shows that nearly 30 percent of patients in [a transitioned] sample ceased filling their hormone prescriptions within four years." (Kaltiala 2023.)

81. The Editor-in-Chief of the *British Medical Journal* (among the most respected medical journals in the world) likewise recently described the international shift away from medicalized transition in favor of psychological support in a recent article, explicitly calling out medical societies in the U.S. which are departing from the evidence:

> The US, however, has moved in the opposite direction. An investigation by The BMJ finds that more and more young people are being offered medical and surgical intervention for gender transition, sometimes bypassing any psychological support. Much of this clinical practice is supported by guidance from medical societies and associations, but closer inspection of that guidance finds that the strength of clinical recommendations is not in line with the strength of the evidence. The risk of overtreatment of gender dysphoria is real. (Abbasi 2023 at 553.)

82. One of the most widely known experts and pioneers of the treatment of gender dysphoria in minors, Dr. Susan Bradley of Canada, recently expressed regret at having employed puberty blockers to treat gender dysphoric minors. She now states:

> We were wrong. . .They're not as irreversible as we always thought, and they have longer term effects on kids' growth and development, including making them sterile and quite a number of things affecting their bone growth. (Duggan 2023.)

F. Dr. Gordon Guyatt confirms that so-called guidelines or standards promoting medicalized transition of minors are not based on or consistent with evidence-based medicine.

83. As I have previously explained, Dr. Gordon Guyatt, Distinguished Professor of Medicine and of Health Research Methods at McMaster University, is recognized as the "father" of evidence-based-medicine. (Cantor Report, Section III.B.) Plaintiffs' experts repeatedly cited Dr. Guyatt in the course of describing the standards by which clinical research is (or should be) assessed, asserting that medicalized transition is consistent with evidence-based-medicine. On the contrary, multiple recent public statements by Dr. Guyatt now confirm that he agrees with my application of the principles of evidence-based medicine to the research on gender dysphoric minors and disagrees with that being put forward by the plaintiffs' experts.

84. Dr. Guyatt has recently stated:

> Current American guidelines for managing gender dysphoria in adolescents [are] untrustworthy. Don't acknowledge the very low certainty evidence regarding alternatives and do not make the very guarded weak/conditional recommendations appropriate for such evidence.[6]

In this post, Dr. Guyatt linked to article in the *British Medical Journal* (BMJ) that relied in part on the author's interview of Dr. Guyatt about the Endocrine Society's guidelines on medicalized transition. The BMJ article in turn quoted and summarized an interview with Dr. Guyatt as follows:

> Guyatt, who co-developed GRADE, found "serious problems" with the Endocrine Society guidelines, noting that the systematic reviews didn't look at the effect of the interventions on gender dysphoria itself, arguably "the most important outcome."
>
> He [Guyatt] also noted that the Endocrine Society had at times paired strong recommendations—phrased as "we recommend"—with weak evidence.… "GRADE discourages strong recommendations with low or very low quality

[6] Retrieved from Gordon H. Guyatt (@GuyattGH), X, https://twitter.com/GuyattGH/status/1641183448063967233?s=20 (last visited February 1, 2024).

> evidence except under very specific circumstances," Guyatt told The BMJ. Those exceptions are "very few and far between." (Block 2023 at 2–3.)

Dr. Guyatt's comments directly oppose Dr. Antommaria's assertion that the Endocrine Society's guideline development procedure was "rigorous." (Antommaria Report at 5.) Dr. Guyatt also directly contradicts Dr. Antommaria's suggestion that it is valid and routine to make strong recommendations on the basis of weak evidence. (Antommaria Report at 14–15.)

85. In another interview, this time with *The New York Times*, Dr. Guyatt was asked about AAP's decision to promulgate a policy on the medicalized transition of minors without having conducted a systematic review. (Ghorayshi 2023.) *The Times* described his response as follows:

> The move is "very clearly putting the cart before the horse," said Dr. Gordon Guyatt, a clinical epidemiologist at McMaster University who helped develop the field of evidence-based medicine.
>
> Based on previous systematic reviews, Dr. Guyatt said, the A.A.P.'s report will most likely find low-quality evidence for pediatric gender care. "The policies of the Europeans are much more aligned with the evidence than are the Americans'," he said. (Ghorayshi 2023.)

G. Both topic experts and research methodology experts continue to discredit the publications of Dr. Jack Turban.

86. The plaintiffs' experts repeatedly cite works by Dr. Turban claiming that those works support the medicalized transition of minors, but which I demonstrated in my report to be misinterpretations of survey data which he analyzed incorrectly. (Cantor Report, Section XVII.) Since then, numerous public statements from Dr. Turban demonstrate his lack of knowledge of even the basic methods of evidence-based medicine, with topic experts documenting numerous errors in his analyses.

87. As noted in my previous report, a substantial proportion of the evidence from the plaintiffs' experts relies upon analyses by Dr. Turban of a 2015 survey, and survey studies represent only very low quality evidence of clinical outcomes. Since the preparation of my

report, further evidence has emerged documenting the unreliability of Dr. Turban's findings and conclusions, including re-analyses of his data by established topic experts, peer-reviewed evaluation of his conclusions, editorial re-review of his work that compelled corrections be published, and his own testimony under oath indicating the limits to his own knowledge of evidence-based medicine research methods.

88. In his recent article, Dr. Turban challenged the validity of rapid onset gender dysphoria (ROGD) on the basis of his analysis of the U.S. Transgender Survey of 2015 (the same survey as reported in his prior works). (Turban et al. 2023a.) Survey-takers (transgender adults, ages 18 and older) were asked "At about what age did you begin to feel that your gender was 'different' from your assigned birth sex?" (Turban et al. 2023 at 2.) To approximate childhood-onset cases with pubertal/adolescent-onset cases, Turban's analysis split the survey-takers into those who responded age ≤10 versus >10. He then concluded that because "a substantial proportion of participants (40.8%) reported that they did not come to realize their TGD identities until adolescence or later," this contradicted "the assumption of identity transience for this group that is an inherent component of the ROGD hypothesis," citing Littman et al. (2018). Immediately upon the release of Turban's claim, multiple authors exposed Turban's confusion: Transience is not a component of the ROGD hypothesis in the first place. (Kulatunga-Moruzi, 2023; Sapir et al. 2023.)

89. Sapir et al. identified a long list of further flaws in Turban et al. (2023a), including:

(1) analyzes the wrong age cohorts in USTS-15,

(2) uses a dubious proxy for "realization,"

(3) uses an unreasonable definition of "disclosure,"

(4) provides misleading analysis of time to disclosure,

(5) misrepresents and underestimates the significance of their sample's female skew, and (6) omits ROGD-relevant data. (Sapir et al. 2023 at 1.)

Sapir et al. demonstrated that, once re-analyzed correctly, the U.S. Transgender Survey data actually *support* the ROGD hypothesis. (See also Cantor Report, Section IX.C.)

90. The plaintiffs' experts also repeatedly cited Turban et al. (2022), which has now also been revealed to contain substantial errors. In that article, *Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults,* Dr. Turban's team asserted that having received cross-sex hormone treatment during adolescence (ages 14–17) was associated with lower odds of reporting suicidality within the year before the survey. Since the submission of my prior declaration, errors in Dr. Turban's data tables and other issues have been identified that were sufficiently serious to require the publication of a correction—Turban et al. (2023c). Jackson's peer-reviewed assessment of studies of the effectiveness of so-called gender-affirming treatment on suicidality identified in Turban et al. (2022) the same deficiencies that have pervaded Turban's earlier studies:

> As mentioned, any current or prior mental health treatments besides hospitalization secondary to suicide attempt(s) were not gathered and controlled for.
>
> It is possible that assessing the confounding of mental-health differences by comparing suicidality over the past year to a lifetime history is insufficient.
>
> There will be a higher likelihood of the presence of lifetime suicidal ideation but none for the past year not just due to mental health differences but as a function of increased age.
>
> There was no accounting for effects due to psychiatric diagnostic history. (Jackson 2023 at 11.)

It is not possible to conclude from Turban et al. (2022) that hormone treatment caused improvement, because of (any of) the several other uncontrolled (confounding) factors that could also explain the reported scores.

91. The identification in Jackson (2023) of uncontrolled and confounding variables in Turban et al. (2022) corresponds to what Biggs also identified and described as the primary question:

> Why 'the range of confounding variables' omits interventions which have been identified in other published studies using the same data—including those with shared authors—as having positive associations with the same outcomes. (Biggs 2022 at 1.)

92. The plaintiff's experts also repeatedly cited Turban et al. (2020), which now has been further critiqued for asserting conclusions not justified by its data. In that article, *Pubertal suppression for transgender youth and risk of suicidal ideation,* Dr. Turban's team asserted that having received puberty-suppressing medication during adolescence was associated with lower odds of suicidality. Jackson, however, found the same deficiencies in Turban et al. (2020) as in Turban's other studies:

> The presence of mental health treatment, substance use, or psychiatric diagnostic history was neither mentioned nor controlled for. (Jackson 2023 at 11.)

Moreover, although some of the preliminary analyses that did not account for other variables at the same time (i.e., univariate analyses) suggested the possibility of statistical significance, they were not significant when the other variables were included at the same time:

> Suicidal ideation within the past year did not reach statistical significance. Lifetime suicide attempts did not reach statistical significance depending on receipt of blockers in univariate analyses and thus were not assessed with multivariate analysis. (Jackson 2023 at 11.)

93. The Jackson (2023) identification of shortcomings correspond and confirm those previously reported by Biggs (2020):

> With multivariate analysis, only one of these nine measures yielded a statistically significant association (at 2227.).
>
> Psychological problems are, therefore, a confounding factor that will create a spurious association between suicidality and treatment (at 2228.).

In sum, it is not possible to conclude from Turban et al. (2020) that puberty-blockers caused improvement, for reasons including inadequate statistical analysis and that uncontrolled (confounding) factors could also explain the suicidality patterns observed.

94. Subsequent to my previous report, Dr. Turban's lack of understanding of the procedures and principles of the systematic review process and of evidence-based medicine has been documented in the public record. Dr. Turban served as an expert witness for the plaintiffs in *Poe et al v Drummond et al*. (Oklahoma, Northern District, Case No. 23-cv-00177-JFH-SH).[7] In his rebuttal declaration in that case, dated July 7, 2023, Dr. Turban told the court:

> Defendants' experts attempt to misleadingly bolster the importance of these reports from select European countries by calling them "systematic reviews." But all a "systematic review" means is that the authors of the reports pre-defined the search terms they used when conducting literature reviews in various databases.[2] (Turban Rebuttal Declaration at 2.)

Dr. Turban is mistaken, however, having omitted critical components of a systematic review. As the Harvard website cited by Turban (in his footnote 2 to the above quote) states, a systematic review is not defined merely by disclosing search terms used to find relevant studies, but also in (a) application of "standardized, systematic methods and pre-selected eligibility criteria reduce the risk of bias in identifying, selecting and analyzing relevant studies," an then conducting "an assessment of the validity or risk of bias of each included study," and finally "a systematic synthesis, analysis and presentation of the findings of the included studies."[8]

[7] I was engaged as an expert witness for the Defendants in that case.
[8] Harvard Countway Library. Systematic Reviews and Meta Analysis Q&A. Accessed: July 6, 2023. Available at: https://guides.library.harvard.edu/meta-analysis/GettingStarted.

95. Any accurate description of the concept of a systematic review within the discipline of evidence-based medicine would include at least these criteria. Dr. Turban, however, appears ignorant of the importance both of evaluating "the validity or risk of bias" of each study, and "a systematic . . . analysis . . . of the findings" of each study. The description of the core components of a systematic review given by the source cited by Dr. Turban does, however, correspond very closely to the one I provided in my prior report. (Cantor Report ¶¶ 40, 41.)

VII. WPATH extensively violated international conflict of interest standards in the course of developing SOC-8, while claiming to comply with them.

96. In my previous report, I provided extensive analysis and opinion on WPATH that included its review of safety and effectiveness in establishing clinical guidelines (Cantor Report, Section VI.B.), its assessment of the research gaps in the area (Cantor Report, Section XII.D.), and an assessment of its published standards (Cantor Report, Section XVI.B.). Further analysis reveals that WPATH was possessed of extensive conflicts of interest throughout the production of Version 8 of its Standards of Care (SOC-8), while making false representations that it was complying with accepted conflict of interest principles for that process.

97. For reference, the following assessment refers to these documents:

Sharma et al. (2018).
: WPATH's pre-registration in the PROSPERO database of the systematic review it planned, identifying each of the specific research questions it would examine.

Baker et al. (2021).
: WPATH's systematic review of studies on the mental health of hormone therapy on transgender people, three of which were on minors.

WPATH (2022) aka Coleman et al. (2022).
: WPATH's completed *Standards of Care*, version 8 (SOC-8).

WHO (2019) aka WHO (2019a).
: The *International Classification of Diseases*, version 11 (ICD-11) of the World Health Organization.

WHO (2014).

> The *WHO Handbook for Guideline Development* (2nd edition) of the World Health Organization. Chapter 6 pertains to the management of conflicts of interest. Chapter 14 pertains to the issuing of strong recommendations on the basis of low quality evidence.

IoM (2011).

> Institute of Medicine. (2011). *Clinical Practice Guidelines We Can Trust.* Washington, DC: The National Academies Press.

98. SOC-8 indicates its guideline development methods in its appendix, on page S247:[9]

> The process for development of the SOC-8 incorporated recommendations on clinical practice guideline development from the National Academies of Medicine and The World Health Organization that addressed transparency, the conflict-of-interest policy, committee composition and group process. (Institute of Medicine Committee on Standards for Developing Trustworthy Clinical Practice, 2011; World Health Organization, 2019a).

An attempt to verify the claim of reliance on those documents leads to dead ends, however.

99. The entry in WPATH's reference list for WHO (2019a) is to:

> World Health Organization. (2019a). *International Statistical Classification of Diseases and Related Health Problems (11th ed.).* World Health Organization. https://icd.who.int/browse11/lm/en#/http://id.who.int/icd/entity/90875286" (SOC-8 at p. S244.)

That document, however (the ICD-11, WHO 2019a), is not a methods manual at all. It does not provide procedures for developing clinical guidelines, for conflict of interest or any other issue.

100. The other document that WPATH cited as its source, "IoM (2011)," does not appear on WPATH's reference list at all, but it appears to refer to the Institute of Medicine's *Clinical Practice Guidelines We Can Trust* (2011). The actual WHO manual for clinical guidelines development is WHO (2014), the *WHO Handbook for Guideline Development,* referenced as above. This handbook is missing altogether from WPATH's reference list.

