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

DREW ADAMS, et al.,

Plaintiff,

v.

THE SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA, et al.,

Defendants.

No. 3:17-cv-00739-TJC-JBT

PLAINTIFF'S REPLY IN FURTHER SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Pursuant to Local Rules 3.01(c) and this Court's Order dated August 7, 2017 (ECF No. 46), Plaintiff Drew Adams ("Drew" or "Plaintiff"), by and through his next friend and mother, Erica Adams Kasper, respectfully submits this reply memorandum in further support of his Motion for Preliminary Injunction (ECF No. 22).

A. Background

On July 19, 2017, Plaintiff filed a Motion for a Preliminary Injunction (the "Motion"). ECF No. 22. On August 4, 2017, Defendant The School Board of St. Johns County, Florida ("Defendant") filed its opposition to the Motion. ECF No. 42. In its opposition, Defendant included numerous documents filed in an unrelated, out-of-circuit case. ECF No. 41-7. Plaintiff submits this brief reply memorandum to provide the Court with evidence rebutting the information from that unrelated case.

B. Argument

Defendant submitted numerous documents filed in a different case, pending in a different district court and circuit jurisdiction, that included testimony regarding sex and gender identity. *See, e.g.*, Ex. 1-4 to ECF No. 41-7. None of the parties here are parties in that case, and the materials were not prepared for this lawsuit nor subscribed for use in this suit by the original declarants. Specifically, Defendants submitted four purported "expert" declarations that were filed in *United States v. North Carolina*, Case No. 1:16−cv−00425−TDS−JEP (M.D.N.C.), which Defendant relies upon for its contentions about what constitutes sex and gender identity, how these issues are determined, and the treatment of gender dysphoria. *See* ECF No. 42 at 9-15. Conspicuously absent from the evidence submitted by Defendant is any indicia of whether these "experts" would testify the same in *this* case, or even if they would testify at all. As such, the evidence tendered by Defendants should not be given any weight. Nonetheless, should the Court be inclined to consider such "evidence," fairness and completeness dictates that the Court also consider the rebuttal evidence offered in *United States v. North Carolina*, as well as resolutions and statements from major medical and professional health organizations rebutting Defendants' purported "expert" testimony. *See* Exs. A - F to the Decl. of Tara L. Borelli.

C. Conclusion

Plaintiff respectfully suggests that this Court disregard the purported "expert" testimony submitted by Defendants because it has no bearing or relevance of the issues and claims pending here. Alternatively, Plaintiff urges the Court to consider and accord substantial weight to the enclosed declarations and documentary evidence setting forth the medical

consensus contravening Defendant's purported "expert" testimony and consistent with Plaintiff's expert testimony in *this* case.

Dated: August 8, 2017

Respectfully submitted,

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Counsel for Plaintiff

Certificate of Service

I hereby certify that on August 8, 2017, I electronically filed the foregoing and all attachments 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.

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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; et al.,

Defendants.

No. 3:17-cv-00739-TJC-JBT

DECLARATION OF TARA L. BORELLI

I, Tara L. Borelli, pursuant to 28 U.S.C §1746, declare as follows:

1. I am over the age of eighteen (18) and make this declaration of my own personal knowledge, and, if called as a witness, I could and would testify competently to the matters stated herein.

2. I am an attorney with Lambda Legal Defense and Education Fund, Inc., and counsel for Plaintiff Drew Adams in this litigation. I am licensed to practice law in Georgia, Washington, and California, and was admitted *pro hac vice* to practice before this Court. I make this declaration in support of Plaintiff's Reply in Further Support of Plaintiff's Motion for Preliminary Injunction.

3. Attached as Exhibit A is a true and correct copy of Supplemental Expert Declaration of George R. Brown, MD, DFAPA in support of the United States' Motion for

Preliminary Injunction submitted in *United States v. North Carolina*, Case No. 1:16−cv−00425−TDS−JEP (M.D.N.C.).

4. Attached as Exhibit B is a true and correct copy of the Expert Declaration of Deanna Adkins, MD in support of the United States' Motion for Preliminary Injunction submitted in *United States v. North Carolina*, Case No. 1:16−cv−00425−TDS−JEP (M.D.N.C.).

5. Attached as Exhibit C is a true and correct copy of the Brief of *Amici Curiae* American Academy of Pediatrics, American Psychiatric Association, American College of Physicians, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American Academy of Physician Assistants, American Medical Women's Association, American Nurses Association, American Psychoanalytic Association, Association of Medical School Pediatric Department Chairs, the Endocrine Society, GLMA: Health Professionals Advancing LGBT Equality, Mental Health America, National Association of Social Workers, Society for Adolescent Health and Medicine, and Society for Physician Assistants in Pediatrics in support of Plaintiff-Appellant submitted in *G.G. v. Gloucester County School*, Case No. 15-2056 (4th Cir.) (Doc. No. 135-1).

6. Attached as Exhibit D is a true and correct copy of Robert Nagler Miller, *AMA takes several actions supporting transgender patients*, AMA News (June 12, 2017), *available at* https://wire.ama-assn.org/ama-news/ama-takes-several-actions-supporting-transgender-patients.

7. Attached as Exhibit E is a true and correct copy of American Academy of Family Physicians, *Resolution No. 508 (Washington C): Transgender Use of Public Facilities* (2015), *available at* http://www.teachtraining.org/wp-content/uploads/2013/10/2016-passed-resolutions.pdf.

8. Attached as Exhibit F is a true and correct copy of American Psychological Association and National Association of School Psychologists, *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools* (2015), *available at* http://www.apa.org/about/policy/orientation-diversity.aspx.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated on this 8th day of August, 2017.

Tara Borelli

Tara L. Borelli

INDEX OF EXHIBITS TO BORELLI DECLARATION

Letter	Title
A	Supplemental Expert Declaration of George R. Brown, MD, DFAPA, *United States v. North Carolina*, Case No. 1:16−cv−00425−TDS−JEP (M.D.N.C.)
B	Expert Declaration of Deanna Adkins, MD, *United States v. North Carolina*, Case No. 1:16−cv−00425−TDS−JEP (M.D.N.C.)
C	*Amici Curiae* Brief of Medical and Mental Health Organizations in *G.G. v. Gloucester Cty. Sch. Bd.*, No. 15-2056 (4th Cir.)
D	*AMA takes several actions supporting transgender patients*, AMA News (June 12, 2017)
E	American Academy of Family Physicians, *Resolution No. 508 (Washington C): Transgender Use of Public Facilities* (2015)
F	American Psychological Association and National Association of School Psychologists, *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools* (2015)

Exhibit A

Exhibit A to Borelli Decl.: Supplemental Expert Declaration of George R. Brown, MD, DFAPA

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

UNITED STATES OF AMERICA, Plaintiff, v. STATE OF NORTH CAROLINA; PATRICK MCCRORY, in his official capacity as Governor of North Carolina; NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY; UNIVERSITY OF NORTH CAROLINA; and BOARD OF GOVERNORS OF THE UNIVERSITY OF NORTH CAROLINA, Defendants.	Case No. 1:16-cv-425

SUPPLEMENTAL EXPERT DECLARATION OF GEORGE R. BROWN, MD, DFAPA IN SUPPORT OF THE UNITED STATES' MOTION FOR PRELIMINARY INJUNCTION

1. As is detailed in my June 20, 2016 declaration submitted in support of the United States' preliminary injunction motion, I am a Professor of Psychiatry and Associate Chairman of the Department of Psychiatry at East Tennessee State University and I have been retained by counsel for the United States as an expert in this litigation. I submit this supplemental declaration to address opinions offered by Defendants' expert witnesses in opposition to the motion.

2. I have been publishing books and articles on the subject of the diagnosis and treatment of Gender Dysphoria for over three decades, as my June 20 declaration makes clear. During this time, I have kept up with published research, continued to contribute original research to the literature on this topic, and I have consistently been deeply engaged with the community of experts in this field through conferences, consultations, lecturing, and other professional activities. I have never before heard of any of Defendants' medical experts prior to reviewing their declarations. To my knowledge, I have never encountered them at any professional conferences

on this subject. I am not aware of any publications by them concerning Gender Dysphoria, or related issues in any book or peer-reviewed scientific journal, and I see none listed on their CVs.

Medical Standards Established in the DSM and WPATH Standards of Care

3. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5") is the authoritative source for psychiatric diagnoses in the United States and many other countries. The process of determining the diagnoses and diagnostic criteria included in the DSM involves a robust review of available evidence by numerous experts with varying perspectives in the relevant field over the course of several years of research, planning and debate. There is no sound basis for concluding that its contents are the product of influence from "political interest groups." (Josephson ¶ 24). The process by which this 947 page document was developed was well publicized, interactive with thousands of clinicians and researchers, and well described in the literature (DSM-5, pp. 5-10, 897-916).

4. There is no basis for Dr. Josephson's assertion that the change to the current diagnosis and nomenclature for Gender Dysphoria was the result of "political interest groups" as opposed to "scientific information." (Josephson ¶ 24). Having been present for discussions about these changes, presented by the Chair of Sexual and Gender Identity Disorders Committee, Dr. Kenneth Zucker, the reasons for the title change from "Gender Identity Disorder" to "Gender Dysphoria" was based on a more thorough understanding of this condition in the intervening 13 years between the publication of DSM's Fourth Edition, Text Revision ("DSM-IV-TR") and DSM-5. Gender Dysphoria, as a diagnosis, focuses on the treatable symptoms that a patient experiences. "Dysphoria," rather than "Identity," is the focus of treatment, and there is substantial evidence that Dysphoria can be treated successfully.

5. Likewise, Dr. Mayer's critique of the DSM-5's diagnosis of Gender Dysphoria in children reveals a lack of understanding of both the DSM and how it is used in practice. He isolates one aspect of a comprehensive set of criteria (gender atypical play preferences) and notes that it would not be a sound basis for a diagnosis. (Mayer ¶¶ 46-47). But that is precisely why it is only part of a comprehensive set of criteria provided to clinical professionals to use in the context of their practice to make a diagnosis. In fact, to arrive at a diagnosis of Gender Dysphoria in a child, a minimum of 6 of 8 specified "A" criteria must be met, accompanied by a minimum time frame criterion and a clinical significance criterion "B." All of these requirements must be met to arrive at a diagnosis. As with all psychiatric diagnoses, patients must be reassessed over time, and diagnoses may or may not be present at future time points.

6. Defendants' medical experts further situate themselves outside the mainstream of the field by rejecting well-accepted treatment protocols recognized by the major medical and mental health professional associations in the United States. As set forth in my June 20 declaration, the World Professional Association of Transgender Health ("WPATH") publishes Standards of Care for treating Gender Dysphoria. WPATH is an internationally recognized association comprising nearly 1,000 medical, surgical, mental health, and other professionals who specialize in the treatment of transgender and gender non-conforming people. The WPATH Standards of Care ("SOC"), which are in their seventh revision, represent the evidence-based consensus of experts in the field and have been recognized as the authoritative treatment protocols by the major medical and mental health associations in the United States, including the American Psychiatric Association, the American Medical Association, and the American Psychological Association. The largest health care system in the United States, the Veterans Health Administration ("VHA"), treats transgender veterans largely based on the guidelines set forth in

the current version of the WPATH SOC, and references these standards in their national training programs. I have been directly involved with the national VHA training program since its inception in 2012.

7. Some of Defendants' expert witnesses characterized WPATH as an advocacy organization with a social and political agenda (Van Meter ¶ 53), as opposed to a professional medical association that uses evidence-based standards. WPATH is a medical association in the same mold as every other medical association dedicated to the treatment of a particular condition— it creates a community of experts to share research and clinical experience; it establishes best practices for treatment based on experts in the field engaging in a robust review of the available evidence; and it supports policies that enhance the well-being of its patient population. There is ample evidence supporting the WPATH SOC, which are in widespread use throughout the United States and other countries. Any psychiatrist or other clinician trained in or with experience in this field would be aware of this.

Illustrative Errors in Defendants' Experts Opinions

8. Many of the opinions offered by Defendants' experts are unsound, reflecting a lack of experience in this field. The following are some pertinent examples.

The Suggestion That Transgender People are Delusional

9. I have not heard the theory that transgender people are suffering from a delusion articulated by any credible mental health professional in over thirty years. That theory has been soundly disproven and rejected by the medical profession.

10. In suggesting that transgender people are suffering from a delusion, Defendants' experts use a dictionary definition of "delusion" to oversimplify a complex psychiatric issue and draw an illogical and ill-informed conclusion that has no basis in evidence.

11. Contrary to Defendants' experts' opinion, the medical definition of a "delusion" is not merely "a fixed, false belief which is held despite clear evidence to the contrary." (Josephson ¶ 42; Van Meter ¶ 50). As the DSM-5 notes, a delusion is a fixed belief not amenable to change in light of conflicting evidence, which is associated with certain psychotic disorders and generally characterized by persecutory, religious or other grandiose themes (DSM-5, pp. 819-820). Delusional ideas or beliefs are "held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary" (DSM-5, p. 819). Delusions are generally treated with antipsychotic medication.

