UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

DREW ADAMS, a minor, by and through his next friend and mother, ERICA ADAMS KASPER, Plaintiff, v. THE SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA, Defendant.	Case No. 3:17-cv-00739-TJC-JBT

PLAINTIFF'S PRELIMINARY FINDINGS OF FACT & CONCLUSIONS OF LAW

Pursuant to the Court's Case Management and Scheduling Order [Dkt. 59], Plaintiff respectfully submits the following Proposed Preliminary Findings of Fact and Conclusions of Law, which incorporate Plaintiff's response to Defendant's Motion to Dismiss [Dkt. 54].

I. PLAINTIFF'S PROPOSED FINDINGS OF FACT

A. Parties.

1. Plaintiff Drew Adams, a minor, sues by and through his mother, Erica Adams Kasper. Drew attends Allen D. Nease High School ("Nease") in Ponte Vedra, Florida, within the St. Johns County School District (the "District").[1]

2. Drew is 17 years old, and a junior in high school. Drew is a boy. He is also

[1] Proposed findings of fact without citations to record evidence constitute a proffer of the evidence Plaintiff will introduce at trial. Plaintiff attaches the expert reports cited herein, but to avoid unnecessarily burdening the Court, has not submitted other cited discovery materials. Plaintiff will gladly submit those materials at the Court's request.

transgender. [Drew Decl. Dkt. 22-1 ¶¶ 7-8; 30(b)(6) Tr. 221:12-18] He is denied access to the boys' restrooms at Nease because he is a transgender boy.

3. Defendant The School Board of St. Johns County, Florida (the "School Board" or "Defendant") operates, supervises, and controls all public schools within the St. Johns County School District (the "District"), including Nease. [RFA 5-7] Defendant has the authority to establish policies for the effective operation of the public schools in the district. [RFA 8] Defendant is a "person" acting under color of state law within the meaning of 42 U.S.C. § 1983 [RFA 1], and is subject to civil suits [RFA 2].

4. Defendant receives federal financial assistance from the U.S. Department of Education, and certain of its education programs and activities benefit from that assistance, making it subject to Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, *et seq.* ("Title IX"). [RFA 3-4; Dkt. 116 at 22 ¶ 2 (stipulation in Joint Final Pretrial Statement)]

B. Plaintiff's Expert Testimony About Drew, Transgender Adolescents, and Gender Dysphoria.

5. Plaintiff offered the testimony of Dr. Deanna Adkins, Drew's treating endocrinologist. Dr. Adkins received her medical degree from the Medical College of Georgia in 1997, and has been licensed to practice medicine in North Carolina since 2001. [Ex. A, Adkins Rpt. ¶¶ 1-2] Dr. Adkins is a Pediatric Endocrinologist at Duke University School of Medicine, where she is Fellowship Director of Pediatric Endocrinology. [*Id.* ¶ 1] She also is Director of the Duke Center for Child and Adolescent Gender Care (the "Clinic"), which she founded in 2015. [*Id.* ¶ 5] Dr. Adkins has treated approximately 300 intersex and transgender patients, and began caring for those patients in her routine practice many years prior to opening the Clinic. [*Id.* ¶¶ 5-6] Dr. Adkins is regularly called upon by colleagues to

assist with the sex assignment of infants where their sex-related characteristics are not completely aligned as male or female. [*Id.* ¶ 8] Dr. Adkins has extensive experience in medical treatment of transgender adolescents and the medical understanding of sex-related characteristics. Dr. Adkins has the qualifications and experience to testify on these topics and the Court found her testimony reliable and relevant.

6. Plaintiff also offered the testimony of Dr. Diane Ehrensaft, a practicing developmental and clinical psychologist for more than 35 years; she specializes in working with children and adolescents experiencing gender dysphoria and their families. Dr. Ehrensaft has provided consultation, therapy and evaluations to more than 500 transgender and gender nonconforming children, and has consulted with more than 200 mental health professionals across the United States to aide them in treating this patient population. Dr. Ehrensaft, along with others, founded the Child and Adolescent Gender Center at the University of California, San Francisco ("UCSF") Benioff Children's Hospital. [Ex. B, Ehrensaft Exp. Rpt. ¶¶ 1-4] She serves on the Board of Directors of Gender Spectrum, a national organization offering educational, training, and advocacy services to schools and youth-serving organizations to become more gender inclusive. [*Id*. ¶ 6] Dr. Ehrensaft is also an adjunct professor at UCSF and has taught courses in The Treatment of Gender-Nonconforming Children; The Emotional Development of Gender-Nonconforming Children; Interdisciplinary Support of Gender-Nonconforming and Transgender Children; Parenting a Gender-Nonconforming/Transgender Child. [*Id*. ¶ 8] She has published numerous books and articles, including peer-reviewed articles, on the subjects relevant to the issues in this case and participated directly in studies relating to medical and mental health outcomes of

gender nonconforming youth. [*Id*. ¶¶ 9-10] Dr. Ehrensaft has the qualifications and experience to testify on these topics and the Court found her testimony reliable and relevant.

7. Everyone has a gender identity, which is a person's inner sense of belonging to a particular gender, such as male or female.[2] [Ex. A, Adkins Rpt. ¶¶ 15, 17; Ex. B, Ehrensaft Rpt. 18; Hruz Depo. Tr. 148:19-23; *id.* at 155:1-3; Pl.'s Ex. 26, American Psychiatric Association, Diagnostic Criteria for Gender Dysphoria, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*] Gender identity is a deeply felt and core component of a person's identity. [Ex. A, Adkins Rpt. ¶ 16; Ex. B, Ehrensaft ¶ 18]

8. Gender identity is not a choice [Hruz Tr. 149:24-25], and cannot be voluntarily altered; it is widely considered unethical to attempt to change the gender identity of others. [Ex. A, Adkins Rpt. ¶¶ 20-21; Ex. B, Ehrensaft Rpt. ¶ 24]

9. Although research regarding the precise determinant of gender identity is still ongoing, evidence suggests, and Defendant's experts agreed, that gender identity has a biological component. [Ex. A, Adkins Rpt. ¶ 22; Hruz Tr. 147:7-19; Josephson Tr. 259:12-16; Pl.'s Ex. 26 (DSM 5)]

10. At birth, infants are generally classified as male or female based solely on observation of their external genitalia. [Ex. A, Adkins Rpt . ¶ 14; Josephson Tr. 17:8-21] Most individuals' gender identity aligns with the sex they were assigned at birth. [Ex. A, Adkins Rpt. ¶ 14]

[2] Plaintiff respectfully refers the Court to *Doe v. Boyertown Area Sch. Dist.*, No. CV 17-1249, 2017 WL 3675418 (E.D. Pa. Aug. 25, 2017), which entered similar factual findings about transgender adolescents, treatment for gender dysphoria, and access to restrooms matching one's gender identity after an evidentiary hearing on a preliminary injunction. *Id.* at *35-41 ¶¶ 322-368; *see also Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 274 n.6 (W.D. Pa. 2017) (designating findings of fact in that decision).

11. For some people, however, external genitalia are not an accurate determinant of their sex. These include transgender people, whose gender identity differs from the sex they were assigned at birth [Ex. A, Adkins Rpt. ¶ 12; Ex. B, Ehrensaft Rpt. ¶ 16]; and intersex people, who have a mixture of sex characteristics typically associated with both "male" and "female" sex designations [Ex. A, Adkins Rpt. ¶ 13].

12. For transgender individuals, the lack of alignment between their gender identity and their sex assigned at birth can cause significant distress. [Ex. A, Adkins Rpt. ¶ 18; Ex. B, Ehrensaft Rpt. ¶ 25] Individuals with this distress can be diagnosed with gender dysphoria. [Ex. A, Adkins Rpt. ¶ 19; Ex. B, Ehrensaft Rpt. ¶ 26]

13. Gender dysphoria is defined by the American Psychiatric Association's Diagnostic and Statistical Manual 5 ("DSM 5") as a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, frequently manifested by the following: A strong desire to be of the other gender or an insistence that one is the other gender, possibly a strong dislike of one's sexual anatomy, and/or a strong desire for the primary and/or secondary sex characteristics that match one's experienced gender. [Ex. A, Adkins Rpt. ¶ 19; Pl.'s Ex. 26 (DSM 5)]

14. There are authoritative standards for caring for individuals who are transgender or suffer from gender dysphoria. These have been published by multiple medical organizations, including the Standards of Care Version 7 by the World Professional Association for Trans gender Health ("WPATH Standards of Care"), Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, and the Guidelines for Psychological Practice with Transgender and Gender

Nonconforming People by the American Psychological Association. [Ex. A, Adkins Rpt. ¶ 27; Ex. B, Ehrensaft Rpt. ¶ 11; Ex. C, Ehrensaft Rpt. ¶ 3]

15. The goal of treatment is to alleviate the gender dysphoria by aligning the adolescent's lived experience and body with his or gender identity. [Ex. A, Adkins Rpt. ¶ 37; Ex. B, Ehrensaft Rpt. ¶ 37]

16. Being transgender is a normal developmental variation, and when the dysphoria is properly treated, nothing about being transgender limits the individual's capacity to have a fulfilling and productive life as a contributor to society. [Ex. A, Adkins Rpt. ¶¶ 24-25; Ex. B, Ehrensaft Rpt. ¶ 22]

17. Defendant offered the testimony of Dr. Allan Josephson and Dr. Paul Hruz. Neither witness treats transgender patients, has examined Drew, or has any basis to question Drew's transgender status or his diagnosis of gender dysphoria and prescribed treatment. [Josephson Tr. 9:25-10:11, 19-24; 14:17-15:1; 16:18-19; Hruz Depo. Tr. 17:9-18:2; *id.* at 46:23-47:22] Dr. Hruz has never treated a patient who is transgender or has gender dysphoria. [Hruz Rpt. Dkt. 128-2 ¶ 8; Hruz Tr. 24:11-24:14; *id.* at 25:20-25:23] Similarly, Dr. Hruz has not conducted any independent research about transgender youth or gender dysphoria, nor has he published peer-reviewed literature on this subject. [Hruz Tr. 61:17-64:7; *id.* at 295:19-295:23] Instead, Dr. Hruz relies solely on his review of studies for purposes of his expert opinion. Dr. Hruz's opinions regarding transgender people, as he admits, are contrary and squarely at odds with the generally accepted opinions, guidelines, and standards of care of the medical and scientific community. [Hruz Tr. 58:21-61:9]

18. Dr. Josephson admitted that he is not an expert in treating transgender patients

or in treating patients with gender dysphoria, and conceded that he is not entrusted to treat transgender patients at his University's Gender Clinic. [Josephson Tr. 86:1-18; 88:1-13; 102:9-14; 101:8-23; 114:25-115:8; 177:7-12; 185:11-186:1] Dr. Josephson's report opined that transgender children meet the criteria for a "delusion," Dkt. 85-1, but when pressed during deposition, he disavowed and contradicted some of his opinions, agreeing for example that if Drew has a birth certificate and driver's license stating that he is male (as Drew does), "that would allow him to say then that he – he is male" and "he would be male." [Josephson Tr. 15:17-17:1; 36:14-37:10]

19. Both Dr. Josephson and Dr. Hruz advocated in their reports that efforts be made to change transgender children's gender identity, and that medical treatment be withheld for their gender dysphoria. [Josephson Tr. 112:8-113:3; 115:9-23; 117:4-9; Hruz Rpt. Dkt. 128-2 ¶ 68] Such efforts, often known as "conversion therapy," fall below the standard of care for transgender children and adolescents, and are widely considered unethical and ineffective. [Ex. B, Ehrensaft Rpt. ¶ 24; Ex. A, Adkins Rpt. ¶¶ 21, 41; Pl's Ex. 37, 48] These methods are illegal in many states and cities. [Ex. C, Ehrensaft Rebuttal Rpt. ¶¶ 17-19] The Court gave the testimony of Dr. Josephson and Dr. Hruz little or no weight, finding that their testimony lacked credibility and reliability, and falls below the standards for admissibility in *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993) for the reasons stated in Plaintiff's motions [Dkt. 127-128], which will be addressed in a separate order.

C. Drew's medical, legal, and social transition.

20. Like non-transgender boys, Drew has a male gender identity. [Drew Decl. Dkt. 22-1 ¶ 16]

21. Drew has been diagnosed with gender dysphoria. [Drew Decl. Dkt. 22-1 ¶ 13; Ex. A, Adkins Rpt. ¶ 13]

22. The standard of care for treating gender dysphoria includes living consistently with one's gender identity in all aspects of one's life. To accomplish that transgender people undertake a process that includes social, legal, and medical transition. [Ex. A, Adkins Rpt. ¶¶ 28-30; Ex. B, Ehrensaft Rpt. ¶¶ 31-33]

a. Drew's social transition included cutting his hair short, wearing clothing typically associated with males, using male pronouns, and using male restrooms in all settings but school. [Drew Decl. Dkt. 22-1 ¶ 11; Scott Tr. 30:25-32:3]

b. Drew's legal transition included correcting his driver's license and birth certificate to reflect his male gender identity. [Pl. Exs. 3-4]

c. Drew's medical transition included hormone therapy, which deepened his voice and will eventually give him facial hair; and a double-mastectomy, which gave him a masculine chest.

23. Drew is widely known and accepted as a boy in all aspects of his life. This includes at Nease, where fellow students, staff, and teachers refer to Drew with male pronouns. [30(b)(6) Tr. 140:24-140:4; RFA 52]

24. When Drew first came out to his parents, both Scott and Erica had already suspected that he might be transgender. Erica and Scott did some research to better understand what it means to be transgender. [Scott Tr. 25:22-26:1] As they absorbed this information, a number of cues from Drew's childhood started to make more sense, *e.g.*, Drew's strong aversion to wearing dresses, and refusal even to open gifts like Barbie dolls.

[Scott Tr. 23:5-24:7]

25. Erica and Scott consulted numerous mental health and medical professions, several of which diagnosed Drew with gender dysphoria and provided him with gender-affirming treatment, in accordance with the WPATH Standards of Care. [Pl.'s Ex. 132-35]

26. Once Drew began treatment, his mood and quality of life improved so dramatically that it was "as if someone had flipped a light switch." [Erica Decl. ECF No. 22-2 ¶ 7] Drew became less anxious and less depressed. His love of life returned.

D. Defendant's policies and practices relating to restrooms and other sex-designated facilities and activities.

27. All individuals, regardless of whether they are transgender, need access to restrooms that match their gender identity. In accordance with his male gender identity, Drew began using the boys' restrooms at Nease at the beginning of his freshman year, and continued to use them for approximately six weeks. [Drew Decl. Dkt. 22-1 ¶ 21] Drew always used a stall, as he does in every boys' restroom he uses outside of school. [*Id.* ¶ 20] In every material way, Drew's restroom use is just like that of other boys; he enters the restroom, relieves himself, washes his hands, and leaves.

28. On or around September 22, 2015, the school allegedly received a report from two female students that they had seen Drew entering the boys' restroom. [30(b)(6) Tr. 19:24-20:6; *id.* 20:9-12; *id.* 100:17-20] There is no documentary evidence of this alleged complaint and neither the District nor Nease officials has been able to identify the students who made this alleged complaint. Before Drew filed suit, not a single boy or parent of a boy complained about Drew's restroom use. [30(b)(6) Tr. 100:22-101:5; *id.* 101:14-20; *id.* 139:10-16; *id.* 101:21-25] Apart from the mere fact of Drew's presence in the boys'

restroom, no one, male or female, ever complained that Drew had engaged in any misconduct while in the restroom. [RFA 25-26, 31-32; Dresback Tr. 120:7-21]

29. Drew was pulled out of class to meet with guidance counselors after the report about his restroom use. [Drew Decl. Dkt. 22-1 ¶ 21] Drew was instructed during that meeting that he was banned from the boys' restroom, and limited to use of the girls' restroom or gender neutral restrooms. *Id.*

30. Drew was given this instruction pursuant to an unwritten policy, and a written set of guidelines entitled ["Best Practices"] (the "guidelines"), adopted by the District.

31. The District's unwritten policy requires students to use restrooms that match their "biological sex." [30(b)(6) Tr. 33:23-34:1; *id.* 36:4-6; *id.* 27:24-28:1] Defendant defines "biological sex" as the individual's sex assigned at birth "based on reproductive anatomy." [30(b)(6) Tr. 55:25-56:10]

a. Dr. Adkins and Dr. Ehrensaft offered testimony that "biological sex" is not considered a medically accurate term, since each individual has multiple sex-related characteristics (*e.g.*, hormones, chromosomes, internal sex organs, external sex organs, and gender identity), which may or may not all be aligned. [Hruz Tr. 199:12-200:11; Ehrensaft Rpt. ¶ 17] When those characteristics are not all aligned, the most important determinant of a person's sex is gender identity. [Ex. B, Ehrensaft Rpt. ¶ 17; Ex. A, Adkins Rpt. ¶ 43]

b. Given that Drew is treated by peers and school personnel alike as a boy, is on testosterone, has a deep voice, and has undergone a double-mastectomy, using the girls' restroom would be intolerable for him. It would also violate Drew's privacy, by indiscriminately disclosing his transgender status to all other girls in the restroom. While

Defendant claims that its policy and guidelines treat all students equally based on "biological sex," Drew is treated differently from other non-transgender students by being relegated to a gender neutral restroom. [30(b)(6) Tr. 224:4-11; 161:14-21]

32. The District's guidelines allow the use of a gender neutral restroom as an additional accommodation, in addition to the restroom matching the student's birth-assigned sex. Although the guidelines do not respect transgender students' gender identity for restroom use, they do recognize it in a variety of other ways. The guidelines provide that schools will: use the pronouns matching a student's consistently-asserted gender identity upon request of a student or parent [RFA 51]; update student records to reflect a transgender student's name and gender upon receipt of a court order [30(b)(6) Tr. 143:22-144:7; Pl.'s Ex. 122]; use a student's chosen name on unofficial school records even without a court order or birth certificate [Pl.'s Ex. 122]; allow transgender students to wear clothing in accordance with their consistently-asserted gender identity [Pl.'s Ex. 122]; not unnecessarily disclose a student's transgender status to others [Pl.'s Ex. 122]; allow students to publicly express their gender identity [Pl.'s Ex. 122]. The guide also cites Florida High School Athletics Association policy providing that students should be allowed to participate in athletics consistent with their gender identity. [Pl.'s Ex. 122]

33. If transgender students violate the policy and guidelines by using the restroom matching their gender identity more than once, they are subject to discipline. [30(b)(6) Tr. 150:1-8]

34. The District is aware of at least 16 transgender students in its schools; at least seven of those students have asked for access to restrooms matching their gender identity.

[Upchurch Tr. 76:13-19]

35. Erica communicated with Nease and District officials to try to resolve this issue informally, and when her efforts were unsuccessful, she filed a complaint with the U.S. Department of Education, Office for Civil Rights ("OCR"). After the OCR complaint languished, Drew filed the instant suit.

E. The Harms Visited on Drew by Defendant's Restroom Policy.

36. Failing to recognize and support a transgender student's gender identity sends a message—both to the transgender student and to others—that the transgender student is different from his or her peers and needs to be segregated, causing the transgender student to experience shame. [Ex. B, Ehrensaft Rpt. ¶¶ 39-40] Refusing to allow a transgender person to fully transition in all aspects—or deciding that he/she cannot be affirmed in a particular area, like in bathroom use—is detrimental and interferes with social transition. [Ex B, Ehrensaft Rpt. ¶¶ 39-40]

37. Dr. Ehrensaft interviewed Drew Adams, and she concluded that his exclusion from the boys' restroom has had a significant impact on him, causing him anxiety, embarrassment, and otherwise stigmatizing him because he is transgender. [Ex. B, Ehrensaft Rpt. ¶ 50] Drew reported that the humiliation of having to walk past the boys' restroom that all other boys are permitted to use causes Drew frequently to avoid restroom use, moderate his fluid intake, and miss valuable class time to use the restroom. [Ex. B, Ehrensaft Rpt. ¶ 50] Dr. Ehrensaft concluded that this prohibition causes him increased anxiety. [Ex. B, Ehrensaft Rpt. ¶ 50]

38. As Drew's treating endocrinologist, Dr. Adkins prescribed that Drew

complete his social transition by living consistent with his gender identity in all aspects of life, including using the boys' restroom. Denying Drew access to the boys' restroom interferes with that prescribed medical treatment. The Pediatric Endocrine Society views denying access to the boys' restroom as a human rights abuse, and the American Medical Association has adopted a position statement supporting restroom use in accordance with gender identity.

39. When Drew is mis-gendered (*i.e.*, referred to as a girl rather than a boy), it is harmful to him, and can cause him to feel anxious and depressed. [Scott Tr. 39:9-40:6; Drew Tr. 82:16-83:13] Erica testified that she and Drew have discussed the restroom exclusion countless times, and that she has observed that Drew experiences the school's differential treatment of him as a profound negation of his identity as a boy, which is painful and difficult for him. [Dkt. 22-2 ¶ 14]

40. Additionally, to avoid the stigmatizing experience of having to use a gender neutral restroom, Drew restricts his liquid intake, and sometimes will hold his bladder.

F. Nease does not have a gender neutral restroom adjacent to each boys' restroom, or each girls' restroom. [RFA 77-78] Drew must walk a longer distance to use the gender neutral restroom compared to his male peers, who have access to restrooms that are both greater in number, and closer to many of Drew's classes, than the gender neutral restrooms. Because it is not possible to access the more distant gender neutral restrooms solely during the breaks between his classes, Drew must sometimes choose between missing class to use them, or the stress and anxiety of holding his bladder in class instead of being able to concentrate fully on his class. Additionally, Drew is deprived of ready access to

gender neutral restrooms several days a week during the lunch hour, when the school has chosen to restrict students to a specific limited area to better supervise them. That area has no gender neutral restroom. Drew could leave the area if he sought permission, but doing so would call unwanted attention to him since no other student is permitted to leave.