[9] SOC-8 also indicates its methods on page S8 providing the text below, with no citation, and noting that "SOC-8 incorporated *the* recommendations" (emphasis added) rather than "SOC-8 incorporated recommendations."

> "The process for development of the SOC-8 incorporated the recommendations on clinical practice guideline development set forth by the National Academies of Medicine and the World Health Organization, which addressed transparency, conflict-of-interest policy, committee composition, and group process."

101. Both IoM (2011) and WHO (2014)[10] provide conflict of interest guidelines, and they detail procedures that WPATH clearly violated: WPATH's SOC-8 were produced entirely by an association and a group of individuals whom both sets of international standards instruct should be excluded or whose role and influence should be strongly limited.

A. WPATH itself suffers a strong "associational conflict of interest" in producing clinical practice guidelines for treatment of gender dysphoria.

102. IoM (2011) and WHO (2014) describe and seek to prevent conflicts of interest pertaining both to individuals developing clinical practice guidelines (CPGs) *and* to the professional associations of those individuals. On the associational level, the international standard (as indicated by the very sources upon which WPATH claimed to have relied) is for such assessments to be conducted by experts at arm's length from those services—sufficiently familiar with topic but *not* professionally engaged in performing the clinical practices under review. IoM (2011) notes:

> Many guidelines developed by medical societies and other private organizations are self-funded, through membership dues, donations, or other means. CPGs funded by medical societies dependent on membership dues may be cause for concern regarding conflict of interest if their recommendations would likely affect their members' income. (IoM 2011 at 47.)

103. This conflict of interest is strongly present in the case of WPATH and its development of SOC-8. WPATH's financial well-being depends upon the number of its dues-paying members which, in turn, depends upon WPATH acting in its members' financial interests: The more people who undergo transition, the greater the market available to WPATH's dues-paying members.

104. Additionally, it is strongly in the financial interest of WPATH members, and thus of

[10] Even though WPATH does not cite WHO (2014), for the purposes of this supplemental report I reference this document as it is the relevant, and current, World Health Organization guidance on conflict of interest.

WPATH, that medicalized transition be deemed eligible for medical insurance as broadly as possible. For example, because medical insurance does not cover "experimental" treatments, WPATH's claims that medicalized transition of minors is *not* experimental represents a very direct conflict between expanding its members' potential market and protecting minors from undergoing experimental treatments unknowingly.

105. This association-level conflict of interest pertains not only to WPATH, but also to the other associations producing guidelines in the U.S., including the Endocrine Society and the American Academy of Pediatrics (AAP) — organizations whose policy I assessed in my initial report (Cantor Report, Sections VI & XVI.). By contrast, examples of health care authorities that are not afflicted with a conflict between the interests of service providers and the interests of patients are the national health care systems, such as those of England, Sweden, and Finland. (Examined in Cantor Report, Sections II & V.) Because their health care systems are *publicly* funded, they are not susceptible to the same association-level conflicts.

106. In direct opposition with IoM's caution to *avoid* association-level conflict of interest, WPATH essentially *required* this conflict, making membership in WPATH a requirement for appointment of professionals to the guideline development team:

> Except for the Chair (Eli Coleman) who was appointed by the WPATH board to maintain a continuity from previous SOC editions, members of the Guideline Steering Committee were selected by the WPATH Board *from WPATH members* applying for these positions…Chapter Leads and Members were *required to be WPATH Full Members* in good standing. . . .[11] (SOC-8 at S248, emphasis added.)

B. WPATH did not screen for or disclose the personal financial and intellectual conflicts of interest of those who participated in developing SOC-8.

107. With respect to individuals who participate in creating a clinical guideline, IoM

[11] Only members of the public, such as parents of gender dysphoric children participating as "stakeholders," were not required to be WPATH members.

(2011) and WHO (2014) emphasize the importance of avoiding both *financial* conflicts of interest (direct and indirect), and *intellectual* conflicts of interest. These documents corroborate and detail the accepted methods to avoid conflict of interest and ensure objective assessment of any particular topic. These widely accepted principles and methods match the summary I set out in my initial report (Cantor Report, Section I.C.). Most importantly, these respected documents agree that the experts best equipped for assessing clinical practice guidelines are *not* the people whose livelihood, prestige, and/or ideological commitments are tied to providing the clinical services under review. Such people have both financial and professional incentives and thus a natural bias towards declaring their services to be effective and safe. IoM (2011) cites peer-reviewed studies that document the real-world effect of this conflict of interest can have:

> Hutchings [& Raine (2006)] identified 22 studies examining the impact of individual participant specialty or profession. Overall, the authors observed that those who performed a procedure, versus those who did not, were more likely to rate more indications as appropriate for that procedure. […] Murphy and colleagues (1998) offer other relevant findings in a systematic review in which they compared guideline recommendations produced by groups of varying composition. The authors concluded that differences in group composition may lead to contrasting recommendations; more specifically, members of a clinical specialty are more likely to promote interventions in which their specialty plays a part. (IoM 2011 at 84.)

108. Instead of complying with recognized conflict of interest principles, WPATH gathered a team of individuals all or most of whom stood to benefit financially from expanding the number of youth approved to obtain medical transition services and expanding the availability of insurance to cover such services; neglected to assess or disclose direct financial benefits to those individuals; publicly (but falsely) declared that none of these individuals had any conflict of interest; claimed it followed established procedures to limit conflicts of interest that it did not follow; excluded the sources of its procedures from its references; and redacted critical information relevant to these conflicts from the documentation it supplied to the present

proceedings under subpoena (in particular, the names of those who advocated for various positions during the process).

109. The team of individuals whom WPATH gathered did not represent the range of opinions among topic experts and did not reflect the diversity of relevant stakeholders. On the contrary, WPATH limited membership on its team to individuals who paid dues to WPATH and excluded from participation any professional with a point of view which would have kept such a professional from joining WPATH. As a result, WPATH's process excluded the input of detransitioners, as well as of the practitioners, researchers, and prominent voices within European health authorities who are expressing scepticism and concern about performing medical transition procedures on minors.

110. Instead, the committee consisted of individuals whose academic and scholarly standing stood to benefit from WPATH's product. As I detail below, the WPATH procedure consisted of exactly the biased and one-sided methods that the IoM and WHO procedures are designed to prevent.

1. WPATH disregarded and failed to disclose extensive direct *financial* conflicts of interest.

111. As noted, both IoM (2011) and WHO (2014) indicate that receiving income from providing the clinical practices being evaluated by the guidelines represents a direct financial conflict of interest. The WPATH policy and disclosure forms, however, did not actually ask participants to disclose (and therefore WPATH did not disclose to the public) participants' *direct* financial interests and thus conflicts of interest. Instead, WPATH asked only about the rare and relatively minor instances of *indirect* financial conflicts of interest.

112. WHO (2014) describes financial conflicts of interest as:

> A financial conflict of interest arises when an individual or organization receives income or monetary support that is related to, or could be affected by, the outcome of the WHO meeting or activity in which they are involved….Financial interests include, for example: *personal financial gain such as paid work,* consulting income or honoraria and travel stipends. . . . (WHO 2014 at 63, emphasis added.)

IoM (2011) provides similar language, dividing financial conflicts of interest into direct, commercial conflicts and non-commercial conflicts:

> Direct financial commercial activities include *clinical services from which a committee member derives a substantial proportion of his or her income;* consulting; board membership for which compensation of any type is received. . . (IoM 2011 at 79, emphasis added.)

and

> Examples of noncommercial financial activities include research grants and other types of support from governments, foundations, or other nonprofit organizations. (IoM 2011 at 79.)

Physicians and therapists in private practice or clinics treating people with gender dysphoria very clearly meet these criteria.

113. Despite ignoring the very clear and explicit indications from both IoM (2011) and WHO (2014) as to what constitutes conflicts of interest, WPATH declared to the public in SOC-8:

> Conflict of interests were reviewed as part of the selection process for committee members and at the end of the process before publication. No conflicts of interest were deemed significant or consequential. (SOC-8 at 177.)

Contrary to this public representation, most or all WPATH committee members possess conflicts of interest that WPATH denied.

114. Widely accepted conflict of interest guidelines recognize that the clinical experiences of individuals who receive income from pertinent clinical activities can have information helpful to guideline developers—indeed the IoM and WHO procedures permit such individuals to function as consultants or stakeholders rather than bar them altogether from participation.

WPATH did not use such methods for managing conflicts of interest, however. Instead, WPATH simply denied such conflicts existed.

115. The importance of the contradiction between WPATH's failure to inquire about and prevent direct financial conflict of interest on the one hand, and what it assured the public on the other, cannot be exaggerated: The guidelines it published contained a list of what it claimed to have been improvements over prior guidelines, explicitly naming management of conflict of interest as such an improvement, noting:

> The main differences in the methodology of the SOC-8 when compared with other versions of the SOC are: […] Management of *conflicts of interest.* (SOC-8 at S247, emphasis added.)

2. WPATH disregarded and failed to disclose extensive *intellectual* conflicts of interest.

116. WHO (2014) defines intellectual conflicts of interest as roles or positions that might interfere with the objective assessment of a body of evidence, providing the following as examples:

- *prior publication of a study or systematic review* that is part of the evidence base under consideration in the guideline;
- prior *public declaration of a firm opinion or position,* as in public testimony during a regulatory or judicial process, or in an editorial in a journal; or
- professional or personal affiliation with an organization advocating for products or services related to the subject of the guideline. (WHO 2014 at 63.)

WHO (2014) also emphasizes that:

> The GDG [guideline development group] should be composed of individuals with diverse perspectives, training and experiences to keep the recommendations from reflecting a single viewpoint that was conceived before examining and discussing the systematic review of the evidence. (WHO 2014 at 71.)

IoM (2011) similarly defines intellectual conflicts of interest:

> A person whose work or professional group fundamentally is jeopardized, or enhanced, by a guideline recommendation is said to have intellectual COI.

> Intellectual COI includes authoring a publication or acting as an investigator on a peer-reviewed grant directly related to recommendations under consideration. (IoM 2011 at 79.)

Adopting language offered by Dr. Gordon Guyatt et al., this includes "academic activities that create the potential for an attachment to a specific point of view that could unduly affect an individual's judgment about a specific recommendation." (Guyatt et al. 2010 at 739.)

117. The importance of appropriate handling of conflicts of interest is not limited to influences on actual decision making. The IoM emphasizes also that "Regardless of the nature of COI or its effects on guideline development, perception of bias undermines guideline users' confidence in guideline trustworthiness as well as public trust in science" (IoM 2011 at 79.)

118. The publicly available list of authors of SOC-8 nonetheless reveals individuals well-known for their many "public declarations," prior publications stating "firm opinions or positions" favoring what they label "gender affirming care," belittling potential risks and harms, and for their strongly expressed political views.

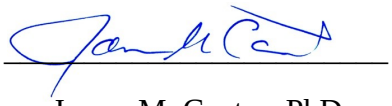
119. Moreover, WPATH itself as an organization has engaged in stridently worded political advocacy and endorsement of specific interpretations of research literature,[12] including its urging that the services its members provide should be eligible for health care insurance coverage, which its members would then receive as income. Thus, WPATH itself and all of its members are necessarily affected by what WHO (2014) identifies as an intellectual conflict of interest resulting from "professional or personal affiliation with an organization advocating for . . . services related to the subject of the guideline."

120. Again, conflict of interest guidelines do recognize that topic experts who receive income from pertinent clinical activities can have valuable information for guidelines developers,

[12] See, for example, the press releases and political advocacy documents posted at https://www.wpath.org/policies, WPATH/USPATH Public Statements (last accessed February 2, 2024).

and the recommendations allow for such individuals to function as consultants or stakeholders, rather than bar them altogether from participation. WPATH did not, however, practice methods for managing conflicts of interest. Instead, WPATH simply denied that such conflicts existed and provided no supervision, tracking, or management of undue influence.

Dated: February 2, 2024



James M. Cantor, PhD

APPENDIX A: CONFIDENTIAL

APPENDIX B: References

Bibliography

Abbasi, K. (2023). Caring for young people with gender dysphoria. [Editorial] *British Medical Journal*, 380, 553.

Abbasi, J. (2023). Surgeon general sounds the alarm on social media use and youth mental health crisis. *JAMA, 330,* 11–12.

American Psychological Association. (2023). *Health advisory on social media use in adolescence.* Washington, DC: American Psychological Association.

Arnoldussen et al. (2020). Re-evaluation of the Dutch approach: Are recently referred transgender youth different compared to earlier referrals? *European Child & Adolescent Psychiatry.* doi: 10.1007/s00787-019-01394-6

Bachelard, M. (2023, December 30). Easy as visiting the GP: Doctors push for accessible hormone treatment as children's waitlist swells. *The Age.* Retrieved from https://www.theage.com.au/national/victoria/as-easy-as-going-to-the-gp-doctors-push-for-accessible-hormone-treatment-as-children-s-waitlist-swells-20231219-p5esis.html

Baker, K. E., Wilson, L. M., Sharma, R., Dukhanin, V., McArthur, K., & Robinson, K. A. (2021). Hormone therapy, mental health, and quality of life among transgender people: A systematic review. *Journal of the Endocrine Society, 5,* 1–16.

Biggs, M. (2022). Estrogen is associated with greater suicidality among transgender males, and puberty suppression is not associated with better mental health outcomes for either sex. *PLOS ONE.* doi: 10.1371/journal.pone.0261039

Bisno, D. I., Lubitz, S., Marshall, I., & Cohen, D. A. (2023). Survey of US endocrinologists who prescribe gender-affirming hormone therapy. *Endocrine Practice, 29,* 465–470.

Bogaerts, A., Claes, L., Buelens, T., Verschueren, M., Palmeroni, N., , Bastiaens T., & Luyckx, K. (2021). Identity synthesis and confusion in early to late adolescents: Age trends, gender differences, and associations with depressive symptoms. *Journal of Adolescence, 87,* 106–116.

Brunette, M. F., Erlich, M. D., Edwards, M. L., Adler, D. A., Berlant, J., Dixon, L., First, M. B., Oslin, D. W., Siris, S. G., & Talley, R. M. (2023). Addressing the increasing mental health distress and mental illness among young adults in the United States. *The Journal of Nervous and Mental Disease, 211,* 961–967.

Cass, H. (2022, February). The Cass Review: Independent review of gender identity services for children and young people Interim report. National Health Service (NHS), UK.