12. By contrast, transgender people have a very clear understanding of the reality that their body does not align with their gender identity. If you asked a transgender woman, prior to her transition, whether she has male genitals, is perceived by others who look at her body to be a man, or whether her birth certificate labels her a male, she is acutely aware of these realities. It is precisely the accurate understanding of these realities coupled with the incongruence between experienced gender identity and objectively observable bodily realities that leads to psychological distress and the diagnosis of Gender Dysphoria. Patients with Gender Dysphoria harbor no delusions whatsoever about "external reality" and to categorize these patients as delusional is not only inaccurate, but completely out of step with modern, mainstream, medical thinking.

The Suggestion That the Only Appropriate Treatment for Gender Dysphoria is to Align Gender Identity with Birth Sex

13. The WPATH Standards of Care emphasize the importance of the social transition for transgender people with Gender Dysphoria. Defendants' expert witnesses seem to suggest that rather than follow these professional standards, clinicians who see such patients should try to help them change their gender identity to align with their birth-assigned sex. As I noted in my June 20 declaration, attempts to do this have been found to be ineffective and are recognized as

potentially harmful by professional associations. The only treatment approaches for Gender Dysphoria in adolescents and adults that is supported by evidence and, thus, represents the medical consensus, is the gender-affirming protocols set forth in the WPATH Standards of Care and in the Endocrine Society's guidelines as applied to the hormonal aspects of multimodal treatment for this condition. I note that two of Defendant's experts are members of the Endocrine Society (Drs. Van Meter and Hruz), but their statements about Gender Dysphoria place them completely out of step with their own professional Society in this regard.

14. Evidence cited by Defendants' expert, Dr. Mayer, supports the conclusion that gender identity is real, fixed, and not generally malleable based on external interventions. Dr. Mayer cites the case of David Reimer, who was reported to have been assigned male at birth with no sign of any intersex condition but whose penis was severely damaged in a botched circumcision. According to the sources cited by Dr. Mayer, David's parents, in an effort to grapple with the consequences of the circumcision, opted for additional surgical and hormonal interventions and raised David as a girl ("Brenda"), concealing his history. These decisions were made after consultation with experts at Johns Hopkins. Notwithstanding this alteration to the external sex characteristics and hormones, as well as consistent social inputs affirming that David was a girl, David's gender identity remained fixed as male, and he suffered psychological distress as a result of the divergence between his male gender identity on the one hand and his female social identity, hormones, and external feminized sexual characteristics on the other hand. David lived the last 20 years of his life (from age 18-38) as a male, consistent with his gender identity. This evidence, offered by Defendants' expert, illustrates well the stability of gender identity in the face of overwhelming external interventions, and not the contrary.

The Erroneous Lumping Together of Pre-Pubertal Children, Adolescents, and Adults

15. Defendants' expert witnesses erroneously generalize about the appropriate course of treatment for Gender Dysphoria in adults or adolescents based on data about pre-pubertal children. The DSM-5 recognizes separate criteria for diagnosing Gender Dysphoria in children, on the one hand, and adults and adolescents on the other. The WPATH Standards of Care have distinct standards of care for pre-pubertal children (generally up to about age 10), adolescents and adults.

16. Defendants' experts point to the fact that some professionals do not favor social transition in pre-pubertal children based on data showing high rates of young gender incongruent children ceasing to experience gender incongruence by adulthood. They erroneously suggest that this applies to adolescents and adults as well. It does not. Gender Dysphoria in postpubertal adolescents and adults is very unlikely to "disappear." For example, in one follow-up study of adolescents treated at a gender clinic, 100% of the 70 individuals treated ultimately underwent hormone therapy and continued to identify with a gender different than the one assigned to them at birth. (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010). In my personal experience, I have had no adult or late adolescent patients with Gender Dysphoria have a resolution of these clinical symptoms without one or more interventions.

Misunderstanding the Evidentiary Basis for the Accepted Treatment Protocols

17. Defendants' expert witnesses assert that there is a lack of evidence demonstrating the effectiveness of the accepted protocols for the treatment of Gender Dysphoria. Dr. Hruz argues that there is a need for clinical research trials on treatments. (Hruz ¶ 33). Dr. Mayer specifically criticizes studies demonstrating positive effect, arguing that they lack a matched

control group. (Mayer ¶ 85). Dr. Josephson also criticizes the absence of controlled studies on youth and adolescents. (Josephson ¶ 34).

18. But these kinds of studies are not the only type of evidence scientists and doctors rely on. Studies demonstrating that patients' conditions improved after treatment can be very informative, whether or not there are matched control groups. (Manieri, Castellano, Crespi, et al., 2014). Moreover, Defendants' experts ignore another critically important source of evidence—the clinical experience of generations of doctors who have treated patients with Gender Dysphoria. There is abundant clinical experience going back 50 years establishing the effectiveness of social transition, hormone therapy and surgeries as treatment for Gender Dysphoria.

19. Medical professionals every day make choices about treatment protocols that are not based on matched control group studies or randomized control trials. For example, many aspects of the treatment protocols for common psychiatric conditions such as bipolar disorder, depression, and schizophrenia (the bulk of patients seen in outpatient psychiatric clinics) are not matched with control group studies or double blind clinical trials, but rather have been accepted by the profession as the standard of care based on clinical experience, limited published data, case series, or other types of evidence available. Another common example is a doctor's decision to select one drug over another in treating a particular condition. In many cases, the decision to select drug A over drug B or drug C is not validated by a control group study demonstrating that drug A produces results superior to drug B or drug C. Instead, the doctor makes a decision among available drugs based on clinical experience and his or her overall assessment of a patient's situation. That decision does not lack an evidentiary basis simply because there is not a matched control group study to support it.

20. I personally would never hold myself up as an expert in a clinical psychological condition without having not just some clinical experience but substantial clinical experience. Clinical experience is particularly important in the specialty area of transgender health. Reviewing relevant literature is not a sufficient basis for developing expertise on these subjects. To draw valid conclusions, one must integrate knowledge of the literature with personally obtained clinical information, up-to-date presentations at conferences, consultation with colleagues who work with similar patients, interviewing family members, and other sources of important clinical information. I am hard-pressed to see evidence of relevant clinical experience with gender dysphoric children, adolescents or adults among the Defendants' experts (or in the case of Dr. Mayer, *any* clinical experience).

The Asserted Definition of Sex

21. To the extent that Defendants' experts define sex based on the ability to procreate or engage in reproduction, they are relying on outdated sources that do not reflect the current medical consensus. As I noted in my June 20 declaration, with citations to the relevant sources reflecting the current consensus view, "biological sex" is a broad and complex concept that consists of a number of variables, including gender identity, genital anatomy (internal and externally visible), secondary sexual characteristics, brain anatomy, hormonal levels in the brain and body, and chromosomal complement. Failure to account for these aspects of sex that extend beyond reproductive systems reflects an incomplete and ill-informed understanding of "sex." Defendants' experts limited definition of "sex" does not account for the many humans who have no ability to procreate and may not or cannot engage in reproduction.

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

Executed on this 14th day of September, 2016.

By: _____
George R. Brown, MD, DFAPA

Bibliography

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (5th ed. 2013).

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de Vries, Annelou & Steensma, Thomas, et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-up Study*, J. Sexual Med. 8(8):2276-83 (2010).

Manieri, Chiara & Castellano, Elena, et al., *Medical Treatment of Subjects with Gender Identity Disorder: The Experience in an Italian Public Health Center*, Int'l J. Transgenderism 15:53-65 (2014).

Mayer, Lawrence & McHugh, Paul, *Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences*, The New Atlantis: A Journal of Technology & Society (2016).

World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*, Version 7 (2011).

Exhibit B

Exhibit B to Borelli Decl.: Expert Declaration of Deanna Adkins, MD

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

UNITED STATES OF AMERICA, Plaintiff, v. STATE OF NORTH CAROLINA; PATRICK MCCRORY, in his official capacity as Governor of North Carolina; NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY; UNIVERSITY OF NORTH CAROLINA; and BOARD OF GOVERNORS OF THE UNIVERSITY OF NORTH CAROLINA, Defendants, STATE OF NORTH CAROLINA; PATRICK MCCRORY, in his official capacity as Governor of North Carolina; NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY, Counterclaim Plaintiffs, v. UNITED STATES OF AMERICA, Counterclaim Defendant.	Case No. 1:16-cv-425

EXPERT DECLARATION OF DEANNA ADKINS, MD, IN SUPPORT OF THE UNITED STATES' MOTION FOR PRELIMINARY INJUNCTION

Qualifications and Background

1. I have been retained by counsel for United States as an expert in connection with the above-captioned litigation. I have also been retained by counsel for the Plaintiffs in the related matter of *Carcaño, et al. v. McCrory, et al*., No. 16-236, and submitted a report in that case and the above-captioned case on August 12, 2016. A true and accurate copy of that report is attached as Exhibit A. I have actual knowledge of the matters stated in this declaration and in the report attached as Exhibit A. My professional background, experience, and publications are detailed in my curriculum vitae, a true and accurate copy of which is included in Exhibit A.

2. As detailed in my attached report and CV, I am currently the Fellowship Program Director of Pediatric Endocrinology at Duke University School of Medicine and the Director of the Duke Center for Child and Adolescent Gender Care. *See* Exhibit A.

3. I have extensive experience working with children with endocrine disorders and I am an expert in the treatment of children with differences of sex development and gender dysphoria. As part of my practice, I stay familiar with the latest medical science and treatment protocols related to differences of sex development and gender dysphoria.

4. In preparing this declaration, I reviewed the materials listed in the Bibliography included in Exhibit A as well as the expert declarations submitted in opposition to the United States' motion for a preliminary injunction. I may rely on those documents as support for my opinions. I have also relied on my years of experience in this field, as set out in my CV and on the materials listed therein. *See* Exhibit A. The materials I have relied upon in preparing this declaration are the same types of materials

that experts in my field of study regularly rely upon when forming opinions on the subject.

5. In the past four years, I have testified as an expert at trial or deposition in the following matter: *United States v. Oversby, Brandon R.*, SPC, U.S. Army, B Company (Second Judicial Circuit, Fort Bragg Oct. 15, 2014).

Standards of Care for Treatment of Gender Dysphoria

6. In my current practice, I treat over 125 patients who have gender dysphoria.

7. I treat my patients based on their individual medical needs and follow the protocols for treatment set out by the World Professional Association for Transgender Health (WPATH) Standards of Care and clinical guidelines for treatment of gender dysphoria developed by the Endocrine Society. These standards recommend gender transition, including social transition, hormone therapy, and surgery depending on the age and medical needs of the patient.

8. The WPATH Standards of Care are recognized by the major medical and mental health groups in the United States–including the American Medical Association, the American Psychiatric Association, and the American Psychological Association–as the authoritative protocols for treating gender dysphoria.

9. Dr. Van Meter suggests that the WPATH Standards of Care should be disregarded because WPATH is "an agenda-driven advocacy organization." (Van Meter, ¶ 53). WPATH, like many other medical associations, is an organization of hundreds of professionals who work to share information about the best ways to treat a medical condition. Just like the American Diabetes Association or the American Heart

Association puts on conferences, develops guidelines for treatment, and educates its members and the community, so too does WPATH. Members of WPATH are invested in the care of individuals with gender dysphoria just like members of the American Diabetes Association are invested in the care of individuals with diabetes. This is not a "social and political agenda." It is about improving outcomes and treatment for individuals with medical needs.

10. The American College of Pediatricians, which rejects the well-established medical protocols for the treatment of gender dysphoria, is not the major medical association of pediatricians in this country. In fact, I had never heard of them until my involvement in this case. The American Academy of Pediatrics, which is the major pediatric professional association with approximately 66,000 members, has called for the repeal of North Carolina's HB 2. The CEO and Executive Director of the American Academy of Pediatrics called for repeal of H.B. 2, saying: "Adolescents who are transgender are already at heightened risk for violence, bullying and harassment, and are already more prone to depression and engaging in self-harm, including suicide . . . HB2 and other measures making their way through state legislatures across the country exacerbate those risks by creating hostile environments for transgender youth, all implying the same message; 'you're different, something is wrong with you, you need to change in order to fit in here.'" American Academy of Pediatrics, AAP News, "AAP calls for repeal of N.C. transgender law" (April 20, 2016) (http://www.aappublications.org/news/2016/04/20/Transgender042016

The Consensus Regarding treatment of Adolescents and Adults with Gender Dysphoria

11. The Defendants' experts mistakenly focus on questions related to the treatment of pre-pubertal children (i.e., pre-Tanner Stage 2, generally around age 10) to challenge well-established treatment protocols for adolescents and adults. There are different approaches within the community of experts treating gender dysphoria about how to treat pre-pubertal children. Some support social transition for pre-pubertal children and others, like Dr. Kenneth Zucker—who is cited repeatedly by Defendants—do not in most cases based in significant part on the fact that there are studies that found that many children with gender incongruence in early childhood did not have gender dysphoria by the time they reached adolescence.