Defendant's Purported Governmental Interests.

41. Defendant asserts that the governmental interests supporting its policy and guidelines consisting of an umbrella interest in student welfare, with the specific components of that interest constituting the protection of student (1) privacy and (2) safety. [30(b)(6) Tr. 78:7-10; *id.* 95:3-7] Several District and Nease administrators admitted that they do not have any valid interest in interfering with a transgender student's medical treatment of their gender dysphoria. [*See, e.g.*, Dresback Tr. 115:13-20]

a. ***Privacy:*** Defendant's privacy interest is purportedly intended to protect the privacy of non-transgender individuals using the restrooms at Nease. [30(b)(6) Tr. 86:21-25] The interest derives from the "the values and expectations of St. Johns County students and their families" that boys will not enter the girls' restroom, and vice versa. [30(b)(6) Tr. 85:23-86:18] Among these values is that "North Florida is more conservative than South Florida," [30(b)(6) Tr. 88:2-7], and that the district is "in a pretty religious area." [Kunze Tr. 22:8-18] The guidelines were developed by a St. Johns County School District task force, which was influenced by those community values. [30(b)(6) Tr. 156:22-157:8] The task force did not, as part of its work, consider allowing transgender students to access restrooms matching their gender identity. [30(b)(6) Tr. 170:4-11]

i. Defendant's privacy interest in its restroom policy and

guidelines also includes protecting students who are "naked or partially naked from exposure to the opposite sex." [30(b)(6) Tr. 225:11-13] But on the occasions where a student might change in a restroom, the student can do so in a stall or a gender neutral restroom. [30(b)(6) Tr. 234:25-235:13]

ii. All boys' and girls' restrooms at Nease contain stalls with doors that close and lock. [30(b)(6) Tr. 84:13-20; *id.* 201:14-19; RFA 57] All students who use a girls' restroom at Nease must use a stall when relieving themselves. [RFA 58] Defendant confirmed that it has not added partitions between the urinals in the boys' restroom, but could do so. [30(b)(6) Tr. 201:20-202:7] Any boy who wishes to use a stall for additional privacy can do so.

iii. Any student at Nease who wants additional privacy, for any reason, can use a gender neutral restroom, regardless of whether that student is transgender. [30(b)(6) Tr. 106:11-16; RFA 59]

iv. Associate Superintendent for Student Support Services Dresback agrees that transgender students have a right of privacy too. [Dresback Tr. 138:2-5]

b. ***Safety:*** Defendant's purported interest in safety is two-fold: First, Defendant recognizes that transgender children are vulnerable to bullying by others and believes that separating them from other students in restrooms will keep them safe. [30(b)(6) Tr. 81:22-82:16] Second, Defendant suggests that someone "could feign being transgender to get into the opposite bathroom to take pictures or peep or whatever." [30(b)(6) Tr. 93:16-20] But Defendant conceded that the second concern is "not number one on [the] list," and that no one "sees Drew Adams as a threat." [30(b)(6) Tr. 93:22-24; Dresback Tr. 126:5-9; *id.*

132:11-133:16; *id.* 134:20-135:8] Defendant's concern is "[p]rimarily" for the safety of transgender individuals. [30(b)(6) Tr. 93:25-94:2]

i. Defendant also suggests that the policy and guidelines are intended to prevent an older male from sexually assaulting a younger female [30(b)(6) Tr. 226:12-18], but the District has a code of conduct which prohibits any kind of misconduct or crime, including assault [30(b)(6) Tr. 233:7-19; RFA 28], and Florida's criminal laws may apply to criminal conduct on campus as well [RFA 30]. Defendant is not aware of any instances of sexual assault in the District involving a transgender man, and concedes that transgender people are not more prone to committing assault than any other person. [30(b)(6) Tr. 233:7-234:13]

ii. The school also has a duty to protect transgender students' safety. After an individual transitions, and is living consistent with their gender identity, it can be dangerous for them to continue to use restrooms that match their sex assigned at birth as they would be at risk of bullying and injury. [Ex. A, Adkins Rpt. ¶ 29; Ex. B]

42. As a practical matter, the school accepts as a student's "biological sex" the gender designated in their enrollment paperwork, in the student's birth certificate, and in other school records. [30(b)(6) Tr. 56: 20-23; *id.* 63:21-64:4]

43. The school does not undertake any protocol or effort to verify the student's sex as it appears in the enrollment paperwork and the student's records. [30(b)(6) Tr. 56:25-57:3] The District does not routinely keep records of, or ask students to identify, their chromosomes, external sex organs, or internal sex organs. [RFA 62-67] Nor does the District routinely ask students if they are intersex. [RFA 68] The District does not inspect

students' anatomy before they use District restrooms. [RFA 69; Dresback Tr. 137:17-19]

44. Apart from the purported report by two girls about Drew's restroom use, Defendant is not aware of any complaints in the District before this lawsuit about any transgender students using a restroom that matches their gender identity. [30(b)(6) Tr. 106:25-108:3, 108:12; 139:22-140:11; *id.* 148:17-23; *id.* 154:12-18; *id.* 230:5-20; Forson Tr. 61:22; *id.* 62:3; *id.* 68:22]

45. After the lawsuit, Defendant received comments from parents supporting Defendant's policy. [30(b)(6) Tr. 108:17-19] At least some of them were prompted by a press release from a member of the St. Johns County Republican Party entitled, "LBGT Bullies Sue St. Johns Schools to Force Transgender Bathrooms." [30(b)(6) Tr. 108:17-19; 109:23-110:12; Pl.'s Ex. 3]

46. Plaintiff also introduced the testimony of three school administrators with experience implementing inclusive policies for transgender students. Dr. Thomas Aberli served as Principal at J. M. Atherton High School in Louisville, Kentucky when the school adopted a policy in 2014 that respects students' gender identity. Michaelle Valbrun-Pope is the Executive Director for Student Support Initiatives for Broward County Public Schools ("BCPS") in Florida, which also adopted an inclusive policy several years ago. BCPS is the sixth largest district in the nation, with more than 271,500 students. Michelle Kefford is the Principal of the Charles W. Flanagan High School, a school within BCPS. Ms. Valbrun-Pope helped develop BCPS's non-discrimination policy, and Principal Kefford helps train educators within BCPS on the policy. All of these policies extend to restrooms, locker rooms, and all other sex-separated spaces and activities.

47. Dr. Aberli, Ms. Valbrun-Pope, and Principal Kefford all testified that the process of implementing their policies was neither difficult nor costly, and that their policies have improved their ability to carry out their mission as educators to help every student to thrive. None have experienced problems under their policies with privacy or safety.

G. The Level of Scrutiny for Transgender Status Discrimination.

48. Transgender people have been subjected to a long history of discrimination that continues into the present day. [Pl.'s Ex. 1 and 2; Ex. B, Ehrensaft Rpt. ¶ 22; Dkt. 114] This history of discrimination includes recent state legislation targeting them for discrimination in public restrooms [Ex. A, Adkins Rpt. ¶ 48; Dkt. 114-2], and a ban imposed by this administration on their military service. [Dkt. 114-1] The DSM 5 acknowledges that gender dysphoria is "associated with high levels of stigmatization, discrimination, and victimization." [Pl.'s Ex. 26; *see also* Pl.'s Ex. 1 and 2; Ex. B, Ehrensaft Rpt. ¶ 22; Dkt. 114]

49. As described above, being transgender does not impair one's ability to be a fully productive and contributing member of society. [Ex. A, Adkins Rpt. ¶¶ 24-25; Ex. B, Ehrensaft Rpt. ¶ 22]

50. Transgender people are a small, discrete minority group, easily identifiable both by self-report and professional assessment. [Ex. B, Ehrensaft Rpt. ¶ 22; Adkins Rpt. ¶ 42; Hruz Tr. 163:21-165-7] Additionally, gender identity is innate, generally fixed, and not subject to voluntary change. [Ex. A, Adkins Rpt. ¶¶ 20-21; Ex. B, Ehrensaft Rpt. ¶¶ 23-24]

51. Transgender people also are relatively politically powerless. [Dkt. 114]

II. PROPOSED CONCLUSIONS OF LAW

A. <u>Equal Protection</u>

1. The Fourteenth Amendment Equal Protection Clause provides that no State may "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1.

2. The Equal Protection Clause is fully applicable to Defendant and public school districts established and maintained under the laws of the State of Florida. *Fitzgerald v. Barnstable Sch. Comm.*, 555 U.S. 246, 258 (2009); *see also West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624, 637 (1943).

3. "Where a governmental entity, like Defendant, by its conduct intentionally treats one person differently from another, or one group of people differently from another group, when they are similarly-situated in all other material respects, the governmental classification must be justified by a standard related to its nature." *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 285 (W.D. Pa. 2017).

4. Here, Defendant's policy facially discriminates against transgender students in violation of the equal protection guarantee of the Fourteenth Amendment.

1. Discrimination on the Basis of Sex.

5. Defendant's bathroom policy discriminates on the basis sex. *Whitaker By Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017) ("Here, the School District's policy cannot be stated without referencing sex, as the School District decides which bathroom a student may use based upon the sex listed on the student's birth certificate. This policy is inherently based upon a sex-classification and heightened review applies."); *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011) ("Accordingly, discrimination against a transgender individual because of her gender-

nonconformity is sex discrimination, whether it's described as being on the basis of sex or gender."); *Smith v. City of Salem*, 378 F.3d 566, 573-75 (6th Cir. 2004); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000); *Schwenk v. Hartford*, 204 F.3d 1187, 1201-02 (9th Cir. 2000); *Stone v. Trump*, No. CV MJG-17-2459, 2017 WL 5589122, at *15 (D. Md. Nov. 21, 2017); *Doe 1 v. Trump*, No. CV 17-1597 (CKK), 2017 WL 4873042, at *28 (D.D.C. Oct. 30, 2017); *Evancho*, 237 F. Supp. 3d at 286; *Bd. of Educ. of the Highland Local Sch. Dist. v. United States Dep't of Educ.*, 208 F. Supp. 3d 850, 873 (S.D. Ohio 2016); *Adkins v. City of New York*, 143 F. Supp. 3d 134, 140 (S.D.N.Y. 2015).

6. Discrimination on the basis of sex necessarily encompasses discrimination based on an individual's gender identity, transgender status, and gender expression, including nonconformity to sex- or gender-based stereotypes. *See Glenn*, 663 F.3d at 1316; *Whitaker*, 858 F.3d at 1048; *Evancho*, 237 F. Supp. 3d at 288-89; *Highland Local Sch. Dist.*, 208 F. Supp. 3d at 869; *see also Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509, 526 (D. Conn. 2016).

7. Discrimination based on gender transition is necessarily based on sex, just as discrimination based on religious conversion is necessarily based on religion. Firing an employee because she converts from Christianity to Judaism "would be a clear case of discrimination 'because of religion,'" even if the employer "harbors no bias toward either Christians or Jews but only 'converts.'" *Schroer*, 577 F. Supp. 2d at 306; *accord Fabian*, 172 F. Supp. 3d at 527; *Macy*, 2012 WL 1435995, at *11.

8. It is settled law in the Eleventh Circuit that discrimination against transgender people necessarily relies upon sex stereotypes, because "[t]he very acts that define

transgender people as transgender are those that contradict stereotypes of gender appropriate appearance and behavior." *Glenn*, 663 F.3d at 1316; *Chavez v. Credit Nation Auto Sales, LLC*, 641 F. App'x 883, 884 (11th Cir. 2016) (reaffirming *Glenn*'s holding that "sex discrimination includes discrimination against a transgender person for gender nonconformity"); *Valentine Ge v. Dun & Bradstreet, Inc.*, No. 6:15-cv-1029-ORL-41GJK, 2017 WL 347582, at *4 (M.D. Fla. Jan. 24, 2017).

9. Put simply, "[t]he defining characteristic of a transgender individual is that their inward identity, behavior, and possibly their physical characteristics, do not conform to stereotypes of how an individual of their assigned sex should feel, act and look." *Doe 1*, 2017 WL 4873042, at *28; *see also Glenn*, 663 F.3d at 1316.

10. Accordingly, excluding transgender individuals from restrooms consistent with their gender identity constitutes government action "on the basis of sex." *Whitaker*, 858 F.3d at 1051; *Evancho*, 237 F. Supp. 3d at 285-86; *Highland Local Sch. Dist.*, 208 F. Supp. 3d at 870. *Cf. Lusardi*, 2015 WL 1607756, at *8.

11. There is no question that "all gender-based classifications today warrant heightened scrutiny." *United States v. Virginia*, 518 U.S. 515, 555 (1996); *see also Glenn*, 663 F.3d at 1319.

2. Discrimination Based On Transgender Status.

12. Defendant's bathroom policy separately triggers, or at least heightened, scrutiny because it discriminates on the basis of transgender status. *See Stone*, 2017 WL 5589122, at *15; *Doe 1*, 2017 WL 4873042, at *27; *Evancho*, 237 F. Supp. 3d at 288; *Highland Loc. Sch. Dist.*, 208 F. Supp. 3d 850, 873-74; *Adkins*, 143 F. Supp. 3d at 140.

13. In identifying whether a classification triggers strict or heightened scrutiny, the Supreme Court has considered whether: (a) the class has historically been "subjected to discrimination," *Bowen v. Gilliard*, 483 U.S. 587, 602 (1987); (b) the class's defining characteristic "frequently bears [a] relation to ability to perform or contribute to society," *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440-41 (1985); (c) the class exhibits "obvious, immutable, or distinguishing characteristics that define them as a discrete group," *Gilliard*, 483 U.S. at 602; and (d) the class is "a minority or politically powerless," *id.*

14. While not all four hallmarks must be present to warrant heightened scrutiny, *see Golinski v. Office of Pers. Mgmt.*, 824 F. Supp. 2d 968, 983 (N.D. Cal. 2012), all four point in favor of at least heightened scrutiny with respect to laws that classify on the basis of transgender status.

15. Transgender people "satisf[y] these criteria." *Doe 1*, 2017 WL 4873042, at *27. *See also Evancho*, 237 F. Supp. 3d at 288; *Highland Local Sch. Dist.*, 208 F. Supp. 3d at 874; *Adkins*, 143 F. Supp. 3d at 139-40.

16. Transgender people have experienced a long history of discrimination, including pervasive discrimination in employment, housing, and access to places of public accommodation or government services. *See Whitaker*, 858 F.3d at 1051; *Doe 1*, 2017 WL 4873042, at *27; *Evancho*, 237 F. Supp. 3d at 288; *Highland Loc. Sch. Dist.*, 208 F. Supp. 3d at 874; *Adkins*, 143 F. Supp. 3d at 139; *Brocksmith v. United States*, 99 A.3d 690, 698 n.8 (D.C. 2014).

17. There is also "obviously no relationship between transgender status and the ability to contribute to society." *Highland Loc. Sch. Dist.*, 208 F. Supp. 3d at 874; *see also*

Doe 1, 2017 WL 4873042, at *27; *Evancho*, 237 F. Supp. 3d at 288; *Adkins*, 143 F. Supp. 3d at 139.

18. Transgender individuals are a discrete minority—it is estimated that only 0.6% of the adults in the United States identify as transgender—and there can be little dispute that they are relatively powerless politically. *See Doe 1*, 2017 WL 4873042, at *28; *Evancho*, 237 F. Supp. 3d at 288; *Highland Loc. Sch. Dist.*, 208 F. Supp. 3d at 874; *Adkins*, 143 F. Supp. 3d at 139-40.

19. Further, a person's gender identity is an innate, effectively immutable characteristic that cannot be altered or be expected to change. *See Evancho*, 237 F. Supp. 3d at 288; *Highland Loc. Sch. Dist.*, 208 F. Supp. 3d at 874; *see also Hernandez-Montiel, v. INS*, 225 F.3d 1084, 1093 (9th Cir. 2000).

3. Defendant's Policy Cannot Be Justified Under Any Standard of Review.

20. Defendant's policy cannot survive *any* level of scrutiny, much less the exacting inquiry required by strict or heightened scrutiny.

21. Defendant's class-based targeting of Plaintiff demands some form of heightened scrutiny, as discrimination based on both sex and transgender status.

22. All sex classifications must be evaluated under heightened scrutiny even when they are based on alleged "biological differences" between men and women. *Tuan Anh Nguyen v. INS*, 533 U.S. 53, 73 (2001).

23. Under the heightened scrutiny required for all sex-based classifications, the government "must show at least that the challenged classification serves important governmental objectives and that the discriminatory means employed are substantially

related to the achievement of those objectives." *Virginia*, 518 U.S. at 533. Under strict scrutiny, a law must be narrowly tailored to advance compelling state interests. *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 227 (1995). Under both, "[t]he burden of justification is demanding and it rests entirely on the State. . . . The justification must be genuine, not hypothesized or invented post hoc in response to litigation. And it must not rely on overbroad generalizations about the different talents, capacities, or preferences of males and females." *Virginia*, 518 U.S. at 533. Moreover, constitutionality is judged based on the "actual state purposes, not rationalizations for actions in fact differently grounded." *Id.* at 535-36. Defendant's policy cannot meet either standard. Indeed, it cannot survive even the most deferential review.

24. "[E]ven in the ordinary equal protection case calling for the most deferential of standards, [courts] insist on knowing the relation between the classification adopted and the object to be obtained." *Romer v. Evans*, 517 U.S. 620, 632 (1996). The justifications offered must have a "footing in the realities of the subject addressed by the legislation." *Heller v. Doe*, 509 U.S. 312, 321 (1993); *U.S. Dep't of Agric. v. Moreno*, 413 U.S. 528, 533-38 (1973). And even when the government offers an ostensibly legitimate purpose, "[t]he State may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 446 (1985). Close scrutiny requires Defendant to demonstrate that the challenged policy is "a meaningful step towards solving a real, not fanciful problem." *Schleifer by Schleifer v. City of Charlottesville*, 159 F.3d 843, 849 (4th Cir. 1998); *see also Brown v. Entm't Merchants Ass'n*, 564 U.S. 786, 799 (2011).

25. Put simply, a "classification must substantially serve an . . . interest *today*, for in interpreting the equal protection guarantee, we have recognized that new insights and societal understandings can reveal unjustified inequality . . . that once passed unnoticed and unchallenged." *Sessions v. Morales-Santana*, No. 15-1191, 582 U.S. ---, 2017 WL 2507339, at *9 (June 12, 2017).

26. Defendant lacks even a legitimate reason to treat Plaintiff differently from his non-transgender peers, let alone an important or compelling one.

27. Plaintiff's unremarkable and uneventful use of the boys' restrooms at the beginning of his freshman year, without any incident, is the best evidence that Defendant's decision to bar his from those same restrooms later was purely arbitrary and based on discriminatory motives. *See Whitaker*, 2016 WL 5239829, at *6.

28. **Privacy:** Defendant appears to have primarily based its policy on a purported interest to protect "bodily privacy," meaning the interest of all students in not having their unclothed bodies observed by a persons of the other sex. [30(b)(6) Tr. 225: 11-13] But Plaintiff does not seek any such thing; he is a boy, and simply seeks to use the boys' restroom like all other boys. Although the protection of students' privacy is a legitimate interest, in the circumstances presented here, Defendant cannot show that the "fit between the means and the important end is 'exceedingly persuasive.'" *Nguyen*, 533 U.S. at 70 (quoting *Virginia*, 518 U.S. at 533). Moreover, Defendant's policy "appear[s] to do little to address any actual privacy concern of any student that is not already well addressed by the physical layout of the bathrooms." *Evancho*, 237 F. Supp. 3d at 289-90; *see also Highland*, 208 F. Supp. 3d at 874; *Whitaker*, 2016 WL 5239829, at *4.

29. Nor can any physiological differences between Plaintiff and non-transgender students of the same gender identity justify Defendant's actions in barring Plaintiff from shared restrooms and singling him out from his peers. Although physiological differences between the sexes in some cases may permit differential treatment in the achievement of an important objective, *see Nguyen*, 533 U.S. at 64, such differences cannot be used to "mask discrimination that is unlawful" or "embod[y] a gender-based stereotype," *id*. at 64, 68. Perhaps most importantly, any such differences must be *relevant* to the governmental interest, but here, Drew's restroom use is similar in every material way to that of his peers (he uses a stall to relieve himself, washes his hands, and leaves).

30. "Although the record reveals some specific concerns driven by the reputed presence (and presence alone) of [] Plaintiff in a restroom matching [his] gender identity," based on a complaint by an anonymous female student who does not use the boys' restrooms, "there is no record evidence that this actually imperiled or risked imperiling any privacy interest of any person." *Evancho*, 237 F. Supp. 3d at 290. Indeed, there is no evidence that Plaintiff ever "did, or threatened to do, anything to actually invade the physical or visual privacy of anyone else." *Id*. at 280.

31. In addition, privacy can be preserved without resorting to discrimination against transgender individuals. As a threshold issue, a purported concern for bodily exposure has no footing in the restroom context, given the divided and enclosed nature of restroom stalls, and the existence and availability of privacy dividers for urinals.

32. Defendant's policy also fails to promote privacy, even on its own terms. The policy continually invades transgender students' own interest in bodily privacy, stigmatizing

them and exposing them to their peers as different. For these reasons, the policy actually undermines any interest in protecting students' privacy by making transgender students' physiological features, particularly those who are not out, the subject of unwanted attention.

33. Defendant's "policy does nothing to protect the privacy rights of each individual student vis-à-vis students who share similar anatomy and it ignores the practical reality of how [Plaintiff], as a transgender boy, uses the bathroom: by entering a stall and closing the door." *Whitaker*, 858 F.3d at 1052.

34. Moreover, Defendant's policy is not tailored to address its hypothetical-concerns about privacy. That is because "any [non-transgender] student concerned with running into a transgender student in a bathroom and who does not think that urinal dividers or toilet stalls provide the requisite protection of their privacy can access one of the single-user facilities." *Doe by & through Doe v. Boyertown Area Sch. Dist.*, No. CV 17-1249, 2017 WL 3675418, at *55 (E.D. Pa. Aug. 25, 2017).

