

RECORD NO. 19-1952

In The
United States Court of Appeals
For The Fourth Circuit

GAVIN GRIMM,

Plaintiff – Appellee,

v.

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant – Appellant.

**ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
AT NEWPORT NEWS**

**JOINT APPENDIX
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APPEAL,CLOSED

**U.S. District Court
Eastern District of Virginia - (Newport News)
CIVIL DOCKET FOR CASE #: 4:15-cv-00054-AWA-RJK**

Grimm v. Gloucester County School Board
Assigned to: District Judge Arenda L. Wright Allen
Referred to: Magistrate Judge Robert J. Krask
Case in other court: 4CCA Case Manager Jennifer Rice, 15-02056
4CCA - Case Manager Jennifer Rice, 16-01733
4CCA Case Manager Cathi Bennett, 19-01952

Date Filed: 06/11/2015
Date Terminated: 08/09/2019
Jury Demand: Defendant
Nature of Suit: 448 Civil Rights: Education
Jurisdiction: Federal Question

Cause: 20:1681 Civil Rights Education Amendments Act 1972

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Date Filed	#	Docket Text
06/11/2015	2	Sealed Complaint per 1 Order entered on 6.16.15. (Attachments: # 1 Exhibit A) # 2 Civil Cover Sheet, # 3 Letter, # 4 Receipt) (epri). (Entered: 06/16/2015)
06/11/2015	3	Sealed Declaration of G.G. Document re 2 Sealed Complaint. (Attachments: # 1 Exhibit A)(epri) (Entered: 06/16/2015)
06/11/2015	4	Sealed Expert Declaration of Randi Ettner, Ph.D. re 2 Sealed Complaint. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(epri) (Entered: 06/16/2015)
06/11/2015	5	SEALED PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION, by G. G. (epri) (Entered: 06/16/2015)
06/11/2015	6	SEALED PLAINTIFF'S MOTION FOR LEAVE TO FILE BRIEF IN EXCESS OF THIRTY PAGES by G. G. (epri) (Entered: 06/16/2015)
06/11/2015	7	Sealed Memorandum in Support of Plaintiff's Motion for Leave to File a Brief in Excess of Thirty Pages re 5 SEALED PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION, by G. G. 6 SEALED PLAINTIFF'S MOTION FOR LEAVE TO FILE BRIEF IN EXCESS OF THIRTY PAGES by G. G. (Attachments: # 1 Proposed Memorandum of law in support of Plaintiff's Motion for Preliminary Injunction)(epri) (Entered: 06/16/2015)
06/11/2015	8	COMPLAINT (Redacted) against Gloucester County School Board (Filing fee \$ 400, receipt number 24683027454.), filed by G. G. (Attachments: # 1 Civil Cover Sheet (Redacted), # 2 Letter (Redacted), # 3 Receipt)(epri) (Entered: 06/16/2015)
06/11/2015	9	Declaration of G. G. re 8 Complaint (epri) (Entered: 06/16/2015)
06/11/2015	10	Expert Declaration of Randi Ettner, Ph.D Preliminary Statement re 8 Complaint (epri) (Entered: 06/16/2015)
06/11/2015	11	PLAINTIFF'S MOTION for Preliminary Injunction by G. G. (epri) (Entered: 06/16/2015)
06/11/2015	12	PLAINTIFF'S MOTION for Leave to File Brief in excess of thirty pages by G. G. (epri) (Entered: 06/16/2015)