Center for Disease Control and Prevention (CDC). (2023). *Youth Risk Behavior Survey: Data summary & trends report.* Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

Chong, M. C., Sharp, M. K., Smith, S. M., O'Neill, M., Ryan, M., Lynch, R., Mahtani, K. R., & Clyne, B. (2023). Strong recommendations from low certainty evidence: A cross-sectional analysis of a suite of national guidelines. *BMC Medical Research Methodology, 23,* 68.

Christensen, J. A., Oh, J., Linder, K., Imhof, R. L., Croarkin, P. E., Bostwick, J. M., & McKean, J. S. (2023). Systematic review of interventions to reduce suicide risk in transgender and gender diverse youth. *Child Psychiatry & Human Development.* doi: 10.1007/s10578-023-01541-w

Coleman, E., et al. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health, 23,* S1–S258.

Duggan, L. (2023). 'We were wrong': Pioneer in child gender dysphoria treatment says trans medical industry is harming kids. *The Daily Caller*. Retrieved from https://www.msn.com/en-us/health/medical/we-were-wrong-pioneer-in-child-gender-dysphoria-treatment-says-trans-medical-industry-is-harming-kids/ar-AA18wUwy?ocid=msedgntp&cvid=e4f85cd7225f4c18b9d8a16cec

Economist, The. (2023). *Suicide rates for girls are rising. Are smartphones to blame?* Retrieved from https://www.economist.com/graphic-detail/2023/05/03/suicide-rates-for-girls-are-rising-are-smartphones-to-blame

Ghorayshi, A. (2023, Aug. 3). Medical group backs youth gender treatments, but calls for research review. *New York Times.* Retrieved from https://www.nytimes.com/2023/08/03/health/aap-gender-affirming-care-evidence-review.html

Glintborg, D., Kjer Møller, J.-J., Hass Rubin, K., Lidegaard, Ø., T'Sjoen, G., Ørsted Larsen, M.-L. J., Hilden, M., & Skovsager Andersen, M. (2023). Gender-affirming treatment and mental health diagnoses in Danish transgender persons: A nationwide register-based cohort study. *European Journal of Endocrinology, 189,* 336–345.

Guyatt, G., Akl, E. A., Hirsh, J., Kearon, C., Crowther, M. Gutterman, D., Lewis, S. Z., Nathanson, I., Jaeschke, R. & Schünemann, H. (2010). The vexing problem of guidelines and conflict of interest: A potential solution. *Annals of Internal Medicine, 152,* 738–741.

Haltigan, J. D., Pringsheim, T. M., & Rajkumar, G. (2023). Social media as an incubator of personality and behavioral psychopathology: Symptom and disorder authenticity or psychosomatic social contagion? *Comprehensive Psychiatry, 121,* 152362.

Harvard Countway Library. Systematic Reviews and Meta Analysis Q&A. Accessed: July 6, 2023. Available at: https://guides.library.harvard.edu/meta-analysis/GettingStarted.

Jackson, D. (2023). Suicide-related outcomes following gender-affirming treatment: A review. *Cureus, 15,* e36425. doi: 10.7759/cureus.36425.

Kaltiala, R., Takala, L., et al. (2023, July 13). Youth gender transition is pushed without evidence. [Letter] *Wall Street Journal.* Retrieved from https://www.wsj.com/articles/trans-gender-affirming-care-transition-hormone-surgery-evidence-c1961e27

Kaltiala, R., Holttinen, T., & Tuisku, K. (2023). Have the psychiatric needs of people seeking gender reassignment changed as their numbers increase? A register study in Finland. *European Psychiatry, 66,* e93, 1–8.

Kaltiala, R., (2023, October 30). Gender-Affirming Care Is Dangerous. I Know Because I Helped Pioneer It. *The Free Press.* Retrieved from https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor

Krokstad, S., Weiss, D. A., Krokstad, M. A., Rangul, V., Kvaløy, K., Ingul, J. M., Bjerkeset, O., Twenge, J., & Sund, E. R. (2022). Divergent decennial trends in mental health according to age reveal poorer mental health for young people: Repeated cross-sectional population-based surveys from the HUNT Study, Norway. *BMJ Open, 12,* e057654.

Kuvalanka, K. A., Weiner, J. L., Munroe, C., Goldberg, A. E., & Gardner, M. (2017). Trans and gender-nonconforming children and their caregivers: Gender presentations, peer relations, and well-being at baseline. *Journal of Family Psychology, 31,* 889–899.

Institute of Medicine. (2011). *Clinical practice guidelines we can trust.* Washington, DC: National Academies Press.

Lebrow, H. (2021, January 8). *Data on U.S. teenagers' smartphone ownership by year.* Retrieved from https://meetmonarch.com/health-resources/articles/loneliness/are-smartphones-to-blame-for-the-teen-loneliness-epidemic

Littman, L., O'Malley, S., Kerschner, H., & Bailey, J. M. (2023). Detransition and desistance among previously trans-identified young adults. *Archives of Sexual Behavior*. doi: 10.1007/s10508-023-02716-1

Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior, 50,* 3353–3369.

Lytle, M. C., Silenzio, V., Homan, C. M., Schneider, P., & Caine, E. D. (2018). Suicidal and help-seeking behaviors among youth in an online lesbian, gay, bisexual, transgender, queer, and questioning social network. *Journal of Homosexuality, 65,* 1916–1933.

MacKinnon, K. R., Gould, W. A., Enxuga, G., Kia, H., Abramovich, A., Lam, J. S. H., & Ross, L. E. (2023). Exploring the gender care experiences and perspectives of individuals who discontinued their transition or detransitioned in Canada. *PlosONE*. doi: 10.1371/journal.pone.0293868

MacKinnon, K. R., Kia, H., Gould, W. A., Ross, L. E., Abramovich, A., Enxuga, G., & Lam, J. S. H. (in press). A typology of pathways to detransition: Considerations for care practice with transgender and gender diverse people who stop or reverse

their gender transition. *Psychology of Sexual Orientation and Gender Diversity.* doi: 10.1037/sgd0000678

McGregor, K., McKenna, J. L., Williams, C. R., Barrera, E. P., & Boskey, E. R. (in press). Association of pubertal blockade at Tanner 2/3 with psychosocial benefits in transgender and gender diverse youth at hormone readiness assessment. *Journal of Adolescent Health.* doi: 10.1016/j.jadohealth.2023.10.028

Marchiano, L. (2017). Outbreak: On transgender teens and psychic epidemics. *Psychological Perspectives, 60,* 345–366.

Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics, 137,* e20153223.

Paul, P. (2024, February). *As Kids, They Thought They Were Trans. They No Longer Do,* The New York Times. Retrieved from https://www.nytimes.com/2024/02/02/opinion/transgender-children-gender-dysphoria.html

Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018) Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behavior among transgender youth. Journal of Adolescent Health, 63, 503–505.

Sanders, T., du Plessis, C., Mullens, A. B., & Brömdal, A. (2023). Navigating detransition borders: An exploration of social media narratives. *Archives of Sexual Behavior, 52,* 1061–1072.

Sansfaçon, A. P., Gelly, M. A., Gravel, R., Medico, D., Baril, A., Susset, F., & Paradis, A. (2023). A nuanced look into youth journeys of gender transition and detransition. *Infant and Child Development, 32,* e2402.

Sansfaçon, A. P., Gravel, É., Gelly, M., Planchat, T., Paradis, A., & Medico, D. (in press) A retrospective analysis of the gender trajectories of youth who have discontinued a transition. *International Journal of Transgender Health.* doi: 10.1080/26895269.2023.2279272

Sapir, L., Littman, L. & Biggs, M. (2023). The U.S. Transgender Survey of 2015 supports Rapid-Onset Gender Dysphoria: Revisiting the "Age of realization and disclosure of gender identity among transgender adults." [Letter] *Archives of Sexual Behavior.* doi: 10.1007/s10508-023-02754-9

Sharma, R., Robinson, K., Wilson, L., & Baker, K. (2018). Effects of hormone therapy in transgender people. PROSPERO 2018 CRD42018115379. Retrieved from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42018115379

Sievert, E. D. C., Schweizer, K., Barkmann, C., Fahrenkrug, S., & Becker-Hebly, I. (2021). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria. *Clinical Child Psychology & Psychiatry, 26,* 79–95.

Sohn, S. Y., Rees, P., Wildridge, B., Kalk, N. J., & Carter, B. (2019). Prevalence of problematic smartphone usage and associated mental health outcomes amongst

children and young people: A systematic review, meta-analysis and GRADE of the evidence. *BMC Psychiatry, 19,* 356.

Stolk, T. H. R., Asseler, J. D., Huirne, J. A. F., van den Boogaard, E., & van Mello, N. M. (2023). Desire for children and fertility preservation in transgender and gender-diverse people: A systematic review. *Best Practice & Research Clinical Obstetrics and Gynaecology, 87,* 102312. doi: 10.1016/j.bpobgyn.2023.102312

Substance Abuse and Mental Health Services Administration. (2022). *Reducing the economic burden of unmet mental health needs.* Retrieved from https://www.whitehouse.gov/cea/written-materials/2022/05/31/reducing-the-economic-burden-of-unmet-mental-health-needs/

Thompson, L., Sarovic, D., Wilson, P., Irwin, L., Visnitchi, D., Sämfjord, A., & Gillberg, C. (2023) A PRISMA systematic review of adolescent gender dysphoria literature: 3) treatment. *PLOS Global Public Health, 3,* e0001478. doi: 10.1371/journal.pgph.0001478

Turban, J. L., Dolotina, B., Freitag, T. M., King, D., & Keuroghlian, A. S. (2023a). Age of realization and disclosure of gender identity among transgender adults. *Journal of Adolescent Health, 72,* 852–859.

Turban, J. L., Dolotina, B., Freitag, T. M., King, D., & Keuroghlian, A. S. (2023b). Rapid-Onset Gender Dysphoria is not a recognized mental health diagnosis—The authors respond. *Journal of Adolescent Health, 73,* 1162–1167.

Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2023c). Correction: Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLOS ONE, 18,* e0287283.

Turban, J. L., King, D., Kobe, J., & Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PlosONE, 17,* e0261039. doi: 10.1371/journal.pone.0261039

Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*, 145(2), e20191725. https://doi.org/10.1542/peds.2019-1725

Twenge, J. M. (2020). Increases in depression, self-harm, and suicide among U.S. adolescents after 2012 and links to technology use: Possible mechanisms. *Psychiatry Research and Clinical Practice, 9,* 19–25.

Twenge, J. (2022). *How much is social media to blame for teens' declining mental health?* Retrieved from https://ifstudies.org/blog/how-much-is-social-media-to-blame-for-teens-declining-mental-health

UK Council for Psychotherapy. (2023, Nov. 2). *UKCP guidance regarding gender critical views.* United Kingdom Council for Psychotherapy: London, England. Retrieved from https://www.psychotherapy.org.uk/news/ukcp-guidance-regarding-gender-critical-views/

Villas-Boas, S. B., White, J. S., Kaplan, S., & Hsia, R. Y. (2023). Trends in depression risk before and during the COVID-19 pandemic. *PLoS One, 18,* e0285282.

Wong, W. I., van der Miesen, A. I., Li, T. G., MacMullin, L. N., & VanderLaan, D. P. (2019). Childhood social gender transition and psychosocial well-being: A comparison to cisgender gender-variant children. *Clinical Practice in Pediatric Psychology, 7,* 241–253.

World Health Organization. (2014). *WHO Handbook for guideline development (2nd ed.).* WHO: Geneva.

World Health Organization. (2019). *International classification of diseases (11th ed.).* Retrieved from https://icd.who.int/

World Health Organization. (2023, December 18). *WHO announces the development of a guideline on the health of trans and gender diverse people.* World Health Organization: Geneva. Retrieved from https://www.who.int/news/item/18-12-2023-who-announces-the-development-of-a-guideline-on-the-health-of-trans-and-gender-diverse-people

World Health Organization. (2024a, January 15). *Extended deadline for feedback on development of a WHO guideline on the health of trans and gender diverse people.* World Health Organization: Geneva. Retrieved from https://www.who.int/news/item/15-01-2024-extended-deadline-for-feedback-on-who-development-of-a-guideline-on-the-health-of-trans-and-gender-diverse-people

World Health Organization. (2024b, January 15). *FAQ: WHO development of a guideline on the health of trans and gender diverse people.* World Health Organization: Geneva. Retrieved from https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/tgd_faq_16012024.pdf?sfvrsn=79eaf57f_1

World Professional Association of Transgender Health. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health, 23,* S1–S258.

Wyckoff, A. S. (2023, Aug. 4). AAP reaffirms gender-affirming care policy, authorizes systematic review of evidence to guide update. *AAP News.* Retrieved from https://publications.aap.org/aapnews/news/25340/AAP-reaffirms-gender-affirming-care-policy?autologincheck=redirected

Other Materials

Documents produced by WPATH under subpoena (BOEAL_WPATH_000001 to BOEAL_WPATH_101726), in particular the documents identified by production number in this supplemental report.

Plaintiffs' and Defendants' expert reports in this case, in particular those reports identified in this supplemental report.

The rebuttal declaration of Dr. Jack Turban, dated July 7, 2023, in the case of *Poe et al v Drummond et al*. (Oklahoma, Northern District, Case No. 23-cv-00177-JFH-SH).

X (formerly Twitter) post of Gordon H. Guyatt (@GuyattGH), https://twitter.com/GuyattGH/status/1641183448063967233?s=20 (last visited February 1, 2024).

X (formerly Twitter) post of Colin Wright (@SwipeWright) https://twitter.com/SwipeWright/status/1571999221401948161?s=20&t=ouHIObZhEllVU-QR9tZYiQ (last visited February 2, 2024).