35. **Safety:** Defendant also asserts a purported interest in protecting students' safety, but notably, there has been no suggestion that Drew poses any safety concerns.

36. Courts repeatedly have rejected the notion that affording transgender students equal access to multi-user restrooms raises any safety concerns for others. *See, e.g.*, *Evancho*, 237 F. Supp. 3d at 289; *Highland Local Sch. Dist.*, 208 F. Supp. 3d at 877 n.15.

37. Defendant's suggestion that its discrimination against transgender students is justified by a concern for their own safety is disingenuous, and should not be credited. Defendant's fanciful suggestion that a non-transgender student might pose as transgender in order to access a restroom of a different sex has no basis in reality. As one court put it,

> For an "imposter" to take such steps would be an extensive social and medical undertaking. That would appear to the Court to be a really big price to pay in order to engage in intentionally wrongful conduct that is unlawful under state law and contrary to the District's stated expectations as to student conduct. The Court . . . can observe with confidence that a one-off, episodic declaration of transgender status in an effort to escape the consequences of engaging in nefarious bathroom behavior would not support a factual finding of transgender "gender identity" as is present in this case.

Evancho, 237 F. Supp. 3d at 291.

38. **Discomfort/Community Values:** Lastly, protecting cisgender students' comfort is an illegitimate interest that cannot justify Defendant's policy. A transgender person's mere presence in a restroom does not violate the rights of cisgender individuals in those spaces. *See Dep't of Fair Emp't & Hous. v. Am. Pac. Corp.*, No. 34-2013-00151153, Order at 4 (Cal. Super. Ct. Mar. 13, 2014); *Lusardi*, 2015 WL 1607756, at *9. *Cf. Glenn*, 663 F.3d at 1321; *Cruzan v. Special Sch. Dist.*, No. 1, 294 F.3d 981, 984 (8th Cir. 2002).

39. To the extent Defendant's policy seeks to validate an objection, whether based on discomfort, community values, or religion, to seeing transgender people in the restroom consistent with their gender identity—which is to say, to their mere presence—that is not a legitimate, let alone an important or compelling, government interest. Similar claims of "discomfort" about simply sharing spaces with those perceived as different have been made throughout history, but never has the correct answer been to indulge that discomfort.

40. Discomfort and personal biases about transgender people, even when wrapped in the cloak of privacy, safety, or community values, is simply not even a legitimate basis, let alone important or compelling, for imposing unequal or stigmatizing treatment. "The question, however, is whether the reality of private biases and the possible injury they might inflict are permissible considerations" for Defendant's policy. *Palmore v. Sidoti*, 466 U.S.

429, 433 (1984). The answer is "they are not." *Id.* "The Constitution cannot control such prejudices but neither can it tolerate them. Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect." *Id.*

41. **The forced use of single-user restrooms is not an appropriate alternative:** Finally, for every student at Nease High School that may feel uncomfortable using a shared restroom, the option also exists for any student to use a single stall bathroom. However, to the extent Defendant argues that "that there should not be an issue here because any student may use the single-user restrooms sprinkled around the High School," "the law does not impose on [] Plaintiff[] the obligation to use single-user facilities in order to 'solve the problem." In these circumstances, "that would compel [him] to use only restrooms inconsistent with [his] gender identit[y] or to use the 'special' restrooms. That is a choice directed by official edict, and it is not a choice compelled of other students." *Evancho,* 237 F. Supp. 3d at 293; *see also Whitaker,* 858 F.3d at 1050; *A.H. v. Minersville Area Sch. Dist.*, No. 3:17-CV-391, 2017 WL 5632662, at *6 (M.D. Pa. Nov. 22, 2017). "It is no answer under the Equal Protection Clause that those impermissibly singled out for differential treatment can, and therefore must, themselves 'solve the problem' by further separating themselves from their peers." *Evancho,* 237 F. Supp. 3d at 293; *see also Hassan v. City of New York,* 804 F.3d 277, 289-92 (3d Cir. 2015).

B. <u>Title IX</u>

42. Title IX provides that "[n]o person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial

assistance." 20 U.S.C. § 1681(a).

43. Title IX's prohibition on sex discrimination extends to "any academic, extracurricular, research, occupational training, or other education program or activity operated by a recipient of federal funding." 34 C.F.R. § 106.31.

44. Defendant is an education program receiving federal financial assistance and is therefore subject to Title IX's prohibition of sex discrimination against any student.

45. Title IX requires schools to provide transgender students access to restrooms that are consistent with their gender identity. "Access to the bathroom is [] an education program or activity under Title IX." *Highland Loc. Sch. Dist.*, 208 F. Supp. 3d 850, 865.

46. "Title IX is a broadly written general prohibition on discrimination, followed by specific, narrow exceptions to that broad prohibition." *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 175 (2005). Thus, while there is an exception which permits the provision of "separate toilet, locker rooms, and shower facilities on the basis of sex," 34 C.F.R. § 106.33, such exception does not permit the exclusion of transgender students from the restrooms congruent with their gender identity.

47. To prove a violation of Title IX, Plaintiff has to show that (1) he experienced discrimination in an education program or activity on the basis of sex, (2) the educational institution was receiving federal financial assistance at the time the discrimination occurred, and (3) the discrimination caused Plaintiff harm. *See Evancho*, 237 F. Supp. 3d at 295; *Highland Loc. Sch. Dist.*, 208 F. Supp. 3d at 865.

48. Title IX's prohibition of discrimination based on sex is generally viewed as parallel to the similar proscriptions contained in Title VII of the Civil Rights Act of 1964,

which prohibits discrimination on the basis of "sex" in the employment context. These statutes' prohibitions on sex discrimination are analogous. *See Davis v. Monroe County Bd. of Educ.*, 526 U.S.629, 651 (1999).

49. "Courts have long interpreted "sex" for Title VII purposes to go beyond assigned sex as defined by the respective presence of male or female genitalia." *Evancho*, 237 F. Supp. 3d at 296. And as noted above, numerous courts with the Eleventh Circuit and elsewhere have held that Title VII's prohibition of discrimination on the basis of "sex" includes discrimination on the basis of gender identity, transgender status, and gender expression, including nonconformity to sex-or gender-based stereotypes. *See Chavez*, 641 Fed. Appx. 883; *Glenn*, 663 F.3d 1312; *Valentine Ge*, 2017 WL 347582; *see also Roberts v. Clark Cty. Sch. Dist.*, 2016 WL 5843046 (D. Nev. 2016); *Fabian*, 172 F.Supp.3d 509; *Finkle v. Howard Cty., Md.*, 12 F. Supp. 3d 780 (D. Md. 2014); *Lopez v. River Oaks Imaging & Diagnostic Grp., Inc.*, 542 F.Supp.2d 653 (S.D. Tex. 2008); *Schroer*, 577 F. Supp. 2d 293.

50. While Title IX "does not define the term 'sex,'" *Conley v. Nw. Florida State Coll.*, 145 F. Supp. 3d 1073, 1076 (N.D. Fla. 2015), the aforementioned conclusions by numerous courts are bolstered by their studied analysis of the definition of "sex" in modern dictionaries as well as those contemporaneous with the enactment of Title IX. Courts that have carefully evaluated and considered definitions of the word from a variety of dictionaries, including definitions from dictionaries at the time Title IX was enacted, have correctly concluded that the term is multi-faceted and that a reasonable interpretation of the term includes a host of sex-related characteristics, including gender identity. *See, e.g.*, *Students and Parents for Privacy*, 2016 WL 6134121, at *17-18; *Highland Loc. Sch. Dist.*,

208 F. Supp. 3d at 866, n.4; *Fabian*, 172 F. Supp. 3d at 526; *see also Radtke v. Misc. Drivers & Helpers Union Local No. 683 Health, Welfare, Eye & Dental Fund*, 867 F. Supp. 2d 1023, 1032 (D. Minn. 2012). *Cf. Conley*, 145 F. Supp. 3d at 1078. Thus, by adopting and implementing its policy, Defendant has discriminated on the basis of sex.

51. The fact that the current administration recently reversed the prior interpretation of Title IX by the U.S. Department of Education is entitled to no weight. "Contrary to Defendant's argument, a specific practice need not be identified as unlawful by the government before a plaintiff may bring a claim under Title IX." *A.H.*, 2017 WL 5632662, at *6.

52. "A policy that requires an individual to use a bathroom that does not conform with his or her gender identity punishes that individual for his or her gender non-conformance, which in turn violates Title IX." *Whitaker*, 858 F.3d at 1049. As such, Defendant's policy subjects Drew, "as a transgender student, to different rules, sanctions, and treatment than non-transgender students, in violation of Title IX." *Whitaker*, 858 F.3d at 1049-50; *see also Whitaker*, 2016 WL 5239829, at *3; *Highland Local Sch. Dist.*, 208 F. Supp. 3d at 867-71.

53. By adopting and enforcing a policy or practice prohibiting Drew, a transgender boy, from accessing and using male-designated restrooms at school, and requiring that he use female-designated restrooms or single-occupancy restrooms, Defendant has discriminated against and continues to discriminate against Drew in his enjoyment of the School District's educational programs and activities by treating him differently from other male students based on his gender identity, the fact that he is transgender, and his

nonconformity with sex stereotypes.

54. Defendant has discriminated against Drew on the basis of sex in violation of Title IX and thereby has denied Drew the full and equal participation in, benefits of, and right to be free from discrimination in the educational opportunities offered by the School District and Nease High School.

55. Defendant has intentionally discriminated against Plaintiff based on his sex, and, thus, violated Title IX.[3]

C. <u>Declaratory and Injunctive Relief, and Damages</u>.

56. As a result of Defendant's policy, Plaintiff suffers irreparable harm each passing day that he is subjected to unequal treatment, and the humiliation, anxiety, depression that accompany that treatment.

57. The emotional distress and symptoms of gender dysphoria, including anxiety, surge significantly in transgender students after being instructed not to use the restrooms consistent with their gender identity. Here, Plaintiff has already experienced some of those consequences. As a result, Plaintiff also increasingly feels isolated, marginalized, and stigmatized by Defendant's actions.

58. "Courts have long recognized that disparate treatment itself stigmatizes members of a disfavored group as innately inferior, and raises the 'inevitable inference' of

[3] In its Case Management and Scheduling Order, Dkt. 59, para. 1, the Court stated that it would carry Defendant's motion to dismiss Plaintiff's Title IX claim with the case and that it would be "decided as part of the Court's Findings of Facts and Conclusions of Law." Accordingly, Plaintiff hereby "incorporate his response in his proposed findings of fact and conclusions of law" and avers that he has stated a plausible claim under Title IX. "When reviewing a motion to dismiss under Rule 12(b)(6), the Court must view the allegations in the light most favorable to the plaintiff and accept the allegations of the complaint as true." *Pucci v. Bank of Am., N.A.*, No. 3:14-CV-1236-J-32MCR, 2016 WL 1162331, at *2 (M.D. Fla. Mar. 23, 2016) (citing *Speaker v. U.S. Dep't of Health & Human Servs.*, 623 F.3d 1371, 1379 (11th Cir. 2010)).

animosity toward those impacted by the involved classification." *Evancho*, 237 F. Supp. 3d at 294. Given the facts here and that Plaintiff, a transgender boy, has been targeted for disparate treatment, "it is not a long leap, nor really a leap at all, to give credence to the Plaintiff['s] assertions that [he] subjectively feel[s] marginalized, and objectively [is] being marginalized, which is causing them genuine distress, anxiety, discomfort and humiliation." *Id.*

59. Because neither of the options established by Defendant's policy are tenable, Plaintiff has been compelled to choose a harmful alternative option: not using the restroom at all at school except when absolutely necessary, which causes him great discomfort. The abstention of using the restroom can also lead to long-term adverse health consequences.

60. Defendant's actions have negatively affected Plaintiff's school work, by forcing seem to work even harder than he otherwise would in order to maintain good grades and his honor student status. In the school context, even "diminished academic motivation" is sufficient to constitute irreparable harm. *Washington v. Ind. High Sch. Athletic Ass'n, Inc.*, 181 F.3d 840, 853 (7th Cir. 1999).

61. Plaintiff thus will undoubtedly suffer serious and irremediable harm if a permanent injunction is not granted.

62. Further, "in a private cause of action brought pursuant to Title IX, 'both injunctive relief and damages are available.'" *A.H.*, 2017 WL 5632662, at *6; *see also Sheely v. MRI Radiology Network, P.A.*, 505 F.3d 1173, 1195-96, 1198 (11th Cir. 2007). "While a plaintiff must prove discriminatory intent to receive money damages, there is no such requirement to receive injunctive relief." *A.H.*, 2017 WL 5632662, at *6.

63. "As a matter of both common sense and case law, emotional distress is a predictable, and thus foreseeable, consequence of discrimination." *Sheely*, 505 F.3d at 1199.

64. As such, the Eleventh Circuit has "long found that violations of antidiscrimination statutes frequently and palpably result in emotional distress to the victims." *See, e.g.*, *Bogle v. McClure*, 332 F.3d 1347, 1354, 1359 (11th Cir. 2003); *Ferrill v. Parker Group, Inc.*, 168 F.3d 468, 476 (11th Cir. 1999); *Stallworth v. Shuler*, 777 F.2d 1431, 1435 (11th Cir. 1985).

65. Because Plaintiff has suffered intentional and purposeful discrimination at the hands of Defendant, Plaintiff is entitled to garden variety, non-economic compensatory damages for the emotional distress and suffering, embarrassment, humiliation, pain and anguish, violation of dignity that have been caused by Defendant's conduct intentionally violating Plaintiff's rights under the Fourteenth Amendment and Title IX.

Dated this 7th of December, 2017.

Respectfully submitted,

s/ Tara L. Borelli
Tara L. Borelli (*admitted pro hac vice*)
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308-1210
Telephone: 404-897-1880
Facsimile: 404-897-1884
tborelli@lambdalegal.org

/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan
(*admitted pro hac vice*)
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005-3919

Kirsten Doolittle, Trial Counsel
Florida Bar No. 942391
THE LAW OFFICE OF KIRSTEN DOOLITTLE, P.A.
The Elks Building
207 North Laura Street, Ste. 240
Jacksonville, FL 32202
Telephone: 904-551-7775
Facsimile: 904-513-9254
kd@kdlawoffice.com

Jennifer Altman
Florida Bar No: 881384
Markenzy Lapointe
Florida Bar No: 172601
Shani Rivaux
Florida Bar No: 42095

Telephone: 212-809-8585
Facsimile: 212-809-0055
ogonzalez-pagan@lambdalegal.org

Paul D. Castillo (*admitted pro hac vice*)
LAMBDA LEGAL DEFENSE
AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: 214-219-8585
Facsimile: 214-219-4455
pcastillo@lambdalegal.org

Natalie Nardecchia
(*admitted pro hac vice*)
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010-3512
Tel. 213-382-7600 | Fax: 213-351-6050
nnardecchia@lambdalegal.org

Aryeh Kaplan
Florida Bar No: 60558
PILLSBURY WINTHROP SHAW PITTMAN, LLP
600 Brickell Avenue Suite 3100
Miami, FL 33131
Telephone: 786-913-4900
Facsimile: 786-913-4901
jennifer.altman@pillsbury.com
markenzy.lapointe@pillsburylaw.com
shani.rivaux@pillsbury.com
aryeh.kaplan@pillsbury.com

Richard M. Segal (*admitted pro hac vice*)
Nathaniel R. Smith (*admitted pro hac vice*)
PILLSBURY WINTHROP SHAW PITTMAN LLP
501 W. Broadway, Suite 1100
San Diego, CA 92101
Telephone: 619-234-5000
Facsimile: 619-236-1995
richard.segal@pillsburylaw.com
nathaniel.smith@pillsburylaw.com

Counsel for Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on December 7, 2017, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system, causing a copy of the foregoing and all attachments to be served on all counsel of record.

/s/ Tara L. Borelli
Tara L. Borelli (*admitted pro hac vice*)
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308-1210
Tel.: 404-897-1880 | Fax: 404-897-1884
tborelli@lambdalegal.org

Exhibit A

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

DREW ADAMS, a minor, by and through his next friend and mother, ERICA ADAMS KASPER, *Plaintiff*, v. THE SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA, *Defendant*.	No. 3:17-cv-00739-TJC-JBT

EXPERT REPORT OF DEANNA ADKINS, M.D.

PRELIMINARY STATEMENT

1. I have been retained by counsel for Plaintiff as an expert in connection with the above-captioned litigation. My professional background, experience, and publications are detailed in my curriculum vitae, a true and accurate copy of which is attached as Exhibit A to this report. I received my medical degree from the Medical College of Georgia in 1997. I am currently the Fellowship Program Director of Pediatric Endocrinology at Duke University School of Medicine ("Duke") and the Director of the Duke Center for Child and Adolescent Gender Care.

2. I have been licensed to practice medicine in the state of North Carolina since 2001.

3. I have extensive experience working with children with endocrine disorders and I am an expert in the treatment of children with differences or disorders of sex development and gender dysphoria.

4. I am a member of the American Academy of Pediatrics, the North Carolina Pediatric Society, the Pediatric Endocrine Society, and The Endocrine Society. I am also a member of the World Professional Association for Transgender Health ("WPATH"), the leading association of medical and mental health professionals in the treatment of transgender individuals.

5. I am the founder of the Duke Center for Child and Adolescent Gender Care ("Gender Care Clinic"), which opened in 2015. I currently serve as the Director of the clinic. The Gender Care clinic treats children and adolescents age 4 years old through 22 years old with gender dysphoria and differences or disorders of sex development. I have been caring for these individuals in my routine practice for many years prior to opening the clinic.

6. I currently treat approximately 240 transgender and intersex young people from North Carolina and across the Southeast at the Gender Care clinic. I have treated approximately 300 transgender and intersex young people in my career.

7. As part of my practice, I stay familiar with the latest medical science and treatment protocols related to differences or disorders of sex development and gender dysphoria.

8. I am regularly called upon by colleagues to assist with the sex assignment of infants who cannot be classified as male or female at birth due to a range of variables in which sex-related characteristics are not completely aligned as male or female.

9. In preparing this report, I reviewed the materials listed in the attached Bibliography (Exhibit B). I may rely on those documents as additional support for my opinions. I have also relied on my years of experience in this field, as set out in my curriculum vitae (Exhibit A), and on the materials listed therein. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

10. I have testified once as an expert at trial or deposition in the past four years, in *U.S. Army v. Specialist Brandon Richard Oversby*, B Company, 50th Signal Battalion, (Expeditionary), 35th Signal Brigade, Fort Bragg, NC.

11. I am not being compensated for my expert work and testimony related to this case. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

WHAT DOES IT MEAN TO BE TRANSGENDER OR INTERSEX?

12. A transgender individual is an individual who has a gender identity that differs from the person's birth-assigned sex.

13. Individuals who are intersex (also known as having "differences of sex development or differentiation") have sex characteristics that are a mixture of those typically associated with both "male" and "female" sex designations.

14. At birth, infants are generally classified as male or female based on observation of their external genitalia. This classification becomes the person's birth-assigned sex but may not be the same as the person's gender identity.

15. A person's gender identity refers to a person's inner sense of belonging to a particular gender, such as male or female.

16. Gender identity is a deeply felt and core component of a person's identity.

17. Everyone has a gender identity.

18. Most people have a gender identity that aligns with the sex they were assigned at birth. However, for some people, their deeply felt, core identification and self-image as a particular gender does not align with the sex they were assigned at birth. This lack of alignment can create significant distress for individuals with this experience and can be felt in children as young as 2 years old.

19. Individuals with this distress may be diagnosed with gender dysphoria. Gender dysphoria is defined by the Diagnostic and Statistics Manual 5 as a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, frequently manifested by the following: A strong desire to be of the other gender or an insistence that one is the other gender, possibly a strong dislike of

one's sexual anatomy, and/or a strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

20. Gender identity is innate and cannot be voluntarily altered, including for individuals whose gender identity does not align with their birth-assigned sex.

21. It is widely considered unethical to attempt to change the gender identity others.

22. Although research regarding the precise determinant of gender identity is still ongoing, evidence strongly suggests that gender identity is innate at a young age and that it has a strong biological basis.

23. Both post-mortem and functional brain studies that have been done on the brains of individuals with gender dysphoria show that these individuals have brain structure, connectivity, and function that do not match their birth-assigned sex. Variations in these studies include overall brain size, intra- and inter-hemispheric connectivity (number of connections within each half of the brain and between halves of the brain). Differences have been shown in visuospatial and verbal fluency tasks and their activation patterns in the brain. Variations in cortical thickness in the sensory motor areas, the white matter microstructure, and regional cerebral blood flow are also present in those with gender incongruence compared to those without.

24. Being transgender is a normal developmental variation.

25. When properly treated, individuals with gender dysphoria can lead happy, healthy, productive lives.

26. Being transgender does not limit one's ability to function in and contribute fully to society.

27. There are authoritative standards for caring for individuals who are transgender. These have been published by multiple medical organizations. These include the Standards of Care Version 7 by the World Professional Association for Transgender Health ("WPATH Standards of Care"), Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, and the Guidelines for Psychological Practice with Transgender and Gender Nonconforming People by the American Psychological Association.

28. There are typically several phases of transitioning from one gender to another. They may or may not all occur and they may occur in different sequences in different individuals. I will discuss here the most common order in which my patients experience their transitions. The first form is social transition. This can include things such as: asking to be called a different name, using different pronouns that match one's gender identity, changing the way one dresses, changing one's haircut, and using restrooms and changing facilities that match one's gender identity.

29. The second form of transition is a medical transition. This is when people begin to take medications that will decrease their own body's hormones and increase the hormone levels that match their gender identity. This step causes physical changes such as breast development in transgender women, and deepening of the voice and growth of facial hair in transgender men. These changes will make their bodies align with their gender identity. At this point it will often be dangerous for them to continue to use restrooms and changing facilities that match their sex assigned at birth as they would be at risk of bullying and injury.