12. When it comes to adolescents and adults, there is no evidence that gender incongruence ceases over time and there is a clear medical consensus recognized by the major medical associations (and Dr. Zucker, who is an author of the most recent WPATH Standards of Care) that gender transition–including social transition, hormone therapy and/or surgeries where medically necessary–is appropriate treatment. Defendants' conflation of pre-pubertal children and adolescents reflects their lack of knowledge about treatment in this field. In fact, the Diagnostic & Statistic Manual (DSM) has completely separate diagnoses for the condition in childhood and the condition in adolescence. *See* American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fifth Ed., "Gender Dysphoria in Children" and "Gender Dysphoria in Adolescents and Adults" (2013).

13. It is incorrect and unsupported by the data to suggest that studies on the treatment of gender incongruence and gender dysphoria in children who are pre-Tanner Stage 2 can be used to draw conclusions about the treatment of adolescents and adults with the condition. Such suggestions misrepresent the understanding and consensus view of experts who research and treat gender dysphoria.

14. For younger children who are pursuing social transition as part of a medically supervised treatment plan, that social transition includes use of single-sex spaces consistent with gender identity. For the young children that I treat, access to such spaces has greatly improved their health and well-being.

15. Dr. Van Meter's description of the nature of puberty blocking treatment for gender dysphoric patients is not accurate. This treatment has been used for decades on children with precocious puberty and none of the potential health consequences cited by Dr. Van Meter have been documented in that population. We only administer hormone blockers to delay the onset of puberty within the typical range. Even the articles cited by Dr. Van Meter to support his contentions in fact say the opposite of what he claims. For example, Dr. Van Meter claims that "[t]here is evidence that bone mineral density is irreversibly decreased if puberty blockers are used." (Van Meter, ¶ 44). But the article that Dr. Van Meter cites to support that claim says the opposite, concluding instead that the use of puberty blockers "is safe and reversible for the reproductive system, [Bone Mineral Density] BMD, and [Body Mass Index] BMI." (Van Meter, n. 25).

Sex Assignment and the Nature of Gender Identity

16. Dr. Mayer's opinion that "biological sex can still be defined strictly in terms of the structure of reproductive systems" is an extremely outdated view of biological sex. (Mayer, ¶ 29). In the past when assigning sex to an individual with sex-related characteristics that did not completely align as stereotypically male or stereotypically female, doctors would assign sex based solely on how the individual would be able to reproduce. This has long since been abandoned as an approach as even Defendants' other experts recognize in favor of a more nuanced approach that takes into account the range of sex-related characteristics with the goal of assigning sex consistent with gender identity.

17. The experience of Dr. John Money's patients discussed by Dr. Mayer demonstrates that a person's gender identity cannot be altered through socialization. The lessons of Dr. Money's failed experiments have significantly influenced how endocrinologists and other doctors assign sex for individuals with differences of sex development (DSDs)—that assignment should be based on gender identity, once it is known. For those of us involved in the care of infants with DSDs, we are deeply concerned about any permanent surgical treatment on an infant before the infant is able to communicate gender identity.

18. The occurrence of intersex conditions (also known as DSDs) are not "rare" as Drs. Hruz and Van Meter suggest. (Hruz, ¶ 20; Van Meter, ¶ 14). The statistic cited by Dr. Van Meter (one in every 4500 to 5500 births) refers to just one subset of intersex conditions—ambiguous genitalia at birth. The article he cites for that statistic also notes

that Klinefelter syndrome–a DSD–is estimated in one of 500 to 1000 births, and that "when all congenital genital anomalies are considered . . . the rate may be as high as [one in 200 to 300]." Lee PA et al., Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care, 2016 Horm Res Paediatr., at 159-60. *See* Exhibit A, ¶¶ 36-38 for a discussion of the nature of the more common intersex conditions. This makes DSDs significantly more common than other common genetic variations such as Down Syndrome, which occurs in approximately 1 in every 1,000 live births. See World Health Organization, Genes and Human Disease, http://www.who.int/genomics/public/geneticdiseases/en/index1.html.

Defendants' Experts are not Individuals Known in the Field of Treatment of Gender Dysphoria

19. To effectively treat my patients, I stay current on the research and literature in the field of treatment for gender dysphoria and I attend conferences and lectures where the latest research is discussed and clinicians share their experience. I have never seen any of the Defendants' experts at a conference or meeting regarding gender dysphoria; nor do I recognize their names as individuals who publish in this field.

20. Physicians who treat children and adolescents with gender dysphoria regularly encounter each other at meetings and conferences regarding treatment, even those of us who take different approaches to the management of the condition. For example, Dr. Kenneth Zucker, who is cited extensively by Drs. Hruz, Van Meter, and Mayer, is a member of WPATH and speaks regularly at meetings regarding the treatment of the condition. I have seen him speak twice in the past year.

21. As in any medical field, attending conferences and being part of a professional community of clinicians provides a doctor with an opportunity to learn about the clinical experience of hundreds of colleagues, which in turn informs the development of generally accepted practices of experts in the field. Clinical experience is an important part of the body of knowledge about any medical condition, including gender dysphoria.

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

Executed on this 13 day of September, 2016.

By: _____
Deanna Adkins, M.D.

Exhibit A

Adkins CV

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

JOAQUÍN CARCAÑO ET AL., *Plaintiffs*, v. PATRICK MCCRORY ET AL., *Defendants*.	No. 1:16-cv-00236-TDS-JEP

EXPERT DECLARATION OF DEANNA ADKINS, M.D.

PRELIMINARY STATEMENT

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this declaration. My professional background, experience, and publications are detailed in my curriculum vitae, a true and accurate copy which is attached as Exhibit A to this declaration. 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 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, adolescents, and young adults between the ages of 7 and 22 who have gender dysphoria and/or 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 90 transgender and intersex young people from North Carolina and across the southeast at the Gender Care Clinic. I have treated approximately 150 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 declaration, 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 declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

10. In the past four years, I have testified as an expert at trial or deposition in the following matter: *United States v. Oversby, Brandon R.*, SPC, U.S. Army, B Company (Second Judicial Circuit, Fort Bragg Oct. 15, 2014).

11. I am being compensated at an hourly rate for actual time devoted, at the rate of $275 per hour. 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") 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. Children usually become aware of their gender identity early in life.

19. 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.

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

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

22. 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.

HOW DO EXPERTS ASSIGN OR "DETERMINE" SEX?

23. From a medical perspective, the appropriate determinant of sex is gender identity.

24. For many people, gender identity aligns with the sex assigned to the individual at birth, so assigning sex based on sex-characteristics such as external genitalia is a proxy for assigning sex based on one's gender identity.

25. For transgender people and people with differences or disorders of sex development, however, 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.

26. 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.

27. Medical science has since recognized that appropriate treatment for individuals who are transgender 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.

28. 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 re-assign or re-classify the individual's sex to align with gender identity.

29. 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 or health of the child.

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

31. 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.

32. For individuals with gender dysphoria and individuals with differences of sex development, gender identity is the only medically supported determinant of sex when sex assignment as male or female is necessary. 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 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 simply because he was assigned female at birth.

33. 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 as male or female. Gender identity does and should control when there is a need to classify an individual as a particular sex.

34. 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"?

35. Rather than assign sex based on gender identity, North Carolina, because of H.B. 2, now by law requires sex assignment in single-sex facilities within public buildings to be based on "biological sex," defined as "the physical condition of being male or female, which is stated on a person's birth certificate." In addition to being

counter to medical science as explained above, this definition and conception of "biological sex" is inherently flawed.

36. 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 nor do they "determine" one's sex. Instead, sex-related characteristics include external genitalia, internal reproductive organs, gender identity, chromosomes, secondary sex characteristics and genes. 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.

37. 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.

38. 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 (CAH) 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 exstrophy 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, despite their female sex assignment. 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 non-transgender men, and thus develop masculine secondary sex characteristics.

39. As the examples above underscore, "biological sex" as used in H.B. 2 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.

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

Executed on 5/13, 2016.

By: _____
Deanna Adkins, M.D.

Expert Declaration of Deanna Adkins, M.D.

EXHIBIT A

CURRICULUM VITAE

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 Center for Child and Adolescent Gender Care

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

Birth Place: Albany, GA, USA

Citizen of: United States

Education	Institution	Date	Degree
High School	Tift County High School	1988	Diploma
College	Georgia Institute of Technology	1993	B.S. Molecular Bio. And Genetics
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
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 Center for 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. 2007 Jan;20(1):79-86. PMID: 17315533
2. **Gordon Worley MD[1*], Blythe Crissman MS CGC[2], Emily Cadogan BS MSI[4], Christie Milleson BA[2], Deanna W. Adkins MD[3], Priya Kishnani MD[4]**; DOWN SYNDROME DISINTEGRATIVE DISORDER: NEW-ONSET AUTISTIC REGRESSION, DEMENTIA, AND INSOMNIA IN OLDER CHILDREN AND ADOLESCENTS WITH DOWN SYNDROME

Non-Refereed Publications:

b. Selected Abstracts

1. **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 American Urological Association 2016
2. **Lydia Snyder, MD, Deanna Adkins, MD, Ali Calikoglu**, MD; Celiac Disease and Type 1 Diabetes: Evening of Scholarship UNC Chapel Hill 3/2015 poster
3. **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 06/2014
4. **Kellee M. Miller[1], David M. Maahs[2], Deanna W. Adkins[3], Sureka Bollepalli[4], Larry A. Fox[5], Joanne M. Hathway[6], Andrea K. Steck[2], Roy W. Beck[1] and**

Maria J. Redondo[7] for the T1D Exchange Clinic Network; Twins Concordant for Type 1 Diabetes in the T1D Exchange -poster at ADA scientific sessions 6/2014

5. **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
6. **Zeger, M.P.D., Adkins, D.W., White, K., Loechner, K.L.**: Opsismodysplasia and Hypophosphatemic Rickets. Pediatric Research Suppl.-from PAS 2005

c: Editorials, Position, and Background Papers

1. **Reviewer Hormone Research, lancet, NC Medical journal**
2. **Reviewer AAP National meeting COCIT submissions**
3. **Review International Journal of Pediatric Endocrinology**
4. **Pediatric OnCall Reviewer Panel**
5. **Journal of Pediatrics Reviewer**

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
American Pediatric Program Directors

Human Rights Campaign
-pediatric and adolescent transgender advisory committee

American Diabetes Association

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

Research:

Novo Nordisk Growth Hormone Registry-closed
Exubera inhaled insulin-trial ended
Type 1 Diabetes Exchange PI-ongoing
Celiac and Type 1 diabetes-collaboration with UNC Chapel Hill-complete publication in process
Metabolic Bone Disease in neonates
Service over education in residency and fellowship-start-up phase
EPA study for pediatric subspecialties-ongoing multicenter study pending publications
Oral Tolvaptan in hyponatremia clinical trial ongoing

Expert Declaration of Deanna Adkins, M.D.

EXHIBIT B

Bibliography

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Wylie C. Hembree et al.; Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline; *J Clin Endocrinol Metab*, September 2009, 94 (9):3132–3154

Melissa Hines; Prenatal endocrine influences on sexual orientation and on sexually differentiated childhood behavior; *Frontiers in Neuroendocrinology* 32 (2011) 170–182.

Elseline Hoekzemaa, et al.**;** Regional volumes and spatial volumetric distribution of gray matter in the genderdysphoric *Psychoneuroendocrinology* (2015) 55, 59—71.

Pasterski V, Zucker KJ, Hindmarsh PC, Hughes IA, Acerini C, Spencer D, Neufeld S, Hines M.; *Arch Sex Behav*. Increased Cross-Gender Identification Independent of Gender Role Behavior in Girls with Congenital Adrenal Hyperplasia: Results from a Standardized Assessment of 4- to 11-Year-Old Children. 2015 Jul; 44 (5):1363-75.

Lee Pa, et al.; Global DSD Update Consortium; Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care**.** *Horm Res Paediatr*. 2016; 85(3):158-80.

Exhibit C

Exhibit C to Borelli Decl.: *Amici Curiae* Brief of Medical and Mental Health Organizations

No. 15-2056

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

G.G., by his next friend and mother, **DEIRDRE GRIMM**,

Plaintiff-Appellant,

v.

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant-Appellee.

