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

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

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

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

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

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

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

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

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

Standards of Care for Working with Transgender Youth

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

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

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

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

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

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

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

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

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

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

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

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

Supporting the Mental Health of Transgender Youth in Schools

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

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

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

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

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

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

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

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

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

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

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

Psychological Report for Drew Adams

47. As part of my duties as expert, I interviewed Drew Adams in three separate video interviews, dated August 27, 2017; September 5, 2017, and September 14, 2017, to ascertain Drew's specific experiences as relates to the matter in this case. I have also reviewed Drew's medical and psychological records. The following is a summary of my psychological findings addressed to the issue of experience and effects of the school district's policy of

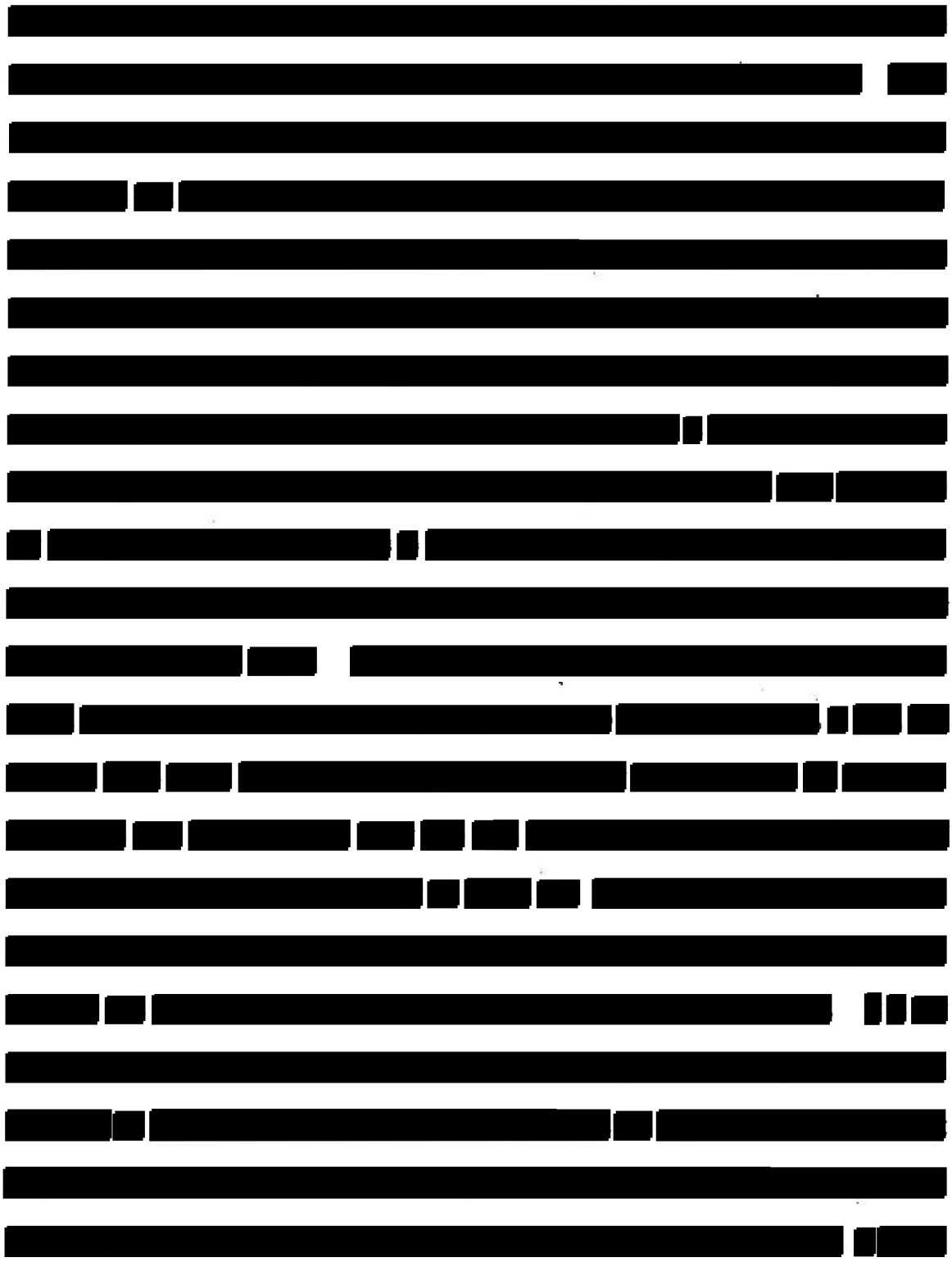
restricting Drew to the use of gender-neutral bathrooms in his present high school, as put into effect in September 2015.

48. In the fall of 2015 Drew Adams entered high school as a freshman. In the summer before his freshman year he had fully socially transitioned as an affirmed male, having been assigned a female sex at birth, and has consistently lived his life and attended school in his authentic male identity. Like other male students, he accessed all facilities and used the boys' bathroom throughout his school day. Late in September of that same school year, Drew was summoned by the administration and informed that someone had complained about his use of male restrooms, and that from thereon in he was offered use of gender-neutral bathrooms throughout the school campus, but no longer allowed to used boys' bathrooms. That policy has remained in place to the present time, and Drew has abided by it, albeit after unsuccessful attempts by him and his parents to overturn the instated policy and return to his initial high school experience of having full access to the boys' bathrooms. This report summarizes the effects of this experience on Drew's psychological, social, and academic functioning over the last two years since being told that he could no longer use the boys' restrooms.

49. [redacted]

[redacted]

50. [redacted]



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51. It should be noted here that the majority of patients who attend our clinic at the University of California suffer from anxiety when first beginning treatment, but the anxiety goes down once they receive medical care and social supports. Drew indeed indicated an increase in positive mood and reduction in anxiety right after receiving testosterone and subsequent to his chest surgery this past spring; however, those positive gains have been compromised by the counteracting experience of not feeling supported by his school, which then creates an up ticking in anxiety when he thinks about it or when he is having to travel across school grounds to take care of his bodily needs when there was a boys' bathroom right next to his classroom that he has been barred from using. It should also be noted that Drew has established an adaptive psychological technique to fortify his resilience and keep him from dropping into anxiety or depression—he either tries not to think of the troublesome situation at all or tries to replace it with good thoughts. This is an adaptive strategy, up to a point. It takes a great deal of psychic energy to keep the monsters at bay, and when the dam breaks, which it inevitably will from time to time, the flood waters enter—in this case, Drew's frustration, by self-report, that he has followed the rules to keep up his good record but feels anger and upset that the matter of bathroom use has not been resolved. In line with his adaptive strategies, Drew keeps his head above water by believing in the possibility that the current situation could be remedied after the scheduled December court hearing on his case. This buoys his spirits, but the psychological trouble ahead will be if that belief does not come to fruition. In that case, it would be important to keep a watch on Drew as the loss of the case could result