UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

BOARD OF EDUCATION OF THE HIGHLAND LOCAL SCHOOL DISTRICT, Plaintiff, vs. UNITED STATES DEPARTMENT OF EDUCATION; JOHN B. KING, JR., in his official capacity as United States Secretary of Education; UNITED STATES DEPARTMENT OF JUSTICE; LORETTA E. LYNCH, in her official capacity as United States Attorney General; and VANITA GUPTA, in her official capacity as Principal Deputy Assistant Attorney General, Defendants.	Case No. 2:16-cv-524 Judge Algenon L. Marbley Magistrate Judge Kimberly A. Jolson
JANE DOE, a minor, by and through her legal guardians JOYCE and JOHN DOE, Intervenor Third-Party Plaintiff, vs. BOARD OF EDUCATION OF THE HIGHLAND LOCAL SCHOOL DISTRICT; HIGHLAND LOCAL SCHOOL DISTRICT; WILLIAM DODDS, Superintendent of Highland Local School District; and SHAWN WINKELFOOS, Principal of Highland Elementary School, Third-Party Defendants.	

REPLY DECLARATION OF DIANE EHRENSAFT, Ph.D.

I, Diane Ehrensaft, declare as follows:

1. I submit this expert declaration based on my personal knowledge.

2. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

3. In preparing this declaration, I was provided with and reviewed the following additional case-specific materials: (1) the declaration of Dr. Allan Josephson and accompanying exhibits; (2) the declaration of Dr. Paul Hruz and accompanying exhibits; and (3) Board of Education of Highland Local School District's Response in Opposition to Intervenor Third-Party Plaintiffs' Motion for Preliminary Injunction.

4. I have not met or spoken with Jane Doe or her legal guardians, Joyce and John Doe, for purposes of this declaration. My opinions are based solely on the information I have been provided by Jane Doe's attorneys as well as my extensive experience studying gender dysphoria and treating transgender patients.

5. To date, I have offered my time and expertise on a pro bono basis. However, for any future services provided in connection with this matter, I will be compensated at my customary hourly rate of $350 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

I. The Conclusions of the Hruz and Josephson Declarations are Methodologically Unsound

6. The conclusions drawn by the declarations of Dr. Hruz and Dr. Josephson contain significant methodological flaws and appear to reflect a particular ideology rather than current scientific and medical knowledge regarding gender identity and transgender persons.[1]

[1] The framing and language used by Dr. Hruz and Dr. Josephson in their declarations is very similar to a position paper entitled "Gender Dysphoria in Children" by the American

Those flaws include misuse of statistics, misrepresentation of the studies they cite and of the limitations of those studies, and failure to cite studies that disprove or undermine their conclusions. This renders the declarations of Dr. Hruz and Dr. Josephson unscientific and unreliable.

7. Although transgender people are a small percentage of the overall population, Dr. Hruz and Josephson inappropriately extrapolate that statistic to support their belief that being transgender is not normal and is a disease that must be cured. *See* Hruz Decl. ¶ 20; Josephson Decl. ¶¶ 25. There are many human variations that are rare or affect only small populations and that are not equated with disease, such as people with high IQs. The rarity of a particular occurrence or trait is just that, evidence of its rate of occurrence within a population; that statistic indicates nothing about whether the occurrence or trait is maladaptive. As discussed later in this declaration, and my prior declaration in this matter, scientific studies and clinical experience demonstrate that being transgender is a normal part of human variation.