On Appeal from the United States District Court
for the Eastern District of Virginia
Newport News Division

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN COLLEGE OF PHYSICIANS, AND 14 ADDITIONAL MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFF-APPELLANT

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DISCLOSURE OF CORPORATE AFFILIATIONS AND OTHER INTERESTS

FRAP RULE 26.1 and LOCAL RULE 26.1

Pursuant to FRAP 26.1 and Local Rule 26.1, American Academy of Pediatrics, the American Psychiatric Association, the American College of Physicians, the American Academy of Child and Adolescent Psychiatry, the American Academy of Family Physicians, the American Academy of Nursing, the American Academy of Physician Assistants, the American Medical Women's Association, the American Nurses Association, the American Psychoanalytic Association, the Association of Medical School Pediatric Department Chairs, the Endocrine Society, GLMA: Health Professionals Advancing LGBT Equality, Mental Health America, the National Association of Social Workers, the Society for Adolescent Health and Medicine, and the Society for Physician Assistants in Pediatrics, who are *amici curiae*, make the following disclosure:

1. No *amicus* is a publicly held corporation or other public entity.
2. No *amicus* has any parent corporations.
3. No publicly held corporation or other publicly held entity owns 10% or more of the stock of any of the *amici*.
4. No publicly held corporation or other publicly held entity has a direct financial interest in the outcome of the litigation.
5. This case does not arise out of a bankruptcy proceeding.

Dated: May 15, 2017

JENNER & BLOCK LLP

/s/ Scott B. Wilkens

Scott B. Wilkens

Counsel for Amici American Academy of Pediatrics, et al.

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/s/ Aaron M. Panner

Aaron M. Panner

Counsel for Amicus Curiae American Psychiatric Association

TABLE OF CONTENTS

TABLE OF AUTHORITIES

INTEREST OF *AMICI CURIAE*[1]

Amici are 17 leading medical and mental health organizations: the American Academy of Pediatrics, the American Psychiatric Association, the American College of Physicians, the American Academy of Child and Adolescent Psychiatry, the American Academy of Family Physicians, the American Academy of Nursing, the American Academy of Physician Assistants, the American Medical Women's Association, the American Nurses Association, the American Psychoanalytic Association, the Association of Medical School Pediatric Department Chairs, the Endocrine Society, GLMA: Health Professionals Advancing LGBT Equality, Mental Health America, the National Association of Social Workers, the Society for Adolescent Health and Medicine, and the Society for Physician Assistants in Pediatrics.

Collectively, *amici* represent hundreds of thousands of physicians and mental health professionals, including specialists in pediatrics and adolescent care, family medicine, internal medicine, and endocrinology; over one hundred thousand physician assistants; and millions of nurses. *Amici* share a commitment to improving

[1] *Amici* hereby certify that no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money intended to fund preparation or submission of this brief, and no person other than *amici* and their counsel contributed money intended to fund preparation or submission of the brief. The parties have consented to the filing of this brief.

the physical and mental health of all Americans—regardless of gender identity—and to informing and educating lawmakers, the judiciary, and the public regarding the public health impacts of laws and policies.

Amici submit this brief to inform the Court of the medical consensus regarding what it means to be transgender; the protocols for the treatment of gender dysphoria; and the predictable harms to the health and well-being of transgender adolescents when they are excluded from restrooms that match their gender identity.

SUMMARY OF ARGUMENT

Transgender individuals have a gender identity that is incongruent with the sex they were assigned at birth. The medical community's understanding of what it means to be transgender has advanced greatly over the past century. It is now understood that being transgender implies no impairment in a person's judgment, stability, or general social or vocational capabilities. According to recent estimates, approximately 1.4 million transgender adults live in the United States—0.6 percent of the adult population.

Many transgender individuals, like Plaintiff-Appellant, have a condition called gender dysphoria, which is characterized by clinically significant distress and impairment of function resulting from the incongruence between one's gender identity and the sex assigned at birth. The international medical consensus regarding treatment for gender dysphoria is to assist the patient to live in accordance with his or her gender identity, thus alleviating the distress. Treatment may include any or all of the following: counseling, social transition (through, *e.g.*, use of a new name and pronouns; new clothes and grooming; and use of single-sex facilities, including restrooms, most consistent with the individual's gender identity), and hormone therapy and surgical interventions.

Access to single-sex facilities that correspond to one's gender identity is a critical aspect of social transition and, thus, successful treatment of gender

dysphoria. By contrast, excluding transgender individuals from facilities consistent with their gender identity undermines their treatment; exposes them to stigma and discrimination; harms their physical health by causing them to avoid restroom use; and impairs their social and emotional development. Similarly, transgender students who must use separate facilities that other students are not required to use are at risk of being bullied and discriminated against and suffer psychological harm. The stigma and minority stress that result from discrimination can, in turn, lead to poorer health outcomes for transgender individuals.

ARGUMENT

I. What It Means To Be Transgender And To Suffer From Gender Dysphoria

Transgender individuals have a "gender identity"—a "deeply felt, inherent sense" of their gender—that is not aligned with the sex assigned to them at birth.[2] Transgender people differ from cisgender (*i.e.*, non-transgender) individuals, whose gender identity aligns with the sex assigned at birth.[3]

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[2] Am. Psychol. Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 Am. Psychologist 832, 834 (2015) **[hereinafter "Am. Psychol. Ass'n Guidelines"]**; *see also* David A. Levine & Comm. on Adolescence, Am. Acad. of Pediatrics Technical Report, *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, 132 Pediatrics e297, 298 (2013) **[hereinafter "AAP Technical Report"]**. Although most people have a gender identity that is male or female, some individuals have a gender identity that is "a blend of male or female[,] or an alternative gender." Am. Psychol. Ass'n Guidelines at 834.

[3] Am. Psychol. Ass'n Guidelines, *supra*, at 861.

Recent estimates suggest that approximately 1.4 million transgender adults live in the United States, or 0.6 percent of the adult population.[4] That said, "population estimates likely underreport the true number of [transgender] people."[5] People of all different races and ethnicities identify as transgender.[6] They live in every state, serve in our military, and raise children.[7] Gender identity is distinct from and does not predict sexual orientation; transgender people, like cisgender people, may identify as heterosexual, gay, lesbian, bisexual, or asexual.[8]

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[4] Andrew R. Flores et al., The Williams Inst., *How Many Adults Identify as Transgender in the United States?* 2 (2016), http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

[5] Am. Psychol. Ass'n Guidelines, *supra*, at 832.

[6] *See* Halley P. Crissman et al., *Transgender Demographics*: *A Household Probability Sample of US Adults, 2014*, 107 Am. J. Pub. Health 213, 214-15 (2017); Andrew R. Flores et al., The Williams Inst., *Race and Ethnicity of Adults Who Identify as Transgender in the United States* 2 (2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Race-and-Ethnicity-of-Transgender-Identified-Adults-in-the-US.pdf.

[7] Gary J. Gates & Jody L. Herman, The Williams Inst., *Transgender Military Service in the United States* (2014), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Transgender-Military-Service-May-2014.pdf; Sandy E. James et al., Nat'l Center for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 2 (2016), http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf; Rebecca L. Stotzer et al., The Williams Inst., *Transgender Parenting: A Review of Existing Research* (2014), http://williamsinstitute.law.ucla.edu/research/parenting/transgender-parenting-oct-2014.

[8] Am. Psychol. Ass'n Guidelines, *supra*, at 835-36; James et al., Nat'l Center for Transgender Equality, *Report of the 2015 U.S. Transgender Survey*, *supra*, at 246.

The medical profession's understanding of gender has advanced considerably over the past fifty years. Throughout much of the twentieth century, individuals who were not gender conforming were often viewed as "perverse or deviant."[9] Practices during that period tried to "correct" this perceived deviance by attempting to force transgender people to live in accordance with the sex assigned to them at birth. These efforts failed and caused significant harm to the individuals subjected to them.[10]

Much as our professions recognize that homosexuality is a normal form of human sexuality—and that stigmatizing gay people causes significant harm—we now recognize that being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."[11]

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[9] Am. Psychol. Ass'n, *Report of the APA Task Force on Gender Identity and Gender Variance* 26-27 (2008), https://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf **[hereinafter "Am. Psychol. Ass'n Task Force Report"]**.

[10] *Id.*; Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* 13, 25 (2015), http://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf.

[11] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (2012), https://psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2012-Transgender-Gender-Variant-Discrimination.pdf.

A. Gender Identity

"[G]ender identity" refers to a person's internal sense of being male, female, or another gender.[12] Every person has a gender identity,[13] which cannot be altered voluntarily[14] or ascertained immediately after birth.[15] Many children develop stability in their gender identity between ages 3 and 4.[16]

"[G]ender expression refers to the way a person communicates gender identity to others through behavior, clothing, hairstyles, voice, or body characteristics."[17] There are many individuals who depart from stereotypical male and female

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[12] Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People, Gender Identity, and Gender Expression* 1 (2014), http://www.apa.org/topics/lgbt/transgender.pdf.

[13] *See* Caitlin Ryan, Family Acceptance Project, *Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual, & Transgender Children*, 17 (2009), http://familyproject.sfsu.edu/sites/default/files/FAP_English%20Booklet_pst.pdf.

[14] Colt Meier & Julie Harris, Am. Psychol. Ass'n, *Fact Sheet: Gender Diversity and Transgender Identity in Children* 1, http://www.apadivisions.org/division-44/resources/advocacy/transgender-children.pdf; *see also* Am. Acad. of Pediatrics, *Gender Identity Development in Children* (2015), https://healthychildren.org/English/ages-stages/gradeschool/Pages/Gender-Identity-and-Gender-Confusion-In-Children.aspx.

[15] Am. Psychol. Ass'n Guidelines, *supra*, at 862.

[16] *Id.* at 841. "Although gender identity is usually established in childhood, individuals may become aware that their gender identity is not in full alignment with sex assigned at birth in childhood, adolescence, or adulthood." *Id.* at 836.

[17] Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People*, *supra*, at 1.

appearances and roles, but who are not transgender.[18] Indeed, most people who express their gender in a non-stereotypical or non-conforming manner are or become comfortable with the sex they were assigned at birth.[19] In contrast, a transgender boy or transgender girl "consistently, persistently, and insistently" identifies as a gender different than the sex they were assigned at birth.[20]

Psychologists, psychiatrists, and neuroscientists are not certain why some people are transgender. Some research suggests there may be biological influences,[21] including, for example, exposure of natal females to elevated levels of

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[18] Ethan C. Cicero & Linda M. Wesp, *Supporting the Health and Well-Being of Transgender Students*, J. Sch. Nursing 1, 6 (2017).

[19] World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* 5 (7th Version, 2011), http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655 **[hereinafter "WPATH Standards of Care"]**.

[20] *See* Meier & Harris, *Fact Sheet: Gender Diversity and Transgender Identity in Children*, *supra*, at 1; *see also* Cicero & Wesp, *Supporting the Health and Well-Being of Transgender Students*, *supra*, at 6.

[21] *See* Am. Acad. of Pediatrics, *Gender Non-Conforming & Transgender Children* (2015), https://healthychildren.org/English/ages-stages/gradeschool/Pages/Gender-Non-Conforming-Transgender-Children.aspx; Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1895 (2008).

testosterone in the womb.[22] Brain scans and neuroanatomical studies of transgender individuals may also support these biological explanations.[23]

B. Gender Dysphoria

Being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."[24] However, many transgender individuals are diagnosed with gender dysphoria, a condition that is characterized by debilitating distress and anxiety resulting from the incongruence between an individual's gender identity and birth-assigned sex.[25]

1. The Diagnostic Criteria And Seriousness Of Gender Dysphoria

The Diagnostic and Statistical Manual of Mental Disorders codifies the diagnostic criteria for gender dysphoria in adolescents and adults as follows: "A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two" out of six criteria, and "clinically significant distress or impairment in social, occupational, or

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[22] Arianne B. Dessens et al., *Gender Dysphoria and Gender Change in Chromosomal Females with Congenital Adrenal Hyperplasia*, 34 Arch. Sexual Behav. 389, 395 (2005).

[23] *See, e.g.*, Francine Russo, *Is There Something Unique About the Transgender Brain?* Sci. Am. (Jan. 1, 2016), https://www.scientificamerican.com/article/is-there-something-unique-about-the-transgender-brain/.

[24] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals*, *supra*.

[25] Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 451-53 (5th ed. 2013) **[hereinafter "DSM-5"]**.

other important areas of functioning."[26] The six criteria include (1) "[a] marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics"; (2) "[a] strong desire to be rid of one's primary and/or secondary sex characteristics"; (3) "[a] strong desire for the primary and/or secondary sex characteristics of the other gender"; (4) "[a] strong desire to be of the other gender (or some alternative gender)"; (5) "[a] strong desire to be treated" as a gender different from one's assigned gender; and (6) "[a] strong conviction that one has the typical feelings and reactions" of a different gender.[27]

Transgender children often experience intensified gender dysphoria and worsening mental health as the hormonal and anatomical changes associated with puberty cause the body to develop in ways that diverge from the child's gender identity.[28] For instance, a deepening voice for male-assigned individuals or the growth of breasts and the beginning of a menstrual cycle for female-assigned individuals can cause severe distress.

If untreated, gender dysphoria can cause debilitating distress, depression, impairment of function, substance use, self-mutilation to alter one's genitals or

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[26] *Id.*

[27] *Id.* at 452.