WPATH/USPATH Public Statements, available at https://www.wpath.org/policies

APPENDIX C: Curriculum Vitae

James M. Cantor, PhD

Toronto Sexuality Centre
2 Carlton Ave., suite 1804
Toronto, Ontario, Canada M5B 1J3

416-766-8733 (o)
416-352-6003 (f)
jamescantorphd@gmail.com

EDUCATION

Postdoctoral Fellowship Jan., 2000–May, 2004
Centre for Addiction and Mental Health • Toronto, Canada

Doctor of Philosophy Sep., 1993–Jun., 2000
Psychology • McGill University • Montréal, Canada

Master of Arts Sep., 1990–Jan., 1992
Psychology • Boston University • Boston, MA

Bachelor of Science Sep. 1984–Aug., 1988
Interdisciplinary Science • Rensselaer Polytechnic Institute • Troy, NY
Concentrations: Computer science, mathematics, physics

EMPLOYMENT HISTORY

Director Feb., 2017–Present
Toronto Sexuality Centre • Toronto, Canada

Senior Scientist (Inaugural Member) Aug., 2012–May, 2018
Campbell Family Mental Health Research Institute
Centre for Addiction and Mental Health • Toronto, Canada

Senior Scientist Jan., 2012–May, 2018
Complex Mental Illness Program
Centre for Addiction and Mental Health • Toronto, Canada

Head of Research Nov., 2010–Apr. 2014
Sexual Behaviours Clinic
Centre for Addiction and Mental Health • Toronto, Canada

Research Section Head Dec., 2009–Sep. 2012
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Psychologist May, 2004–Dec., 2011
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Clinical Psychology Intern Sep., 1998–Aug., 1999
Centre for Addiction and Mental Health • Toronto, Canada

Teaching Assistant Sep., 1993–May, 1998
Department of Psychology
McGill University • Montréal, Canada

Pre-Doctoral Practicum Sep., 1993–Jun., 1997
Sex and Couples Therapy Unit
Royal Victoria Hospital • Montréal, Canada

Pre-Doctoral Practicum May, 1994–Dec., 1994
Department of Psychiatry
Queen Elizabeth Hospital • Montréal, Canada

ACADEMIC APPOINTMENTS

Associate Professor Jul., 2010–May, 2019
Department of Psychiatry
University of Toronto Faculty of Medicine • Toronto, Canada

Adjunct Faculty Aug. 2013–Jun., 2018
Graduate Program in Psychology
York University • Toronto, Canada

Associate Faculty (Hon) Oct., 2017–Dec., 2017
School of Behavioural, Cognitive & Social Science
University of New England • Armidale, Australia

Assistant Professor Jun., 2005–Jun., 2010
Department of Psychiatry
University of Toronto Faculty of Medicine • Toronto, Canada

Adjunct Faculty Sep., 2004–Jun., 2010
Clinical Psychology Residency Program
St. Joseph's Healthcare • Hamilton, Canada

PUBLICATIONS

1. Cantor, J. M. (2023). Paraphilia, gender dysphoria, and hypersexuality. In R. F. Krueger & P. H. Blaney (Eds.), *Oxford textbook of psychopathology* (4th ed.) (pp. 549–575). New York: Oxford University Press.
2. Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy, 46,* 307–313. doi: 10.1080/0092623X.2019.1698481
3. Shirazi, T., Self, H., Cantor, J., Dawood, K., Cardenas, R., Rosenfield, K., Ortiz, T., Carré, J., McDaniel, M., Blanchard, R., Balasubramanian, R., Delaney, A., Crowley, W., S Marc Breedlove, S. M., & Puts, D. (2020). Timing of peripubertal steroid exposure predicts visuospatial cognition in men: Evidence from three samples. *Hormones and Behavior, 121, 104712*.
4. Stephens, S., Seto, M. C., Cantor, J. M., & Lalumière, M. L. (2019). The Screening Scale for Pedophilic Interest-Revised (SSPI-2) may be a measure of pedohebephilia. *Journal of Sexual Medicine, 16,* 1655−1663. doi: 10.1016/j.jsxm.2019.07.015
5. McPhail, I. V., Hermann, C. A., Fernane, S., Fernandez, Y. M., Nunes, K. L., & Cantor, J. M. (2019). Validity in phallometric testing for sexual interests in children: A meta-analytic review. *Assessment, 26,* 535–551. doi: 10.1177/1073191117706139
6. Cantor, J. M. (2018). Can pedophiles change? *Current Sexual Health Reports, 10,* 203–206. doi: 10.1007/s11930-018-0165-2
7. Cantor, J. M., & Fedoroff, J. P. (2018). Can pedophiles change? Response to opening arguments and conclusions. *Current Sexual Health Reports, 10,* 213–220. doi: 10.1007/s11930-018-0167-0z
8. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2018). Age diversity among victims of hebephilic sexual offenders. *Sexual Abuse, 30,* 332–339. doi: 10.1177/1079063216665837
9. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2018). The relationships between victim age, gender, and relationship polymorphism and sexual recidivism. *Sexual Abuse, 30,* 132−146. doi: 10.1177/1079063216630983
10. Stephens, S., Newman, J. E., Cantor, J. M., & Seto, M. C. (2018). The Static-99R predicts sexual and violent recidivism for individuals with low intellectual functioning. *Journal of Sexual Aggression, 24,* 1–11. doi: 10.1080/13552600.2017.1372936
11. Cantor, J. M. (2017). Sexual deviance or social deviance: What MRI research reveals about pedophilia. *ATSA Forum, 29*(2). Association for the Treatment of Sexual Abusers. Beaverton, OR. http://newsmanager.commpartners.com/atsa/issues/2017-03-15/2.html
12. Walton, M. T., Cantor, J. M., Bhullar, N., & Lykins, A. D. (2017). Hypersexuality: A critical review and introduction to the "Sexhavior Cycle." *Archives of Sexual Behavior, 46,* 2231–2251. doi: 10.1007/s10508-017-0991-8
13. Stephens, S., Leroux, E., Skilling, T., Cantor, J. M., & Seto, M. C. (2017). A taxometric analysis of pedophilia utilizing self-report, behavioral, and sexual arousal indicators. *Journal of Abnormal Psychology, 126,* 1114–1119. doi: 10.1037/abn0000291
14. Fazio, R. L., Dyshniku, F., Lykins, A. D., & Cantor, J. M. (2017). Leg length versus torso length in pedophilia: Further evidence of atypical physical development early in life. *Sexual Abuse: A Journal of Research and Treatment, 29,* 500–514. doi: 10.1177/1079063215609936

15. Seto, M. C., Stephens, S., Lalumière, M. L., & Cantor, J. M. (2017). The Revised Screening Scale for Pedophilic Interests (SSPI-2): Development and criterion-related validation. *Sexual Abuse: A Journal of Research and Treatment, 29,* 619–635. doi: 10.1177/1079063215612444
16. Stephens, S., Cantor, J. M., Goodwill, A. M., & Seto, M. C. (2017). Multiple indicators of sexual interest in prepubescent or pubescent children as predictors of sexual recidivism. *Journal of Consulting and Clinical Psychology, 85,* 585–595. doi: 10.1037/ccp0000194
17. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2017). Evidence of construct validity in the assessment of hebephilia. *Archives of Sexual Behavior, 46,* 301–309. doi: 10.1007/s10508-016-0907-z
18. Walton, M. T., Cantor, J. M., & Lykins, A. D. (2017). An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior. *Archives of Sexual Behavior, 46,* 721–733. doi: 10.1007/s10508-015-0606-1
19. Cantor, J. M., Lafaille, S. J., Hannah, J., Kucyi, A., Soh, D. W., Girard, T. A., & Mikulis, D. J. (2016). Independent component analysis of resting-state functional magnetic resonance imaging in pedophiles. *Journal of Sexual Medicine, 13,* 1546–1554. doi: 10.1016/j.jsxm.2016.08.004
20. Cantor, J. M., & McPhail, I. V. (2016). Non-offending pedophiles. *Current Sexual Health Reports, 8,* 121–128. doi: 10.1007/s11930-016-0076-z
21. Cantor, J. M. (2015). Milestones in sex research: What causes pedophilia? In J. S. Hyde, J. D. DeLamater, & E. S. Byers (Eds.), *Understanding human sexuality* (6th Canadian ed.) (pp. 452–453). Toronto: McGraw-Hill Ryerson.
22. Cantor, J. M. (2015). Pedophilia. In R. Cautin & S. Lilienfeld (Eds.), *Encyclopedia of clinical psychology.* Malden, MA: Wiley-Blackwell. doi: 10.1002/9781118625392.wbecp184
23. Nunes, K. L., & Cantor, J. M. (2015). Sex offenders. In P. Whelehan & A. Bolin (Eds.), *International encyclopedia of human sexuality.* Malden, MA: Wiley-Blackwell.
24. Cantor, J. M., Lafaille, S., Soh, D. W., Moayedi, M., Mikulis, D. J., & Girard, T. A. (2015). Diffusion Tensor Imaging of pedophilia. *Archives of Sexual Behavior, 44,* 2161–2172. doi: 10.1007/s10508-015-0599-9
25. Cantor, J. M., & McPhail, I. V. (2015). Sensitivity and specificity for the phallometric test of hebephilia. *Journal of Sexual Medicine, 12,* 1940–1950. doi: 10.1111/jsm12970
26. Dyshniku, F., Murray, M. E., Fazio, R. L., Lykins, A. D., & Cantor, J. M. (2015). Minor physical anomalies as a window into the prenatal origins of pedophilia. *Archives of Sexual Behavior, 44,* 2151–2159. doi: 10.1007/s10508-015-0564-7
27. Fazio, R. L., & Cantor, J. M. (2015). Factor structure of the Edinburgh Handedness Inventory versus the Fazio Laterality Inventory in a population with established atypical handedness. *Applied Neuropsychology, 22,* 156–160. doi: 10.1080/23279095.2014.940043
28. Lykins, A. D., Robinson, J. J., LeBlanc, S., & Cantor, J. M. (2015). The effects of common medications on volumetric phallometry. *Journal of Sexual Aggression, 21,* 385–393. doi: 10.1080/13552600.2014.900121
29. Sutton, K. S., Stratton, N., Pytyck, J., Kolla, N. J., & Cantor, J. M. (2015). Patient characteristics by type of hypersexuality referral: A quantitative chart review of 115 consecutive male cases. *Journal of Sex and Marital Therapy, 41,* 563−580. doi: 10.1080/0092623X.2014.935539

30. Cantor, J. M. (2014). Gold star pedophiles in general sex therapy practice. In Y. M. Binik and K. Hall (Eds.), *Principles and practice of sex therapy* (5th ed.) (pp. 219–234). New York: Guilford.
31. Cantor, J. M., & Sutton, K. S. (2014). Paraphilia, gender dysphoria, and hypersexuality. In P. H. Blaney & T. Millon (Eds.), *Oxford textbook of psychopathology* (3rd ed.) (pp. 589–614). New York: Oxford University Press.
32. Chivers, M. L., Roy, C., Grimbos, T., Cantor, J. M., & Seto, M. C. (2014). Specificity of sexual arousal for sexual activities in men and women with conventional and masochistic sexual interests. *Archives of Sexual Behavior, 43,* 931−940. doi: 10.1007/s10508-013-0174-1
33. Fazio, R. L., Lykins, A. D., & Cantor, J. M. (2014). Elevated rates of atypical-handedness in paedophilia: Theory and implications. *Laterality, 19,* 690−704. doi: 10.1080/1357650X.2014.898648
34. Lykins, A. D., & Cantor, J. M. (2014). Vorarephilia: A case study in masochism and erotic consumption. *Archives of Sexual Behavior, 43,* 181–186. doi: 10.1007/s10508-013-0185-y
35. Cantor, J. M., Klein, C., Lykins, A., Rullo, J. E., Thaler, L., & Walling, B. R. (2013). A treatment-oriented typology of self-identified hypersexuality referrals. *Archives of Sexual Behavior, 42,* 883–893. doi: 10.1007/s10508-013-0085-1
36. Blanchard, R., Kuban, M. E., Blak, T., Klassen, P. E., Dickey, R., & Cantor, J. M. (2012). Sexual attraction to others: A comparison of two models of alloerotic responding in men. *Archives of Sexual Behavior, 41,* 13–29. doi: 10.1007/s10508-010-9675-3
37. Cantor, J. M. (2012). Brain research and pedophilia: What it says and what it means [Invited article]. *Sex Offender Law Report, 13,* 81–85.
38. Cantor, J. M. (2012). Is homosexuality a paraphilia? The evidence for and against. *Archives of Sexual Behavior, 41,* 237–247. doi: 10.1007/s10508-012-9900-3
39. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010). Sexual arousal to female children in gynephilic men. *Sexual Abuse: A Journal of Research and Treatment, 22,* 279–289. doi: 10.1177/1079063210372141
40. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010). The relation between peak response magnitudes and agreement in diagnoses obtained from two different phallometric tests for pedophilia. *Sexual Abuse: A Journal of Research and Treatment, 22,* 42–57. doi: 10.1177/1079063209352094
41. Cantor, J. M., Blanchard, R., & Barbaree, H. E. (2009). Sexual disorders. In P. H. Blaney & T. Millon (Eds.), *Oxford textbook of psychopathology* (2nd ed.) (pp. 527–548). New York: Oxford University Press.
42. Barbaree, H. E., Langton, C. M., Blanchard, R., & Cantor, J. M. (2009). Aging versus stable enduring traits as explanatory constructs in sex offender recidivism: Partitioning actuarial prediction into conceptually meaningful components. *Criminal Justice and Behavior: An International Journal, 36,* 443–465. doi: 10.1177/0093854809332283
43. Blanchard, R., Kuban, M. E., Blak, T., Cantor, J. M., Klassen, P. E., & Dickey, R. (2009). Absolute versus relative ascertainment of pedophilia in men. *Sexual Abuse: A Journal of Research and Treatment, 21,* 431–441. doi: 10.1177/1079063209347906