College of Pediatricians. American College of Pediatricians, Position Statement: Gender Dysphoria in Children (2016), *available at*, https://www.acpeds.org/the-college-speaks/position-statements/gender-dysphoria-in-children. The American College of Pediatricians is an association of pediatricians who view being gay or transgender as a disorder, despite the scientific evidence to the contrary. The organization has filed amicus briefs supporting state bans on marriage by same-sex couples and state laws restricting adoption by same-sex couples, as well as seeking to invalidate state law prohibiting the use of conversion therapy on minors. *See* Brief of Amicus Curiae American College of Pediatricians, et al., in Support of Respondents, *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015) (Nos. 14-566, 14-562, 14-571, 14-574), 2015 WL 1534077; Brief of Amicus Curiae American College of Pediatricians in Support of Plaintiffs and Appellees and in Support of Affirming the Decision of the U.S. District Court, *Welch v. Brown*, 728 F.3d 1042 (9th Cir. 2013) (No. 13–15023), 2013 WL 950389 (appeal consolidated with *Pickup v. Brown* (No. 12–17681)); Brief of Amicus Curiae American College of Pediatricians in Support of Appellant Florida Department of Children & Families, *Fla. Dep't of Children & Families v. Adoption of X.X.G.*, 45 So.3d 79 (Fla. 2010) (No. 3D08–3044), *available at*, https://www.acpeds.org/wordpress/wp-content/uploads/Amicus_Brief_2009B.pdf (last accessed on Sept. 12, 2016). These and other amicus briefs are made available by the American College of Pediatricians on its website, https://www.acpeds.org/hub/briefs-bylaws-and-newsletters/amicus-briefs.

8. The declarations also mischaracterize research on transgender people. For example, Dr. Josephson cited a longitudinal study on the mortality rates of post-operative transgender people in Sweden to support his assertion that transgender people are inherently disordered. That study did find a higher mortality rate among post-operative transgender people than a control population. However, the authors noted a critical limitation of the study, which is

> that the current study is only informative with respect to transsexuals persons health after sex reassignment; *no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism.* In other words, the results should not be interpreted such as sex reassignment *per se* increases morbidity and mortality. Things might have been even worse without sex reassignment. As an analogy, similar studies have found increased somatic morbidity, suicide rate, and overall mortality for patients treated for bipolar disorder and schizophrenia. This is important information, but it does not follow that mood stabilizing treatment or antipsychotic treatment is the culprit.

Dhejne C, *et al.*, *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLoS ONE 6(2): e16885 (2011), *available at*, http://journals.plos.org/plosone/article/asset?id=10.1371/journal.pone.0016885.PDF (last accessed Sept. 9, 2016).

9. The declarations similarly misrepresent research relating to the desistence rates among children diagnosed with gender dysphoria. First, Dr. Hruz and Dr. Josephson fail to point out a critical limitation in those studies, which is that those studies focused on children with gender dysphoria (or its predecessor, gender identity disorder), but not transgender youth. Although all transgender youth meet the criteria for gender dysphoria, not all youth diagnosed with gender dysphoria are transgender.

10. Second, a number of key articles that Dr. Hruz and Dr. Josephson rely on in their discussion of the desistence of gender dysphoria have additional methodological weaknesses. For example, in "Psychosexual Outcome of Gender-Dysphoric Children," by Madeleine

Wallien and Peggy Cohen-Kettenis, the study started with a cohort of seventy-seven children who had been diagnosed with gender identity disorder, which is now referred to as gender dysphoria. Of that cohort, twenty-three were lost to follow up and for another ten the follow up was conducted with a parent, not the youth. Instead of excluding those children from the statistical analysis, the authors combined them with those deemed to have "desisted" (*i.e.*, no longer met the diagnostic criteria for gender identity disorder) – resulting in an artificially depressed 27% "persistence" rate. A similar methodological error was made in "Desisting and Persisting Gender Dysphoria After Childhood: A Qualitative Follow-up Study," by Thomas Steensma, *et al*. That study started with a cohort of fifty-three adolescents who had been diagnosed with gender identity disorder. Of that cohort, twenty-four were lost to follow up. The authors noted in the article that "[a]s the Amsterdam Gender Identity Clinic for children and adolescents is the only one in the country, we assumed that their gender dysphoric feelings had desisted." This causal assumption is clearly flawed, as these adolescents might have many reasons for not returning to the clinic beyond whether they continued to be gender dysphoric. Because of those serious flaws, these articles provide no reliable information about desistence rates for transgender youth.