[28] Am. Psychol. Ass'n Task Force Report, *supra*, at 45; Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 3.

secondary sex characteristics, other self-injurious behaviors, and suicide.[29] Transgender individuals also are frequently subjected to prejudice and discrimination in multiple areas of their lives, which exacerbates these negative health outcomes.[30]

2. The Accepted Treatment Protocols For Gender Dysphoria

Until the middle of the twentieth century, most mental health practitioners treated transgender people by attempting to make the patient's gender identity consistent with the sex assigned at birth.[31] There is no evidence that these methods alleviate gender dysphoria or that they can prevent someone from being transgender.[32] To the contrary, they can "often result in substantial psychological

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[29] *See, e.g.*, DSM-5, *supra*, at 455, 458; Stephanie A. Brill & Rachel Pepper, *The Transgender Child: A Handbook for Families and Professionals* 202 (2008) (discussing risk of self-mutilation).

[30] Michael L. Hendricks & Rylan J. Testa, *A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model*, 43 Prof'l Psychol.: Research & Practice 460 (2012); Jessica Xavier et al, Va. Dep't of Health, *The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians* (2007), http://www.vdh.virginia.gov/content/uploads/sites/10/2016/01/THISFINALREPORTVol1.pdf.

[31] Am. Psychol. Ass'n Guidelines, *supra*, at 835; Jack Drescher, *Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual*, 39 Arch. Sexual Behav. 427, 436-40 (2010).

[32] Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 26; Jack Drescher, *Controversies in Gender Diagnoses*, 1 LGBT Health 9, 12 (2013).

pain by reinforcing damaging internalized attitudes,"[33] and can damage family relationships and individual functioning by increasing feelings of shame.[34]

In the last few decades, transgender people and those suffering from gender dysphoria have gained widespread access to gender-affirming psychological and medical support.[35] For over 30 years, the generally-accepted treatment protocols for gender dysphoria[36] have aimed at alleviating the distress associated with the incongruence between gender identity and birth-assigned sex.[37] These protocols are laid out in the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (Version 7)* developed by the World Professional Association for Transgender Health ("WPATH").[38] Many of the major medical and mental health groups in the United States recognize the WPATH Standards of Care

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[33] Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression* (2012), http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender.

[34] Darryl B. Hill et al., *An Affirmative Intervention for Families with Gender Variant Children: Parental Ratings of Child Mental Health and Gender*, 36 J. Sex & Marital Therapy 6, 10 (2010); Robert Wallace & Hershel Russell, *Attachment and Shame in Gender-Nonconforming Children and Their Families: Toward a Theoretical Framework for Evaluating Clinical Interventions*, 14 Int'l J. Transgenderism 113, 119-20 (2013).

[35] Am. Psychol. Ass'n Guidelines, *supra*, at 835; WPATH Standards of Care, *supra*, at 8-9.

[36] Earlier versions of the DSM used different terminology, *e.g.*, gender identity disorder, to refer to this condition. Am. Psychol. Ass'n Guidelines, *supra*, at 861.

[37] Am. Med. Ass'n, Comm. on Human Sexuality, *Human Sexuality* 38 (1972).

[38] WPATH Standards of Care, *supra*.

as representing the consensus of the medical and mental health community regarding the appropriate treatment for gender dysphoria.[39]

The recommended treatment for transgender people with gender dysphoria includes assessment, counseling, and, as appropriate, social transition, puberty-blocking drug treatment, hormone therapy, and surgical interventions to bring the body into alignment with one's gender identity.[40] However, each patient

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[39] Am. Med. Ass'n House of Delegates, Resolution 122 (A-08), *Removing Financial Barriers to Care for Transgender Patients* 1 (2008); Am. Psychol. Ass'n Task Force Report, *supra*, at 32; AAP Technical Report, *supra*, at 307-08.

[40] Am. Psychol. Ass'n Task Force Report, *supra*, at 32-39; Am. Psychol. Ass'n & Nat'l Ass'n of Sch. Psychologists, *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools* (2015), http://www.apa.org/about/policy/orientation-diversity.aspx **[hereinafter "APA/NASP Resolution"]**; Am. Psychiatric Ass'n Workgroup on Treatment of Gender Dysphoria, *Assessment and Treatment of Gender Dysphoria and Gender Variant Patients: A Primer for Psychiatrists* 16-18 (2016); AAP Technical Report, *supra*, at 307-09. Some clinicians still offer versions of "reparative" or "conversion" therapy based on the idea that being transgender is a mental disorder. However, all of the leading medical professional organizations have explicitly rejected such treatments. *See* Am. Med. Ass'n, Policy Number H-160.991, *Health Care Needs of Lesbian, Gay, Bisexual, and Transgender Populations* (rev. 2016), https://searchpf.ama-assn.org/SearchML/searchDetails.action?uri=%2FAMA Doc%2FHOD.xml-0-805.xml; Am. Sch. Counselor Ass'n, *The School Counselor and LGBTQ Youth* (2016), https://www.schoolcounselor.org/asca/media/asca/PositionStatements/PS_LGBTQ.pdf; Hillary Daniel et al., *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians*, 163 Annals Internal Med. 135, 136 (2015); AAP Technical Report, *supra*, at 301; Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression*, *supra*.

requires an individualized treatment plan that accounts for the patient's specific needs.[41]

Social transition—*i.e.*, living one's life fully in accordance with one's gender identity—is often a critically important part of treatment. This typically includes publicly identifying oneself as that gender; adopting a new name; using different pronouns; grooming and dressing in a manner typically associated with one's gender identity; and using restrooms and other single-sex facilities consistent with that identity.[42] Transgender children who live in accordance with their gender identity in all aspects of life have lower rates of depression compared to transgender children who have not socially transitioned.[43]

For some adults and adolescents, hormone treatment to feminize or masculinize the body may be medically necessary to treat their gender dysphoria.[44]

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[41] Am. Psychol. Ass'n Task Force Report, *supra*, at 32.

[42] AAP Technical Report, *supra*, at 308; Am. Psychol. Ass'n Guidelines, *supra*, at 840.

[43] Lily Durwood et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. Child & Adolescent Psychiatry 116 (2017); Kristina R. Olson et al., *Mental Health of Transgender Children Who Are Supported in Their Identities*, 137 Pediatrics 1 (2016).

[44] Am. Med. Ass'n House of Delegates, Resolution 122 (A-08), *Removing Financial Barriers to Care for Transgender Patients*, *supra*, at 1; Am. Psychol. Ass'n Guidelines, *supra*, at 861, 862; Madeline B. Deutsch, Center of Excellence for Transgender Health, University of California, San Francisco, *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* 23 (2d ed. 2016); WPATH Standards of Care, *supra*, at 33, 54.

Both the Endocrine Society and the Lawson Wilkins Pediatric Endocrine Society consider these treatments to be the standard of care for gender dysphoria.[45] A transgender boy undergoing hormone treatment, for example, will be exposed to the same levels of testosterone as other boys who go through male puberty; and just as they would in any other boy, these hormones will affect most of his major body systems.[46] Hormone treatment alters the appearance of the patient's genitals and produces secondary sex characteristics such as increased muscle mass, increased facial hair, and a deepening of the voice in transgender boys and men, and breast growth and decreased muscle mass in transgender girls and women.[47] For children experiencing the onset of puberty, treatment may include medication to prevent further progression of puberty ("puberty blockers").[48] This fully reversible treatment allows children with gender dysphoria to delay the development of secondary sex characteristics that do not match their gender identity, giving them

[45] *See* Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. Clinical Endocrinology & Metabolism 3132, 3132 (2009); *see also* Alessandra D. Fisher et al., *Cross-Sex Hormone Treatment and Psychobiological Changes in Transsexual Persons: Two-Year Follow-Up Data*, 101 J. Clinical Endocrinology & Metabolism 4260 (2016).

[46] Hembree et al., *Endocrine Treatment of Transsexual Persons*, *supra*, at 3132-33; *see also* Brill & Pepper, *The Transgender Child*, *supra*, at 217.

[47] Hembree et al., *Endocrine Treatment of Transsexual Persons*, *supra*, at 3140-45.

[48] *Id.* at 3138.

additional time to decide whether hormone treatment to feminize or masculinize the body is appropriate.[49]

Surgical interventions may also be an appropriate and medically necessary treatment for some patients. These procedures could include chest reconstruction surgery for transgender men, breast augmentation (*i.e.* implants) for transgender women, or genital surgery.[50] Studies show these procedures are effective in reducing gender dysphoria and improving mental health.[51] Because these surgical procedures are largely irreversible, some are recommended only for transgender individuals who have reached the age of legal majority.[52]

Ultimately—regardless of the particular treatments required for a specific individual and when such treatment begins—the goal is for individuals with gender dysphoria to experience "identity integration," where "being transgender is no

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[49] *Id.* at 3133, 3140-41; Am. Psychol. Ass'n Guidelines, *supra*, at 842; WPATH Standards of Care, *supra*, at 18-20.

[50] Hembree et al., *Endocrine Treatment of Transsexual Persons*, *supra*, at 3148-49; *see also* WPATH Standards of Care, *supra*, at 57-58.

[51] William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 Arch. Sexual Behav. 759, 778-79 (2012); Annelou L.C. de Vries, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014).

[52] WPATH Standards of Care, *supra*, at 21.

longer the most important signifier of one's identity" and the individual can refocus on their relationships, school, jobs, and other life activities.[53]

Some who oppose the medical protocols for gender dysphoria—including Dr. Paul R. McHugh et al.—claim that most gender dysphoric children "desist" and ultimately have a gender identity that matches their sex assigned at birth.[54] In fact, studies indicate that children who actually are transgender—those who persistently, consistently, and insistently identify as a gender other than the sex assigned at birth (as distinguished from gender non-conforming children generally)—are unlikely to desist.[55] Moreover, McHugh et al. conflate the vastly different experiences of pre-

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[53] Walter Bockting & Eli Coleman, *Developmental Stages of the Transgender Coming-Out Process: Toward an Integrated Identity*, *in Principles of Transgender Medicine and Surgery* 137, 153 (Randi Ettner, Stan Monstrey & Eli Coleman eds., 2d ed. 2016).

[54] Brief of *Amici Curiae* Dr. Paul R. McHugh, M.D., et al. in Support of Petitioner at 12, *Gloucester County School Board v. G.G. ex rel. Grimm*, 137 S. Ct. 1239 (2017) (No. 16-273), 2017 WL 219355.

[55] *See, e.g.*, Am. Acad. of Pediatrics, *Gender Non-Conforming & Transgender Children*, *supra* ("Research suggest that children who are persistent, consistent, and insistent about their gender identity are the ones who are most likely to become transgender adults."); Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-up Study*, 8 J. Sexual Med. 2276, 2281 (2011); Thomas D. Steensma et al., *Desisting and Persisting Gender Dysphoria after Childhood: A Qualitative Follow-up Study*, 16 Clinical Child Psychol. & Psychiatry 499, 504, 505 (2011); Madeleine S.C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual Outcome of Gender-Dysphoric Children*, 47 J. Am. Acad. Child & Adolescent Psychiatry 1413, 1420-21 (2008). The research relied on by opponents of the standard protocols tracked broad groups of prepubertal children who were referred to clinics for gender expansive non-conforming behavior, and counted any child who did not return for follow-up treatment as someone who desisted, thereby running "a strong risk of inflating estimates of the

pubertal children and adolescents.[56] There is no evidence that adolescents, like Plaintiff-Appellant, whose gender identities do not match their birth-assigned sex, are likely to desist.[57] For these reasons, among others, nearly 600 academics and clinicians with expertise in gender development have challenged Dr. McHugh's work.[58]

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number of youth" who desist. Am. Psychol. Ass'n Guidelines, *supra*, at 842; *see also* Thomas D. Steensma & Peggy Cohen-Kettenis, *More Than Two Development Pathways in Children with Gender Dysphoria?*, 54 J. Am. Acad. Child & Adolescent Psychiatry 147, 147 (2015).

[56] The McHugh et al. brief filed in the Supreme Court relies substantially on a publication of the American College of Pediatricians that Dr. McHugh co-authored, and an article written by the College's president, Michelle Cretella. The American College of Pediatricians "does not acknowledge the scientific and medical evidence regarding sexual orientation, sexual identity, sexual health, or effective health education." Am. Acad. of Pediatrics, *Just the Facts About Sexual Orientation and Youth* (Apr. 13, 2010), https://web.archive.org/web/20101119095249/http://aap.org/featured/sexualorientation.htm (alerting school administrators to a campaign by the College, "which is in no way affiliated with the American Academy of Pediatrics," and encouraging school officials, parents, and youth to "utilize the AAP developed and endorsed resources on this issue for reliable, sound, scientific, medical advice").

[57] De Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, *supra*; Am. Psychol. Ass'n Task Force Report, *supra*, at 48; Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, *supra*, at 763 ("GID that persists into adolescence is more likely to persist into adulthood."); Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 3.