06/11/2015	13	Memorandum in Support of Plaintiff's Motion for Leave to File a Brief in Excess of Thirty Pages re 11 PLAINTIFF'S MOTION for Preliminary Injunction 12 PLAINTIFF'S MOTION for Leave to File Brief in excess of thirty pages filed by G. G. (Attachments: # 1 Proposed Memorandum of law in support of Plaintiff's Motion for Preliminary Injunction)(epri) (Entered: 06/16/2015)
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		Sealed ORDER Signed by District Judge Robert G. Doumar on 6/15/2015. (epri) (Entered: 06/16/2015)
06/16/2015	14	One Summons, with service copy, Issued as to Gloucester County School Board. (Attachments: # 1 Civil Motions Procedures)(epri) (Entered: 06/16/2015)
06/17/2015	15	Motion to appear Pro Hac Vice by Joshua Abraham Block and Certification of Local Counsel Rebecca Kim Glenberg Filing fee \$ 75, receipt number 0422-4501488. by G. G.. (Glenberg, Rebecca) (Entered: 06/17/2015)
06/17/2015	16	Motion to appear Pro Hac Vice by Leslie Jill Cooper and Certification of Local Counsel Rebecca Kim Glenberg Filing fee \$ 75, receipt number 0422-4501506. by G. G.. (Glenberg, Rebecca) (Entered: 06/17/2015)
06/17/2015	17	ORDER granting 12 Motion for Leave to File a brief in excess of thirty pages in support of the plaintiff's motion for a preliminary injunction.. Signed by Magistrate Judge Tommy E. Miller on 6/17/2015. (Miller, Tommy) (Entered: 06/17/2015)
06/18/2015	18	Memorandum in Support re 11 MOTION for Preliminary Injunction filed by G. G.. (Deady, Gail) (Entered: 06/18/2015)
06/18/2015	19	Request for Hearing by G. G. re 11 MOTION for Preliminary Injunction (Deady, Gail) (Entered: 06/18/2015)
06/23/2015	20	ORDER granting 15 Motion for Pro hac vice for Joshua Abraham Block as to G. G.. Signed by District Judge Robert G. Doumar on 6/23/15. (tlev,) (Entered: 06/24/2015)
06/23/2015	21	ORDER granting 16 Motion for Pro hac vice for Leslie Jill Cooper as to G. G.. Signed by District Judge Robert G. Doumar on 6/23/15. (tlev,) (Entered: 06/24/2015)
06/29/2015	22	AFFIDAVIT of Service by G. G. (bgra,). (Entered: 06/29/2015)
06/29/2015	23	NOTICE of Appearance by David P. Corrigan on behalf of Gloucester County School Board (Corrigan, David) (Entered: 06/29/2015)
06/29/2015	24	NOTICE of Appearance by Jeremy David Capps on behalf of Gloucester County School Board (Capps, Jeremy) (Entered: 06/29/2015)
06/29/2015	25	NOTICE of Appearance by Maurice Scott Fisher, Jr on behalf of Gloucester County School Board (Fisher, Maurice) (Entered: 06/29/2015)
06/29/2015	26	MOTION for Extension of Time to File Response/Reply to <i>Motion for Preliminary Injunction</i> by Gloucester County School Board. (Fisher, Maurice) (Entered: 06/29/2015)
06/29/2015	27	RESPONSE to Motion re 26 MOTION for Extension of Time to File Response/Reply to <i>Motion for Preliminary Injunction</i> filed by G. G.. (Glenberg, Rebecca) (Entered: 06/29/2015)
06/29/2015	28	Statement of Interest of The United States by The United States. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(bgra) (Entered: 06/29/2015)