30. The next form of transition is surgical. This is the most variable of all of the stages. Many people do not have any surgery.

31. Surgery is not recommended by any of our standards of care for minors. However, once adolescents have started on hormonal treatment, they begin to take on physical characteristics that make it obvious that they have transitioned to a gender different than the one they were assigned at birth. These changes, as mentioned above, make using restrooms other that those that match their new appearance and gender identity dangerous and give away to others that they are transgender. This may occur even when they are forced to use gender neutral restrooms which their peers are not being asked to use. This interferes with their right to privacy. This also not consistent with the standards of care which recommend that individuals who are transgender use restrooms consistent with their gender identity.

32. In addition to my expert testimony in this case, I have served as Drew's treating physician since July 2016. Drew has been properly diagnosed with gender dysphoria by his own mental health provider as well as our mental health provider at Duke. Drew's gender identity is male, and accordingly Drew is a boy and should be treated that way in all aspects of his life. Drew is receiving treatment in accordance the WPATH Standards of Care as well as the Endocrine Society's Clinical Guidelines from 2017.

HOW DO EXPERTS ASSIGN OR "DETERMINE" SEX?

33. The medically appropriate determinant of sex is gender identity.

34. For many people, gender identity aligns with the sex assigned to the individual at birth.

35. For transgender people and people with differences or disorders of sex development, there is not complete alignment among sex-related characteristics. Medicine and science require that where a more careful consideration of sex assignment is needed that it be based on gender identity rather than other sex characteristics.

36. In the past, when mental health and medical practitioners identified a disconnect between a person's gender identity and assigned sex at birth, treatment often focused on efforts to bring the individual's gender identity into alignment with the assigned sex. These practices were unsuccessful and incredibly harmful. Deep depression, psychosis, and suicide frequently resulted.

37. Medical science has since recognized that appropriate treatment for individuals who are transgender and suffer from gender dysphoria must focus on alleviating distress through supporting outward expressions of the person's gender identity and bringing the body into alignment with that identity to the extent deemed medically appropriate based on assessments between individual patients and their medical and mental health providers. These treatments have been very successful. Data in the medical literature shows a better response rate for these treatments than most medications.

38. In infants with sex-characteristics associated with both males and females, if an assignment is made that later conflicts with gender identity, then the only appropriate medical course is to correct the misassignment of the individual's sex to align with gender identity.

39. It is harmful to make sex assignments based on characteristics other than gender identity. For example, in cases where surgery was done prior to the ability of the

child to understand and express their gender identity, there has been significant distress in these individuals who then have to endure further surgeries to reverse the earlier treatments. It has become standard practice to wait until the gender identity is clear to make permanent surgical changes in these patients unless the changes are required to maintain the life and health of the child.

40. Genital surgery is not medically indicated for minors. There are many reasons that many people never undergo genital surgery including medical conditions that could make surgery dangerous, cost, and a lack of insurance coverage.

41. A person's gender identity (regardless of whether that identity matches other sex-related characteristics) is fixed, is not subject to voluntary control, cannot be voluntarily changed, and is not undermined or altered by the existence of other sex-related characteristics that do not align with it.

42. Today, medical and mental health care providers who specialize in the treatment of these individuals with gender dysphoria recognize that being transgender is a normal developmental variation. Current estimates of transgender individuals in the U.S. is 0.3% of the population based on a study by the Williams Institute in 2011. As a comparison The American Diabetes Association and the Centers for Disease Control and Prevention together estimate that the prevalence of type 1 diabetes mellitus in the U.S. is 0.38%.

43. For individuals with gender dysphoria and individuals with differences of sex development, gender identity is the only appropriate determinant of sex when sex assignment as male or female is necessary for social and legal purposes. It would be unethical and extremely harmful to, for example, force a man with congenital adrenal

hyperplasia, discussed below, to be classified as a woman for all legal and social purposes simply because he was classified as female at birth. Likewise it would be unethical and extremely harmful to force a man who has gender dysphoria to be classified as female for all social and legal purposes simply because he was assigned female at birth.

44. Requiring individuals with gender dysphoria to use single-sex facilities that are inconsistent with their gender identity is not only harmful to their mental health and stigmatizing; when these individuals are excluded from restrooms that match their gender identity, rather than use restrooms of a different gender or gender neutral restrooms, they often will avoid restroom use for long periods of time, resulting in urinary tract infections, kidney problems, and other medical complications. The American Medical Association has recently passed a resolution in their House of Delegates supporting access to restrooms that match one's gender identity.

45. Being denied access to restrooms that match one's gender identity interferes with treatment based on the standards of care, specifically that transgender individuals have the ability to live in accordance with their gender identity in all aspects of life.

46. Being denied access to restrooms that match their gender identity heightens transgender individuals' dysphoria, worsens depression and anxiety and can lead to self-harm.

47. On the other hand, respecting a person's gender identity leads to significant improvement in dysphoria, anxiety, and depression.

48. I have first-hand knowledge of these issues based on transgender patients I have treated in North Carolina. The state previously enacted a law called H.B. 2, which restricted transgender individuals' restroom access to those that match their birth certificates. Prior to the passage of H.B. 2, most of my patients used restrooms and changing facilities consistent with their gender identity in various settings. The ability to use restrooms consistent with their gender identity lowered their anxiety levels. After the passage of H.B. 2, my patients who are transgender and intersex largely avoided using public restrooms and this was detrimental to their health and wellbeing. In other medical conditions where there is urinary retention, such as diabetes mellitus and diabetes insipidus, it is well documented in the medical literature that this leads to bladder spasms, damage and kidney injury.

49. The cost of not assigning sex based on gender identity is dire. It is counter to medical science to use chromosomes, hormones, internal reproductive organs, external genitalia, or secondary sex characteristics to override gender identity for purposes of classifying someone's sex. Gender identity does and should control when there is a need to classify an individual as a particular gender.

50. With the exception of some serious childhood cancers, gender dysphoria is the most fatal condition that I treat because of the harms that flow from not properly recognizing gender identity. Attempted suicide rates in the transgender community are over 40%, which is a risk of death that far exceeds most other medical conditions. The only treatment to avoid this serious harm is to recognize the gender identity of patients with gender dysphoria and differences of sex development.

WHAT IS "BIOLOGICAL SEX"?

51. I understand that the defendant in this case restricts use of multi-occupancy restrooms to "biological sex," *i.e.*, one's sex assigned at birth. In addition to being counter to medical science as explained above, this definition and conception of "biological sex" is inherently flawed.

52. Although we generally label infants as "male" or "female" based on observing their external genitalia at birth, external genitalia do not account for the full spectrum of sex-related characteristics or determine one's sex. Instead, sex-related characteristics include external genitalia, internal reproductive organs, chromosomes, secondary sex characteristics, genes, and gender identity. These sex-related characteristics do not always align as completely male or completely female in a single individual. In fact, this occurs frequently enough that doctors use a scale called the Prader Scale to describe the genitalia on a spectrum from male to female.

53. Particularly for individuals with a difference or disorder of sex development, sex assignment at birth can involve the evaluation of the sex chromosomes, the external genitalia, the internal genitalia, hormonal levels, and sometimes, specific genes. There are also cases in which the appearance of the external genitalia can change at puberty as well as variations in the appearance of secondary sex characteristics that may signal that there is a difference in sex development in a person.

54. Many individuals, including individuals who have intersex traits or gender dysphoria, have biological, sex-related characteristics that are typically associated with both men and women. For example:

a. Individuals with Complete Androgen Insensitivity have 46-XY chromosomes, which are typically associated with males, but do not have the tissue receptors that respond to testosterone or other androgens. The body, therefore, does not develop external genitalia or secondary sex characteristics typically associated with males but does, generally, have testes. At birth, based on the appearance of the external genitalia, individuals with Complete Androgen Insensitivity are generally assigned female.

b. Individuals with Klinefelter Syndrome have 47-XXY chromosomes and internal and external genitalia typically associated with males, however, the testicles in individuals diagnosed with Klinefelter Syndrome lose function over time. This may lead to breast development and infertility in addition to a number of other health issues.

c. Individuals with Turner Syndrome have 45-XO chromosomes, which means they have one less chromosome than everyone else. In utero, these individuals form sex characteristics typically associated with females including all internal structures but the ovaries begin to die soon after birth and the individuals are unable to make estrogen. Without treatment, individuals with Turner Syndrome do not develop secondary sex characteristics typically associated with women.

d. Individuals with Mosaic Turner Syndrome may have two different sets of chromosomes. They lose a sex chromosome in the early stages of embryonic development. The cells that are descendants of the cell that

lost a chromosome will have Turner Syndrome features. The cells that are descendants of the cells that did not lose a sex chromosome will have features of the embryo's initial chromosomal sex. Sometimes this initial sex was XX and sometimes it is XY. When there are cells with XY chromosomes present, the fetus produces testosterone and there is at least some testicular tissue. There may also be ovarian tissue. The external genitalia can then be a mixture of external genitalia typically associated with both males and females.

e. Individuals with congenital adrenal hyperplasia are individuals who have XX chromosomes and external genitalia typically associated with women but are born with extra androgens, including testosterone, and from early in gestation, their brains are exposed to high levels of androgen. Despite frequently being assigned female at birth because of external genitalia, many individuals with this condition have a male gender identity.

f. Individuals with 5-alpha reductase are chromosomally XY but they have an enzyme deficiency that does not allow them to convert testosterone to dihydrotestosterone, the active form of testosterone. At birth, based on external genitalia, they are often assigned female, but their gender identity is almost always male as adults. Their external genitalia also changes at puberty because hormonal changes allow them to make more dihydrotestosterone which is needed for the physical changes that occur causing the development of external genitalia typically associated with

males. During early development there is enough testosterone to affect the brain, which often results in a male gender identity.

g. Individuals with cloacal extrophy have external genitalia at birth that is often split in half and most of their internal pelvic organs are located on the outside of their bodies. They are born with both XX and XY chromosomes. However, because of the severity of the changes in their external genitalia, most of the XY patients had sex reassignment in infancy and were raised as females. Follow-up studies of these patients as adults show that almost all of the XY patients have a gender identity of male. This is powerful evidence that one's core gender identity cannot be changed.

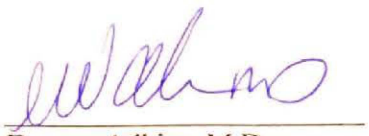
h. A transgender person who transitioned at a young age and takes hormone blockers would not develop the secondary sex characteristics typically associated with their birth-assigned sex. This process suspends their pubertal development until the blockers are stopped or until gender affirming hormones are added.

i. A woman who is transgender may have XY chromosomes, undergo hormone treatment and surgery, and have external genitalia and secondary sex characteristics typically associated with women.

j. A man who is transgender may undergo hormone therapy, have hormone levels comparable to a man assigned the sex of male at birth, and thus develop masculine secondary sex characteristics.

55. As the examples above underscore, "biological sex" is not an accurate or useful medical term with respect to individuals whose sex-related characteristics are not in alignment with each other. Rather, the medically appropriate determinant of sex is gender identity and should be treated as such.

Executed on October 11, 2017.

By: 
Deanna Adkins, M.D.

Expert Report of Deanna Adkins, M.D.

Exhibit A – Curriculum Vitae

CURRICULUM VITAE
Date Prepared: October 1, 2017

Name:	Deanna Wilson Adkins, MD
Primary Academic Appointment:	Assistant Professor **Program Director** Pediatric Endocrinology **Director** Pediatric Diabetes and Endocrinology Duke Children's Raleigh **Director** Duke Child and Adolescent Gender Care **Medical Director** Duke Children's and WakeMed Children's Consultative Services of Raleigh
Primary Academic Department:	Department of Pediatrics Division of Endocrinology
Present Academic Rank and Title :	Assistant Professor
Date and Rank of First Duke Faculty Appointment:	July 1, 2004 Clinical Associate
Medical Licensure:	North Carolina License #:200100207 Date of License: March 15, 2001
Specialty Certification:	Pediatrics current Pediatric Endocrine current

EDUCATIONAL BACKGROUND

Level	Institution	Date	Degree
High School	Tift County High School	1988	Diploma
College	Georgia Institute of Technology	1993	B.S.
Graduate or Professional School	Medical College of Georgia	1997	MD

PROFESSIONAL TRAINING AND ACADEMIC CAREER

Institution	Position/Title	Dates
University of North Carolina Hospitals, Chapel Hill, North Carolina	Pediatrics Resident	1997-2000

Name: Adkins, Deanna W.

University of North Carolina Hospitals, Chapel Hill, North Carolina	Pediatric Endocrine Fellow	2000-2004
Duke University Medical Center, Durham, North Carolina	Clinical Associate/Medical Instructor	2004-2008
Duke University Medical Center, Durham, North Carolina	Assistant Clinical Professor	2008-present
Duke University Medical Center, Durham, North Carolina	Fellowship Program Director Pediatric Endocrinology	2008-2010
Duke University Medical Center, Durham, North Carolina	Associate Fellowship Program Director Pediatric Endocrinology	2010-2014
Duke University Medical Center, Durham, North Carolina	Fellowship Program Director Pediatric Endocrinology	2014-present
Duke University Medical Center, Durham, North Carolina	Director Duke Child and Adolescent Gender Care	2015-present

PUBLICATIONS

Refereed Journals:

1. Zeger MD, Adkins D, Fordham LA, White KE, Schoenau E, Rauch F, & Loechner KJ. "Hypophosphatemic rickets in opsismodysplasia." *J Pediatr Endocrinol Metab.* 20, no. 1 (2007): 79-86. PMID: 17315533

2. Gordon Worley MD, Blythe Crissman MS CGC, Emily Cadogan BS MSI, Christie Milleson BA, Deanna W. Adkins MD, & Priya Kishnani MD. "Down Syndrome Disintegrative Disorder: New-Onset Autistic Regression, Dementia, and Insomnia in Older Children and Adolescents With Down Syndrome." *J. Child Neurol.* 30, no. 9 (2015): 1147-52.

3. Tejwani R, Jiang R, Wolf S, Adkins DW, Young BJ, Alkazemi M, Wiener JS, Pomann GM, Purves JT, & Routh JC. "Contemporary Demographic, Treatment, and Geographic Distribution Patterns for Disorders of Sex Development." *Clinical Pediatrics* (Jul. 2017). doi: 10.1177/0009922817722013. PMID:28758411

Collaborations in National studies: SPIN

4. Mink RB, Schwartz A, Herman BE, Turner DA, Curran ML, Myers A, Hsu DC, Kesselheim JC, Carraccio CL and the Steering Committee of the Subspecialty Pediatrics Investigator Network (SPIN). "Validity of Level of Supervision Scales for Assessing Pediatric Fellows on the Common Pediatric Subspecialty Entrustable Professional Activities." *Academic Medicine* (Jul. 2017). doi: 10.1097/ACM.0000000000001820.

5. Mink R, Carraccio C, High P, Dammann C, McGann K, Kesselheim J, Herman B. "Creating the Subspecialty Pediatrics Investigator Network (SPIN)." Provisionally accepted to *J. Peds.* (2017).

6. Mink RB, Carraccio CL, Herman BE, Weiss P, Turner DA, Stafford DE, Hsu DC, High PC, Fussell JJ, Curran ML, Chess PR, Schwartz A for SPIN. "The link between milestone levels and fellow entrustment for the common pediatric subspecialty entrustable professional activities." Oral and poster presentation at the annual education meeting of the Accreditation Council for Graduate Medical Education, February, 2016, National Harbor, Maryland.

7. Mink RB, Schwartz A, Herman BE, Turner DA, Myers AL, Kesselheim JC, Hsu DC, Curran ML, Carraccio CL for SPIN. "Reliability and validity of a supervision scale for the common pediatric subspecialty entrustable professional activities." Poster presentation at the annual education meeting of the Accreditation Council for Graduate Medical Education, February, 2016, National Harbor, Maryland.

8. Mink RB, Carraccio CL, Schwartz A, Dammann CE, High PC, McGann KA, Herman BE for SPIN. "Creation of a pediatric subspecialty educational research network." Poster presentation at the annual spring meeting of the Association of Pediatric Program Directors, April, 2016, New Orleans.

9. Mink RB, Schwartz A, Herman BE, Curran ML, Hsu DC, Kesselheim JC, Myers AL, Turner DA, Carraccio CL. "Creation and validation of entrustment scales for the common pediatric subspecialty entrustable professional activities (EPAs)." Oral presentation at the annual spring meeting of the Association of Pediatric Program Directors, April, 2016, New Orleans.

10. Mink RB, Carraccio CL, Herman BE, Aye T, Baffa JM, Chess PR, Fussell JJ, Sauer CG, Stafford DE, Weiss P, Schwartz A for SPIN. "Do fellowship program directors (FPD) and clinical competency committees (CCC) agree in fellow entrustment decisions?" Poster presentation at the annual spring meeting of the Association of Pediatric Program Directors, April, 2016, New Orleans.

11. Mink RB, Carraccio CL, Schwartz A, Dammann CE, High P, Kesselheim JC, McGann K, Herman BE. "Establishing a medical education research network for the pediatric subspecialties." Poster presentation at annual spring meeting of the Pediatric Academic Societies, May, 2016, Baltimore, Maryland.

12. Mink RB, Carraccio CL, Herman BE, Dammann C, Mahan J, Pitts S, Sauer CG, Schwartz A. "Variability in fellow entrustment across the pediatric subspecialties for the common pediatric subspecialty entrustable professional activities (EPAs)." Poster presentation at annual spring meeting of the Pediatric Academic Societies, May, 2016, Baltimore, Maryland.

Name: Adkins, Deanna W.

Selected Abstracts:

13. Rohit Tejwani, Deanna Adkins, Brian J. Young, Muhammad H. Alkazemi, Steven Wolf, John S. Wiener, J. Todd Purves, and Jonathan C. Routh. "Contemporary Demographic and Treatment Patterns for Newborns Diagnosed with Disorders of Sex Development." Poster presentation at AUA meeting 2016.

14. Deanna W. Adkins, MD, Kristen Russell, LCSW, Dane Whicker, PhD, Nancy Zucker, Ph. D: Departments of Pediatrics and Psychiatry, Duke University Medical Center. "Evaluation of Eating Disturbance and Body Image Disturbance in the Trans Youth Population." WPATH International Scientific Meeting June 2016; Amsterdam, The Netherlands.

15. Lydia Snyder, MD, Deanna Adkins, MD, Ali Calikoglu, MD. "Celiac Disease and Type 1 Diabetes: Evening of Scholarship." UNC Chapel Hill 3/2015 poster.

16. Laura Page, MD; Benjamin Mouser, MD; Kelly Mason, MD; Richard L. Auten, MD; Deanna Adkins, MD. "Cholesterol Supplementation In Smith-Lemli-Opitz: A Case of Treatment During Neonatal Critical Illness." Poster presentation June 2014.

17. Kellee M. Miller, David M. Maahs, Deanna W. Adkins, Sureka Bollepalli, Larry A. Fox, Joanne M. Hathway, Andrea K. Steck, Roy W. Beck and Maria J. Redondo for the T1D Exchange Clinic Network. "Twins Concordant for Type 1 Diabetes in the T1D Exchange." Poster presentation at ADA scientific sessions June 2014.

18. Adkins, D.W. and Calikoglu, A.S. "Delayed puberty due to isolated FSH deficiency in a male." *Pediatric Research Suppl*. 51: Abstract #690, page 118A.

19. Zeger, M.P.D., Adkins, D.W., White, K., Loechner, K.L. "Opsismodysplasia and Hypophosphatemic Rickets." *Pediatric Research Suppl.* from PAS 2005.

20. Redding-Lallinger RC, Adkins DW, Gray N. "The use of diaries in the study of priapism in sickle cell disease." Poster presentation Abstract in Blood November 2003.

Non-Refereed Publications:

Editorials, Position, and Background Papers

1. Reviewer: Hormone Research, Lancet, NC Medical journal, Journal of Pediatrics, Pediatrics, Transgender Health, International Journal of Pediatric Endocrinology

2. Reviewer: AAP National meeting COCIT submissions

Name: Adkins, Deanna W.

Invited Speaker:

1. Annual Diversity and Inclusion Symposium, Duke School of Medicine
2. Duke Endocrinology Grand Rounds
3. Duke School of Nursing Course
4. The Seminar, Fort Lauderdale, FL
5. Duke Urology Grand Rounds
6. Greensboro News and Record Community Forum, Greensboro, NC
7. ECU School of medicine first year course lecture, Greenville, NC
8. ECU Ob/Gyn Grand Rounds, Greenville, NC
9. North Carolina Child Psychiatry Annual Meeting, Asheville, NC
10. WPATH Science Meeting Amsterdam, The Netherlands
11. Course Instructor Duke School of Medicine Cultural Determinants of Health and Disparities course
12. The Magic Foundation, Chicago, Il.
13. The Duke School, Teacher Education Seminar
14. Duke Ob/Gyn Grand Rounds
15. NAPNAP nurse practitioner monthly education course

CONSULTANT APPOINTMENTS:

North Carolina Newborn Screening Committee

PROFESSIONAL AWARDS AND SPECIAL RECOGNITIONS:

ESPE Fellows Summer School, 2001
NIH Loan Repayment Program Recipient
Lawson Wilkins AstraZeneca Research Fellow,
2003-2004

ORGANIZATIONS AND PARTICIPATION:

American Academy of Pediatrics
-Council on Information Technology
----Reviewer AAP annual meeting presentations
-Section on Endocrinology

NC Pediatric Society

The Endocrine Society

WPATH-International transgender society

Pediatric Endocrine Society
--Education Committee
--web publication for pediatrician education

Name: Adkins, Deanna W.