[58] Letter dated Mar. 22, 2017, https://medschool.vanderbilt.edu/lgbti/files/lgbti/publication_files/ExpertLGBTIConcensusLetter.pdf; *see also* Chris Beyrer, Robert W. Blum, & Tonia C. Poteat, Opinion, *Hopkins Faculty Disavow 'Troubling' Report on Gender and Sexuality*, Balt. Sun, Sept. 28, 2016, http://www.baltimoresun.com/news/opinion/oped/bs-ed-lgbtq-hopkins-20160928-story.html.

Thus, while there are those like McHugh et al. who oppose the medical consensus regarding gender dysphoria—as there are outliers in every area of medicine—the protocols discussed above are well-established in the fields of medicine and psychology.

II. Excluding Transgender Individuals From Facilities Consistent With Their Gender Identity Endangers Their Health, Safety, And Well-Being.

Transgender students should have access to the sex-segregated facilities, activities, and programs that are *consistent* with their gender identity—including but not limited to bathrooms, locker rooms, sports teams, and classroom activities.[59] Evidence confirms that policies excluding transgender individuals from facilities consistent with their gender identity (hereinafter, "exclusionary policies") have detrimental effects on the physical and mental health, safety, and well-being of transgender individuals. And while schools like Gloucester High School often provide private restrooms for any student who seeks greater privacy for any reason, forcing transgender students to use those separate facilities sends a stigmatizing message that can have a lasting and damaging impact on the health and well-being of the young person.

In contrast, there is no evidence of any harm to the physical or mental health of other children and adolescents when transgender students use facilities that match

[59] APA/NASP Resolution, *supra*, at 9.

their gender identity. *Amici* are not hearing from their members about students experiencing any such harm—even though numerous states and school districts have policies allowing transgender individuals to use restrooms that match their gender identity.

A. Exclusionary Policies Exacerbate Gender Dysphoria And Are Contrary To Widely Accepted, Evidence-Based Treatment Protocols.

For transgender individuals, being treated differently from other men and women can cause tremendous pain and harm.[60] Indeed, exclusionary polices that force transgender people to disregard or deny their gender identity every time they must use a restroom disrupt medically appropriate treatment protocols. While those protocols provide that transgender individuals should live all aspects of their life in the gender with which they identify, *see supra* at 11-19, exclusionary policies require transgender individuals to live one facet of their lives in contradiction with their gender identity. As a result, exclusionary policies threaten to exacerbate the risk of "anxiety and depression, low self-esteem, engaging in self-injurious behaviors, suicide, substance use, homelessness, and eating disorders among other adverse outcomes" that many transgender individuals face.[61] Those risks are already all too serious: in a comprehensive survey of over 27,000 transgender individuals, 40

[60] *See, e.g.*, Sam Winter et al., *Transgender People: Health at the Margins of Society*, 388 Lancet 390, 394 (2016).

[61] APA/NASP Resolution, *supra*, at 4.

percent reported a suicide attempt—a rate *nine times* that reported by the general U.S. population.[62]

B. Exclusionary Policies Expose Transgender Individuals To Harassment And Abuse.

Exclusionary policies expose transgender individuals to harassment and abuse by forcing them to occupy gender-segregated spaces where their presence may be met with hostility, harassment, and abuse. For example, transgender men are visually recognized as men by other individuals; the presence of a transgender man in a women's restroom would be just as alarming as the presence of a cisgender man in the same women's restroom.

Exclusionary policies thus force transgender individuals to disclose their transgender status, because it is only transgender individuals who must use facilities that are incongruent with their gender identity and how they live and are recognized in the world. Because some children will have transitioned before they arrive in a particular school, exclusionary policies may be the only way that they are forcibly "outed" to their peers as transgender.

Such compelled disclosure of one's transgender status is harmful for at least two reasons. First, control over the circumstances in which a person may choose to disclose being transgender is fundamental to the development of individuality and

[62] James et al., Nat'l Center for Transgender Equality, *Report of the 2015 U.S. Transgender Survey*, *supra*, at 114.

autonomy.[63] Exclusionary policies rob transgender individuals of the personal choice regarding whether and when to reveal their transgender status. Disclosure of one's status as transgender is often anxiety-inducing and fraught; it is critical to a person's sense of safety, privacy, and dignity to have control over when and how that information is shared.

Second, such compelled disclosure exposes transgender individuals to the risk of harassment or abuse. In a 2013 survey, 68 percent of transgender respondents reported experiencing at least one instance of verbal harassment, and 9 percent reported suffering at least one instance of physical assault in gender-segregated bathrooms.[64]

These harms affect youth and adults alike. "[M]any gender and sexual orientation diverse children and adolescents experience harassment, bullying, and physical violence in school environments."[65] Because unwanted disclosure may cause such significant harm, the American Academy of Pediatrics' guidance states

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[63] Am. Acad. of Pediatrics, *American Academy of Pediatrics Opposes Legislation that Discriminates Against Transgender Children* (Apr. 18, 2016), https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAPOpposesLegislationAgainstTransgenderChildren.aspx.

[64] Jody L. Herman, *Gendered Restrooms and Minority Stress: The Public Regulation of Gender and its Impact on Transgender People's Lives*, 19 J. Pub. Mgmt. & Soc. Pol'y 65, 73 (2013).

[65] APA/NASP Resolution, *supra*, at 5; *see* Joseph G. Kosciw et al., GLSEN, *The 2015 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth In Our Nation's Schools* 12 (2016).

that care should be confidential, and it is not the role of the pediatrician to inform parents/guardians about a patient's sexual identity or behavior as doing so could expose the patient to harm.[66] Indeed, the American Academy of Pediatrics announced its opposition to exclusionary policies by noting that they undermine children's ability "to feel safe where they live and where they learn."[67]

C. Exclusionary Policies Exacerbate Stigma And Discrimination, Leading To Negative Health Outcomes.

It is well documented that transgender individuals experience widespread prejudice and discrimination, and that this discrimination frequently takes the form of violence, harassment, or other abuse.[68] For example, in a Virginia survey of transgender individuals, 50 percent of participants reported that they had experienced discrimination in healthcare, employment, or housing, and many individuals had experienced discrimination in more than one area.[69]

Exclusionary policies perpetuate such stigma and discrimination, both by forcing transgender individuals to disclose their status, and by marking transgender

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[66] AAP Technical Report, *supra*, at 305.

[67] Am. Acad. of Pediatrics, *American Academy of Pediatrics Opposes Legislation that Discriminates Against Transgender Children*, *supra*.

[68] Jamie M. Grant et al., Nat'l Center for Transgender Equality, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* 2-8 (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

[69] Judith Bradford et al., *Experiences of Transgender-Related Discrimination and Implications for Health: Results from the Virginia Transgender Health Initiative Study*, 103 Am. J. Pub. Health 1820, 1825 (2013).

individuals as "others" who are unfit to use the restrooms used by everyone else. Such policies inherently convey the state's judgment that transgender individuals are different and deserve inferior treatment.

Research increasingly shows that stigma and discrimination can have deleterious health consequences,[70] including striking effects on the daily functioning and emotional and physical health of transgender persons.[71] A 2012 study of transgender adults found a rate of hypertension twice that in the general population, which it attributed to the known effects of emotions on cardiovascular health.[72] Another study concluded that "living in states with discriminatory policies . . . was associated with a statistically significant increase in the number of psychiatric disorder diagnoses."[73] And a third study demonstrated that past school victimization may result in greater risk for post-traumatic stress disorder, depression, anxiety, and

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[70] *See generally* Am. Psychol. Ass'n, *Stress in America: The Impact of Discrimination* (2016), https://www.apa.org/news/press/releases/stress/2015/impact-of-discrimination.pdf.

[71] *See, e.g.,* Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression*, *supra* ("bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health").

[72] Randi Ettner et al., *Secrecy and the Pathophysiology of Hypertension*, Int'l J. Family Med. (2012).

[73] Bradford et al., *Experiences of Transgender-Related Discrimination and Implications for Health*, *supra*, at 1827.

suicidality.[74] As the American Psychological Association has concluded, "the notable burden of stigma and discrimination affects minority persons' health and well-being and generates health disparities."[75] There is thus every reason to anticipate that exclusionary policies will negatively affect the health of transgender individuals.

D. Exclusionary Policies Lead To Avoidance Of Restroom Use, Harming Physical Health.

Exclusionary policies have more immediate health effects as well. Though most of us take it for granted, all individuals require regular access to a restroom. Exclusionary policies that preclude transgender individuals from using restrooms consistent with their gender identity put transgender individuals to a difficult choice: (1) violate the policy and face potential disciplinary consequences; (2) use the restroom inconsistent with their gender identity or "special" single-user restrooms, which undermines their health care needs and risks discrimination or harassment; or (3) attempt not to use the restroom at all.

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[74] Russell B. Toomey et al., *Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth: School Victimization and Young Adult Psychosocial Adjustment*, 46 Developmental Psychology 1580, 1581 (2010).

[75] APA/NASP Resolution, *supra*, at 3-4; *see also* Institute of Medicine Committee on LGBT Issues and Research Gaps and Opportunities, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* 13 (2011) (noting that "prejudice, discrimination, and violence" underlie the "health disparities" between transgender and cisgender populations).

This difficult choice produces heightened anxiety and distress around restroom use, which may make it difficult for transgender individuals to concentrate or focus at school or work and potentially cause them to eschew social activities or everyday tasks.[76] At least one study of transgender college students associated being denied access to restrooms consistent with one's gender identity to an increase in suicidality.[77]

Studies also show that it is common for transgender students to avoid using restrooms.[78] But that avoidance can have medical consequences, including recurrent urinary tract infections and constipation, as well as the possibility of more serious health complications, including hematuria (blood in the urine), chronic kidney disease or insufficiency, urolithiasis (stones in the kidney, bladder, or urethra), infertility, and cancer.[79]

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[76] Herman, *Gendered Restrooms and Minority Stress*, *supra*, at 75.

[77] Kristie L. Seelman, *Transgender Adults' Access to College Bathrooms and Housing and the Relationship to Suicidality*, 63 J. Homosexuality 1378, 1388-89 (2016).

[78] Am. Psychol. Ass'n Guidelines, *supra*, at 840.

[79] *See, e.g.*, Herman, *Gendered Restrooms and Minority Stress*, *supra* at 75 (surveying of transgender and gender non-conforming people in Washington D.C., and finding that 54% of respondents reported a "physical problem from trying to avoid using public bathrooms" including dehydration, urinary tract infections, kidney infection, and other kidney-related problems); James et al., Nat'l Center for Transgender Equality, *Report of the 2015 U.S. Transgender Survey*, *supra*, at 246; Anas I. Ghousheh et al., *Advanced Transitional Cell Carcinoma of the Bladder in a 16-Year-Old Girl with Hinman Syndrome*, 80 Urology 1141 (2012).

Some transgender students experiencing fear and anxiety about restroom usage may attempt to dehydrate themselves so that they will need to urinate less frequently.[80] Chronic dehydration has been linked to a variety of conditions, including urinary tract infections, kidney stones, blood clots, kidney disease, heart disease, and colon and bladder cancer.[81]

These negative outcomes are not alleviated by forcing students into separate single-user restrooms. Being required to use separate facilities may force disclosure of one's transgender status and cause anxiety and fear related to being singled out and separated from peers. Additionally, single-user facilities are generally less available and more inconvenient, causing people to further avoid restroom use or disrupt their schedules to go to the restroom. Separate restrooms thus do not alleviate the anxiety, fear, or negative health consequences that result from exclusionary bathroom policies.

E. Exclusionary Policies Harm Adolescent Social And Emotional Development—With Lifelong Effects.

Finally, exclusionary policies have a particularly deleterious effect on the social and emotional development of children and adolescents. Discrimination and harassment of children and adolescents in their formative years may have effects that

[80] Herman, *Gendered Restrooms and Minority Stress*, *supra*, at 75.

[81] Lawrence E. Armstrong, *Challenges of Linking Chronic Dehydration and Fluid Consumption to Health Outcomes*, 70 Nutrition Rev. S121, 122 (2012).

linger long *after* they leave the school environment. Unsurprisingly, unwelcoming school environments produce particularly poor educational outcomes for transgender individuals.[82] Poorer educational outcomes, standing alone, may lead to lower lifetime earnings and an increased likelihood of poorer health outcomes later in life.[83]

Moreover, and as already discussed, exclusionary policies may produce and compound the stigma and discrimination that transgender children and adolescents face in the school environment. That stigma and discrimination, in turn, is associated with an increased risk of post-traumatic stress disorder, depression, anxiety, and suicidality in subsequent years.[84]

Conversely, evidence demonstrates that a safe and welcoming school environment may promote positive social and emotional development and health

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[82] *See* APA/NASP Resolution, *supra*, at 6; Emily A. Greytak et al., GLSEN, *Harsh Realities: The Experiences of Transgender Youth in Our Nation's Schools* (2009).

[83] *See, e.g.*, Emily B. Zimmerman et al., U.S. Dep't of Health and Human Servs. Agency for Healthcare Research & Quality, *Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives* (2015), https://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html.