06/30/2015		Motion Hearing as to 11 MOTION for Preliminary Injunction set for 7/20/2015 at 02:30 PM in Norfolk Mag Courtroom 1 before District Judge Robert G. Doumar. (lbax,) (Entered: 06/30/2015)
06/30/2015		MOTIONS REFERRED to Magistrate Judge: Tommy E. Miller. 26 MOTION for Extension of Time to File Response/Reply to <i>Motion for Preliminary Injunction</i> (bgra) (Entered: 06/30/2015)
06/30/2015	29	ORDER granting 26 Motion for Extension of Time to File Response/Reply re 11 MOTION for Preliminary Injunction. Response due July 7, 2015.Signed by Magistrate Judge Tommy E. Miller on 6/30/2015. (bgra) (Entered: 06/30/2015)
07/07/2015	30	Opposition to 11 MOTION for Preliminary Injunction filed by Gloucester County School Board. (Attachments: # 1 Exhibit Exhibit A -, # 2 Exhibit Exhibit B, # 3 Exhibit Exhibit C)(Corrigan, David) (Entered: 07/07/2015)
07/07/2015	31	MOTION to Dismiss for Failure to State a Claim by Gloucester County School Board. (Corrigan, David) (Entered: 07/07/2015)
07/07/2015	32	Brief in Support to 31 MOTION to Dismiss for Failure to State a Claim filed by Gloucester County School Board. (Attachments: # 1 Exhibit Exhibit 1) (Corrigan, David) (Entered: 07/07/2015)
07/07/2015	33	CERTIFICATE of Service re 30 Opposition by David P. Corrigan on behalf of Gloucester County School Board (Corrigan, David) (Entered: 07/07/2015)
07/07/2015	34	CERTIFICATE of Service re 31 MOTION to Dismiss for Failure to State a Claim by David P. Corrigan on behalf of Gloucester County School Board (Corrigan, David) (Entered: 07/07/2015)
07/07/2015	35	CERTIFICATE of Service re 32 Brief in Support by David P. Corrigan on behalf of Gloucester County School Board (Corrigan, David) (Entered: 07/07/2015)
07/08/2015	36	MOTION for Hearing re 31 MOTION to Dismiss for Failure to State a Claim by Gloucester County School Board. (Corrigan, David) Mo (Entered: 07/08/2015)
07/08/2015	37	Brief in Support to 36 MOTION for Hearing (Corrigan, David) Modified docket text on 7/8/2015 (ccol); Modified docket text to correct linkage to motion on 7/10/2015 (bgra). (Entered: 07/08/2015)
07/08/2015	38	RESPONSE in Opposition re 36 MOTION for Hearing re 31 MOTION to Dismiss for Failure to State a Claim filed by G. G.. (Glenberg, Rebecca) (Entered: 07/08/2015)
07/10/2015	39	Motion to appear Pro Hac Vice by Victoria Lill and Certification of Local Counsel Clare P. Wuerker by The United States. (Attachments: # 1 Exhibit Pro Hac Vice Application)(Wuerker, Clare) (Entered: 07/10/2015)
07/10/2015	40	Reply to Motion re 36 MOTION for Hearing re 31 MOTION to Dismiss for Failure to State a Claim filed by Gloucester County School Board. (Corrigan, David) (Entered: 07/10/2015)
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		REPLY to Response to Motion re 11 MOTION for Preliminary Injunction filed by G. G.. (Attachments: # 1 Exhibit A)(Deady, Gail) (Entered: 07/13/2015)
07/13/2015		Notice of Correction: The filing user has been notified to file a separate Certificate of Service. re 41 Reply to Response to Motion (bgra) (Entered: 07/16/2015)
07/16/2015	42	ORDER granting 39 Motion for Pro hac vice for Victoria Lill as to The United States. Signed by District Judge Robert G. Doumar on 7/15/15. (tlev,) (Entered: 07/16/2015)
07/16/2015	43	CERTIFICATE of Service re 41 Reply, Reply to Response to Motion by Gail Marie Deady on behalf of G. G. (Deady, Gail) (Entered: 07/16/2015)
07/16/2015	44	RESPONSE in Opposition re 31 MOTION to Dismiss for Failure to State a Claim filed by G. G.. (Attachments: # 1 Exhibit A - Tudor Opinion, # 2 Exhibit B - Tudor Intervenor Complaint)(Glenberg, Rebecca) (Entered: 07/16/2015)
07/17/2015	45	ORDER: This Court will hear the fully briefed Motion to Dismiss before it will consider any other motions. The hearing set on July 20, 2015, is hereby VACATED, and no motions will be heard at that time. Instead, all motions then pending and responded to will be heard on July 27, 2015 at 11:00 a.m. in this Court. Copies distributed to all counsel of record. re 36 Motion for Hearing. Signed by District Judge Robert G. Doumar on 7/16/2015. (bgra) (Entered: 07/17/2015)
07/17/2015		Reset Hearing as to 31 MOTION to Dismiss for Failure to State a Claim , and Motions :. Motion Hearing reset for 7/27/2015 at 11:00 AM in Norfolk Grand Jury Courtroom before District Judge Robert G. Doumar. (ptom,) (Entered: 07/17/2015)
07/17/2015		Reset Hearing as to 31 MOTION to Dismiss for Failure to State a Claim , and Motions. Motion Hearing set for 7/27/2015 at 11:00 AM in Norfolk Mag Courtroom 1 before District Judge Robert G. Doumar. (Courtroom change from Grand Jury Room to Mag Courtroom 1) (ptom,) (Entered: 07/17/2015)
07/22/2015	46	Reply to Motion re 31 MOTION to Dismiss for Failure to State a Claim , REPLY to Response to Motion , Reply filed by Gloucester County School Board. (Corrigan, David) (Entered: 07/22/2015)
07/27/2015	47	Motion Hearing before District Judge Robert G. Doumar held on 7/27/2015 re 11 MOTION for Preliminary Injunction filed by G.G., 31 MOTION to Dismiss for Failure to State a Claim filed by Gloucester County School Board. Appearances: Rebecca K. Glenberg, Gail Deady, Leslie J. Cooper and Joshua A. Block appeared for the Plaintiff. David P. Corrigan and Jeremy D. Capps appeared for the Defendant. Clare P. Wuerker and Victoria Lill appeared on behalf of the Interested Party, The United States. Arguments of counsel. Comments of Court. The Court DISMISSED the Title IX claim but takes the remainder of the motions under advisement. The Court will issue a written opinion as to its findings. The Defendants will have 21 days from the filing of the Court's opinion to file an answer. The case will be referred for scheduling at that time. Court adjourned. (Court Reporter Heidi Jeffreys, OCR.)(lbax,) (Entered: 07/28/2015)