44. Blanchard, R., Lykins, A. D., Wherrett, D., Kuban, M. E., Cantor, J. M., Blak, T., Dickey, R., & Klassen, P. E. (2009). Pedophilia, hebephilia, and the DSM–V. *Archives of Sexual Behavior, 38,* 335–350. doi: 10.1007/s10508-008-9399-9.
45. Cantor, J. M. (2008). MRI research on pedophilia: What ATSA members should know [Invited article]. *ATSA Forum, 20*(4), 6–10.
46. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2008). Cerebral white matter deficiencies in pedophilic men. *Journal of Psychiatric Research, 42,* 167–183. doi: 10.1016/j.jpsychires.2007.10.013
47. Blanchard, R., Kolla, N. J., Cantor, J. M., Klassen, P. E., Dickey, R., Kuban, M. E., & Blak, T. (2007). IQ, handedness, and pedophilia in adult male patients stratified by referral source. *Sexual Abuse: A Journal of Research and Treatment, 19,* 285–309. doi: 10.1007/s11194-007-9049-0
48. Cantor, J. M., Kuban, M. E., Blak, T., Klassen, P. E., Dickey, R., & Blanchard, R. (2007). Physical height in pedophilia and hebephilia. *Sexual Abuse: A Journal of Research and Treatment, 19,* 395–407. doi: 10.1007/s11194-007-9060-5
49. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2006). Interaction of fraternal birth order and handedness in the development of male homosexuality. *Hormones and Behavior, 49,* 405–414. doi: 10.1016/j.yhbeh.2005.09.002
50. Blanchard, R., Kuban, M. E., Blak, T., Cantor, J. M., Klassen, P., & Dickey, R. (2006). Phallometric comparison of pedophilic interest in nonadmitting sexual offenders against stepdaughters, biological daughters, other biologically related girls, and unrelated girls. *Sexual Abuse: A Journal of Research and Treatment, 18,* 1–14. doi: 10.1007/s11194-006-9000-9
51. Blanchard, R., Cantor, J. M., & Robichaud, L. K. (2006). Biological factors in the development of sexual deviance and aggression in males. In H. E. Barbaree & W. L. Marshall (Eds.), *The juvenile sex offender* (2nd ed., pp. 77–104). New York: Guilford.
52. Cantor, J. M., Kuban, M. E., Blak, T., Klassen, P. E., Dickey, R., & Blanchard, R. (2006). Grade failure and special education placement in sexual offenders' educational histories. *Archives of Sexual Behavior, 35,* 743–751. doi: 10.1007/s10508-006-9018-6
53. Seto, M. C., Cantor, J. M., & Blanchard, R. (2006). Child pornography offenses are a valid diagnostic indicator of pedophilia. *Journal of Abnormal Psychology, 115,* 610–615. doi: 10.1037/0021-843X.115.3.610
54. Zucker, K. J., Mitchell, J. N., Bradley, S. J., Tkachuk, J., Cantor, J. M., & Allin, S. M. (2006). The Recalled Childhood Gender Identity/Gender Role Questionnaire: Psychometric properties. *Sex Roles, 54,* 469–483. doi 10.1007/s11199-006-9019-x
55. Cantor, J. M., Blanchard, R., Robichaud, L. K., & Christensen, B. K. (2005). Quantitative reanalysis of aggregate data on IQ in sexual offenders. *Psychological Bulletin, 131,* 555–568. doi: 10.1037/0033-2909.131.4.555
56. Cantor, J. M., Klassen, P. E., Dickey, R., Christensen, B. K., Kuban, M. E., Blak, T., Williams, N. S., & Blanchard, R. (2005). Handedness in pedophilia and hebephilia. *Archives of Sexual Behavior, 34,* 447–459. doi: 10.1007/s10508-005-4344-7
57. Cantor, J. M., Blanchard, R., Christensen, B. K., Dickey, R., Klassen, P. E., Beckstead, A. L., Blak, T., & Kuban, M. E. (2004). Intelligence, memory, and handedness in pedophilia. *Neuropsychology, 18,* 3–14. doi: 10.1037/0894-4105.18.1.3

58. Blanchard, R., Kuban, M. E., Klassen, P., Dickey, R., Christensen, B. K., Cantor, J. M., & Blak, T. (2003). Self-reported injuries before and after age 13 in pedophilic and non-pedophilic men referred for clinical assessment. *Archives of Sexual Behavior, 32,* 573–581.
59. Blanchard, R., Christensen, B. K., Strong, S. M., Cantor, J. M., Kuban, M. E., Klassen, P., Dickey, R., & Blak, T. (2002). Retrospective self-reports of childhood accidents causing unconsciousness in phallometrically diagnosed pedophiles. *Archives of Sexual Behavior, 31,* 511–526.
60. Cantor, J. M., Blanchard, R., Paterson, A. D., Bogaert, A. F. (2002). How many gay men owe their sexual orientation to fraternal birth order? *Archives of Sexual Behavior, 31,* 63–71.
61. Cantor, J. M., Binik, Y. M., & Pfaus, J. G. (1999). Chronic fluoxetine inhibits sexual behavior in the male rat: Reversal with oxytocin. *Psychopharmacology*, *144*, 355–362.
62. Binik, Y. M., Cantor, J., Ochs, E., & Meana, M. (1997). From the couch to the keyboard: Psychotherapy in cyberspace. In S. Kiesler (Ed.), *Culture of the internet* (pp. 71–100). Mahwah, NJ: Lawrence Erlbaum.
63. Johnson, M. K., O'Connor, M., & Cantor, J. (1997). Confabulation, memory deficits, and frontal dysfunction. *Brain and Cognition*, *34*, 189–206.
64. Keane, M. M., Gabrieli, J. D. E., Monti, L. A., Fleischman, D. A., Cantor, J. M., & Nolan, J. S. (1997). Intact and impaired conceptual memory processes in amnesia. *Neuropsychology*, *11*, 59–69.
65. Pilkington, N. W., & Cantor, J. M. (1996). Perceptions of heterosexual bias in professional psychology programs: A survey of graduate students. *Professional Psychology: Research and Practice*, *27*, 604–612.

PUBLICATIONS

LETTERS AND COMMENTARIES

1. Cantor, J. M. (2015). Research methods, statistical analysis, and the phallometric test for hebephilia: Response to Fedoroff [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2499–2500. doi: 10.1111/jsm.13040
2. Cantor, J. M. (2015). In his own words: Response to Moser [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2502–2503. doi: 10.1111/jsm.13075
3. Cantor, J. M. (2015). Purported changes in pedophilia as statistical artefacts: Comment on Müller et al. (2014). *Archives of Sexual Behavior, 44,* 253–254. doi: 10.1007/s10508-014-0343-x
4. McPhail, I. V., & Cantor, J. M. (2015). Pedophilia, height, and the magnitude of the association: A research note. *Deviant Behavior, 36,* 288–292. doi: 10.1080/01639625.2014.935644
5. Soh, D. W., & Cantor, J. M. (2015). A peek inside a furry convention [Letter to the Editor]. *Archives of Sexual Behavior, 44,* 1–2. doi: 10.1007/s10508-014-0423-y
6. Cantor, J. M. (2012). Reply to Italiano's (2012) comment on Cantor (2011) [Letter to the Editor]. *Archives of Sexual Behavior, 41,* 1081–1082. doi: 10.1007/s10508-012-0011-y
7. Cantor, J. M. (2012). The errors of Karen Franklin's *Pretextuality* [Commentary]. *International Journal of Forensic Mental Health, 11,* 59–62. doi: 10.1080/14999013.2012.672945
8. Cantor, J. M., & Blanchard, R. (2012). White matter volumes in pedophiles, hebephiles, and teleiophiles [Letter to the Editor]. *Archives of Sexual Behavior, 41, 749–752.* doi: 10.1007/s10508-012-9954-2
9. Cantor, J. M. (2011). New MRI studies support the Blanchard typology of male-to-female transsexualism [Letter to the Editor]. *Archives of Sexual Behavior, 40*, 863–864. doi: 10.1007/s10508-011-9805-6
10. Zucker, K. J., Bradley, S. J., Own-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex and Marital Therapy, 34,* 287–290.
11. Cantor, J. M. (2003, Summer). Review of the book *The Man Who Would Be Queen* by J. Michael Bailey. *Newsletter of Division 44 of the American Psychological Association, 19*(2), 6.
12. Cantor, J. M. (2003, Spring). What are the hot topics in LGBT research in psychology? *Newsletter of Division 44 of the American Psychological Association, 19*(1), 21–24.
13. Cantor, J. M. (2002, Fall). Male homosexuality, science, and pedophilia. *Newsletter of Division 44 of the American Psychological Association, 18*(3), 5–8.
14. Cantor, J. M. (2000). Review of the book *Sexual Addiction: An Integrated Approach. Journal of Sex and Marital Therapy, 26*, 107–109.

EDITORIALS

1. Cantor, J. M. (2012). Editorial. *Sexual Abuse: A Journal of Research and Treatment, 24*.

2. Cantor, J. M. (2011). Editorial note. *Sexual Abuse: A Journal of Research and Treatment, 23,* 414.
3. Barbaree, H. E., & Cantor, J. M. (2010). Performance indicates for *Sexual Abuse: A Journal of Research and Treatment* (SAJRT) [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 22,* 371–373.
4. Barbaree, H. E., & Cantor, J. M. (2009). *Sexual Abuse: A Journal of Research and Treatment* performance indicators for 2007 [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 21,* 3–5.
5. Zucker, K. J., & Cantor, J. M. (2009). Cruising: Impact factor data [Editorial]. *Archives of Sexual Research, 38,* 878–882.
6. Barbaree, H. E., & Cantor, J. M. (2008). Performance indicators for *Sexual Abuse: A Journal of Research and Treatment* [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 20,* 3–4.
7. Zucker, K. J., & Cantor, J. M. (2008). The *Archives* in the era of online first ahead of print[Editorial]. *Archives of Sexual Behavior, 37,* 512–516.
8. Zucker, K. J., & Cantor, J. M. (2006). The impact factor: The *Archives* breaks from the pack [Editorial]. *Archives of Sexual Behavior, 35,* 7–9.
9. Zucker, K. J., & Cantor, J. M. (2005). The impact factor: "Goin' up" [Editorial]. *Archives of Sexual Behavior, 34,* 7–9.
10. Zucker, K., & Cantor, J. M. (2003). The numbers game: The impact factor and all that jazz [Editorial]. *Archives of Sexual Behavior, 32,* 3–5.

FUNDING HISTORY

Principal Investigators:	Doug VanderLaan, Meng-Chuan Lai
Co-Investigators:	James M. Cantor, Megha Mallar Chakravarty, Nancy Lobaugh, M. Palmert, M. Skorska
Title:	*Brain function and connectomics following sex hormone treatment in adolescents experience gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Behavioural Sciences-B-2
Funds:	$650,250 / 5 years (July, 2018)

Principal Investigator:	Michael C. Seto
Co-Investigators:	Martin Lalumière , James M. Cantor
Title:	*Are connectivity differences unique to pedophilia?*
Agency:	University Medical Research Fund, Royal Ottawa Hospital
Funds:	$50,000 / 1 year (January, 2018)

Principal Investigator:	Lori Brotto
Co-Investigators:	Anthony Bogaert, James M. Cantor, Gerulf Rieger
Title:	*Investigations into the neural underpinnings and biological correlates of asexuality*
Agency:	Natural Sciences and Engineering Research Council (NSERC), Discovery Grants Program
Funds:	$195,000 / 5 years (April, 2017)

Principal Investigator:	Doug VanderLaan
Co-Investigators:	Jerald Bain, James M. Cantor, Megha Mallar Chakravarty, Sofia Chavez, Nancy Lobaugh, and Kenneth J. Zucker
Title:	*Effects of sex hormone treatment on brain development: A magnetic resonance imaging study of adolescents with gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Transitional Open Grant Program
Funds:	$952,955 / 5 years (September, 2015)

Principal Investigator:	James M. Cantor
Co-Investigators:	Howard E. Barbaree, Ray Blanchard, Robert Dickey, Todd A. Girard, Phillip E. Klassen, and David J. Mikulis
Title:	*Neuroanatomic features specific to pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$1,071,920 / 5 years (October, 2008)

Principal Investigator:	James M. Cantor
Title:	*A preliminary study of fMRI as a diagnostic test of pedophilia*
Agency:	Dean of Medicine New Faculty Grant Competition, Univ. of Toronto
Funds:	$10,000 (July, 2008)

Principal Investigator:	James M. Cantor
Co-Investigator:	Ray Blanchard
Title:	*Morphological and neuropsychological correlates of pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$196,902 / 3 years (April, 2006)

KEYNOTE AND INVITED ADDRESSES

1. Cantor, J. M. (2022, December 5). The science of gender dysphoria and transgenderism. Lund University, Latvia. https://files.fm/f/4bzznufvb
2. Cantor, J. M. (2021, September 28). *No topic too tough for this expert panel: A year in review.* Plenary Session for the 40th Annual Research and Treatment Conference, Association for the Treatment of Sexual Abusers.
3. Cantor, J. M. (2019, May 1). *Introduction and Q&A for 'I, Pedophile.'* StopSO 2nd Annual Conference, London, UK.
4. Cantor, J. M. (2018, August 29). *Neurobiology of pedophilia or paraphilia? Towards a 'Grand Unified Theory' of sexual interests.* Keynote address to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
5. Cantor, J. M. (2018, August 29). *Pedophilia and the brain: Three questions asked and answered.* Preconference training presented to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
6. Cantor, J. M. (2018, April 13). *The responses to* I, Pedophile *from We, the people.* Keynote address to the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
7. Cantor, J. M. (2018, April 11). *Studying atypical sexualities: From vanilla to* I, Pedophile. Full day workshop at the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
8. Cantor, J. M. (2018, January 20). *How much sex is enough for a happy life?* Invited lecture to the University of Toronto Division of Urology Men's Health Summit, Toronto, Canada.
9. Cantor, J. M. (2017, November 2). Pedophilia as a phenomenon of the brain: Update of evidence and the public response. Invited presentation to the 7th annual SBC education event, Centre for Addiction and Mental Health, Toronto, Canada.
10. Cantor, J. M. (2017, June 9). Pedophilia being in the brain: The evidence and the public's reaction. Invited presentation to *SEXposium at the ROM: The science of love and sex,* Toronto, Canada.
11. Cantor, J. M., & Campea, M. (2017, April 20). *"I, Pedophile" showing and discussion.* Invited presentation to the 42nd annual meeting of the Society for Sex Therapy and Research, Montréal, Canada.
12. Cantor, J. M. (2017, March 1). *Functional and structural neuroimaging of pedophilia: Consistencies across methods and modalities.* Invited lecture to the Brain Imaging Centre, Royal Ottawa Hospital, Ottawa, Canada.
13. Cantor, J. M. (2017, January 26). *Pedophilia being in the brain: The evidence and the public reaction.* Inaugural keynote address to the University of Toronto Sexuality Interest Network, Toronto, Ontario, Canada.
14. Cantor, J. M. (2016, October 14). *Discussion of CBC's "I, Pedophile."* Office of the Children's Lawyer Educational Session, Toronto, Ontario, Canada.
15. Cantor, J. M. (2016, September 15). *Evaluating the risk to reoffend: What we know and what we don't.* Invited lecture to the Association of Ontario Judges, Ontario Court of Justice Annual Family Law Program, Blue Mountains, Ontario, Canada. [Private link only: https://vimeo.com/239131108/3387c80652]
16. Cantor, J. M. (2016, April 8). *Pedophilia and the brain: Conclusions from the second*

generation of research. Invited lecture at the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.