11. Third, the impetus behind undertaking scientific studies on desistence was to hone the diagnostic criteria used by professionals to more accurately distinguish between transgender youth and non-transgender youth who are gender non-conforming or experiencing transient gender dysphoria for other reasons. As reflected in the current medical consensus of experts in this field, that goal has been largely achieved. As discussed in "Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Qualitative Follow-Up Study," by Thomas Steensma, *et al*., four commonly used hallmarks have been identified to

differentiate children with transient gender dysphoria from transgender children: (i) the intensity of gender dysphoria; (ii) that the child indicates they are the "other" sex as opposed to wishing to be the "other" sex; (iii) evidence of a significant degree of discomfort with their genitals (body dysphoria); and (iv) age of referral. Dr. Hruz and Dr. Josephson fail to acknowledge this research, which is widely accepted and relied upon by experts in treating transgender children.

12. Finally, in addition to relying on incomplete, outdated, and methodologically flawed data, Dr. Hruz and Dr. Josephson extrapolate from that unreliable data to support their view that treatment of transgender children should seek to alter the child's gender identity to conform to the child's sex assigned at birth. That view has no support in the scientific literature or in current medical knowledge and practice, which recognizes that such treatments are harmful and unethical. *See* U.S. Dep't of Health and Human Servs., Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* (2015), *available at*, http://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf (last accessed Sept. 12, 2016); American Psychological Association, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (2009), *available at*, http://www.apa.org/pi/lgbc/publications/therapeutic-resp.html (last accessed Sept. 12, 2016); World Prof. Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (2011), *available at*, https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf (last accessed Sept. 12, 2016).

13. Similarly, there is no support for the conclusion that affirming a transgender child's gender identity will cause a child whose gender dysphoria would have otherwise

desisted to persist. All data point to the fact that children who underwent an early social transition had already exhibited the objective hallmarks previously mentioned. Thus, consistent with the standard of care, social transition was the appropriate treatment and supporting those children through a social transition contributed to their overall positive mental health.

II. The Conclusions of the Hruz and Josephson Declarations Lack a Scientific Foundation And Conflict with Current Medical Knowledge and Clinical Practice Regarding Transgender Youth.

14. The views expressed by Dr. Hruz and Dr. Josephson are based on outdated information and a lack of understanding of current medical knowledge and clinical practice when treating youth with gender dysphoria, particularly pre-pubertal children. They indicate a significant lack of exposure to the treatment of these young children and also a lack of training on treating such children.

15. Both declarations also contain glaring omissions in their citations to and discussions of recent studies. For example, neither declaration cited a 2016 article published in Pediatrics, a pre-eminent peer-reviewed journal, entitled "Mental Health of Transgender Children who are Supported in Their Identities." That study found "[s]ocially transitioned, prepubescent transgender children showed typical rates of depression and only slightly elevated rates of anxiety symptoms compared with population averages." Of equal importance, the data showed that "transgender children supported in their identities had internalizing symptoms that were well below even the preclinical range . . . . suggest[ing] that familial support in general, or specifically via the decision to allow their children to socially transition, may be associated with better mental health outcomes among transgender children." Kristina Olson, *et al.*, *Mental Health of Transgender Children who are Supported in Their Identities*, 137 Pediatrics 1 (2016).

16. Similarly, Pediatrics published another important paper on transgender youth in September 2015 that was not even mentioned by Dr. Hruz and Dr. Josephson. That article, entitled "Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment," reported on a long-term study of mental health outcomes of fifty-five transgender young adults who were treated with puberty-delaying medication and accessed surgical interventions as part of their transition. This study concluded that:

> [p]sychological functioning improved steadily over time, resulting in rates of clinical problems that are indistinguishable from general population samples (e.g., percent in the clinical range dropped from 30% to 7% on the YSR/ASR30) and quality of life, satisfaction with life, and subjective happiness comparable to same-age peers. Apparently the clinical protocol of a multidisciplinary team with mental health professionals, physicians, and surgeons gave these formerly gender dysphoric youth the opportunity to develop into well-functioning young adults.