American Pediatric Program Directors

American Diabetes Association

1. Course Director: ADA Camp Carolina Trails rotation for fellows and residents
2. 2014 Walk Recruitment Committee and Team Captain

RESEARCH:

1. Novo Nordisk Growth Hormone Registry-closed
2. Exubera inhaled insulin-trial ended
3. Type 1 Diabetes Exchange PI-ongoing
4. INC research trial on oral tolvaptan-ended
5. Celiac and Type 1 diabetes-collaboration with UNC Chapel Hill-complete publication in process
6. Metabolic Bone Disease in neonates
7. Service over education in residency and fellowship-start-up phase
8. SPIN study for pediatric subspecialties-ongoing multicenter study
9. Trent Center funding for research on eating disorders and gender dysphoria

Expert Report of Deanna Adkins, M.D.

Exhibit B – Bibliography

BIBLIOGRAPHY

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Exhibit B

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

DREW ADAMS, a minor, by and through his next friend and mother, ERICA ADAMS KASPER, *Plaintiff*, v. THE SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA, *Defendants*.	No. 3:17-cv-00739-TJC-JBT

EXPERT REPORT OF DIANE EHRENSAFT, Ph.D.

Qualifications and Experience

1. I am a developmental and clinical psychologist. I specialize in working with children and adolescents experiencing gender dysphoria and their families. A true and correct copy of my Curriculum Vitae is attached hereto as Exhibit A.

2. During my thirty-five year career as a psychologist, I have provided consultation, therapy, and evaluations for more than 500 transgender and gender nonconforming children and adolescents and their families.

3. Due to my expertise in this area, a portion of my private practice includes consulting with mental health providers across the United States to assist those providers in working with transgender youth. Over the years, I have consulted with approximately 200 mental health and related providers to assist them in their treatment of transgender youth and their families.

4. In addition to my private practice, I helped found the Child and Adolescent Gender Center ("CAGC") at the University of California, San Francisco ("UCSF") Benioff Children's Hospital in San Francisco, California, along with several colleagues. I have served as CAGC's Director of Mental Health since its inception in July 2009 and was appointed an Adjunct Associate Professor at the UCSF Department of Pediatrics.

5. As part of my work through CAGC, I organize and facilitate a group of local mental health providers that work with children and adolescents experiencing gender dysphoria called "Mind the Gap." The group meets every month to discuss issues we see in our respective practices and provide support and outreach to each other so that we can provide the best care

possible to our patients. Mind the Gap has developed training materials and assessment protocols, and provides community psychotherapy and evaluation for patients who attend the UCSF Child and Adolescent Gender Center Clinic at Benioff Children's Hospital in San Francisco and San Mateo, and at the Children's Hospital in Oakland. There are approximately 175 providers who participate in the group.

6. I serve on the Board of Directors of Gender Spectrum, a national organization offering educational, training, and advocacy services to schools and youth-serving organizations to become more gender inclusive. The organization also develops resources for parents and schools regarding transgender youth in school. For example, Gender Spectrum was a lead co-author of *Schools in Transition: A Guide for Supporting Transgender Students in K-12 Schools*, which was co-authored by the National Education Association; and, more recently authored *Transgender Students and School Bathrooms: Frequently Asked Questions,* a resource endorsed and supported by the American School Counselor Association, the National Association of Elementary School Principals, the National Association of School Psychologists, and the National Association of Secondary School Principals. Furthermore, I am actively involved in designing the organization's training program for healthcare professionals, and regularly conduct trainings as the group's mental health consultant to provide better education and services for those counseling and interacting with transgender youth and their families.

7. I am also a senior consultant, founding member, and board member of A Home Within, a national organization focusing on the emotional needs of children and youth in foster care and offering pro bono long-term psychotherapy to children in foster care.

8. As an Adjunct Associate Professor in the Department of Pediatrics at UCSF, I have taught courses including The Treatment of Gender-Nonconforming Children; The Emotional Development of Gender-Nonconforming Children; Interdisciplinary Support of Gender-Nonconforming and Transgender Children; Parenting a Gender nonconforming/Transgender Child. I have also lectured at the University of California, Berkeley and The Wright Institute, which is a clinical psychology graduate school, in Berkeley, California.

9. I am currently working as a co-investigator on a five-year study operating at four sites (UCSF, Boston Children's Hospital, Los Angeles Children's Hospital, and Lurie Children's Hospital of Chicago), funded by a National Institute of Health ("NIH") grant to study the medical and mental health outcomes of gender nonconforming youth receiving puberty blockers and/or cross-sex hormones as part of their treatment.

10. My recent publications include The Gender Creative Child, The Experiment Press (2016); Look, Mom, I'm a Boy—Don't Tell Anyone I Was a Girl, 10 J. of LGBT Youth 1–20 (2013); From Gender Identity Disorder to Gender Identity Creativity: True Gender Self Child Therapy, 59 J. of Homosexuality 337-356 (2012); Gender Born, Gender Made, The Experiment Press (2011); and Boys Will Be Girls, Girls Will Be Boys, 28 Psychoanalytic Psychology 528-548 (2011). A listing of my publications is included in my curriculum vitae, attached hereto as Exhibit A.

11. I belong to a number of professional organizations and associations relating to (i) the health and well-being of children and adolescents, including those who are transgender; and (ii) appropriate medical treatments for transgender individuals. For example, I am a

member of the World Professional Association for Transgender Health ("WPATH"), an international multidisciplinary professional association to promote evidence-based care, education, research, advocacy, public policy and respect in transgender health. WPATH publishes the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, which leading medical and mental health associations, including the American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association, have endorsed as the authoritative standards of care for transgender people. I also sit on the subcommittee of WPATH tasked with drafting the new version of the Standards of Care. A complete list of my involvement in various professional associations is located in my Curriculum Vitae, Exhibit A.

12. In preparation for my testimony, I have reviewed the materials listed in the bibliography attached hereto as Exhibit B, and which consist relevant medical and scientific materials related to transgender people and gender dysphoria. I may rely on those documents, in addition to the documents specifically cited as supportive examples in particular sections of this declaration, as additional support for my opinions. I reserve the right to supplement the materials listed in the bibliography. I have also relied on my years of experience in this field, as set out in my curriculum vitae, Exhibit A, and on the materials listed therein. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

13. In the past four years, I have testified as an expert and provided testimony in the following matters: *Evancho v. Pine-Richland Sch. Dist.*, Case No. 2:16-cv-1537-MRH (W.D. Pa.); *Bd. of Educ. of the Highland Local Sch. Dist. v. United States Dep't of Educ.*, Case

No. 2:16-CV-524 (S.D. Ohio); *Brashar v. Or. Health Plan* (Or.); *Miller v. Perdue* (Colo.); and *Stephane Huard v. Dr. Barwín and Broadvíew Fertility Clinic* (Quebec, 2016).

14. I am being compensated at an hourly rate for actual time devoted, at the rate of $350 per hour for any review of records, or preparation of reports or declarations, and for deposition and trial testimony; and $1,000 per day for travel time. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

15. In addition to the materials listed in the bibliography attached hereto as Exhibit B, I was provided with and have reviewed the following case-specific materials: (1) the Complaint filed in this matter; (2) the declarations of Plaintiff Drew Adams and his mother, Erica Adams Kasper, that were submitted in support of Plaintiff's motion for preliminary injunction; (3) the transcript of the court hearing on Plaintiff's motion for preliminary injunction, held on August 10, 2017; and (4) Plaintiff Drew Adams's medical and psychological records, as specified on Exhibit B. I have also interviewed Drew Adams in three separate video interviews, dated August 27, 2017; September 5, 2017, and September 14, 2017.

Gender Identity Development and Gender Dysphoria

16. At birth, infants are assigned a sex, either male or female, based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate and their birth-assigned sex matches that person's actual sex. However, a transgender person's birth-assigned sex does not reflect that person's actual sex.

17. By the beginning of the twentieth century, scientific research had established that external genitalia alone—the typical criterion for assigning sex at birth—is not an accurate proxy for a person's sex. Instead, current medical understanding recognizes that a person's

sex is comprised of a number of components including: chromosomal sex, gonadal sex, fetal hormonal sex (prenatal hormones produced by the gonads), internal morphologic sex (internal genitalia, i.e., ovaries, uterus, testes), external morphological sex (external genitalia, i.e., penis, clitoris, vulva), hypothalamic sex (i.e., sexual differentiations in brain development and structure), pubertal hormonal sex, neurological sex, and gender identity and role. When there is a divergence between these factors, neurological sex and related gender identity are the most important and determinative factors.

18. Gender identity is a person's inner sense of belonging to a particular gender, such as male or female. It is a deeply felt and core component of human identity. It appears to be related to one's brain messages and mind functioning, the factors that are now included under the category of neurological sex.

19. Like non-transgender people (referred to in the Complaint as "cisgender" people), transgender people do not simply have a "preference" to act or behave consistently with their gender identities. Every person has a gender identity, which is a deep-seated, deeply felt component of human identity for each person. A person's gender identity is not a personal decision, preference, or belief.

20. The only difference between transgender people and non-transgender people is that the latter have gender identities that are consistent with their birth-assigned sex whereas the former do not. A transgender boy cannot simply turn off his gender identity like a switch, any more than anyone else could.

21. In other words, transgender boys are boys and transgender girls are girls.

22. Transgender individuals are no different than any other citizen in their ability and talents to make a contribution to society, as long as they are not obstructed by discrimination in doing so. In this regard, transgender people are defined as a group of individuals whose authentic gender is either opposite to or other than the gender that matches the sex assigned to them at birth. What we know in this moment in history, as recent census surveys will tell us, is that transgender people are a discrete, small minority group in our society, easily identifiable both by self-report and professional assessment.

23. Current science recognizes that gender identity is innate or fixed at a young age and that gender identity has a biological basis. For example, both post-mortem and functional brain imaging studies in living people show that transgender people have areas of the brain that differ from the brains of non-transgender individuals. Additionally, research has found that the probability of a sibling of a transgender person also being transgender is almost five times higher than that of the general public, and that twins have a 33.3% concordance rate, even when raised apart, suggesting a genetic component to the incongruity in the biological markers of gender.

24. The evidence demonstrating that gender identity cannot be altered, either for transgender or for non-transgender individuals, further underscores the innate and immutable nature of one's gender identity. Past attempts to "cure" transgender individuals by means of psychotherapy, aversion treatments or electroshock therapy, in order to change their gender identity to match their birth-assigned sex, have proven ineffective. As importantly, evidence suggests that such efforts may cause extreme psychological damage. All major associations of medical and mental health providers, such as the American Medical Association, the

American Psychiatric Association, the American Psychological Association, and WPATH's Standards of Care, consider such efforts unethical and dangerous, as they may cause extreme psychological harm.

25. Children typically become aware of their gender identity at a young age, as early as between the ages of two and four. Once aware that their gender identity does not match the sex they were assigned at birth, transgender children often begin to express their cross-gender identity to their family members and caregivers. The statements and actions transgender children use to communicate their cross-gender identity differ significantly from the occasional adoption of a cross-gender identity, or cross-gender clothing by non-transgender children in imaginative play. Transgender children are insistent, persistent, and consistent over time in their cross-gender identification. They may also show signs of psychological distress as a result of the mismatch between their birth-assigned sex and their actual sex.

26. Gender dysphoria is the medical diagnosis for the significant distress and/or problems functioning that result from the incongruity between various aspects of one's sex. It is a serious medical condition and is listed in both the DSM-5 and the World Health Organization's International Classification of Diseases, the diagnostic and coding compendia for mental health and medical professionals, respectively. People diagnosed with gender dysphoria have an intense and persistent discomfort with their assigned sex.

27. Gender dysphoria was previously referred to as gender identity disorder. In 2013, the American Psychiatric Association changed the name and diagnostic criteria to be "more descriptive than the previous DSM-IV term gender identity disorder and focus[] on dysphoria as the clinical problem, not identity per se." DSM-5 at 451.

28. The psychophysiological experiences of gender dysphoria symptoms vary in kind and degree. Not all transgender young people experience dysphoria. Different types of biological and environmental triggers can cause onset of symptoms.

29. Some environmental triggers of gender dysphoria symptoms are related to a lack of respect for social transition including, but not limited to, misgendering in the form of pronoun use, prohibition of involvement in activities in accordance with one's gender identity, and denying someone access to a restroom or changing facilities that match the person's gender identity.

Standards of Care for Working with Transgender Youth

30. Like all children, when loved, supported, and affirmed by their parents and caretakers and by their social environment, transgender children can thrive, grow into healthy adults and have the same capacity for happiness, achievement, and contribution to society as others. For these youth, that means supporting their need to live in a manner consistent with their gender identity.

31. Obtaining treatment for gender dysphoria and ensuring that a transgender child is in an environment that does not undermine that treatment are critical to a transgender child's healthy development and well-being. For young transgender children, the treatment of gender dysphoria consists of social transition, which involves changes that bring the child's outer appearance and lived experience into alignment with the child's core gender. Changes often associated with a social transition include changes in clothing, name, pronouns, and hairstyle.

32. Support for social transition—such as dressing in accord with one's gender identity, respecting a person's chosen name and correct pronouns, and providing access to

restrooms that match who they are—can thus both treat and prevent negative psychological and psychophysiological symptoms of gender dysphoria. Mental health care can also address symptoms of gender dysphoria.

33. Research and clinical experience have shown that consistent respect and inclusive acknowledgement of a transgender youth's gender identity (i.e., positive reinforcement of social transition) improves that child's mental health and reduces the risk that the child will engage in self-harming or suicidal behaviors. In fact, undergoing a social transition before puberty often provides tremendous and immediate relief because there are few, if any, observable physical differences between boys and girls at that age.

34. There are no pharmacologic treatments for gender dysphoria until after the onset of puberty. However, after the onset of puberty, adolescents suffering from gender dysphoria may be placed on puberty suppressors (i.e. hormone blockers) to block the stopping the development of secondary sex characteristics that do not align with the adolescent's gender identity. Thereafter, usually around the age of 16, gender dysphoric adolescents are treated with cross-sex hormones to bring their bodies into alignment with their sex, as primarily determined by their gender identity. For example, a transgender girl will receive estrogens which result in breast growth and female fat distribution, while a transgender boy will receive androgens and will become more muscular and develop a lower voice as well as facial and body hair.

35. Surgical treatment is not typically recommended until an adolescent is, at minimum, in his or her mid- to late-teens, depending on the specific procedure. However, once gender dysphoric adolescents come of age and meet the eligibility criteria, they can be eligible

for surgical interventions meant to bring their bodies into alignment with their identity. The need, timing, and nature of the surgical treatment will differ from patient to patient.

36. Many transgender individuals never undergo surgery or do so only later in life. For many transgender individuals, surgery is not medically necessary or may be safely delayed for some time as their dysphoria is alleviated through social role transition and other medical treatments.

37. A person's gender identity is an innate, effectively immutable characteristic; a person's sex is not determined by a particular medical treatment or procedure. Thus, from a medical and scientific perspective, a person's gender is not dependent on whether or not that person has undergone surgery or any other medical treatment. The medical treatments provided to transgender people (including social transition for transgender children), do not "change a girl into a boy" or vice versa. Instead, they affirm the authentic gender that an individual person *is*. Treatments fall below the accepted standards of care if they fail to recognize that a youth's affirmed gender identity is not how they feel, but rather who they are. The goal of proper treatment is to align the person's body and lived experience with the person's fixed identity as male or female, which already exists. Treatment creates more alignment between the person's identity and the person's appearance, attenuating the dysphoria, and allowing the person's actual sex, male or female, to be seen and recognized by others.

38. Failure to recognize and support a transgender student's gender identity also relies on an outmoded and scientifically unsound premise that transgender identity is only how a person feels, not who they are, and that a transgender girl can never be a "real" girl and a

transgender boy can never be a "real' boy because they lack the chromosomes and genitalia stereotypically-associated with their gender identity. Scientific evidence is now available indicating that gender identity not only has a strong core component but also is primarily dictated by messages from our brain rather than either chromosomes or physiological sex characteristics. With that said, it should be noted that a transgender youth's gender identity—translated to the sex they live in—is as real as any cisgender youth's and should be treated accordingly in all settings, including schools.

Supporting the Mental Health of Transgender Youth in Schools

39. In the school setting, providing appropriate support includes ensuring that teachers and other staff refer to transgender students by their chosen names and correct pronouns, permitting the transgender student to use the sex-separated facilities that are consistent with their gender identity on the same terms as their peers, and generally treating transgender students in a manner consistent with their gender identity for all purposes. Failing to recognize and support a transgender student's gender identity sends a message—both to the transgender student and to others—that the transgender student is different from his or her peers and needs to be segregated, causing the transgender student to experience shame.

40. Transgender children experience significant psychological distress when parents/caregivers or school staff repeatedly fail to acknowledge the child's gender identity or treat the child in a manner consistent with his or her inaccurate, birth-assigned gender. Because gender is a core aspect of a person's identity, transgender children who are treated in this way experience that mistreatment as a profound rejection of their core self, which has serious negative consequences for their development and their long-term health and well-being. The

intensity of that distress is directly correlated to the level of rejection or disapproval expressed by a parent, caregiver, or school staff. Greater levels of rejecting behaviors significantly increase the risk that the child will develop long-term mental health conditions, including serious negative mental health consequences such as low self-esteem, anxiety, depression, substance use issues, self-harming behaviors, and suicidal ideation. These conditions accumulate in their severity and also show up immediately in the face of rejecting circumstances, such as when transgender children are told that they cannot use the restroom that matches the gender they know themselves to be.

41. Rejecting or disapproving of a child's gender identity interferes with the child's healthy development across all domains, including difficulty maintaining healthy interpersonal relationships and developing emotional resilience, among others.

42. Given the amount of time that students spend in school, the school environment has a tremendous impact on a transgender student's development and well-being. Ensuring that schools support a transgender student's gender is critical to their long-term health and well-being. In a study of transgender youth between ages 15 and 21, participants identified school to be the most traumatic aspect of growing up. Experiences of rejection and discrimination from teachers and school personnel led to feelings of shame and unworthiness. The stigmatization to which transgender youth were routinely subjected led many to experience academic difficulties and to drop out of school. The longer a child experiences rejection from his or her family, school, or community, the more significant and long-lasting the negative consequences. Research and surveys have found that transgender adults who experienced discrimination in schools were more likely to have attempted suicide. Research

and surveys have also found that a high percentage of transgender people used drugs and alcohol to cope with the mistreatment they experienced based on their gender identity.

43. The negative mental health effects of rejection can also cause a transgender child to develop co-occurring mental health conditions, such as major depression, generalized anxiety disorder, and eating disorders. The symptoms associated with those co-occurring conditions typically alleviate significantly once a transgender child's gender identity is affirmed. However, if the child remains in an environment, whether at home or in school, where the child's gender identity is not recognized and supported, that mistreatment can exacerbate those conditions, resulting in lasting harm.

44. Partial acceptance is not enough. If a caretaking or school environment offers support in certain domains—such as appropriate pronoun and name use—yet fails to offer support in other areas—such as allowing the child to use the restroom that matches the gender they know themselves to be and/or sending harmful messages that the child, if incorrectly assigned female at birth will always be a girl—such inconsistency can be a confusing and stressful experience for the youth. This stress-inducing experience can in turn result in a lack of trust in an environment that both supports and punishes the same behavior, in this instance the child's affirmation of his or her actual sex. Research has consistently shown that children who receive inconsistent rather than consistent reinforcement of behaviors are at risk for behavioral problems, generalized anxiety, and psychiatric symptoms.

45. Based on my extensive experience researching and working with transgender children, it would be psychologically damaging for a transgender child to be forced to use either the sex-segregated restroom that does not comport with their gender identity or a

separate single-user restroom that other students are not required to use. In addition, there are serious health concerns, as these youth, when barred from using the restroom that matches their affirmed gender identity, will instead typically choose to restrict or forego restroom use at school, putting them at risk for urinary tract infections and impacted bowels.

46. I understand that an administrator in Drew's school district has expressed a concern that some transgender students might take advantage of communal restroom facilities to display their genitals to others. This is simply wrong, and profoundly at odds with the reality of transgender youth's experiencing gender dysphoria and their restroom use. The issue for transgender students is overwhelmingly one in which they seek privacy and discreteness in restroom use, as their genitalia or any part of their body that reveals secondary sex characteristics is typically the source of significant-to-severe body dysphoria and distress related to such dysphoria. In other words, exposing parts of their body that are often associated with gender dysphoria, such as genitalia, is generally the last thing any transgender student wants to do. Nor are transgender students disproportionately likely to engage in misconduct of any kind, in restrooms or any other facility. Certainly there is no evidence that they would be more likely than any other individual to engage in such inappropriate behaviors.