17. Cantor, J. M. (2016, April 7). *Hypersexuality without the hyperbole.* Keynote address to the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.
18. Cantor, J. M. (2015, November). *No one asks to be sexually attracted to children: Living in Daniel's World.* Grand Rounds, Centre for Addiction and Mental Health. Toronto, Canada.
19. Cantor, J. M. (2015, August). *Hypersexuality: Getting past whether "it" is or "it" isn't.* Invited address at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
20. Cantor, J. M. (2015, July). *A unified theory of typical and atypical sexual interest in men: Paraphilia, hypersexuality, asexuality, and vanilla as outcomes of a single, dual opponent process.* Invited presentation to the 2015 Puzzles of Sexual Orientation conference, Lethbridge, AL, Canada.
21. Cantor, J. M. (2015, June). *Hypersexuality.* Keynote Address to the Ontario Problem Gambling Provincial Forum. Toronto, Canada.
22. Cantor, J. M. (2015, May). *Assessment of pedophilia: Past, present, future.* Keynote Address to the International Symposium on Neural Mechanisms Underlying Pedophilia and Child Sexual Abuse (NeMUP). Berlin, Germany.
23. Cantor, J. M. (2015, March). *Prevention of sexual abuse by tackling the biggest stigma of them all: Making sex therapy available to pedophiles.* Keynote address to the 40th annual meeting of the Society for Sex Therapy and Research, Boston, MA.
24. Cantor, J. M. (2015, March. *Pedophilia: Predisposition or perversion?* Panel discussion at Columbia University School of Journalism. New York, NY.
25. Cantor, J. M. (2015, February). *Hypersexuality.* Research Day Grand Rounds presentation to Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario, Canada.
26. Cantor, J. M. (2015, January). *Brain research and pedophilia: What it means for assessment, research, and policy.* Keynote address to the inaugural meeting of the Netherlands Association for the Treatment of Sexual Abusers, Utrecht, Netherlands.
27. Cantor, J. M. (2014, December). *Understanding pedophilia and the brain: Implications for safety and society.* Keynote address for The Jewish Community Confronts Violence and Abuse: Crisis Centre for Religious Women, Jerusalem, Israel.
28. Cantor, J. M. (2014, October). *Understanding pedophilia & the brain.* Invited full-day workshop for the Sex Offender Assessment Board of Pennsylvania, Harrisburg, PA.
29. Cantor, J. M. (2014, September). *Understanding neuroimaging of pedophilia: Current status and implications.* Invited lecture presented to the Mental Health and Addition Rounds, St. Joseph's Healthcare, Hamilton, Ontario, Canada.
30. Cantor, J. M. (2014, June). *An evening with Dr. James Cantor.* Invited lecture presented to the Ontario Medical Association, District 11 Doctors' Lounge Program, Toronto, Ontario, Canada.
31. Cantor, J. M. (2014, April). *Pedophilia and the brain.* Invited lecture presented to the University of Toronto Medical Students lunchtime lecture. Toronto, Ontario, Canada.
32. Cantor, J. M. (2014, February). *Pedophilia and the brain: Recap and update.* Workshop presented at the 2014 annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Cle Elum, WA.

33. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, February). *Functional connectivity in pedophilia.* Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario, Canada.
34. Cantor, J. M. (2013, November). *Understanding pedophilia and the brain: The basics, the current status, and their implications.* Invited lecture to the Forensic Psychology Research Centre, Carleton University, Ottawa, Canada.
35. Cantor, J. M. (2013, November). *Mistaking puberty, mistaking hebephilia.* Keynote address presented to the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
36. Cantor, J. M. (2013, October). *Understanding pedophilia and the brain: A recap and update.* Invited workshop presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
37. Cantor, J. M. (2013, October). *Compulsive-hyper-sex-addiction: I don't care what we all it, what can we* do*?* Invited address presented to the Board of Examiners of Sex Therapists and Counselors of Ontario, Toronto, Ontario, Canada.
38. Cantor, J. M. (2013, September). *Neuroimaging of pedophilia: Current status and implications.* McGill University Health Centre, Department of Psychiatry Grand Rounds presentation, Montréal, Québec, Canada.
39. Cantor, J. M. (2013, April). *Understanding pedophilia and the brain.* Invited workshop presented at the 2013 meeting of the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, MN.
40. Cantor, J. M. (2013, April). *The neurobiology of pedophilia and its implications for assessment, treatment, and public policy.* Invited lecture at the 38th annual meeting of the Society for Sex Therapy and Research, Baltimore, MD.
41. Cantor, J. M. (2013, April). *Sex offenders: Relating research to policy.* Invited roundtable presentation at the annual meeting of the Academy of Criminal Justice Sciences, Dallas, TX.
42. Cantor, J. M. (2013, March). *Pedophilia and brain research: From the basics to the state-of-the-art.* Invited workshop presented to the annual meeting of the Forensic Mental Health Association of California, Monterey, CA.
43. Cantor, J. M. (2013, January). *Pedophilia and child molestation.* Invited lecture presented to the Canadian Border Services Agency, Toronto, Ontario, Canada.
44. Cantor, J. M. (2012, November). *Understanding pedophilia and sexual offenders against children: Neuroimaging and its implications for public safety.* Invited guest lecture to University of New Mexico School of Medicine Health Sciences Center, Albuquerque, NM.
45. Cantor, J. M. (2012, November). *Pedophilia and brain research.* Invited guest lecture to the annual meeting of the Circles of Support and Accountability, Toronto, Ontario, Canada.
46. Cantor, J. M. (2012, January). *Current findings on pedophilia brain research.* Invited workshop at the San Diego International Conference on Child and Family Maltreatment, San Diego, CA.
47. Cantor, J. M. (2012, January). *Pedophilia and the risk to re-offend.* Invited lecture to the Ontario Court of Justice Judicial Development Institute, Toronto, Ontario, Canada.
48. Cantor, J. M. (2011, November). *Pedophilia and the brain: What it means for assessment, treatment, and policy.* Plenary Lecture presented at the Association for the Treatment of Sexual Abusers, Toronto, Ontario, Canada.

49. Cantor, J. M. (2011, July). *Towards understanding contradictory findings in the neuroimaging of pedophilic men.* Keynote address to 7th annual conference on Research in Forensic Psychiatry, Regensberg, Germany.
50. Cantor, J. M. (2011, March). *Understanding sexual offending and the brain: Brain basics to the state of the art.* Workshop presented at the winter conference of the Oregon Association for the Treatment of Sexual Abusers, Oregon City, OR.
51. Cantor, J. M. (2010, October). *Manuscript publishing for students.* Workshop presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
52. Cantor, J. M. (2010, August). *Is sexual orientation a paraphilia?* Invited lecture at the International Behavioral Development Symposium, Lethbridge, Alberta, Canada.
53. Cantor, J. M. (2010, March). *Understanding sexual offending and the brain: From the basics to the state of the art.* Workshop presented at the annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Blaine, WA.
54. Cantor, J. M. (2009, January). *Brain structure and function of pedophilia men.* Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario.
55. Cantor, J. M. (2008, April). *Is pedophilia caused by brain dysfunction?* Invited address to the University-wide Science Day Lecture Series, SUNY Oswego, Oswego, NY.
56. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, September). *MRIs of pedophilic men.* Invited presentation at the 25th annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
57. Cantor, J. M., Blanchard, R., & Christensen, B. K. (2003, March). *Findings in and implications of neuropsychology and epidemiology of pedophilia.* Invited lecture at the 28th annual meeting of the Society for Sex Therapy and Research, Miami.
58. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, July). *Neuropsychological functioning in pedophiles.* Invited lecture presented at the 27th annual meeting of the International Academy of Sex Research, Bromont, Canada.
59. Cantor, J. M., Blanchard, R., Christensen, B., Klassen, P., & Dickey, R. (2001, February). *First glance at IQ, memory functioning and handedness in sex offenders.* Lecture presented at the Forensic Lecture Series, Centre for Addiction and Mental Health, Toronto, Ontario, Canada.
60. Cantor, J. M. (1999, November). *Reversal of SSRI-induced male sexual dysfunction: Suggestions from an animal model.* Grand Rounds presentation at the Allan Memorial Institute, Royal Victoria Hospital, Montréal, Canada.

PAPER PRESENTATIONS AND SYMPOSIA

1. Cantor, J. M. (2020, April). "I'd rather have a trans kid than a dead kid": Critical assessment of reported rates of suicidality in trans kids. *Paper presented at the annual meeting of the Society for the Sex Therapy and Research.* Online in lieu of in person meeting.
2. Stephens, S., Lalumière, M., Seto, M. C., & Cantor, J. M. (2017, October). *The relationship between sexual responsiveness and sexual exclusivity in phallometric profiles.* Paper presented at the annual meeting of the Canadian Sex Research Forum, Fredericton, New Brunswick, Canada.
3. Stephens, S., Cantor, J. M., & Seto, M. C. (2017, March). *Can the SSPI-2 detect hebephilic sexual interest?* Paper presented at the annual meeting of the American-Psychology Law Society Annual Meeting, Seattle, WA.
4. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Victim choice polymorphism and recidivism.* Symposium Presentation. Paper presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
5. McPhail, I. V., Hermann, C. A., Fernane, S. Fernandez, Y., Cantor, J. M., & Nunes, K. L. (2014, October). *Sexual deviance in sexual offenders against children: A meta-analytic review of phallometric research.* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
6. Stephens, S., Seto, M. C., Cantor, J. M., & Goodwill, A. M. (2014, October). *Is hebephilic sexual interest a criminogenic need?: A large scale recidivism study.* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
7. Stephens, S., Seto, M. C., Cantor, J. M., & Lalumière, M. (2014, October). *Development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI–2).* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, September). *Pedophilia and the brain: White matter differences detected with DTI.* Paper presented at the 13th annual meeting of the International Association for the Treatment of Sexual Abusers, Porto, Portugal.
9. Stephens, S., Seto, M., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2014, March). *The role of hebephilic sexual interests in sexual victim choice.* Paper presented at the annual meeting of the American Psychology and Law Society, New Orleans, LA.
10. McPhail, I. V., Fernane, S. A., Hermann, C. A., Fernandez, Y. M., Nunes, K. L., & Cantor, J. M. (2013, November). *Sexual deviance and sexual recidivism in sexual offenders against children: A meta-analysis.* Paper presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
11. Cantor, J. M. (2013, September). *Pedophilia and the brain: Current MRI research and its implications.* Paper presented at the 21st annual World Congress for Sexual Health, Porto Alegre, Brazil. [Featured among Best Abstracts, top 10 of 500.]
12. Cantor, J. M. (Chair). (2012, March). *Innovations in sex research.* Symposium conducted at the 37th annual meeting of the Society for Sex Therapy and Research, Chicago.
13. Cantor, J. M., & Blanchard, R. (2011, August). fMRI versus phallometry in the diagnosis of pedophilia and hebephilia. In J. M. Cantor (Chair), *Neuroimaging of men's object*

preferences. Symposium presented at the 37th annual meeting of the International Academy of Sex Research, Los Angeles, USA.

14. Cantor, J. M. (Chair). (2011, August). *Neuroimaging of men's object preferences.* Symposium conducted at the 37th annual meeting of the International Academy of Sex Research, Los Angeles.
15. Cantor, J. M. (2010, October). A meta-analysis of neuroimaging studies of male sexual arousal. In S. Stolerú (Chair), *Brain processing of sexual stimuli in pedophilia: An application of functional neuroimaging.* Symposium presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
16. Chivers, M. L., Seto, M. C., Cantor, J. C., Grimbos, T., & Roy, C. (April, 2010). *Psychophysiological assessment of sexual activity preferences in women.* Paper presented at the 35th annual meeting of the Society for Sex Therapy and Research, Boston, USA.
17. Cantor, J. M., Girard, T. A., & Lovett-Barron, M. (2008, November). *The brain regions that respond to erotica: Sexual neuroscience for dummies.* Paper presented at the 51st annual meeting of the Society for the Scientific Study of Sexuality, San Juan, Puerto Rico.
18. Barbaree, H., Langton, C., Blanchard, R., & Cantor, J. M. (2007, October). *The role of age-at-release in the evaluation of recidivism risk of sexual offenders.* Paper presented at the 26th annual meetingof the Association for the Treatment of Sexual Abusers, San Diego.
19. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, July). *Pedophilia and brain morphology.* Abstract and paper presented at the 32nd annual meeting of the International Academy of Sex Research, Amsterdam, Netherlands.
20. Seto, M. C., Cantor, J. M., & Blanchard, R. (2006, March). *Child pornography offending is a diagnostic indicator of pedophilia*. Paper presented at the 2006 annual meeting of the American Psychology-Law Society Conference, St. Petersburg, Florida.
21. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2005, August). *Interaction of fraternal birth order and handedness in the development of male homosexuality.* Abstract and paper presented at the International Behavioral Development Symposium, Minot, North Dakota.
22. Cantor, J. M., & Blanchard, R. (2005, July). *Quantitative reanalysis of aggregate data on IQ in sexual offenders.* Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
23. Cantor, J. M. (2003, August). *Sex reassignment on demand: The clinician's dilemma.* Paper presented at the 111th annual meeting of the American Psychological Association, Toronto, Canada.
24. Cantor, J. M. (2003, June). *Meta-analysis of VIQ–PIQ differences in male sex offenders.* Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
25. Cantor, J. M. (2002, August). *Gender role in autogynephilic transsexuals: The more things change…* Paper presented at the 110th annual meeting of the American Psychological Association, Chicago.

26. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, June). *IQ, memory functioning, and handedness in male sex offenders.* Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
27. Cantor, J. M. (1998, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 106th annual meeting of the American Psychological Association.
28. Cantor, J. M. (1997, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 105th annual meeting of the American Psychological Association.
29. Cantor, J. M. (1997, August). *Convention orientation for lesbian, gay, and bisexual students*. Paper presented at the 105th annual meeting of the American Psychological Association.
30. Cantor, J. M. (1996, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 104th annual meeting of the American Psychological Association.
31. Cantor, J. M. (1996, August). *Symposium: Question of inclusion: Lesbian and gay psychologists and accreditation*. Paper presented at the 104th annual meeting of the American Psychological Association, Toronto.
32. Cantor, J. M. (1996, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 104th annual meeting of the American Psychological Association.
33. Cantor, J. M. (1995, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 103rd annual meeting of the American Psychological Association.
34. Cantor, J. M. (1995, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 103rd annual meeting of the American Psychological Association.
35. Cantor, J. M. (1994, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 102nd annual meeting of the American Psychological Association.
36. Cantor, J. M. (1994, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 102nd annual meeting of the American Psychological Association.
37. Cantor, J. M., & Pilkington, N. W. (1992, August). *Homophobia in psychology programs: A survey of graduate students.* Paper presented at the Centennial Convention of the American Psychological Association, Washington, DC. (ERIC Document Reproduction Service No. ED 351 618)
38. Cantor, J. M. (1991, August). *Being gay and being a graduate student: Double the memberships, four times the problems*. Paper presented at the 99th annual meeting of the American Psychological Association, San Francisco.