Annelou de Vries, *et al*., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 1 (2014) (internal footnotes omitted).

17. The declarations also fail to mention or address the current professional guidelines and standards of care promulgated by relevant professional associations. For example, Dr. Hruz does not even mention that the Standards of Care published by the World Professional Association for Transgender Health, which are endorsed by the Pediatric Endocrine Society, unequivocally state that "[t]reatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success" and that "such treatment is no longer considered ethical" (internal citations omitted). That statement was repeated in the "Guidelines for Psychological Practice with Transgender and Gender Non-Conforming People," released by the American Psychological Association in December 2015.

18. Although Dr. Josephson laments that there are not controlled studies on the effects of conversion therapy, the evidence regarding efforts to change a person's sexual orientation or gender identity show that such efforts are ineffective and put patients at risk of serious harm. In addition, as noted in my previous declaration, research on the impact of family rejection, including attempts to change a child's sexual orientation or gender identity, show that such rejection is correlated with serious negative health outcomes for children, including severe depression and suicide attempts. Indeed, based on that evidence, conducting further studies of conversion therapy would be unethical due to the harm it would cause the subjects of those studies.[2]

19. Dr. Hruz and Dr. Josephson also demonstrate a complete misunderstanding of the clinical practice of working with prepubescent youth with gender dysphoria. The standard of care requires clinicians *not* to presume that the child is transgender; quite the opposite, the clinician's goal is to create a safe space where the clinician and child can discuss the child's gender exploration, allowing the clinician to gain insight into the root causes of the dysphoria. Through that process, well-trained clinicians are able to assess the cause(s) of the gender dysphoria and whether the young person is transgender, and make appropriate treatment recommendations based on that assessment.

20. The declarations of Dr. Hruz and Dr. Josephson also fail to acknowledge the current medical consensus that gender identity is an important factor in determining a person's sex, that gender identity is highly likely to have a biological foundation, and that when the various characteristics that comprise a person's sex do not align, as is the case for intersex and

[2] Inexplicably, Dr. Josephson blames poor family dynamics for causing a child's gender dysphoria, yet his "treatment" for gender dysphoria requires the parents to reject their child, an approach that is as baseless as it is unethical.

transgender persons, the person's gender identity is determinative of the person's sex for purposes of medical treatment, as well as for how the person should be regarded and treated by others.

21. The notion that transgender youth are delusional is wholly unsupported by the DSM-5, the literature on transgender people, and the clinical experience of mental health providers who work with transgender youth.

III. The Declarations of Dr. Hruz and Dr. Josephson Do Not Demonstrate Expertise or Meaningful Experience Regarding the Current Scientific Understanding and Medical Treatment of Transgender Persons

22. Based on their declarations, Dr. Hruz and Dr. Josephson do not have significant clinical experience treating prepubescent transgender youth. Based on their declarations, Dr. Josephson has treated a total of thirty-five transgender people in his career, some or none of whom may have been prepubescent children, and Dr. Hruz has not seen any transgender patients. Moreover, neither has published any papers on transgender people—let alone youth—in any journal, peer-reviewed or otherwise.

IV. The Statements of Dr. Hruz and Dr. Josephson Regarding Autism are Unfounded

23. The declarations of Dr. Hruz and Dr. Josephson contain a number of statements regarding autism that are wholly inaccurate and inflammatory.

24. Although there is ongoing research and discussion among clinicians to better understand the high incidence of autism among children with gender dysphoria, there is already a consensus that neither condition causes the other and rejecting the especially specious notion that there is any causal connection based on the social and other communication difficulties associated with autism. *See* Hruz Decl. ¶ 46.

25. Dr. Josephson makes a similarly unsupportable claim about people with autism. Even though people with autism experience difficulty with social interaction, autism is a spectrum disorder; thus people with autism have varying degrees of difficulty in this area and, despite those difficulties, they can, and do, experience psychological harm when rejected by their family, peers, and community.

This declaration was executed this 13th day of September, 2016, in Alameda County, California.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dr. Diane Ehrensaft, PhD