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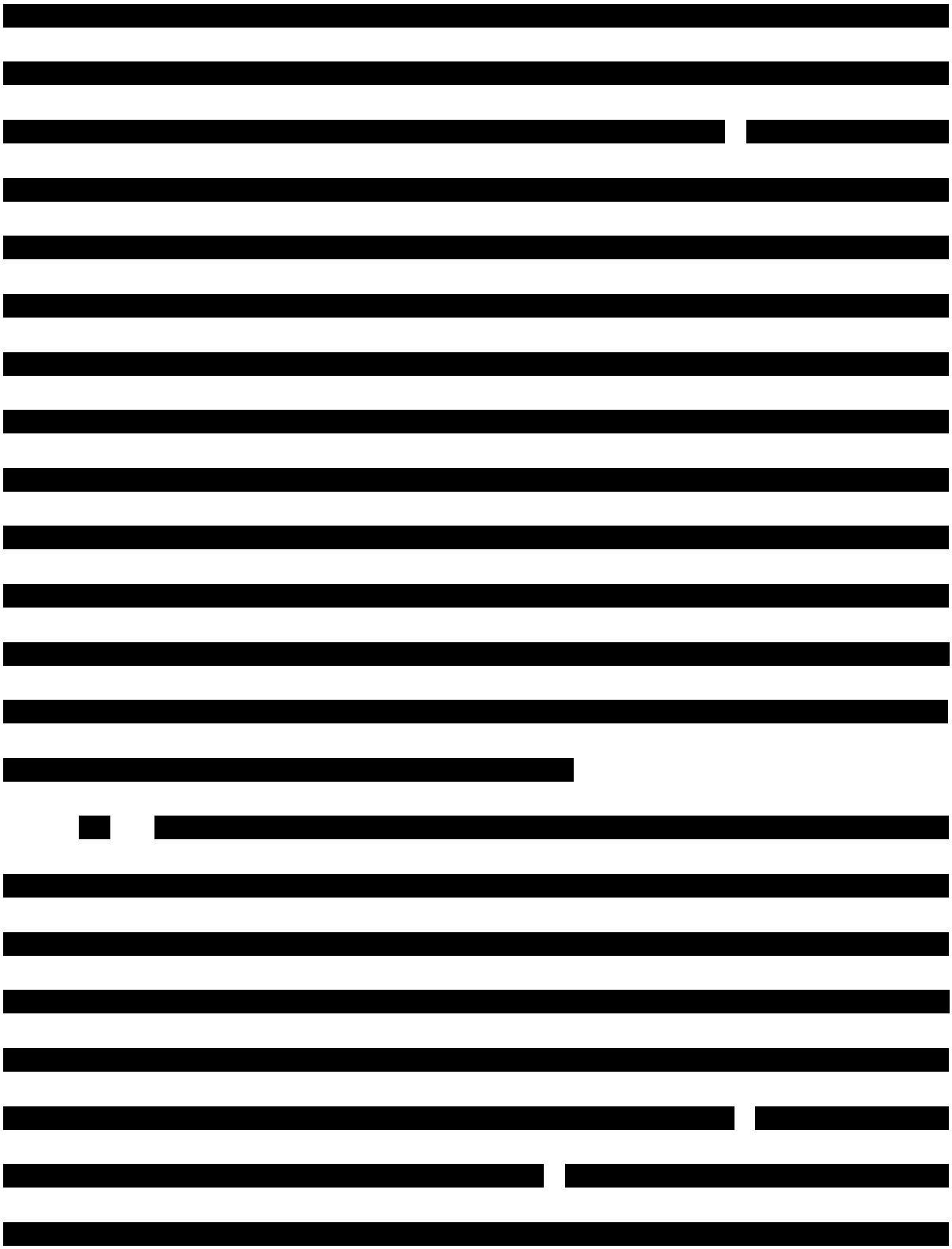

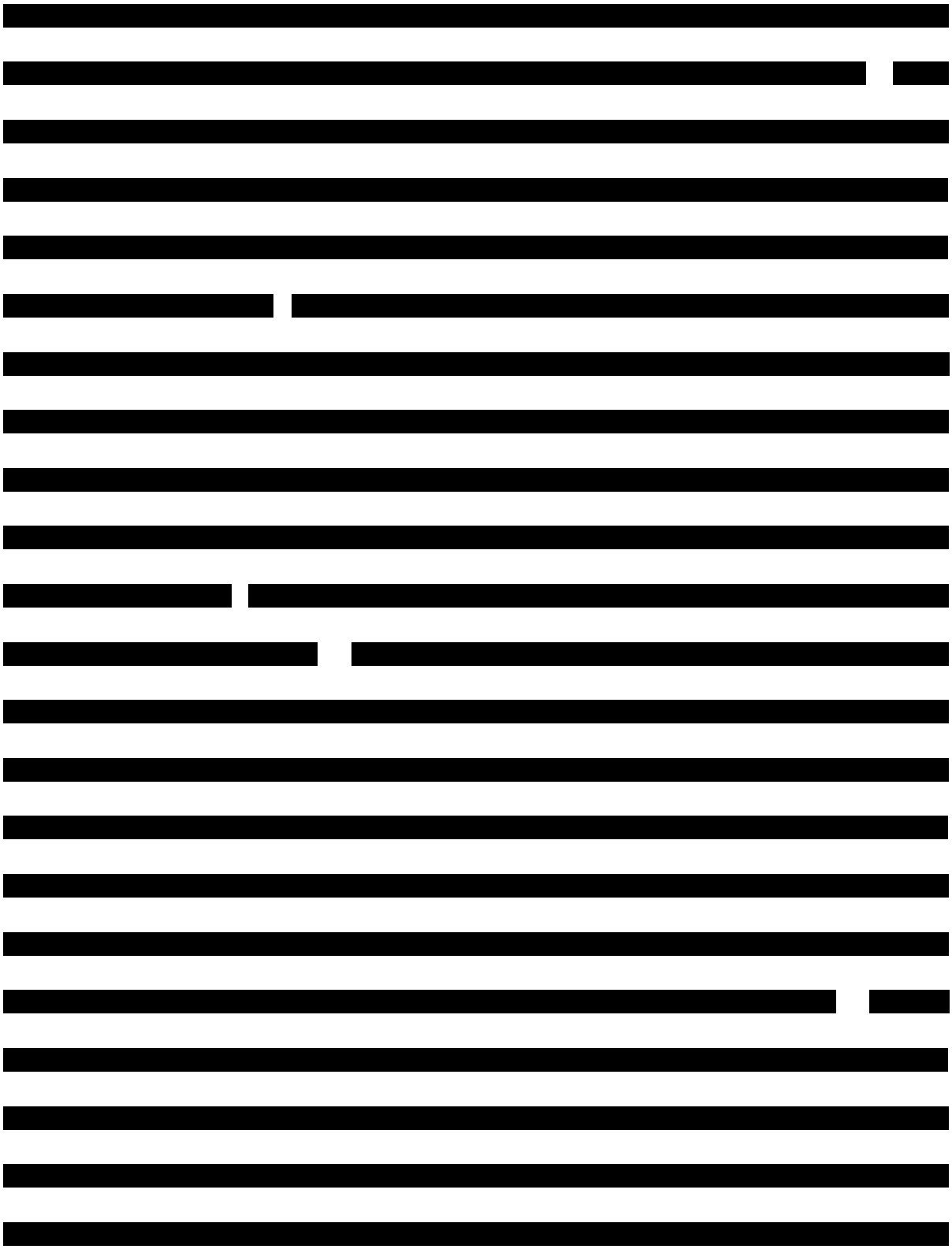

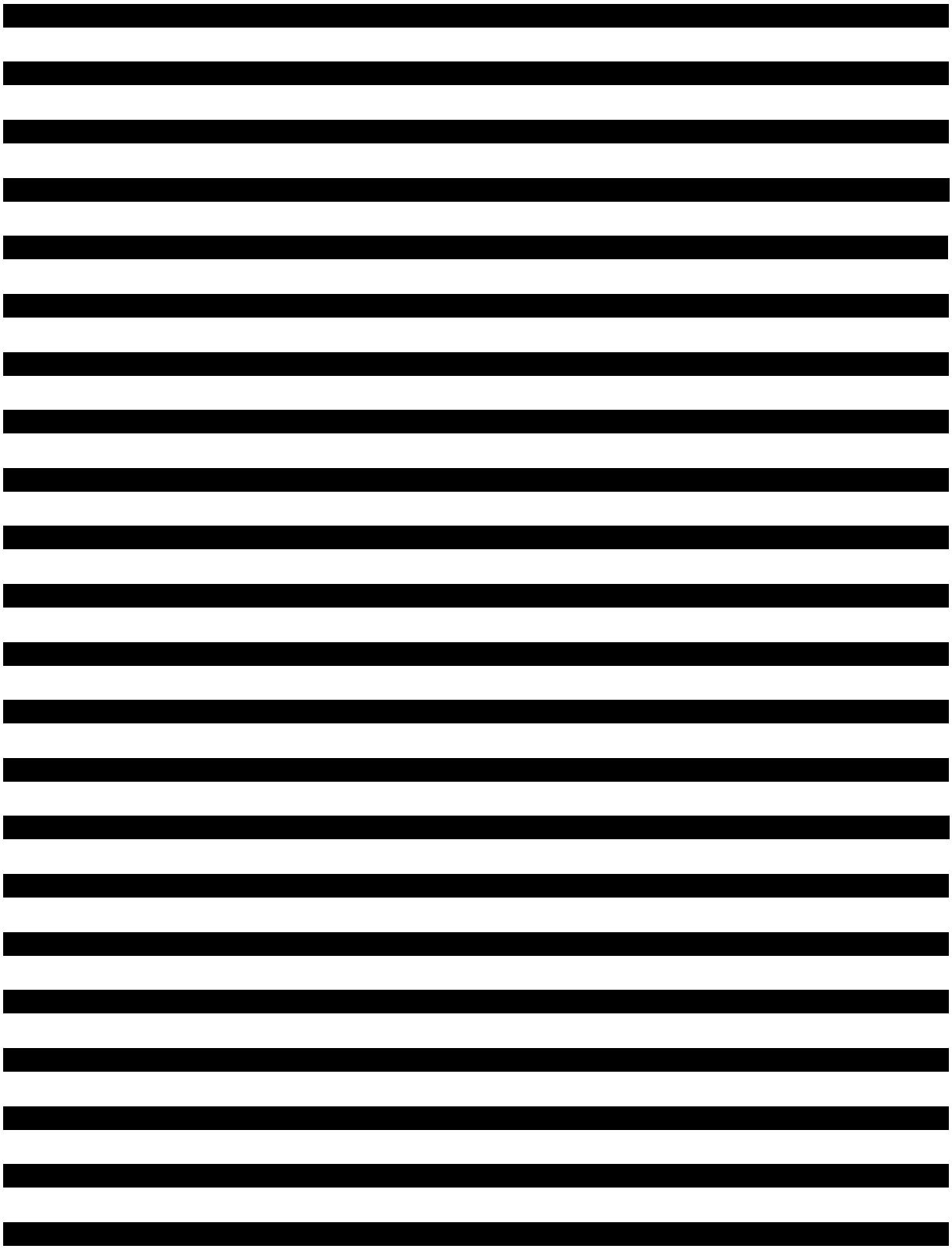

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57. I respectfully reserve the right to modify and expand upon my testimony as the facts are developed in this matter.

Dated this _21st___ day of September, 2017.

Diane Ehrensaft, Ph.D.

Expert Report for Diane Ehrensaft, Ph.D.

Exhibit A – Curriculum Vitae

CURRICULUM VITAE

NAME: Diane Ehrensaft, Ph.D.

ADDRESS: 445 Bellevue Avenue Suite 302,
Oakland, California 94610
TELEPHONE: 510-547-4147
FAX: 510-547-7692
E-MAIL: dehrensaft@earthlink.net

***PRESENT POSITIONS*:**

- Adjunct Associate Professor, Child Gender Clinic, Department of Pediatrics, University of California San Francisco, San Francisco, CA
    - Responsibilities: Assessment, Treatment, and Consultation advising with gender-nonconforming children and their families
- Director of Mental Health, Child and Adolescent Gender Center CAGC, San Francisco Bay Area
    - Responsibilities: Coordinating mental health services and directing consortium of child gender specialists
- Faculty, Psychoanalytic Institute Of Northern California, San Francisco, CA
    - Responsibilities: Teaching, Research Development
    - Areas:
        - Gender, Childhood and Adolescence
        - Reproductive Technology
- Clinical Psychologist, Private Practice, Oakland, CA
    - Responsibilities:
        - Psychotherapy with children and adults
        - Psychological evaluations
        - Custody evaluations
        - Mediation
        - Parenting consultations
        - Training and consultation
        - Forensic work: expert witness

***STATUS*:**

- Ph.D. in Psychology
- Licensed Clinical Psychologist (California License # PSY 7342)

***EDUCATION*:**

- University of Michigan: B.A. in Psychology 1964-1968
    - Graduated with honors in Honors Psychology Program
- University of Michigan: Ph.D. in Psychology 1968-1974
    - Received Ph.D. in May 1974
    - Course work Concentration: Child development; child psychotherapy; socialization; family
    - Psychology Prelim Exams: Communal child rearing and the social development of the child
    - Dissertation title: "Sex role socialization in a preschool setting"

***EDUCATIONAL AWARDS AND APPOINTMENTS*:**

- 1968, 1969, 1970: NIMH Traineeship, University of Michigan
- 1970: Teaching Assistantship, School of Social Work, U. of Michigan
- 1971: Teaching Assistantship, Psychology Department, U. of Michigan
- 1971: Rackham Predoctoral Fellowship, University of Michigan
- 1972: University of Michigan Dissertation Grant
- 2012: Annual Scholarship Award, Section on Gender and Psychoanalysis, Division of Psychoanalysis, American Psychological Association
- 2013: Award for Outstanding Service, Section on Childhood and Adolescence, Division of Psychoanalysis, American Psychological Association
- 2014: Community Service Award, for Commitment to Child and Adolescent Gender Center, Northern California Society for Psychoanalytic Psychology

***GRANTS*:**

- 2015 National Institute of Health (NIH)
    - R01HD082554: The Impact of Early Treatment of Transgender Youth
    - 08/01/2015-06/30/2020
    - Role: co-Investigator.

***EMPLOYMENT EXPERIENCE*:**

- 2012 to present: Adjunct Associate Professor, Department of Pediatrics, UCSF
- 1980 to present: Clinical Psychologist in private practice
- 1981 to 2004: Professor, The Wright Institute, Berkeley, California
- 1986 to 2005: Expert panel, Family Court, Counties of Alameda & San Francisco
    - Responsibilities: Court-appointed child and custody evaluations
- 1994 to present: Senior clinical faculty, A Home Within
    - Project offering pro bona long-term psychotherapy to children in foster care

- 1999 to present: Faculty, Psychoanalytic Institute of Northern California
- 2000 to present: Clinical Supervisor and Consultant, West Coast Children's Center
    - Responsibility: Supervision of interns, clinical training and consultation
- 1995 to 1999: Member, Mediation Resources
    - Interdisciplinary team of psychologists and lawyers offering mediation, evaluation, and consultation services pertaining to dispute resolution in family and commercial matters
- 1995 to 1999: Clinical faculty, Mt. Zion Psychiatric Department, University of California, San Francisco
    - Responsibilities: Clinical supervision of psychology interns
- 1992 to 1998: Clinical faculty, Ann Martin Children's Center, Piedmont, California
    - Responsibilities: Clinical supervision to psychology interns
- 1986 to 1992: Clinical faculty, Department of Psychiatry, Children's Hospital San Francisco
    - Responsibilities: Clinical supervision of psychology interns
- 1986 to 1990: Clinical consultant, Children's Hospital Medical Center of Northern California, Oakland
    - Responsibilities: Clinical training
- 1985 to 1986: Consulting Psychologist Health America Rockridge, Oakland, California
    - Responsibilities: Consultation to Pediatrics Department
- 1982 to 1988: Independent contractor to Child Development Center, Children's Hospital Medical Center of Northern California
    - Responsibilities: Psychological Evaluations of developmentally disabled children, consultation with staff and parents.
- 1980 to 1983: Mental Health Consultant, Alameda Headstart, Alameda, CA
    - Responsibilities: Clinical consultation and training with Headstart staff in areas of child and family mental health; observation and evaluation of children enrolled in Headstart program; psychological consultations with families enrolled in the program
- 1980 to 1981: Post Doctoral Fellowship Child Guidance Clinic and Adult Psychiatric Services Children's Hospital San Francisco
    - Responsibilities: Psychological testing, evaluation, and treatment Of adults, children, and families; consultation with schools and related hospital services
- 1979 to 1981: Faculty, University of San Francisco Faculty member of the Family Reunification Project, sponsored by the University of San Francisco in conjunction with the San Francisco Department of Social Services
    - Responsibilities: Teaching courses in the area of child psychopathology to Department of Social Service social workers enrolled in in-service Masters of Arts in Public Services program.

- 1979 to 1980: Post-Doctoral Internship Family Guidance Services, Children's Hospital Medical Center
    - Responsibilities: Evaluation of children and families in a multi- disciplinary mental health clinic serving a broad range of families
- 1979 to 1980: Post-Doctoral Internship Child Development Center, Children's Hospital Medical Center
    - Responsibilities: Psychological screening and evaluation of young children referred for developmental disabilities and related problems; treatment planning; consultation to schools, day care programs, and community agencies
- 1977 to 1979: Faculty, Field Studies Program, University of California, Berkeley
    - Responsibilities: Teaching field based courses in the areas of child rearing, parenting, and the family; women, gender, and social change. Administrative responsibilities involving staff development and program evaluation
- 1974 to 1978: Faculty, Interdisciplinary Program on Day Care and Child Development, University of California, Berkeley Graduate Program funded by the Carnegie and Grant Foundations and sponsored jointly by the Department of Education, School of Social Welfare, and School of Public Health offering advanced training to a selected group of pediatricians, educators, and social workers.
    - Responsibilities: Evaluate effectiveness of graduate training program in day care and child development; program development; teaching
- 1974 to 1978: Faculty, School of Social Welfare, University of California, Berkeley
    - Responsibilities: Teaching in areas of research theory and methods, children and the family; women and mental health; dissertation supervision
- 1972 to 1973: Faculty, Sociology Department, Sir George Williams University, Montreal, Quebec
    - Responsibilities: Teaching courses on the sociology of the family
- 1972: Director, Park Avenue Day Care Center, Montreal, Quebec
    - Government-sponsored preschool program for Greek immigrant families to teach them French and English language skills and prepare them for entrance into Montreal school system.
    - Responsibilities: Program administration; liaison with Quebec and Canadian government; mental health consultation to staff and program families
- 1971: Teaching Assistant, Department of Psychology, University of Michigan
    - Responsibilities: Running the developmental psychology lab for undergraduate and graduate level students; teaching in develop- mental psychology class
- 1970: Teaching Assistant, School of Social Work, University of Michigan
    - Responsibilities: Assistant teaching in course on complex organizations
- 1970: Clinician and research assistant, Project on marital communication and family therapy in a natural setting, School of Social Welfare, University of Michigan

    - Responsibilities: Family therapy in office and home setting; compilation and analysis of research data on therapeutic outcome
- 1969: Group therapist, Huron Valley Child Guidance Clinic, Ypsilanti, Michigan Nonresidential summer therapy program for emotionally disturbed boys ages 5-14.
    - Responsibilities: Co-led group therapy with a group of 9-10 year old boys.
- 1968 to 1969: Graduate clinical internship, Office of Economic Opportunity Day Care Center, Ecorse, Michigan
    - Responsibilities: Mental health consultation to staff and families, play therapy with children enrolled in program
- 1968 to 1969: Graduate clinical internship, Downriver Child Guidance Clinic, Lincoln Park, Michigan
    - Responsibilities: Therapy with school-age children and families
- 1968: Research Assistant, Department of Psychology, University of Michigan Clinical research on aggression and dependency in college students
    - Responsibilities: Analysis of Thematic Apperception Test protocols
- 1967: Research Assistant, Institute for Industrial Relations, University of Michigan Project on American ghettoes
    - Responsibilities: Library research, document preparation, analysis of data.