POSTER PRESENTATIONS

1. Klein, L., Stephens, S., Goodwill, A. M., Cantor, J. M., & Seto, M. C. (2015, October). *The psychological propensities of risk in undetected sexual offenders.* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
2. Pullman, L. E., Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Why are incest offenders less likely to recidivate?* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
3. Seto, M. C., Stephens, S. M., Cantor, J. M., Lalumiere, M. L., Sandler, J. C., & Freeman, N. A. (2015, August). *The development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI-2).* Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
4. Soh, D. W., & Cantor, J. M. (2015, August). *A peek inside a furry convention.* Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
5. VanderLaan, D. P., Lobaugh, N. J., Chakravarty, M. M., Patel, R., Chavez, S. Stojanovski, S. O., Takagi, A., Hughes, S. K., Wasserman, L., Bain, J., Cantor, J. M., & Zucker, K. J. (2015, August). *The neurohormonal hypothesis of gender dysphoria: Preliminary evidence of cortical surface area differences in adolescent natal females.* Poster presentation at the 31st annual meeting of the International Academy of Sex Research. Toronto, Canada.
6. Cantor, J. M., Lafaille, S. J., Moayedi, M., Mikulis, D. M., & Girard, T. A. (2015, June). *Diffusion tensor imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses.* Harvey Stancer Research Day, Toronto, Ontario Canada.
7. Newman, J. E., Stephens, S., Seto, M. C., & Cantor, J. M. (2014, October). *The validity of the Static-99 in sexual offenders with low intellectual abilities.* Poster presentation at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Lykins, A. D., Walton, M. T., & Cantor, J. M. (2014, June). *An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior.* Poster presentation at the 30th annual meeting of the International Academy of Sex Research, Dubrovnik, Croatia.
9. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, November). *The utility of phallometry in the assessment of hebephilia.* Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
10. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, October). *The role of hebephilic sexual interests in sexual victim choice.* Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
11. Fazio, R. L., & Cantor, J. M. (2013, October). *Analysis of the Fazio Laterality Inventory (FLI) in a population with established atypical handedness.* Poster presented at the 33rd annual meeting of the National Academy of Neuropsychology, San Diego.
12. Lafaille, S., Hannah, J., Soh, D., Kucyi, A., Girard, T. A., Mikulis, D. M., & Cantor, J. M. (2013, August). *Investigating resting state networks in pedohebephiles.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.

13. McPhail, I. V., Lykins, A. D., Robinson, J. J., LeBlanc, S., & Cantor, J. M. (2013, August). *Effects of prescription medication on volumetric phallometry output.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
14. Murray, M. E., Dyshniku, F., Fazio, R. L., & Cantor, J. M. (2013, August). *Minor physical anomalies as a window into the prenatal origins of pedophilia.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
15. Sutton, K. S., Stephens, S., Dyshniku, F., Tulloch, T., & Cantor, J. M. (2013, August). *Pilot group treatment for "procrasturbation."* Poster presented at 39th annual meeting of the International Academy of Sex Research, Chicago.
16. Sutton, K. S., Pytyck, J., Stratton, N., Sylva, D., Kolla, N., & Cantor, J. M. (2013, August). *Client characteristics by type of hypersexuality referral: A quantitative chart review.* Poster presented at the 39th annual meeting of the International Academy of Sex Research, Chicago.
17. Fazio, R. L., & Cantor, J. M. (2013, June). *A replication and extension of the psychometric properties of the Digit Vigilance Test.* Poster presented at the 11th annual meeting of the American Academy of Clinical Neuropsychology, Chicago.
18. Lafaille, S., Moayedi, M., Mikulis, D. M., Girard, T. A., Kuban, M., Blak, T., & Cantor, J. M. (2012, July). *Diffusion Tensor Imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses.* Poster presented at the 38th annual meeting of the International Academy of Sex Research, Lisbon, Portugal.
19. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010, July). *Sexual arousal to female children in gynephilic men.* Poster presented at the 38th annual meeting of the International Academy of Sex Research, Prague, Czech Republic.
20. Cantor, J. M., Girard, T. A., Lovett-Barron, M., & Blak, T. (2008, July). *Brain regions responding to visual sexual stimuli: Meta-analysis of PET and fMRI studies.* Abstract and poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
21. Lykins, A. D., Blanchard, R., Cantor, J. M., Blak, T., & Kuban, M. E. (2008, July). *Diagnosing sexual attraction to children: Considerations for DSM-V.* Poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
22. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, October). *Physical height in pedophilia and hebephilia.* Poster presented at the 26th annual meeting of the Association for the Treatment of Sexual Abusers, San Diego.
23. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, August). *Physical height in pedophilia and hebephilia.* Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
24. Puts, D. A., Blanchard, R., Cardenas, R., Cantor, J., Jordan, C. L., & Breedlove, S. M. (2007, August). *Earlier puberty predicts superior performance on male-biased visuospatial tasks in men but not women.* Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
25. Seto, M. C., Cantor, J. M., & Blanchard, R. (2005, November). *Possession of child pornography is a diagnostic indicator of pedophilia.* Poster presented at the 24th annual meeting of the Association for the Treatment of Sexual Abusers, New Orleans.

26. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove. S. M., & Ellis, L. (2005, July). *Interaction of fraternal birth order and handedness in the development of male homosexuality.* Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
27. Cantor, J. M., & Blanchard, R. (2003, July). *The reported VIQ–PIQ differences in male sex offenders are artifactual?* Abstract and poster presented at the 29th annual meeting of the International Academy of Sex Research, Bloomington, Indiana.
28. Christensen, B. K., Cantor, J. M., Millikin, C., & Blanchard, R. (2002, February). *Factor analysis of two brief memory tests: Preliminary evidence for modality-specific measurement.* Poster presented at the 30th annual meeting of the International Neuropsychological Society, Toronto, Ontario, Canada.
29. Cantor, J. M., Blanchard, R., Paterson, A., Bogaert, A. (2000, June). *How many gay men owe their sexual orientation to fraternal birth order?* Abstract and poster presented at the International Behavioral Development Symposium, Minot, North Dakota.
30. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, November). *Fluoxetine inhibition of male rat sexual behavior: Reversal by oxytocin*. Poster presented at the 26th annual meeting of the Society for Neurosciences, Washington, DC.
31. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, June). *An animal model of fluoxetine-induced sexual dysfunction: Dose dependence and time course*. Poster presented at the 28th annual Conference on Reproductive Behavior, Montréal, Canada.
32. Cantor, J. M., O'Connor, M. G., Kaplan, B., & Cermak, L. S. (1993, June). *Transient events test of retrograde memory: Performance of amnestic and unimpaired populations*. Poster presented at the 2nd annual science symposium of the Massachusetts Neuropsychological Society, Cambridge, MA.

EDITORIAL AND PEER-REVIEWING ACTIVITIES

Editor-in-Chief

Sexual Abuse: A Journal of Research and Treatment Jan., 2010–Dec., 2014

Editorial Board Memberships

Journal of Sexual Aggression Jan., 2010–Dec., 2021
Journal of Sex Research, The Jan., 2008–Aug., 2020
Sexual Abuse: A Journal of Research and Treatment Jan., 2006–Dec., 2019
Archives of Sexual Behavior Jan., 2004–Present
The Clinical Psychologist Jan., 2004–Dec., 2005

Ad hoc Journal Reviewer Activity

American Journal of Psychiatry
Annual Review of Sex Research
Archives of General Psychiatry
Assessment
Biological Psychiatry
BMC Psychiatry
Brain Structure and Function
British Journal of Psychiatry
British Medical Journal
Canadian Journal of Behavioural Science
Canadian Journal of Psychiatry
Cerebral Cortex
Clinical Case Studies
Comprehensive Psychiatry
Developmental Psychology
European Psychologist
Frontiers in Human Neuroscience
Human Brain Mapping
International Journal of Epidemiology
International Journal of Impotence Research
International Journal of Sexual Health
International Journal of Transgenderism
Journal of Abnormal Psychology
Journal of Clinical Psychology
Journal of Consulting and Clinical Psychology
Journal of Forensic Psychology Practice
Journal for the Scientific Study of Religion
Journal of Sexual Aggression
Journal of Sexual Medicine
Journal of Psychiatric Research
Nature Neuroscience
Neurobiology Reviews
Neuroscience & Biobehavioral Reviews
Neuroscience Letters
Proceedings of the Royal Society B (Biological Sciences)
Psychological Assessment
Psychological Medicine
Psychological Science
Psychology of Men & Masculinity
Sex Roles
Sexual and Marital Therapy
Sexual and Relationship Therapy
Sexuality & Culture
Sexuality Research and Social Policy
The Clinical Psychologist
Traumatology
World Journal of Biological Psychiatry

GRANT REVIEW PANELS

2017–2021 Member, College of Reviewers, *Canadian Institutes of Health Research,* Canada.

2017 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2017 Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2016 Reviewer. National Science Center [*Narodowe Centrum Nauki*], Poland.

2016 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2015 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2015 Reviewer. *Czech Science Foundation,* Czech Republic.

2015 Reviewer, "Off the beaten track" grant scheme. *Volkswagen Foundation,* Germany.

2015 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada

2015 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2014 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2014 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada.

2014 Panel Member, Dean's Fund—Clinical Science Panel. *University of Toronto Faculty of Medicine*, Canada.

2014 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2013 Panel Member, Grant Miller Cancer Research Grant Panel. *University of Toronto Faculty of Medicine*, Canada.

2013 Panel Member, Dean of Medicine Fund New Faculty Grant Clinical Science Panel. *University of Toronto Faculty of Medicine,* Canada.

2012 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence (2nd round). *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2012 External Reviewer, University of Ottawa Medical Research Fund. *University of Ottawa Department of Psychiatry*, Canada.

2012 External Reviewer, Behavioural Sciences—B. *Canadian Institutes of Health Research*, Canada.

2011 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

TEACHING AND TRAINING

PostDoctoral Research Supervision
Law & Mental Health Program, Centre for Addiction and Mental Health, Toronto, Canada

Dr. Katherine S. Sutton	Sept., 2012–Dec., 2013
Dr. Rachel Fazio	Sept., 2012–Aug., 2013
Dr. Amy Lykins	Sept., 2008–Nov., 2009

Doctoral Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Michael Walton • University of New England, Australia	Sept., 2017–Aug., 2018
Debra Soh • York University	May, 2013–Aug, 2017
Skye Stephens • Ryerson University	April, 2012–June, 2016

Masters Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Nicole Cormier • Ryerson University	June, 2012–present
Debra Soh • Ryerson University	May, 2009–April, 2010

Undergraduate Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Kylie Reale • Ryerson University	Spring, 2014
Jarrett Hannah • University of Rochester	Summer, 2013
Michael Humeniuk • University of Toronto	Summer, 2012

Clinical Supervision (Doctoral Internship)
Clinical Internship Program, Centre for Addiction and Mental Health, Toronto, Canada

Katherine S. Sutton • Queen's University	2011–2012
David Sylva • Northwestern University	2011–2012
Jordan Rullo • University of Utah	2010–2011
Lea Thaler • University of Nevada, Las Vegas	2010–2011
Carolin Klein • University of British Columbia	2009–2010
Bobby R. Walling • University of Manitoba	2009–2010

TEACHING AND TRAINING

Clinical Supervision (Doctoral- and Masters- level practica)
Centre for Addiction and Mental Health, Toronto, Canada

Tyler Tulloch • Ryerson University	2013–2014
Natalie Stratton • Ryerson University	Summer, 2013
Fiona Dyshniku • University of Windsor	Summer, 2013
Mackenzie Becker • McMaster University	Summer, 2013
Skye Stephens • Ryerson University	2012–2013
Vivian Nyantakyi • Capella University	2010–2011
Cailey Hartwick • University of Guelph	Fall, 2010
Tricia Teeft • Humber College	Summer, 2010
Allison Reeves • Ontario Institute for Studies in Education/Univ. of Toronto	2009–2010
Helen Bailey • Ryerson University	Summer, 2009
Edna Aryee • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Iryna Ivanova • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Jennifer Robinson • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Zoë Laksman • Adler School of Professional Psychology	2005–2006
Diana Mandelew • Adler School of Professional Psychology	2005–2006
Susan Wnuk • York University	2004–2005
Hiten Lad • Adler School of Professional Psychology	2004–2005
Natasha Williams • Adler School of Professional Psychology	2003–2004
Lisa Couperthwaite • Ontario Institute for Studies in Education/Univ. of Toronto	2003–2004
Lori Gray, née Robichaud • University of Windsor	Summer, 2003
Sandra Belfry • Ontario Institute for Studies in Education/Univ. of Toronto	2002–2003
Althea Monteiro • York University	Summer, 2002
Samantha Dworsky • York University	2001–2002
Kerry Collins • University of Windsor	Summer, 2001
Jennifer Fogarty • Waterloo University	2000–2001
Emily Cripps • Waterloo University	Summer, 2000
Lee Beckstead • University of Utah	2000

PROFESSIONAL SOCIETY ACTIVITIES

OFFICES HELD

2018–2019	Local Host. Society for Sex Therapy and Research.
2015	Member, International Scientific Committee, World Association for Sexual Health.
2015	Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers
2012–2013	Chair, Student Research Awards Committee, Society for Sex Therapy & Research
2012–2013	Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers
2011–2012	Chair, Student Research Awards Committee, Society for Sex Therapy & Research
2010–2011	Scientific Program Committee, International Academy of Sex Research
2002–2004	Membership Committee • APA Division 12 (Clinical Psychology)
2002–2003	Chair, Committee on Science Issues, APA Division 44
2002	Observer, Grant Review Committee • Canadian Institutes of Health Research Behavioural Sciences (B)
2001–2009	Reviewer • APA Division 44 Convention Program Committee
2001, 2002	Reviewer • APA Malyon-Smith Scholarship Committee
2000–2005	Task Force on Transgender Issues, APA Division 44
1998–1999	Consultant, APA Board of Directors Working Group on Psychology Marketplace
1997	Student Representative • APA Board of Professional Affairs' Institute on TeleHealth
1997–1998	Founder and Chair • APA/APAGS Task Force on New Psychologists' Concerns
1997–1999	Student Representative • APA/CAPP Sub-Committee for a National Strategy for Prescription Privileges
1997–1999	Liaison • APA Committee for the Advancement of Professional Practice
1997–1998	Liaison • APA Board of Professional Affairs
1993–1997	Founder and Chair • APA/APAGS Committee on LGB Concerns