[84] Toomey et al., *Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth*, *supra*, at 1581; *see also* APA/NASP Resolution, *supra*, at 6.

outcomes. Numerous studies show that safer school environments lead to *reduced* rates of depression, suicidality, or other negative health outcomes.[85]

* * *

With appropriate support—including safe and supportive schools—transgender youth can become happy and productive adults who contribute much to our society. By making schools into places of stress and conflict rather than welcoming spaces, exclusionary policies worsen stigma and discrimination against transgender students, causing myriad harms to their health, safety, and overall well-being.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge this Court to reverse the judgment below.

[85] AAP Technical Report, *supra*, at 301, 302, 304-05; *see, e.g.*, Marla E. Eisenberg et al., *Suicidality Among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors*, 39 J. Adolescent Health 662 (2006); Stephen T. Russell et al., *Youth Empowerment and High School Gay-Straight Alliances*, 38 J. Youth Adolescence 891 (2009).

Dated: May 15, 2017

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMIT

This brief complies with the type-volume limits because, excluding the parts of the brief exempted by Fed. R. App. P. 32(f) (cover page, disclosure statement, table of contents, table of citations, statement regarding oral argument, signature block, certificates of counsel, addendum, attachments), this brief contains 6,425 words, based on the "Word Count" feature of Microsoft Word 2016.

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Dated: May 15, 2017

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CERTIFICATE OF SERVICE

I hereby certify that on May 15, 2017, I electronically filed the foregoing *amici curiae* brief with the Clerk of the Court for the United States Court of Appeals for the Fourth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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Exhibit D

Exhibit D to Borelli Decl.: ***AMA takes several actions supporting transgender patients,*** **AMA News (June 12, 2017)**

AMA NEWS

AMA takes several actions supporting transgender patients

JUN 12, 2017

Robert Nagler Miller
Contributing Writer
AMA Wire

Acknowledging that individuals' gender and sexual identities do not always fit neatly into binary paradigms, delegates to the 2017 AMA Annual Meeting in Chicago took several actions that support broadening how gender identity is defined within medicine and how transgender patients are treated by society.

The AMA House of Delegates (HOD) did so in an attempt to enhance care for the thousands of Americans who identify as transgender, as well as for many others who do not identify with one particular gender.

Delegates directed the AMA to work with other appropriate organizations to "inform and educate the medical community and the public on the medical spectrum of gender identity." The authors of the adopted resolution wrote that gender is "incompletely understood as a binary selection" because gender, gender

identity, sexual orientation, and genotypic and phenotypic sex are not always aligned.

The HOD also adopted policy opposing any efforts that would prevent a transgender person from "accessing basic human services and public facilities in line with one's gender identity." Transgender people who live in states with discriminatory policies have "statistically significant increases in mental health and psychiatric diagnoses," according to the resolution delegates adopted.

"Prejudice and discrimination affect transgender individuals in many ways throughout their daily lives, often in the form of physical or verbal abuse or bullying," said Jesse M. Ehrenfeld, MD, MPH, member of the AMA Board of Trustees.

"Laws and policies that restrict the use of public facilities based on biological gender can have immediate and lingering physical consequences, as well as severe mental health repercussions," Dr. Ehrenfeld added. To protect the public health and to promote social equality and safe access to public facilities and services, the American Medical Association is opposed to policies that prevent transgender individuals from accessing basic human services and public facilities in line with their gender identity."

In another action, delegates called upon the AMA to work with the Food and Drug Administration to establish a gender-neutral patient categorization in risk evaluation and mitigation strategies (REMS). The idea is to take the focus away from gender identity and place

it on reproductive potential. That is because there are patients who identify as male who may be taking medication that puts them at risk for damage to their biologically female reproductive systems.

Delegates also called for future AMA meetings to take place, whenever possible, only in those counties, cities and states that have nondiscriminatory policies.

Read more news coverage from the 2017 AMA Annual Meeting.

House of Delegates Health Disparities

Medical Ethics

Submitted by renejaxbooks on Monday, June 12, 2017 - 23:59

AMA dear lord what is wrong with you all? Where was your support of transgender patients when Hirschfeld operated on Einer Wegener and killed him with that experimental surgery? Where was your support when Harry Benjamin began giving female hormones to his first male patient without first understanding the causative factors of the condition? Where was your support and concern for transsexual patients when John Money destroyed the lives of the Reiner Twins and family? Where was your support when Stoller separated Gender out from sex and not a single one of your members questioned or challenged his theory? And now you want to stand up and show your support with this linguistic tap dancing BS that

"males can be pregnant" and show just how sensitivity the medical profession is to the patient. OMG. If the lot of you want to show your support for patients who are confused about their sex and sex role, then find out what is the cause of it. Then do real research, real scientific, down in the weeds research and find out if all these pills and plastic surgery and sexual mutilation is the right treatment for the ailment. It's been a hundred years of brutal, deadly and Nazi like experimentation and none of you know the reason why I and thousands like me are confused with our sex and social roles. Now you doctors want to show your support by playing this linguistic mind game by using neutral gender pronouns. Keep your politically correct show of support and give me cold hard irrefutable science to back up your medical treatments. Then and only then I will applaud your support.

Submitted by boyd2345 on Thursday, June 15, 2017 - 14:57

America sees that the AMA is a group of doctors that states that "transgender" is a mental disorder, but should be accepted and supported by everyone. The act of forcing everyone to accept the actions of transgender people against their will, takes away the rights and privileges given unto other people. North Carolina past House Bill 142 that forces everyone and place to allow everyone to use the restrooms, showers and locker rooms of the sex in which they identify with and against the will of the opposite sex with them in these places. This action effects the rights, mental comparison and actions other people will take against these actions. The First Amendment states in the US Constitution "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of

speech, or of the press; or the right of the people peaceably to assemble and to petition the Government for a redress of grievances." This means that Congress, judges and the AMA can not take any action that takes away the rights of other people to exercise their religious beliefs and freedom of speech. This also means that everyone has the right to exercise their belief that the actions of transgenders to be wrong and that they believe their actions are hurting America with their right to freedom of speech. NC's House Bill 142 has students in public schools using the restrooms, showers and locker rooms of the gender they identify with against the will of other students and their parents. The acts of transgenders are welcome in public schools against the will of other people, but followers of Christianity is denied in every public school. Does the AMA not believe that all transgender students should attend and learn from private schools like the government has forced Christians to do? Does the AMA believe that transgenders should have their own restrooms and not be forced upon people of the opposite sex against their will? NC has had men stating they are transgender, enter women's restrooms and take pictures of females using the restroom. The police said these men did nothing wrong. How far should these actions of supporting transgenders continue before laws are past against it, placing restrictions on transgender's actions. The AMA and doctors supporting these actions of the transgenders, can be sued by other citizens for malpractice for the amount of money they believe their malpractice has hurt them. Think of the billions of dollars that AMA and doctors are ready to be paying for their support of transgender's actions. Is the cost worth this action of support?

Submitted by archerb on Wednesday, June 21, 2017 - 12:52

Why are the effects on transgenders the only concern? “Prejudice and discrimination affect transgender individuals in many ways throughout their daily lives, often in the form of physical or verbal abuse or bullying" may certainly be a concern, but where is the report of the effects on six year old girls coming out of swim practice at the local YMCA who have to share a shower with a grown man? I'm all for protecting the dignity and privacy of the transgender individuals who make up 0.03% of our population, but I'm even more concerned about privacy, dignity and innocence of those that make up the other 99.97%. The only excuse I can find is that that AMA lacks the ability to perform basic math or this is a political report rather than a medical one. Bathrooms, locker rooms, showers and all other separated facilities where privacy is expected are not separated by identity. Claiming that they are separated by "gender identity" is denying the very reason these facilities were separated in the first place. They are separated by genitalia. Locker rooms are not a gender social club where men and women separate to relax among people of their own kind. They are separated so that people don't have to expose their genitals to members of the opposite sex and they don't have to have genitals from members of the opposite sex exposed to them. The keyword is SEX and sex is defined by genitalia, not identity or personal preference.

AMA NEWS

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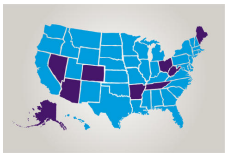

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Exhibit E

Exhibit E to Borelli Decl.: American Academy of Family Physicians, *Resolution No. 508 (Washington C): Transgender Use of Public Facilities* (2015)

RESOLUTION NO. 501 (California A): Endorse Access Without Age Restriction to Over-the-Counter Oral Contraceptive Pills

RESOLVED, That the American Academy of Family Physicians write to the U.S. Food and Drug Administration (FDA) to encourage that all adolescents, regardless of age, be included in the over-the-counter (OTC) oral contraceptives studies required by the FDA (e.g., label comprehension study, actual use study) to determine whether OTC access is appropriate for this population.

RESOLUTION NO. 508 (Washington C): Transgender Use of Public Facilities

RESOLVED, That the American Academy of Family Physicians support existing state and federal laws that protect people from discrimination based on gender expression and identify, and oppose laws that compromise the safety and health of transgender people by failing to provide this protection, and be it further

RESOLVED, That the American Academy of Family Physicians support the ability of transgender people to use the public facilities of the gender with which they identify and actively oppose any legislation which would infringe upon that ability.

RESOLUTION NO. 502 (California B): Medicaid Coverage of Over-the-Counter (OTC) Emergency Contraception (EC)

RESOLVED, That the American Academy of Family Physicians advocate that emergency contraception, whether over-the-counter or by prescription, be a covered benefit under all Medicaid programs for all women of reproductive age.

RESOLUTION NO. 503 (New York A): Increase Access to Comprehensive Reproductive Health Care Services for Incarcerated Women

RESOLVED, That the American Academy of Family Physicians advocate that comprehensive and appropriate health care be provided to incarcerated women in federal detention facilities including but not limited to reproductive health.

RESOLUTION NO. 402 (Colorado A): Diversity Support

RESOLVED, That the American Academy of Family Physicians (AAFP) establish an “Office of Diversity" that will serve as the official AAFP repository for policies and information related to discrimination, diversity, and cultural proficiency that will coordinate active promotion of messaging related to same, and that will work to support members and efforts towards non-discrimination in education, training, and practice, and be it further

RESOLVED, That the American Academy of Family Physicians reaffirm and proclaim its support for its members through newly created Office of Diversity through the use of press releases and messaging to members, public, and elected officials restating its strong position against discrimination towards students, residents, members, staff, patients, community directed at them because of their religious, cultural, ethnic, racial, national, gender, or sexual identify, and be it further,

RESOLVED, (Through the newly created Office of Diversity), that the American Academy of Family Physicians, support the development and implementation of anti-discrimination and hate crime laws and public policies that seek to support and protect victims of discrimination targeted at their refugee, immigration, gender-identity, race, color, religion, gender, sexual orientation, or disability status.

RESOLUTION NO. 405 (Oregon C): Gun Violence as a Public Health Issue

Exhibit F

Exhibit F to Borelli Decl.: APA and NASP, *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools* (2015)

AMERICAN PSYCHOLOGICAL ASSOCIATION

Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools

Adopted by the Council of Representatives, August 2014. Amended by the Council of Representatives, February 2015. (Suggested citation is included with references.)

WHEREAS people express and experience great diversity in sexual orientation and gender identity and expression;

WHEREAS communities today are undergoing rapid cultural and political change around the treatment of sexual minorities and gender diversity;

WHEREAS all persons, including those who are sexual or gender minority children and adolescents, or those who are questioning their gender identities or sexual orientations, have the right to equal opportunity and a safe environment within all public educational institutions;

Sexual Orientation and Gender Identity

WHEREAS some children and adolescents are aware of their attraction to members of the same gender or of their status as lesbian, gay, or bisexual persons by early adolescence (Remafedi, 1987; Savin-Williams, 1990; Slater, 1988; Troiden, 1988), although this awareness may vary by culture and acculturation (Morales, 1990; Rosario, Schrimshaw & Hunter, 2004);

WHEREAS sexual orientation and gender identity are separate, but related, aspects of the human experience (Bockting & Gray, 2004; Chivers & Bailey, 2000; Coleman, Bockting, & Gooren, 1993; Docter & Fleming, 2001; Docter & Prince, 1997);

WHEREAS some children and adolescents may experience a long period of questioning their sexual orientations or gender identities, experiencing stress, confusion, fluidity or complexity in their feelings and social identities (Hollander, 2000; Remafedi, Resnick, Blum, & Harris, 1992);

WHEREAS there are few resources and supportive adults available and little peer support individually or within student groups for gender and sexual orientation diverse children and adolescents, particularly those residing in rural areas or small towns, (Kosciw, Greytak, Diaz, & Bartkiewicz, 2010; Robinson & Espelage, 2011);

Gender Diversity

WHEREAS a person's gender identity develops in early childhood and some young children may not identify with the gender assigned to them at birth (Brill & Pepper, 2008; Zucker, 2004);

WHEREAS it may be medically and therapeutically indicated for some transgender and other gender diverse children and adolescents to transition from one gender to another using any of the following: change of name, pronoun, hairstyle, clothing, pubertal suppression, cross-sex hormone treatment, and surgical treatment (Coleman et al., 2011; Forcier & Johnson, 2012; Olson, Forbes, & Belzer, 2011);

Consequences of Stigma and Minority Stress

WHEREAS minority stress is recognized as a primary mechanism through which the notable burden of stigma and discrimination affects minority persons' health and well-being and generates health disparities (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer, 2003; Meyer, Schwartz, & Frost, 2008; Mirowsky & Ross, 1989);

WHEREAS many gender and sexual orientation diverse children and adolescents have reported higher rates of anxiety and depression, low self-esteem, engaging in self-injurious behaviors, suicide, substance use, homelessness, and eating disorders among other adverse outcomes (Austin et al., 2009; Corliss, Goodenow, Nichols,& Austin, 2011; Gibson, 1989; Gipson, 2002; Gonsiorek, 1988; Grossman & D'Augelli, 2007; Harry, 1989; Hetrick & Martin, 1988; Mustanski, Garofalo, & Emerson, 2010; Poteat, Aragon, Espelage, & Koenig, 2009; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Russell, Huebner, Dias, & Sanchez, 2010; Savin-Williams, 1990; Schutzmann, Brinkmann, Schacht, & Richter-Appelt, 2009).