***PROFESSIONAL ACTIVITIES*:**

- 2015: Co-Chair, APA Division of Psychoanalysis (39) Spring Meeting, Life in Psychoanalysis in Life, San Francisco, CA
- 2014: AbbVie Trans Advisory Board Member
- 2010: President, Professional Advisory Board, A Home Within
- 2009 to present: Member of Professional Advisory Board, A Home Within
- 2008 to present: Board Member, Gender Spectrum
- 2008 to present: Board Member, Section IX, Psychoanalysis and Social Responsibility, Division of Psychoanalysis, American Psychological Association
- 2007 to present: Member of Mental Health mental health professional group of the American Society for Reproductive Medicine
- 2007 to present: Chair, Reproductive Technology Research Group, Psychoanalytic Institute of Northern California
- 2004 to 2009: Vice President, Board of Directors, A Home Within
- 2004 to present: Member of Board of Directors, A Home Within
- 2002 to 2008: Board Member, Section III (Gender and Psychoanalysis), Division 39 (Psychoanalysis), American Psychological Association
- 2001 to 2004: Secretary, Board of Directors, A Home Within
- 2000 to 2003: Board Member, Division 39 (Division of Psychoanalysis) Board of Directors, American Psychological Association

- 1999 to present: Editorial Board Member, Studies in Gender and Sexuality, a journal on psychoanalysis, cultural studies, treatment, and research
- 1998 to present: Board Member and Membership Chair, Section II (Childhood and Adolescence) of Division 39 (Division of Psychoanalysis), American Psychological Association
- 1994 to present: Senior clinician, Children's Psychotherapy Project
    - Project established to offer pro bona long-term psychotherapy to children referred through the Department of Social Services Senior clinicians run consultation groups for psychotherapists who provide the therapy services and are also involved on program development, training, administration, and evaluation.
- 1993 to present: Editorial review board, American Journal of Orthopsychiatry
- 1992-1993: Co-chair, Education Committee, Northern California Society for Psychoanalytic Psychology
- 1992: Development Committee, Child Care Employee Project
- 1991-1992: Committee Member, Education Committee, Northern California Society for Psychoanalytic Psychology
- 1983 to 1996: Employer and Supervisor to psychological assistants working under my license in my private practice
- 1978: Consultant to Childhood and Government Project, University of California, Berkeley
- 1978: Consultant to Child Care Switchboard, San Francisco
- 1976: Berkeley Child Care Advisory Committee
- 1974 to 1977: Designing and conducting staff training workshops on sex role stereotyping in the preschools
- 1973 to 1976: The Children's Project, A Bay Area women's group investigating the status of women and children in the United States.
- 1973 to 1976: Development, coordination, and participation in parent-run preschool program

***SELECTED LECTURES AND SPEAKING ENGAGEMENTS*:**

- 2015: Invited Plenary Speaker, *Different Approaches to Treating gender-nonconforming children*, American Psychological Association Annual Meeting, Toronto, Ontario
- 2015: Speaker, *Gender as Cure*, UCSF Transgender Health Summit, Oakland, CA
- 2015: Grand Rounds: *What's your gender?*, Alta Bates Summit Hospital, Berkeley, CA
- 2014: Grand Rounds: *Treating Gender-Nonconforming Children*, California Pacific Medical Center, San Francisco, CA
- 2014: Invited Speaker, *Controversies in the Treatment of Transgender Children and Adolescents*, American Psychiatric Association Annual Meeting, New York, New York

- 2013: Invited Speaker, *Gender-nonconforming children*, Pediatric Endocrine Society Symposium, Washington, D.C.
- 2013: Invited Speaker, *Found in Translation: Listening and Learning from Gender-nonconforming Children*, William Alanson White Institute, New York, New York
- 2012: Keynote Address: *From Gender Identity Disorder to Gender Creativity*, Gender Creative ids Workshop, Concordia University, Montreal, Quebec
- 2010: Invited Speaker, *A Terrible Thing Happened on the Way to Becoming a Girl*, Division of Psychoanalysis, APA Annual Meeting, Chicago, Illinois
- 2010 Invited Speaker, *Transcending Humpty Dumpty: The Case of an Egg Donor Mother*, International Association for Relational Psychoanalysis and Psychotherapy, San Francisco, CA
- 2010: Invited Speaker, *Outcomes for the Children*, American Psychoanalytic Association Group on Reproductive Technology, The American Psychoanalytic Society's Annual Meeting, New York
- 2010: *Wherefore baby? Searching Beyond Infertility*, Northern California Society for Psychoanalytic Psychology, Scientific Meeting
- 2010: Invited Speaker, *Priuses, Smoothies, and Tranys: Transgender Care in the Beginning: The Early Childhood Years*, Northern California Psychiatry Society Annual Meeting, Monterey, California.
- 2009: Invited Speaker, American Psychiatric Association's Annual Meeting, San Francisco: *Gender Made, Gender Nurtured: The Child Shapes the Parent as the Parent Shapes the Child in Families with A Gender Variant Child*, Panel: Symposium: Lesbian, Gay, Transgender Youth: Family Approaches.
- 2009: Division of Psychoanalysis APA Annual Meeting, San Antonio: Panel Presentation: *Boys Will Be Girls, Girls Will Be Boys: Familial Effects on Children's Gender Freedom*, Panel: The Transmission of Sexism and Homophobia within the Family
- 2009: Division of Psychoanalysis APA Spring Meeting, San Antonio: Paper Presentation: *I'm a Prius: A Child Case of a Gender/Ethnic Hybrid*, Panel: The Transmission of Sexism and Homophobia within the Family, Sexualities and Gender Identities Committee Invited Panel
- 2008: Invited Speaker, Seattle Psychoanalytic Society and Institute: *The Stork Didn't Bring You, You Came From a Dish*.
- 2008: Invited Speaker, Harvard Medical School: Treating Contemporary Families: Mental Health Aspects of Alternative Reproduction, Adoption, and Parenting, Boston: *The Psychodynamics of the Contemporary Family: Mothers, Fathers, Donors, Surrogates, and Children*
- 2008: American Psychological Association Annual Convention, Boston: Paper presentation: *One Pill Makes You Boy, One Pill Makes You Girl*, Panel: Doctor, What About Pills? Psychoanalytic Thought and Medication

- 2007: Invited Speaker, St. Louis Psychoanalytic Society, *The Stork Didn't Bring You, You Came From a Dish*
- 2007: Keynote Speaker, ANZICA The Australian and New Zealand Infertility Counsellors Association, Hobart, Tasmania: *When Things Go Pear-Shaped?*
- 2007: Invited Speaker, The Fertility Conference of Australia Annual Conference, Hobart, Tasmania: *Building Strong Donor Families*
- 2006: Invited Speaker, Mothers and Fathers of Invention, IPTAR Conference, New York: *The Stork Didn't Bring Me, I Came from a Dish: Psychological Experiences of Children Conceived through Assisted Reproductive Technology*
- 2001 Invited Speaker, Division 39 Invited Roundtable, APA Annual Meeting, *Growing Up and Growing Old: Continuity and Change in the Wishes and Desires over the Course of Life*
- 2001 Invited Speaker, Division 39 Annual Spring Meeting, Santa Fe: Session on Sex and Gender, *Bending and Blending: A Developmental Perspective*
- 2000: Invited Speaker, Division 39 Annual Spring Meeting, Session on Contemporary Child Psychotherapy: *Who's in the Room and What are We Doing?*
- 1997 to present: Public Speaking, TV and Radio Appearances: Topic: *Spoiling Childhood*
- 1997: Presenter, with Dr. Anne Bernstein at Annual Conference of the Academy of Family Mediators Topic: *When the Parents Aren't the Cleavers and the Children Aren't "The Beaver": Mediation with Non-Traditional Families*
- 1997: Presenter, Round Table Discussion, Northern California Society for Psychoanalytic Psychology Topic: *Whose Oedipus? Development, Dynamics, and Identity in the 1990s*.
- 1996: Presenter, Grand Rounds, Mt. Zion Psychiatric Service Topic: *The New Silent Majority: The Underaggressive Parent*
- 1996: Presenter, Parent Association, Marin Public Schools Topic: *Harried Parents and the Haloed Child*
- 1996: Invited presenter, International Conference: The Costs of Children Sponsored by the city of Bologna, Bologna, Italy, Sept. 27-28. Topic: *The Perils of Parenthood*
- 1995: Faculty, Perspectives on Motherhood: Myths and Realities, Conference sponsored by the San Francisco Institute for Psycho- Analytic Psychotherapy and Psychology, Mills College, and the San Francisco Salon Workshop Leader: *Defining Differences: Parenthood vs. Motherhood*
- 1994: Presentation: *The Perils of Parenting: Psychological Conflicts of Child Rearing in the 1990s*, Sponsored by The Friends of the San Francisco Psychoanalytic Institute
- 1994: Workshop: *Parenting in the 90s: An Impossible Task*, Parenting University, Piedmont Adult Education, Piedmont Unified School District
- 1994: Presentation: *The Things Grandma Never Told Us: Parenting in the 90s*, Sacred Hearts School, San Francisco

- 1994: Grand Rounds: *Sex and Violence in the Nursery: Lessons from the Presidio*, Children's Hospital Medical Center, Oakland
- 1994: Presentation: *Sexual Abuse in a Preschool Setting*, Child and Adolescent Sexual Abuse Resource Center, Department of Public Health, San Francisco
- 1993: Panel member, *Sexualized Transferences: Clinical Considerations and Ethical Implications*, panel presentation at monthly meeting of California Association of Marriage and Family Therapists
- 1993: Workshop: *Disassembling and Reassembling the Family: Psychoanalytic perspectives on Evaluation and Treatment*. Co-led with Toni Heineman, D. M. H., sponsored by the Northern California Society for Psychoanalytic Psychology
- 1992: Grand Rounds: *Sex and Violence in the Nursery*, Alta Bates Medical Center Department of Psychiatry
- 1992: Panel Organizer and Presenter: *Parenting in the 1990s: A Need for a New Psychoanalytic Perspective*, sponsored by the Northern California Society for Psychoanalytic Psychology
- 1992: Discussant, *The lesbian parenting Couple--Cultural and Clinical Issues*, Conference sponsored by The Psychotherapy Institute, Berkeley, California
- 1991: Panel organizer and chair, *Object Relations Theory, Mothers, and children: A Feminist Perspective*, American Psychological Association
- 1991: Paper presentation: *Sex and Violence in the Nursery: Lessons from the Presidio*, Annual Meeting of the American Orthopsychiatric Association
- 1990: Presentation: *Death, Loss, Grief, and Trauma*, Lecture delivered to New Perspectives clinical staff and associates, a school-based mental health delivery agency
- 1990: Guest, Oprah Winfrey Show Topic: *Stressed Out Dads*
- 1989: Community Lecture: *Lessons from the Presidio: Institutional Sexual Abuse*. Sponsored by Alameda Child Abuse Council
- 1989: Community Lecture: *Effects of Removing Children from their Homes*, Sponsored by Bay Area Coalition of Child Abuse Councils
- 1988: Corresponding Faculty, the American Orthopsychiatric Association Annual Meeting
- 1988: Workshop: *Aggression and Anger in Children*, Walden School, Berkeley, California
- 1988: Workshop: *Children's Fears*, Walden School, Berkeley, California
- 1987: Numerous radio and television appearances, local and national Topic: *Men and Women Sharing the Care of their Children*
- 1985: Presentation: *When Women and Men Mother*, Family Forum Lecture Series, College of Marin
- 1984 to 1985: Professional consultation to authors of Redwook and Cosmopolitan magazines in the area of gender and adult relationships

- 1981: Guest Speaker: *Mothers and Fathers, Together and Apart*, University of California Day Care Services, Berkeley
- 1981: Panel speaker: *Motherhood and Feminism*, Conference on Feminism in the 1980s, sponsored by Stanford University
- 1977: Keynote Speaker, Palomar College Topic: *Gender Development in Young Children*
- 1977: Keynote Speaker, California Child Development Association Topic: *Sex Role Stereotyping in Preschools*
- 1974: Colloquium: *Sex Role Socialization in a Preschool Setting*, School of Social Welfare, University of California, Berkeley

***PROFESSIONAL AFFILIATIONS*:**

- American Society for Reproductive Medicine
- International Association for Relational Psychoanalysis and Psychotherapy
- California Psychological Association
- Division of Psychoanalysis (Division 39), American Psychological Association
- Section II (Childhood and Adolescence) of Division 39
- Section III (Women, Gender, and Sexuality) of Division 39
- Section IX, (Psychoanalysis and Social Responsibility) of Division 39 Northern California Society for Psychoanalytic Psychology
- Council on Contemporary Families

***PUBLICATIONS AND PAPERS*:**

- Gender nonconforming youth: current perspectives *Adolescent Health, Medicine and Therapeutics 2017:8 57–67*
- Promoting children's gender health: a guideline for professionals. *Carlat Report—Child Psychiatry*, 7:8: 1-2, Nov/Dec 2016.
- *The Gender Creative Child*. D. Ehrensaft, New York: The Experiment, 2016.
- *The Gender Affirmative Model: A New Approach to Supporting Gender Non-Conforming and Transgender Children*, Colt Meier, Ph.D. & Diane Ehrensaft, Ph.D.(eds.), American Psychological Association Publications, in process.
- "It Takes a Gender Creative Parent" in A. Lev & A. Gottlieb (eds.), *Families in Transiton: Parent Perspective in Raising the Gender Nonconforming or Trans Child* (in press).
- "Baby Making: It Takes an Egg and Sperm and a Rainbow of Genders" in Katie Gentile (ed.), *The Business of Being Made: Producing Liminal Temporalities through ARTS*, New York: Routledge, 2015.
- http://www.wired.com/2015/07/must-put-end-gender-conversion-therapy-kids (07/06/2015 Wired)

- Found in Transition: Our Littlest Transgender People. *Contemporary Psychoanalysis*, 50:4: 571-592, 2014.
- Psychological and medical care of gender nonconforming youth. Vance S, Ehrensaft D, Rosenthal S. M. *Pediatrics*, 2014.
- Gender Nonconforming/Gender Expansive and Transgender Children and Teens. Sherer I., Baum J., Ehrensaft D., Rosenthal S.M., *Contemp Pediatrics*, 2014.
- Child and Adolescent Gender Center: A multidisciplinary collaboration to improve the lives of gender nonconforming children and teens. Sherer I, Rosenthal SM, Ehrensaft D., Baum J., *Pediatr Rev* 33:273-275, 2012.
- "Listening and Learning from gender-nonconforming children. *The Psychoanalytic Study of the Child*, Vol. 68, 28-56, 2014 .
- "Family complexes and Oedipal circles: mothers, fathers, babies, donors, and surrogates. In M. Mann (ed.) Psychoanalytic Aspects of Assisted Reproductive Technology. London: Karnac, 2014.
- "From gender identity disorder to gender identity creativity: The liberation of gendernonconforming children and youth." In E.J. Meyer and A.P. Sansfacon (eds.), *Supporting Transgender and Gender Creative Youth.* New York: Peter Lang, 2014.
- "A terrible Thing happened on the way to becoming a girl: transgender trauma, parental loss, and recovery." In P. Cohen, M. Sossin, & R. Ruth (eds.), *Healing after Parent Loss in Childhood and Adolescence*. Lanham: Rowman & Littlefield, 2014.
- "The Gender affirmative model: what we know and what we aim to learn." Hidalgo, M.A., Ehrensaft, D. Tishelman, A.C., Clark, L.F., Garofalo, R., Rosenthal, S.M., Spack, N.P., & Olson, J., *Human Development*, 56: 285-290, 2013.
- "Look, Mom, I'm a boy—don't tell anyone I was a girl." *Journal of LGBT Youth*, 10:928, 2013.
- "The 'Birth Other' in Assisted Reproductive Technology" In M. O'Reilly-Landry (ed.), *A Psychodynamic Understanding of Modern Medicine*. London: Radcliffe, 2012.
- "From gender Identity disorder to gender identity creativity: True gender self child therapy. *Journal of Homosexuality*, 59:3, 337-356, 2012.
- *Gender Made, Gender Born*, The Experiment Press, 2011.
- "Boys will be girls, girls will be boys." *Psychoanalytic Psychology*, 28: 4, 2011, 528548, 2011.
- "I'm a Prius." *Journal of Gay and Lesbian Mental Health*, 15:1, 46-57, 2011.
- One Pill Makes You Boy, One Pill Makes You Girl. *International Journal of Applied Psychoanalytic Studies*, 6:1, 12-24, 2009.
- "Just Molly and Me, and "Donor Makes Three" Journal of Lesbian Studies, 12: 2-3, 161-178, 2008.
- "When Baby Makes Three or Four or More" *Psychoanalytic Study of The Child*, Vol. 63, 3-23, 2008.

- Guest Editor. Special Issue on Foster Care. *Journal of Infant, Child, and Adolescent Psychotherapy*, 7:2, July 2008.
- "A Child is Being Eaten: Failure, Fear, Fantasy, and Repair in the Lives of Foster Children" Journal of Infant, Child, and Adolescent Psychotherapy, 7:2, 100-108, 2008.
- "Raising Girlyboys: A Parent's Perspective." Studies in Gender and Sexuality, 8(3), 269-302, 2007.
- "The Stork Didn't Bring Me, I Came From a Dish: Psychological Experiences of Children Conceived through Assisted Reproductive Technology." *Journal of Infant, Child, and Adolescent Psychotherapy*, 6(2): 124-140, 2007.
- *Mommies, Daddies, Donors, Surrogates: Answering Tough Questions and Building Strong Families*, New York: Guilford Publications, 2005.
- Toni Heineman and Diane Ehrensaft (eds.), *Building A Home Within: Meeting the Emotional Needs of Children and Youth in Foster Care*. Baltimore: Brookes, 2005.
- "Raising Girlyboys: A Parent's Perspective," paper presented at the APA Division 39 Spring Meeting, Santa Fe, New Mexico, April 27, 2001.
- "Ode to Anna Freud: Intersubjectivity and Child Psychotherapy," paper presented at APA Division 39 Spring Meeting, San Francisco, CA, April 6, 2000.
- "Alternatives to the Stork: Fatherhood Fantasies in Donor Insemination Families, *Studies in Gender and Sexuality*, Vol. 1, No. 4, 2000, 371-397.
- "The Kinderdult: The New Child Board to Conflict between Work and Family," in Rosanna Hertz and Nancy L. Marshall (eds.), *Families and Work: Today's Realities and Tomorrow's Possibilities*, Berkeley, CA: University of California Press, 2000, 585-627.
- "Use the Rod/Lose the Child; Spoil the Child/Lose the Parent," paper presented at American Psychological Association Annual Meeting, August 18, 1998.
- "Alternatives to the Stork: Fatherhood Fantasies in Sperm Donor Families," paper presented at APA Division 39 Meetings, Boston, Massachusetts, April 25, 1998.
- *Spoiling Childhood: How Well Meaning Parents Are Giving Children Too Much--But Not What They Need* (Guilford Press, 1997)
- "Child Psychotherapy and Intersubjective Theory: Ode to Anna Freud," *Fort-Da, Journal of the Northern California Society for Psychoanalytic Psychology*. Spring 1998.
- Susan Bernadett-Shapiro, Diane Ehrensaft, & Jerrold Lee Shapiro, "Father Participation in Childcare and the Development of Empathy in Sons: An Empirical Study," *Family Therapy*, Volume 23, No. 2, 1996, 77-93.
- "Bringing in Fathers: The Reconstruction of Mothering," in Jerrold Lee Shapiro, Michael Diamond, & Martin Greenberg (eds.), *Becoming a Father*, New York: Springer, 1995, 43-59.
- Toni V. Heineman & Diane Ehrensaft, "The Children's Psychotherapy Project, *Fort Da, Journal of the Northern California Society for Psychoanalytic Psychology*, Vol. I., No. 2, November 1995.

- "Solomon's Child: Dilemmas in the Joint Custody Family," paper presented at the annual meeting of the American Psychological Association, August, 1993.
- "Your Majesty, the Baby: Normative Narcissism and Confused Parenting," paper delivered at annual meeting of the Division of Psychoanalysis, American Psychological Association, April 15, 1993.
- "Preschool Sexual Abuse: The Aftermath of the Presidio Case," *American Journal of Orthopsychiatry*, 62 (2), April 1992, 234-244.
- "Your Majesty the Baby: Normative Narcissism, Confused Parenting, and the Changing Concept of Childhood, paper delivered at the Northern California Society of Psychoanalytic Psychology Forum, Parenting in the Nineties: The Need for a New Psychoanalytic Perspective, May 9, 1992.
- "Sex and Violence in the Nursery," paper presented at scientific meeting of the Northern California Society for Psychoanalytic Psychology, November 1991.
- "The Reconstruction of Mothering," paper delivered at the annual meeting of the American Psychological Association, August 1991.
- "Sex and Violence in the Nursery: Lessons from the Presidio," paper delivered at the annual meeting of the American Orthopsychiatric Association, April 1991.
- "Feminists Fight (for) Fathers," *Socialist Review*, Vol. 20, No. 4, October - December 1990, 57-80.
- "When Women and Men Mother," in Karen Hansen and Ilene Philipson (eds.), Women, Class, and the Feminist Imagination, Philadelphia: Temple University Press, 1990, 399430.
- "A Parent's Love for a Child: Mother-Father Differences in the Shared Parenting Family," paper presented at the annual meeting of the Division of Psychoanalysis, American Psychological Association, February, 1988.
- "Dual Parenting and the Dual of Intimacy: Mother-Father Dynamics in the Shared Parenting Family," paper delivered at the first annual Children's Hospital Alumni Association Meeting, March 1988.
- "The Experts Who Speak for the Baby Who Can't: What Behooves Them to Prove," paper delivered at the annual meeting of The American Orthopsychiatric Association, March 1988.
- *Parenting Together: Men and Women Sharing the Care of their Children*. New York: The Free Press, 1987.
- "Attachment and Androgyny: The Children of Shared Parenting," paper delivered at The annual meeting of The American Orthopsychiatric Association, March 1987.
- "Gender Issues in Clinical Work: Parenting Issues," paper delivered at the annual meeting of The American Orthopsychiatric Association, March 1987.
- "Dual Parenting and the Duel of Intimacy," in G. Handel (ed.), *The Psychosocial Interior of the Family*, New York: Aldine Press, 1985.

- *"Man, Woman, and Child: the New Shared Parenting Family."* ERIC Publications, Ann Arbor, Michigan, 1985.
- "Androgynous Men and Headstrong women: The Shared Parenting Couple," paper delivered at The Future of Parenting Conference, California State University, Chico, February 1985.
- "Dual Parenting and the Duel of Intimacy," paper delivered at the annual meeting of The American Sociological Association, August 1983.
- "When Women and Men Mother," in Joyce Trebilcot (ed.), *Mothering: Essays in Feminist Theory*, New Jersey: Littlefield, Adams, and Co., 1983.
- Book Review: Myra Liefer, "Psychological Effects of Motherhood," in *Sociology and Social Research*, Vol. 66, No. 2, January 1982.
- "When Women and Men Mother," *Socialist Review*, No. 49, January-February 1980, 3773 (reprinted in Politics and Power, London, England).
- "From Sex to Gender: The Hidden Curriculum in the Preschools," 1980.
- Report: Evaluation Report of the Interdisciplinary Program on Day Care and Child Development, 1977-1978, University of California, Berkeley.
- Report: Evaluation of the Interdisciplinary Program on Day Care and Child Development, 1974-1977, University of California, Berkeley.
- "We Followed Them to School One Day: Sex Role Socialization in the Preschool," in Jerome and Evelyn Oremland (eds.). *The Sexual and Gender Development of Young Children*, New York: Ballinger Press, 1977.

Expert Report for Diane Ehrensaft, Ph.D.

Exhibit B – Bibliography

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Literature

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Bockting, W. (2014). The impact of stigma on transgender identity development and mental health. In Kreukels, Steensma, and De Vries (eds), *Gender dysphoria and disorders of sex development: Progress in care and knowledge*. New York: Springer.

Bockting, W. & Coleman, E. Developmental stages of the transgender coming out process: Toward an integrated identity. In Ettner, Monstrey & Eyler (eds.), *Principles of Transgender Medicine and Surgery*. New York: Haworth Press.

Brill, S. & Pepper, R. (2008). *The Transgender Child.* San Francisco: Cleis Press.

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D'Augelli, A.R., Grossman, A.H. & Starks, M.T. (2006). Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence*, 21:1462–1482.

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de Vries, A.L. & Cohen-Kettenis, P.T. (2012). Clinical management of gender dysphoria in children and adolescents: The dutch approach. *Journal of Homosexuality*, 59(3):301– 320

de Vries, Annelou L.C., *et al.* (2010) Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents, *J. Autism Dev. Disord.* 2010 Aug. 40(8):930-36.