07/30/2015	49	Transcript Redaction Request re 48 Transcript,,, by attorney Rebecca Kim Glenberg. (Glenberg, Rebecca) (Entered: 07/30/2015)
07/31/2015	50	Redacted Version of 48 Transcript (afar) (Entered: 07/31/2015)
07/31/2015	51	ORDER: The Court ORDERS that G.G.'s identifying information, as shown on page fifteen (15) of the transcript of the June 27, 2015 hearing, lines fourteen (14), fifteen (15), sixteen (16), and eighteen (18), shall be under seal. The Court further ORDERS that this identifying information shall not be released by the Clerk or any party or individual without a specific order of the Court. Copy of Order provided to all counsel of record. Signed by District Judge Robert G. Doumar on 7/31/2015. (bgra) (Entered: 07/31/2015)
09/03/2015		Case Reassigned to Magistrate Judge Douglas E. Miller. Magistrate Judge Tommy E. Miller no longer assigned to the case. (afar) (Entered: 09/03/2015)
09/04/2015	53	ORDER - DENIES 11 Plaintiff's Motion for Preliminary Injunction. Signed by District Judge Robert G. Doumar on 9/4/15. (afar) (Entered: 09/04/2015)
09/08/2015	54	NOTICE OF APPEAL as to 53 Order on Motion for Preliminary Injunction by G. G.. Filing fee \$ 505, receipt number 0422-4626161. (Glenberg, Rebecca) (Entered: 09/08/2015)
09/09/2015	55	Transmission of Notice of Appeal to US Court of Appeals re 54 Notice of Appeal (All case opening forms, plus the transcript guidelines, may be obtained from the Fourth Circuit's website at www.ca4.uscourts.gov) (Attachments: # 1 Notice of Appeal)(bgra) (Entered: 09/09/2015)
09/10/2015	56	USCA Case Number 15-2056 4CCA Case Manager Jennifer Rice for 54 Notice of Appeal filed by G. G. (15-2056) (bgra) (Entered: 09/10/2015)
09/17/2015	57	MEMORANDUM OPINION - the Court GRANTED the Motion to Dismiss as to Count II, Plaintiff's claim under Title IX, and DENIED the Plaintiff's Motion for Preliminary Injunction. Signed by District Judge Robert G. Doumar on 9/17/15. (afar) (Entered: 09/17/2015)
09/22/2015	58	Consent MOTION for Leave to File <i>Corrected Copies of Redacted Documents</i> by G. G.. (Attachments: # 1 Corrected Decl. of G.G., # 2 Corrected Decl. of Dr. Ettner)(Dedy, Gail) (Entered: 09/22/2015)
09/23/2015		MOTIONS REFERRED to Magistrate Judge: Douglas E. Miller. 58 Consent MOTION for Leave to File <i>Corrected Copies of Redacted Documents</i> (bgra) (Entered: 09/24/2015)
10/01/2015	59	ORDER granting 58 Motion for Leave to File Corrected Copies of Redacted Exhibits. The corrected copies attached to the Motion (ECF Nos. 58-1 and 58-2) may be filed as substitutes for the redacted Declarations of G.G. and Dr. Randi Ettner originally filed in support of the Motion for Preliminary Injunction (ECF Nos. 9 and 10). Signed by Magistrate Judge Douglas E. Miller on October 1, 2015. (Miller, Douglas) (Entered: 10/01/2015)
10/05/2015	60	Declaration re 9 Declaration - <i>Corrected</i> by G. G.. (Dedy, Gail) (Entered: 10/05/2015)
10/05/2015	61	