WHEREAS many transgender and gender diverse children and adolescents experience elevated rates of depression, anxiety, self-harm, and other health risk behaviors (American Psychological Association, 2009; Coleman et al., 2011; McGuire, Anderson, Toomey, & Russell, 2010);

WHEREAS some gender and sexual orientation diverse adolescents are at an increased risk for pregnancy (Goodenow, Szalacha, Robin, & Westheimer, 2008; Russell et al., 2011; Ryan et al., 2010; Saewyc, Poon, Homma, & Skay, 2008; Savin-Williams, 1990;

WHEREAS, some gender and sexual orientation diverse adolescent sub-populations, including young men who have sex with men, homeless adolescents, racial/ethnic minority adolescents, transgender women of color, and adolescents enrolled in alternative schools, are at heightened risk for sexually transmitted infections, including HIV (Center for Disease Control and Prevention, 2012; Markham et al., 2003), due to complex and interacting factors related to stigma, socioeconomic class and minority stress (Hatzenbuehler, Phelan & Link, 2013; Link & Phelan, 1995; Meyer, 2003; Phelan, Link, & Tehranifar, 2010);

WHEREAS some children and adolescents with intersex/DSD[1] conditions report rates of self-harm and suicidality comparable to individuals who have experienced physical or sexual abuse (Schutzmann, et al., 2009);

WHEREAS individuals with intersex/DSD conditions often report a history of silence, stigma, and shame regarding their bodies and medical procedures imposed on them (MacKenzie, Huntington, & Gilmour, 2009; Wiesemann, Udo-Koeller, Sinnecker, & Thyen, 2010);

WHEREAS invasive medical procedures that are not medically necessary in nature (e.g., genital surgery for purposes of 'normalization') continue to be recommended to parents of intersex/DSD children, often proceed without the affected individual's assent, and lack research evidence on long-term quality of life, reproductive functioning, and body satisfaction (Wiesemann et al., 2010);

WHEREAS adults with intersex/DSD conditions report negative emotional, psychological and physical consequences that result from repeated and often questionable medical exams and procedures that lack research evidence to support their purported long-term reduction of distress (MacKenzie et al., 2009; Wiesemann et al., 2010);

WHEREAS gender and sexual orientation diverse young people with intersecting identities face additional challenges to their psychological well-being as a result of the negative consequences of discrimination based on sexual orientation and ethnic/racial minority status, religious identity, and country of origin, among other characteristics (Garnets & Kimmel, 1991; Herek, Gillis, & Cogan, 2009; Moradi et al., 2010; Poteat et al., 2009; Russell et al., 2011; Ryan et al., 2009; Szymanski & Gupta, 2009);

WHEREAS gender and sexual orientation diverse children and adolescents who come from impoverished or low-income families may face additional risks (Gipson, 2002; Gordon, Schroeder, & Abramo, 1990; Russell et al., 2011);

WHEREAS gender and sexual orientation diverse children and adolescents in rural areas and small towns experience additional challenges, such as living in typically more conservative and less diverse communities (compared to those in urban settings) and having limited access to affirming community-based supports, which can lead to greater feelings of social isolation (Cohn & Leake, 2012; O'Connell, Atlas, Saunders, & Philbrick, 2010);

WHEREAS gender and sexual orientation diverse children and adolescents with physical or mental disabilities are at increased risk of negative health outcomes due to the consequences of societal prejudice toward persons with mental and physical disabilities (Duke, 2011; Hingsburger & Griffiths, 1986; Pendler & Hingsburger, 1991);

[1] **Intersex** refers to a range of conditions associated with atypical development of physical sex characteristics (American Psychological Association, 2006). Intersex individuals may be born with chromosomes, genitals, and/or gonads that do not fit typical female or male presentations (Organization Intersex International in the United States of America, 2013). Since 2006, the medical and research community has used the term **Disorders of Sex Development**. This term refers to congenital conditions characterized by atypical development of chromosomal, gonadal, or anatomical sex (Houk, Hughes, Ahmed, Lee, & Writing Committee for the International Intersex Consensus Conference Participants, 2006). An alternate term — **Differences of Sex Development** — has been recommended to prevent a view of these conditions as diseased or pathological (Wisemann, Udo-Koeller, Sinnecker, & Thyen, 2010). In order to be inclusive of various terminology preferences, this document will use **intersex/DSD** when referring to individuals who are part of this community.

Concerns and Issues in the Context of Schools

WHEREAS many gender and sexual orientation diverse children and adolescents experience harassment, bullying, and physical violence in school environments (Brooks, 2000; Fineran, 2002; Greytak, Kosciw, & Diaz, 2009; Kosciw et al., 2010; McGuireet al., 2010; Poteat & Rivers, 2010; Russell, Franz, & Driscoll, 2001; Sausa, 2005);

WHEREAS low numbers of school personnel intervene to stop harassment or bullying against transgender and other gender diverse students in school settings and may even participate in harassment of transgender and gender diverse students (Greytak et al., 2009; McGuire et al., 2010; Sausa, 2005);

WHEREAS gender and sexual orientation diverse children and adolescents who are victimized in school are at increased risk for mental health problems, suicidal ideation and attempts, substance use, high-risk sexual activity, and poor academic outcomes, such as high level of absenteeism, low grade point averages, and low interest in pursuing post-secondary education (Birkett, Espelage, & Koenig, 2009; Bontempo & D'Augelli, 2002; D'Augelli, Pilkington, & Hershberger, 2002; Kosciw et al., 2010; O'Shaughnessy, Russell, Heck, Calhoun, & Laub, 2004; Russell et al., 2011);

WHEREAS some studies suggest that transgender and other gender diverse students experience even poorer educational outcomes compared to lesbian, gay and bisexual students, including low achievement levels, higher likelihood of being "pushed out" of high school prior to graduation, low educational aspirations, and high incidences of truancy and weapons possession (Greytak et al., 2009; Toomey, Ryan, Diaz, Card, & Russell, 2010);

WHEREAS recent research has identified a number of school policies, programs, and practices that may help reduce risk and/or increase well-being for gender and sexual orientation diverse children and adolescents (Blake et al 2001; Eisenberg & Resnick, 2006; Goodenow, Szalacha, & Westheimer, 2006; Graybill, Varjas, Meyers, & Watson, 2009; Heck, Flentje, & Cochran 2011; Murdock & Bolch, 2005; Szalacha, 2003; Toomey et al., 2010; Walls, Kane, & Wisneski, 2010; Watson, Varjas, Meyers, & Graybill, 2010);

WHEREAS gender and sexual orientation diverse students report increased school connectedness and school safety when school personnel intervene in the following ways: (1) addressing and stopping bullying and harassment, (2) developing administrative policies that prohibit discrimination based on sexual orientation, gender identity and gender expression, (3) supporting the use of affirming classroom activities and the establishment of gender and sexual orientation diverse-affirming student groups, and (4) valuing education and training for students and staff on the needs of gender and sexual orientation diverse students (Case & Meier, 2014; Greytak et al., 2009; Kosciw et al., 2010; McGuire et al., 2010; National Association of School Psychologists, 2011; Sausa, 2005);

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WHEREAS school psychologists, school counselors, and school social workers advocate for inclusive policies, programs and practices within educational environments (NASP, 2010a; NASP 2010b; NASP, 2011), and

WHEREAS the field of psychology promotes the individual's healthy development of personal identity, which includes the sexual orientation, gender expression, and gender identity of all individuals (APA, 2002; APA, 2012; Coleman et al., 2011; NASP, 2010a; NASP, 2011);

THEREFORE BE IT RESOLVED that the American Psychological Association and the National Association of School Psychologists affirm that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists affirm that diverse gender expressions, regardless of gender identity, and

diverse gender identities, beyond a binary classification, are normal and positive variations of the human experience;

Policies

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will advocate for local, state and federal policies and legislation that promote safe and positive school environments free of bullying and harassment for all children and adolescents, including gender and sexual orientation diverse children and adolescents and those who are perceived to be lesbian, gay, bisexual, transgender or gender diverse;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend schools develop policies that respect the right to privacy for students, parents, and colleagues with regard to sexual orientation, gender identity, or transgender status, and that clearly state that school personnel will not share information with anyone about the sexual orientation, gender identity, intersex/DSD condition, or transgender status of a student, parent, or school employee without that individual's permission;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that school administrations and mental health providers, in the context of schools, develop partnerships and networks to promote cross-agency collaboration to create policies that directly affect the health and wellbeing of gender and sexual orientation diverse adolescents and children;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage state educational agencies to collect data on sexual orientation, taking care to ensure student anonymity, as part of efforts to monitor and study adolescents' risk behaviors in the CDC Youth Risk Behavior Survey, and to develop and validate measures of gender identity for inclusion in the Youth Risk Behavior Survey, as well;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that inclusive data collection be incorporated into the Department of Education's Mandatory Civil Rights Data Collection, another important measurement of youth experiences in schools that could help inform effective interventions to better support gender and sexual orientation diverse children and adolescents in schools;

Programs and Interventions

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists support efforts to ensure the funding of basic and applied research, and scientific evaluations of interventions and programs, designed to address the issues of gender and sexual orientation diverse children and adolescents in the schools;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend the continued development and evaluation of school-level interventions that promote academic success and resiliency, that reduce bullying and harassment, that reduce risk for sexually transmitted infections, that reduce risk for pregnancy among adolescents,

that reduce risk for self-injurious behaviors, and that foster safe and supportive school environments for gender and sexual orientation diverse students;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that special sensitivity be given to the diversity within the population of gender and sexual orientation diverse students, with new interventions that incorporate the concerns of sexual minorities often overlooked or underserved, and the concerns of racial/ethnic minorities and recently immigrant children and adolescents who are also gender and sexual orientation diverse students;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists support affirmative interventions with transgender and gender diverse children and adolescents that encourage self-exploration and self-acceptance rather than trying to shift gender identity and gender expression in any specific direction;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage school-based mental health professionals to advocate for efforts to educate and train school professionals about the full range of sex development, gender expression, gender identity, and sexual orientation;

Training and Education

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will encourage education, training, and ongoing professional development about the needs and the supports for gender and sexual orientation diverse students for educators and trainers of school personnel, education and mental health trainees, school-based mental health professionals, administrators, and school staff, and such training and education should be available to students, parents, and community members;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will encourage school-based mental health professionals to learn how strictly binary notions of sex, sex development and gender limit all children from realizing their full potential, create conditions that exacerbate bullying, and prevent many students from fully focusing on and investing in their own learning;

Practices

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage school-based mental health professionals to serve as allies and advocates for gender and sexual orientation diverse children and adolescents in schools, including advocacy for the inclusion of gender identity, gender expression and sexual orientation in all relevant school district policies, especially anti-bullying and anti-discrimination policies;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage school staff to support the decisions of children, adolescents, and families regarding a student's gender identity or expression, including whether to seek treatments

and interventions, and discourage school personnel from requiring proof of medical treatments as a prerequisite for such support;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that administrators create safer environments for gender diverse, transgender, and intersex/DSD students, allowing all students, staff, and teachers to have access to the sex-segregated facilities, activities, and programs that are consistent with their gender identity, including, but not limited to, bathrooms, locker rooms, sports teams, and classroom activities, and avoiding the use of gender segregation in school uniforms, school dances, and extracurricular activities, and providing gender neutral bathroom options for individuals who would prefer to use them; and

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will work with other organizations in efforts to accomplish these ends.

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American Psychological Association & National Association of School Psychologists. (2015). *Resolution on gender and sexual orientation diversity in children and adolescents in schools*. Retrieved from http://www.apa.org/about/policy/orientation-diversity.aspx

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