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *Journal of Gay & Lesbian Psychotherapy* 8(1-2):41-67.

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Diamond, M. (2000). Sex and gender: Same or different? *Feminism* & *Psychology*, 10:46–54.

Dimen, M. (2003). *Sexuality, intimacy, power*. Hillsdale, NJ: The Analytic Press.

Drescher, J., Cohen-Kettenis, P.T. & Reed, G.M. (2016). Gender Incongruence of childhood in the ICD-11: controversies, proposal, and rationale. *Lancet Psychiatry*, 3:297-304.

Ehrensaft, D. (2016). *The Gender Creative Child: Pathways for Nurturing and Supporting Children Who Live Outside Gender Boxes.* New York: The Experiment.

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Case-Specific Documents

- Complaint, *Adams v. The Sch. Bd. of St. Johns Cty., Fla.*, Case No. 3:17-cv-00739-TJC-JBT (M.D. Fla. June 28, 2017) (Docket No. 1)

- Declaration of Drew Adams, *Adams v. The Sch. Bd. of St. Johns Cty., Fla.*, Case No. 3:17-cv-00739-TJC-JBT (M.D. Fla. July 19, 2017) (Docket No. 22-1)

- Declaration of Erica Adams Kasper, *Adams v. The Sch. Bd. of St. Johns Cty., Fla.*, Case No. 3:17-cv-00739-TJC-JBT (M.D. Fla. July 19, 2017) (Docket No. 22-2)

- Hearing Transcript, *Adams v. The Sch. Bd. of St. Johns Cty., Fla.*, Case No. 3:17-cv-00739-TJC-JBT (M.D. Fla. Aug. 10, 2017) (Docket No. 57)

- Amended Complaint, *Adams v. The Sch. Bd. of St. Johns Cty., Fla.*, Case No. 3:17-cv-00739-TJC-JBT (M.D. Fla. Sept. 7, 2017) (Docket No. 60)

Medical and Psychological Records for Drew Adams

- Records from Nemours Children's Clinic – Jacksonville, including:
    - Records from Dr. Michael De La Hunt, MD
    - Records from Dr. Lisa M. Buckloh, Ph.D.
    - Records from Dr. Priscila C. Gagliardi, MD
    - Records from Dr. Monica M. Mortensen, DO
- Records from Duke Health, Department of Pediatrics, including:
    - Records from Dr. Deanna W. Adkins, MD
- Records from Baptist Medical Center South
- Records from Dr. Kamalesh Pai, MD
- Records from Dr. Naomi Jacobs, Ph.D.
- Records from Dr. Erica Tarbox/Baptist Pediatrics, Inc.
- Records from Dr. Russell F. Sassani, MD/Take Shape Plastic Surgery, P.A.
- Records from Judith A. Asermely, LCSW, LLC
- Records from counselor Claudia Rojas

Exhibit C

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

DREW ADAMS, a minor, by and through his next friend and mother, ERICA ADAMS KASPER, *Plaintiff*, v. THE SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA, *Defendants*.	No. 3:17-cv-00739-TJC-JBT

REBUTTAL EXPERT REPORT OF DIANE EHRENSAFT, Ph.D.

1. In preparing this rebuttal report, in addition to the materials listed in the expert report previously submitted on October 2, 2017, I have relied on my review of the expert witness report submitted by Dr. Allan M. Josephson; as well as reviewed the World Professional Association for Transgender Health ("WPATH") Standards of Care, Version 7; the 2017 guidelines for transgender care recently released by the Endocrine Society; the 2015 American Psychological Association guidelines for transgender care; and the 2017 Australian guidelines for transgender care, released in September 2017. In addition, I have reviewed my notes for the interviews I conducted with Drew Adams and a 2017 article authored by Dr. Jack Turban and myself, *Research Review: Gender identity in youth: treatment paradigms and controversies,* which was just published in the Journal of Child Psychology and Psychiatry.

2. The conclusions drawn by the report of 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] Those flaws include misuse of statistics, misrepresentation of the studies cited and of the limitations of

[1] The framing and language used by Dr. Josephson in his report is very similar to a position paper entitled "Gender Dysphoria in Children" by the American College of Pediatricians. American College of Pediatricians, Position Statement: Gender Dysphoria in Children (2016), available at, https://www.acpeds.org/the-collegespeaks/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. In 2010, Francis S. Collins, M.D., the Director of the National Institute of Health, in a statement made of NIH letterhead, referred to the American College of Pediatricians as a special interest group distorting scientific information to make points against homosexuality, pulling language out of context to "support an ideology that can cause unnecessary anguish and encourage prejudice" John Commins, *NIH Director Raps American College of Pediatricians for Distorting Research on Homosexuality*, HealthLeaders Media (Apr. 16, 2010), available at, http://www.healthleadersmedia.com/physician-leaders/nih-director-raps-american-college-pediatricians-distorting-research-homosexuality.

those studies, and failure to cite studies that disprove or undermine conclusions drawn. This renders the report of Dr. Josephson unscientific and unreliable.

I. Standards of Care and Guidelines Are the Most Reliable Source for Providing Optimal Gender Care in light of Scientific and Clinical Evidence.

3. The basic tenets of care for transgender care and treatment of gender dysphoria are reflected in the WPATH Standards of Care, Version 7; The American Psychological Association Guidelines for Psychological Practice with Transgender and Gender Nonconforming People; the Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline; and the most recently released standards of care, the Australian and New Zealand Standards of Care for Transgender and Gender Diverse Children and Youth, published in September 2017.

4. Standards of care are constructed specifically to direct practitioners toward best practices in the treatment of their patients, based on existing scientific evidence and professional consensus among entities assigned the task of designing those standards. Practice or clinical guidelines offer recommendations to practitioners to assist them in providing competent care in a particular area of treatment, but are not meant to be as rigorously followed as standards of care.

5. As stated succinctly by the authors of the American Psychological Association Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, "Standards are mandates to which all psychologists must adhere, whereas guidelines are aspirational." (p. 833). However, the construction of both standards of care and guidelines are based on review of available scientific evidence and consensus among the working group of professionals constructing the manuals, a consensus drawn from both review of the scientific

evidence and professional knowledge from clinical practice across senior practitioners in the field.

6. Noteworthy in the area of care for transgender and gender diverse children, adolescents, and adults is the present consistency across the most recent documents released, specifically, the WPATH Standards of Care (2011); the APA Guidelines for Transgender Care (2015), the Endocrine Guidelines for Transgender Care (2017), and the most recent standards of care released, The Australian and New Zealand Standards of Care (September, 2017). Consistent across all these documents is that:

a. Being transgender is a healthy and natural component of the human condition, not a disease;

b. Attempts to alter an individual's gender to fit social expectations are harmful and should not be practiced;

c. Psychiatric co-occurring conditions, prevalent in the transgender population, are typically a result of minority distress and environmentally induced stigma, rather than internal mental disturbance;

d. Positive acceptance, support, and provision of gender-affirming treatments that respect an individual's expressed gender identity promotes healthy physical and psychological outcomes, while lack of acceptance/support and denial of such treatments puts an individual at risk for negative physical and psychological outcomes; and

e. Practitioners should develop a knowledge base and be trained in these gender-affirming practices if they are to be interfacing with gender diverse and transgender patients.

7. Failure to follow these guidelines or standards of care, in a professional community that relies on both to keep them abreast of the most recent scientific discoveries in their field, inform them of best practices, and direct them toward competent care, is typically assessed as substandard practice. This is especially true in situations when existent standards or guidelines from the dominant professional organizations in their field are consistent with each other and in agreement about best practices, as they are regarding transgender care.

8. It should also be noted that within these documents are also references to best practices not just for mental health and health professionals, but for families, schools, religious institutions, and community organizations.

9. Representative of this consistency across major health organizations internationally, itemized here are the major tenets of standards of care, as articulated in the most recently published document: Telfer, M.M., Tollit, M.A., Pace, C.C., & Panga, K.C. *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents*, Melbourne: The Royal Children's Hospital, 2017. These standards were established on the basis of available scientific and empirical evidence and clinical consensus:

a. "In the past, psychological practices attempting to change a person's gender identity to be more aligned with their sex assigned at birth were used. Such practices, typically known as conversion or reparative therapies, lack efficacy,

and are considered unethical and may cause lasting damage to a child or adolescent's social and emotional health and well-being." (p. 5);

b. "Being trans or gender diverse is now largely viewed as part of the natural spectrum of human diversity." (p 2); and

c. "Increasing evidence demonstrates that with supportive, gender affirming care during childhood and adolescence, harms can be ameliorated and mental health and wellbeing outcomes can be significantly improved." (p. 2).

10. In summary, the role of the mental health professional is to do a thorough assessment and provide avenues for a child or adolescent to explore and consolidate their affirmed gender identity, with additional services offered to parents to strengthen their levels of support to the child, and counsel the youth and parents, in adolescence, about possible available medical interventions.

11. Practices that encourage parents to set arbitrary or inappropriate limits on their children's authentic gender expression or the categorization of a child's persistent declarations of a cross-gender identity as a psychiatric disturbance violate the standards of care. Included in those violations would be reference to the child needing to be met with firm, empathic limits, and redirection and likening the child's gender articulations to childhood insistence on countless things that are not healthy or good for them, as Dr. Josephson suggests in paragraph 24 of his report.

12. It also violates those standards of care to treat a desire to live in accordance to one's affirmed gender identity as an avoidance of challenging developmental hurdles rather than "dealing with struggles on the road to health" with meaningful psychotherapy as an

empathic combination of support/affirmation and encouragement to change and improve," as Josephson suggests in paragraph 32. Although Josephson does not specifically define in that paragraph what he is referring to when he speaks of change and improvement, if change and improvement involve recognizing the "delusion of transgender ideation," as stated in other sections of Dr. Josephson's report, that would be antithetical to the extant standards of care and clinical guidelines of all major health organizations, which clearly state that being transgender is not a disease.

13. The assertion that the current available medical interventions for treating transgender adolescents constitute "eliminating puberty" shows a lack of understanding of the standards of care and medical protocols. (See Josephson report, paragraph 27). There is no existing practice or scientific evidence that puberty could ever be eliminated, as stated in Dr. Josephson's report (See Josephson report, paragraph 27). Instead, best practices are to make available to a transgender youth through medical interventions (puberty blockers and masculinizing or feminizing hormones) the possibility of a puberty more in alignment with their affirmed gender than with the sex assigned to them at birth.

II. Extant Standards of Care and Clinical or Practice Guidelines for Transgender Youth Consistently Endorse a Gender Affirmative Model of Care.

14. The gender affirmative model of care is defined as a model of care recognizing that gender is a combination of biology, environment, and culture and that goals of treatment should be to facilitate a process for a child or youth to live in their legitimate affirmed gender. As stated above, in all these documents gender variations are perceived as a healthy variation among human beings and it is understood that psychological symptoms are most likely a result

of minority stress (i.e., the psychological distress or angst resulting from negative behavior and discrimination targeted at the individual from the social world) rather than disease.

15. Although gender is understood to be a complex interplay of nature, nurture, and culture, it is recognized that for transgender people there is a strong biological underpinning. Gender identity is an internal core component of one's identity, one that may or may not match the sex assigned at birth, and one that is not enforced or legislated by others but internally driven.

16. Care is individualized, with no single form of treatment for all people. For example, in the WPATH Standards of Care, Version 7 (the latest edition), it is no longer required that a person have a "real life" experience (living in the gender role that matches their affirmed gender identity) before receiving medical treatments, and ongoing psychotherapy is no longer a prerequisite to receiving medical care or making a social transition. What has taken the place of either mandatory real life experience or psychotherapy is an interdisciplinary model in which careful assessment and facilitation occurs as the team, consisting of medical and mental health professionals, with the help of the child and family, assesses and acquires knowledge of a child's authentic gender.

III. Legal Statutes Exist Supporting the Present Standards of Care and Practice Guidelines.

17. In nine states (California, Rhode Island, New Jersey, Oregon, Nevada, New Mexico, Illinois, Vermont, Connecticut) and the District of Columbia, legislative statutes exist prohibiting psychotherapeutic practices that attempt to change a minor's sexual orientation or gender behaviors. Similar bills have been introduced in 20 other states, and the Canadian province of Ontario also has legislation banning such clinical practices.

18. In addition to existing laws in a number of states prohibiting discrimination based on gender identity or transgender status in public accommodations, the state of California has also passed legislation that states that every student in the public school system shall be able to use all facilities and engage in all school activities in conformance with their affirmed gender identity, rather than the sex indicated on their birth certificate. Since the passing of that bill there has been no reported instance of any student's privacy being violated by bathroom use according to one's affirmed gender rather than sex assigned at birth.

19. Legislative actions are moving in alignment with the present standards of care and clinical guidelines in assuring the health and well-being of gender diverse and transgender students and prohibiting practices that are implicitly or explicitly advocated in Dr. Josephson's report.

IV. All Clinical Practice Should Involve Careful and Thoughtful Exploration, Rather Than Cursory Endorsement, of a Youth's Initial Reporting About Their Gender.

20. I agree with Dr. Josephson that clinical practice should involve careful and thoughtful exploration rather than cursory endorsement of a youth's initial reporting about their gender (See Josephson, Paragraph 34). Problematic, however, is his assumption that the gender affirmative model of care fails to engage in such practices. The model of care promoted in both the extant standards and guidelines involves careful investigation and exploration of a youth's gender, along with consideration of co-existing psychological issues for a youth that may interface with their gender explorations or self-understandings. No cursory endorsement is involved.

21. The best indication of this model in practice is a consideration of the plaintiff in this complaint, Drew Adams. Having had the opportunity to interview Drew directly and to also review his clinical records, there is sufficient documentation and clinical evidence, along with my own observations, that Drew, with the aid of several mental health and health professionals, has spent much time exploring and bringing into focus his thoughts, feelings, and stresses related to his gender, and with the help of extensive professional care and support came to the realization that his authentic gender is male. In accordance with operationalizing that realization through a social and medical transition, again with continued support from trained professionals, Drew is now only asking that he be allowed to live as the boy he is in every aspect of daily life, which would include access to bathrooms that match his gender, not the sex assigned to him at birth.

V. The Conclusions of Dr. Josephson's Report are Methodologically Unsound.

22. Dr. Josephson relies on incomplete, outdated, and methodologically flawed data, as will be described below, and then extrapolates from that unreliable data to support the 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; American Psychological Association, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (2009),

available at, https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf; 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.

23. The report misrepresents research relating to the desistence rates among children diagnosed with gender dysphoria. First, Dr. Josephson fails 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. Further, Dr. Josephson draws conclusions about transgender children from a sample of children diagnosed with gender dysphoria, which is not the same as it includes children who are not transgender, and fails to recognize that not all transgender children will be captured by a diagnosis of gender dysphoria.

24. Second, a number of key articles that Dr. Josephson relies on in his 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, which is a necessary methodical requirement in scientific research, the authors

continued to count them as subjects in the longitudinal study and 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, and furthermore, as mentioned above, it is not allowable to count individuals who have dropped out of a study as subjects once lost to the examiner. Further, the critical variables to be measured to determine transgender status, which included measures of gender identity and measures of gender expression, were not the independent variables used in the studies of desisters and persisters, as they should have been if the focus of the study is to determine whether one is transgender or not. Qualifying for a diagnosis of gender identity disorder, the independent variable used in these studies and for which the diagnostic criteria were different than diagnosis of gender dysphoria, fails to meet the standard of measurements necessary to determine transgender status, which includes measures of gender identity and gender expression. Because of those serious flaws, these articles provide no reliable information about the desistance rates for children diagnosed early in life with gender dysphoria.

25. 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 youth who are gender-nonconforming. 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 who are grappling with their preferred gender expressions but not their gender identity 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. Josephson fails to acknowledge the investigators' review of their own research, information which is widely accepted and relied upon by experts in treating transgender children (e.g, cf. D. Ehrensaft, *Gender Born, Gender Made* & *The Gender Creative Child*).

26. As a result, 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, i.e., were already clearly transgender in their own understanding of themselves and as observed by others, including mental health and medical professionals. Thus, consistent with the standards of care, social transition was the appropriate treatment and supporting those children through a social transition contributed to their overall positive mental health.

27. Lastly, the persister/desister research which Dr. Josephson relies on in his report does not pertain to transgender youth who do not surface with either gender dysphoria or a transgender knowledge of self until adolescence, often triggered by the onset of puberty which feels discordant to the youth.

VI. Transgender Youth Are a Small Percentage of the Population, But That Does Not Render Them Abnormal.

28. Although transgender people are a small percentage of the overall population, Dr. Josephson inappropriately extrapolates that statistic to support the belief that being transgender is not normal and is a disease that must be cured. *See* Josephson Report, para. 22. 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.

29. Stated differently, minority status does not equate with psychiatric abnormality. Presently it is estimated that somewhere between 1 and 2% of the population is transgender, and it is assessed that these are underestimates, due to the reluctance of many to report their transgender status. In addition to the analogy of the comparatively rare number of individuals rated as having superior intelligence, we can also refer to the analogy of handedness. Left-handed people represent only 10% of the population; therefore, individuals who hold this status qualify as a minority population, possessing a variation in brain make-up, but not abnormality.

30. As discussed presently in this statement, and in my prior declaration in this matter, scientific studies and clinical experience demonstrate that being transgender is a normal part of human variation.

VII. Transgender Status Is Not a Mental Disorder.

31. By all existent mental health diagnostic measures, being transgender does not qualify as a mental disease or a delusion, although specifically stated in Paragraph 16 of Dr. Josephson's report and suggested, in referring to transgender ideation as delusion, in Paragraph 43 of his report.

32. In 2013, the DSM-V replaced the DSM-IV. The previous child and adolescent gender diagnosis "Gender Identity Disorder" was removed from the DSM manual and replaced by the "Gender Dysphoria" diagnosis, a diagnostic category that replaces the concept of disorder with the acknowledgement of the stress or distress that may accompany a youth's realization that the gender they experience themselves as being to be discordant with the gender that would match the sex assigned to them at birth.

33. In preparing for the new ICD 11, there has been extensive field study investigation as to whether a childhood gender diagnosis should exist at all, and if it does, whether it should be renamed "gender incongruence" and be removed from chapters on mental disorders, for the precise reason that it is not a disorder in itself.

34. Presently, within the community of health care community there is much debate as to whether a childhood gender diagnosis should exist. While the overwhelming consensus is that gender nonconformity is not pathological, nonetheless some want to retain the diagnosis for practical reasons related to access to care. Specific concerns among those opposing a childhood mental health gender diagnosis are 1) that having such a diagnosis is in tension with the most recent standards of care which consistently de-pathologize gender nonconformity and transgender identity, and 2) that the diagnosis will be misused by those who are ideologically

opposed to the concept of gender diversity and will use the diagnosis to maintain a stance that transgender ideation or identity is a mental illness, promoting an obsolete notion that such experiences represent a mental illness. The latter concern among opponents to the childhood diagnosis is well-founded, as evidenced in the narrative of Dr. Josephson's expert witness report, as when he states for example, "A transgender individual meets the technical, psychiatric criterion for maintaining a delusion: a false, fixed belief, minimally responsive to reason . . . . A deluded person has the freedom to choose beliefs, and should be respected in that choosing, but he/she does not have the freedom to redefine reality" (Josephson report, para. 25). Even those who have been in favor of retaining the diagnosis indicate that the purpose of doing so is not to label a child as disordered but to clinically identify those children and youth who are suffering from stress or distress related to their gender in order to get them the needed treatment for their angst and the supports to live life more authentically in accordance with their experienced gender identity or expressions rather than in accordance to the sex assigned to them at birth.

35. Perhaps of most significance is that no major health organization, including The American Psychological Association, The World Professional Organization for Transgender Health, and the Endocrine Society, presently recognizes transgender identity as a disorder to be cured but rather as a core component of one's identity that may be accompanied by stress or suffering as a result of poor environmental provisions, such as lack of support, respect, or acceptance of the individuals' authentic gender.

36. Scientific evidence that transgender children function within normal range psychologically can be found in the peer-reviewed studies of Dr. Kristina Olson and her

colleagues at University of Washington. Findings were that children who have been identified as transgender and allowed to socially transition to their affirmed gender, when matched with non-transgender peers, showed no differences in psychological functioning from their non-transgender peers, except for a slight elevation in anxiety symptoms, but even then with no areas of psychiatric measures within a clinical range, meaning that the measures indicate these children are within normal range of all psychological areas of functioning measured and indicated rates similar to their non-transgender peers.

37. Nowhere in the standards of care or clinical and practice guidelines is transgender status referred to as a delusion.

* * * * *

38. In conclusion, Dr. Josephson's underlying assumption that being transgender is a disease rather than a natural and healthy variation of humanity is both a violation of present standards of care, in contradiction to both scientific research and clinical or practice guidelines, and a critical flaw in the arguments made in his expert report.

Dated this 2nd day of November, 2017.

Diane Ehrensaft, Ph.D.

Rebuttal Expert Report of Diane Ehrensaft, Ph.D.

Exhibit A – Bibliography

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CERTIFICATE OF SERVICE

I hereby certify that on November 3, 2017, I caused a true and complete copy of the foregoing REBUTTAL EXPERT REPORT OF DIANE EHRENSAFT, Ph.D., to be served upon the following parties hereto via email:

Robert J. Sniffen (rsniffen@sniffenlaw.com)
Michael P. Spellman (mspellman@sniffenlaw.com)
Terry J. Harmon (tharmon@sniffenlaw.com)
Kevin C. Kostelnik (kkostelnik@sniffenlaw.com)
SNIFFEN & SPELLMAN, P.A.
123 North Monroe Street
Tallahassee, FL 32301
Attorneys for Defendant, The School Board of St. Johns County, Florida

/s/ Tara L. Borelli
Tara L. Borelli (*admitted pro hac vice*)
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308-1210
Tel.: 404-897-1880 | Fax: 404-897-1884
tborelli@lambdalegal.org