PROFESSIONAL SOCIETY ACTIVITIES

MEMBERSHIPS

2017–2021 Member • *Canadian Sex Research Forum*

2009–Present Member • *Society for Sex Therapy and Research*

2007–Present Fellow • *Association for the Treatment and Prevention of Sexual Abuse*

2006–Present Full Member (elected) • *International Academy of Sex Research*

2006–Present Research and Clinical Member • *Association for the Treatment and Prevention of Sexual Abuse*

2003–2006 Associate Member (elected) • *International Academy of Sex Research*

2002 Founding Member • CPA Section on Sexual Orientation and Gender Identity

2001–2013 Member • *Canadian Psychological Association* (CPA)

2000–2015 Member • *American Association for the Advancement of Science*

2000–2015 Member • *American Psychological Association* (APA)

APA Division 12 (Clinical Psychology)

APA Division 44 (Society for the Psychological Study of LGB Issues)

2000–2020 Member • *Society for the Scientific Study of Sexuality*

1995–2000 Student Member • *Society for the Scientific Study of Sexuality*

1993–2000 Student Affiliate • *American Psychological Association*

1990–1999 Member, American Psychological Association of Graduate Students (APAGS)

CLINICAL LICENSURE/REGISTRATION

Certificate of Registration, Number 3793
College of Psychologists of Ontario, Ontario, Canada

AWARDS AND HONORS

2022 Distinguished Contribution Award
Association for the Treatment and Prevention of Sexual Abuse (ATSA)

2011 Howard E. Barbaree Award for Excellence in Research
Centre for Addiction and Mental Health, Law and Mental Health Program

2004 fMRI Visiting Fellowship Program at Massachusetts General Hospital
American Psychological Association Advanced Training Institute and NIH

1999–2001 CAMH Post-Doctoral Research Fellowship
Centre for Addiction and Mental Health Foundation and Ontario Ministry of Health

1998 Award for Distinguished Contribution by a Student
American Psychological Association, Division 44

1995 Dissertation Research Grant
Society for the Scientific Study of Sexuality

1994–1996 McGill University Doctoral Scholarship

1994 Award for Outstanding Contribution to Undergraduate Teaching
"TA of the Year Award," from the McGill Psychology Undergraduate Student Association

MAJOR MEDIA

(Complete list available upon request.)

Feature-length Documentaries

Vice Canada Reports. *Age of Consent.* 14 Jan 2017.
Canadian Broadcasting Company. *I, Pedophile.* Firsthand documentaries. 10 Mar 2016.

Appearances and Interviews

11 Mar 2020. Ibbitson, John. It is crucial that Parliament gets the conversion-therapy ban right. *The Globe & Mail.*
25 Jan 2020. Ook de hulpvaardige buurman kan verzamelaar van kinderporno zin. *De Morgen.*
3 Nov 2019. Village of the damned. *60 Minutes Australia.*
1 Nov 2019. HÅKON F. HØYDAL. Norsk nettovergriper: – Jeg hater meg selv: Nordmannen laster ned overgrepsmateriale fra nettet – og oppfordrer politiet til å gi amnesti for slike som ham.
10 Oct 2019. Smith, T. Growing efforts are looking at how—or if—#MeToo offenders can be reformed. *National Public Radio.*
29 Sep 2019. Carey, B. Preying on Children: The Emerging Psychology of Pedophiles. *New York Times.*
29 Apr 2019. Mathieu, Isabelle. La poupée qui a troublé les Terre-Neuviens. *La Tribune.*
21 Mar 2019. Pope Francis wants psychological testing to prevent problem priests. But can it really do that? *The Washington Post.*
12 Dec 2018. Child sex dolls: Illegal in Canada, and dozens seized at the border. Ontario Today with Rita Celli. *CBC.*
12 Dec 2018. Celli, R. & Harris, K. Dozens of child sex dolls seized by Canadian border agents. *CBC News.*
27 Apr 2018. Rogers, Brook A. The online 'incel' culture is real–and dangerous. *New York Post.*
25 Apr 2018. Yang, J. Number cited in cryptic Facebook post matches Alek Minassian's military ID: Source. *Toronto Star.*
24 Ap 2018 Understanding 'incel'. *CTV News.*
27 Nov 2017. Carey, B. Therapy for Sexual Misconduct? It's Mostly Unproven. *New York Times.*
14 Nov 2017. Tremonti, A. M. The Current. *CBC.*
9 Nov2017. Christensen, J. Why men use masturbation to harass women. *CNN.* http://www.cnn.com/2017/11/09/health/masturbation-sexual-harassment/index.html
7 Nov 2017. Nazaryan, A. Why is the alt-right obsessed with pedophilia? *Newsweek.*
15 Oct 2017. Ouatik, B. Déscouvre. Pédophilie et science. *CBC Radio Canada.*
12 Oct 2017. Ouatik, B. Peut-on guérir la pédophilie? *CBC Radio Canada.*
11 Sep 2017. Burns, C. The young paedophiles who say they don't abuse children. *BBC News.*
18 Aug 2017. Interview. *National Post Radio.* Sirius XM Canada.
16 Aug 2017. Blackwell, Tom. Man says he was cured of pedophilia at Ottawa clinic: 'It's like a weight that's been lifted': But skeptics worry about the impact of sending pedophiles into the world convinced their curse has been vanquished. *National Post.*
26 Apr 2017. Zalkind, S. Prep schools hid sex abuse just like the catholic church. *VICE.*
24 Apr 2017. Sastre, P. Pédophilie: une panique morale jamais n'abolira un crime. *Slate France.*
12 Feb 2017. Payette, G. Child sex doll trial opens Pandora's box of questions. *CBC News.*
26 Nov 2016. Det morke uvettet ["The unknown darkness]". *Fedrelandsvennen.*
13 July 2016. Paedophilia: Shedding light on the dark field. *The Economist.*

1 Jul 2016. Debusschere, B. Niet iedereen die kinderporno kijkt, is een pedofiel: De mythes rond pedofilie ontkracht. *De Morgen.*
12 Apr 2016. O'Connor, R. Terence Martin: The Tasmanian MP whose medication 'turned him into a paedophile'. *The Independent.*
8 Mar 2016. Bielski, Z. 'The most viscerally hated group on earth': Documentary explores how intervention can stop pedophiles. *The Globe and Mail.*
1 Mar 2016. Elmhirst, S. What should we do about paedophiles? *The Guardian.*
24 Feb 2016. The man whose brain tumour 'turned him into a paedophile'. *The Independent.*
24 Nov 2015. Byron, T. The truth about child sex abuse. *BBC Two.*
20 Aug 2015. The Jared Fogle case: Why we understand so little about abuse. *Washington Post.*
19 Aug 2015. Blackwell, T. Treat sex offenders for impotence—to keep them out of trouble, Canadian psychiatrist says. *National Post.*
2 Aug 2015. Menendez, J. BBC News Hour. *BBC World Service.*
13 Jul 2015. The nature of pedophilia. *BBC Radio 4.*
9 Jul 2015. The sex-offender test: How a computerized assessment can help determine the fate of men who've been accused of sexually abusing children. *The Atlantic.*
10 Apr 2015. NWT failed to prevent sex offender from abusing stepdaughter again. *CBC News.*
10 Feb 2015. Savage, D. "The ethical sadist." In Savage Love. *The Stranger.*
31 Jan 2015. Begrip voor/van pedofilie [Understanding pedophilia]. *de Volkskrant.*
9 Dec 2014. Carey, B. When a rapist's weapon is a pill. *New York Times*.
1 Dec 2014. Singal, J. Can virtual reality help pedophiles? *New York Magazine.*
17 Nov2014. Say pedófile, busco aydua. *El Pais.*
4 Sep 2014. Born that way? *Ideas, with Paul Kennedy.* CBC Radio One.
27 Aug 2014. Interrogating the statistics for the prevalence of paedophilia. BBC.
25 Jul 2014. Stephenson, W. The prevalence of paedophilia. *BBC World Service.*
21 Jul 2014. Hildebrandt, A. Virtuous Pedophiles group gives support therapy cannot. *CBC.*
26 Jan 2014. Paedophilia a result of faulty wiring, scientists suggest. *Daily Mail.*
22 Dec 2013. Kane, L. Is pedophilia a sexual orientation? *Toronto Star.*
21 Jul 2013. Miller, L. The turn-on switch: Fetish theory, post-Freud. *New York Magazine.*
1 Jul 2013. Morin, H. Pédophilie: la difficile quête d'une origine biologique. *Le Monde.*
2 Jun 2013. Malcolm, L. The psychology of paedophilia. *Australian National Radio.*
1 Mar 2013. Kay, J. The mobbing of Tom Flanagan is unwarranted and cruel. *National Post.*
6 Feb 2013. Boy Scouts board delays vote on lifting ban on gays. *L.A. Times.*
31 Aug 2012. CNN Newsroom interview with Ashleigh Banfield. *CNN.*
24 Jun 2012. CNN Newsroom interview with Don Lemon. *CNN.*

EXPERT WITNESS TESTIMONY

2010

In Re the detention of William G. Dutcher
Case No 08-2-38259-1 SEA
Superior Court, King County, Seattle, WA

2015

State of Florida vs Jon Herb
Case No 11-2013-CF-001958-AXXX-XX

2017

In re Commitment of Nicholas Bauer (Frye Hearing)
Case No. 2-18-0905; Appeal No. 2009-MR-64
Appellate Court of Illinois, Lee County, Second District

U.S. vs. William Hutcheson Leford (Presentencing Hearing)
Case No. 3:16-CR-00012-1
Southern District of Georgia, Dublin Division

2018

NY State Office Mental Health/Dept. of Corrections & Comm Superv vs. Fernando Little
Index# CA2016-002179; RJI No 32-16-7108; Consec No. 290430
Application for discharge from Central NY Psychiatric Center
Utica, New York

2019

John Fitzpatrick v Her Majesty the Queen
Ontario Superior Court of Justice, Canada

Re Commitment of Steven Casper (Frye Hearing)
Case No. 09 MR 135, IDOC No. B23461; DHS No. 887057
Kendall County, Illinois

Re Commitment of Ian Inger (Frye Hearing)
Poughkeepsie, NY

Helen Spiegel v. Keeley Savoie
Docket No HS14D0435 DR
Probate & Family Court, Hampshire Division, Massachusetts

Southern District of New York vs. Peter Bright
Case No. 1:19 Cr -00521 PKC
U.S. District Court, New York, Southern District

2021

State of Arizona vs Franklin Arnett Clifton
IR# JWID 14-70629; Cr2017-150114-001
Maricopa County, Arizona

B.P.J. v West Virginia
Civil Action No. 2:21-cv-00316
US District Court, Southern District, Charleston Division

Cross, et al. v Loudoun School Board
Case No. CL21-3254
Circuit Court, County of Loudoun, VA

Re Commitment of Michael Hughes (Frye Hearing)
Case No. 10-CR-80013
Circuit Court, Cook County, Chicago, Illinois

In the Matter of Alexander Aurora Cox
Cause number 48C02-215-JC-000143
Madison Circuit Court 2, Indiana

Josephson v University of Kentucky
Case No: 3:19-cv-00230-RGJ
Kentucky Western District, Louisville Division

2022

A.M. v. Indianapolis Public Schools, et al.
Cause No. 1:22-cv-01705-JMS-DLP
U.S. District Court, Southern District of Indiana

Boe et al, USA v Marshall
Civil Action No. 2:22-cv-00184- LCB
U.S. District Court, Middle District of Alabama, Northern Div

Bridge, et al. v Oklahoma State Department of Education, et al.
Case No. CIV-22-787-JD
Oklahoma, Western District Court

Dekker, et al. v Florida Agency for Health Care Admin.
Case 4:22-cv-00325-RH-MAF
Florida, Northern District Court

Doe, et al. v Abbott, et al.
Case No. D-1-GN-22-000977
Texas, Travis County

Xavier Hersom and John Doe v West Virginia

Civil Action No. 2:21-cv-00450
US District Court, Southern District, Charleston Division

NY v Frederick B. (Re: Commitment of Frederick B.)
Index No. 001141/2022
New York Supreme Court

Pamela Ricard v USD 475 Geary County School Board
Case No. 5:22-cv-04015
US District Court, District of Kansas

Roe, et al. v. Utah High School Activities Association, et al.
Case No. 220903262
Salt Lake County, Utah Third Judicial District Court

Voe, PFLAG, et al. v Abbott
NO. D-1-GN-22-002569
Texas, Travis County District Court

2023

Doe, et al. v. Thornbury, et al.
Civil No. 3:23CV-230-RGJ
U.S. District Court, Western District of Kentucky

Doe, et al. v. Horne, et al.
Case No. 4:23-cv-00185-JGZ
District of Arizona, Tucson Division

K.C., et al. v. Medical Licensing Board of Indiana, et al.
Case No. 1:23-CV-595
Southern District of Indiana, Indianapolis Division

L.W., et al. v. Skrmetti, et al.
Case No. 3:23-cv-00376
Middle District of Tennessee, Nashville Division

Poe, et al., v. Drummond, et al.
Case No. 23-CV-00177-JFH-SH
Northern District of Oklahoma

Koe, et al., v. Noggle, et al.
Civil Action No. 1:23-cv-02904-SEG
U.S. District Court, Northern District of Georgia, Atlanta Div

Poe, et al., v. Labrador
Case No. 1:23-cv-00269-CWD
U.S. District Court, District of Idaho, Southern Division

Roe, et al., v. Critchfield, et al.
Case No. 1:23-cv-00315-DCN
U.S. District Court, District of Idaho

Lazaro Loe v Texas
Cause No. D-1-GN-23-003616
201st Judicial District, Travis County, Texas

Noe, et al., v. Parson, et al.
Case No 23AC-CC04530
Circuit Court of Cole County, State of Missouri

Van Garderen, et al. v. Montana, et al.
Cause No. DV 2023–0541
Montana Fourth Judicial District Court, Missoula County

B.C. College of Nurses and Midwives v Amy HAMM
Citation issued under Health Professional Act

Voe, et al. v Mansfield, et al.
Civil No. 1:23-cv-864
U.S. District Court, North Carolina, Middle District, Durham Div.

TD, et al. v Wrigley, et al.
Case No. 08-2023-CV-2189
District Court, South Central Judicial District, North Dakota