		Declaration re 10 Declaration - <i>Corrected</i> by G. G.. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Deady, Gail) (Entered: 10/05/2015)
04/19/2016	62	Published Opinion of USCA (Copy): Reversed in part, Vacated in part, and Remanded. re 54 Notice of Appeal attached copy of judgment will not take effect until issuance of the mandate. (15-2056) (bgra) (Entered: 04/19/2016)
04/19/2016	63	USCA JUDGMENT as to 54 Notice of Appeal filed by G. G.: In accordance with the decision of this court, the judgment of the district court is reversed in part and vacated in part. This case is remanded to the district court for further proceedings consistent with the court's decision. This judgment shall take effect upon issuance of this court's mandate in accordance with Fed. R. App. P. 41. (15-2056) (bgra) (Entered: 04/19/2016)
05/03/2016	64	STAY OF MANDATE: Under Fed. R. App. P. 41(d)(1), the timely filing of a petition for rehearing or rehearing en banc or the timely filing of a motion to stay the mandate stays the mandate until the court has ruled on the petition for rehearing or rehearing en banc or motion to stay. In accordance with Rule 41 (d)(1), the mandate is stayed pending further order of this court. as to 54 Notice of Appeal filed by G.G. (cchr) (Entered: 05/03/2016)
05/31/2016	65	PUBLISHED ORDER of USCA : denying Motion for rehearing en banc 54 Notice of Appeal filed by G. G. (15-2056) (bgra) (Entered: 06/01/2016)
06/07/2016	66	STAY OF MANDATE re 54 Notice of Appeal : Under Fed. R. App. P. 41(d) (1), the timely filing of a petition for rehearing or rehearing en banc or the timely filing of a motion to stay the mandate stays the mandate until the court has ruled on the petition for rehearing or rehearing en banc or motion to stay. In accordance with Rule 41(d)(1), the mandate is stayed pending further order of this court. (15-2056) (bgra) (Entered: 06/08/2016)
06/09/2016	67	ORDER of USCA as to 54 Notice of Appeal filed by G. G. Upon consideration of the motion to stay mandate pending filing of petition for writ of certiorari, the court denies the motion. Judge Floyd and Senior Judge Davis voted to deny the motion. Judge Niemeyer voted to grant the motion. (15-2056) (bgra) (Entered: 06/09/2016)
06/17/2016	68	USCA Mandate re 54 Notice of Appeal. The judgment of this court, entered 4/19/2016, takes effect today. This constitutes the formal mandate of this court issued pursuant to Rule 41(a) of the Federal Rules of Appellate Procedure. (15-2056) (bgra) (Entered: 06/17/2016)
06/23/2016		Rule 16(b) Scheduling Conference set for 6/29/2016 at 10:00 AM in Norfolk Grand Jury Courtroom before District Judge Robert G. Doumar. (lbax,) (Entered: 06/23/2016)
06/23/2016	69	ORDER: Based on the evidence submitted through declarations previously proffered for the purpose of the hearing on the Preliminary Injunction, this Court, pursuant to Title IX, hereby ORDERS that Gloucester County School Board permit the plaintiff, G.G., to use the boys' restroom at Gloucester High School until further order of this Court. Copy of Order delivered to all counsel of record. Signed by District Judge Robert G. Doumar on 6/23/2016. (bgra) (Entered: 06/23/2016)

06/27/2016	70	NOTICE OF APPEAL as to 69 Order, by Gloucester County School Board. Filing fee \$ 505, receipt number 0422-5050850. (Corrigan, David) (Entered: 06/27/2016)
06/28/2016		Transmission of Notice of Appeal to US Court of Appeals re 70 Notice of Appeal (All case opening forms, plus the transcript guidelines, may be obtained from the Fourth Circuit's website at www.ca4.uscourts.gov) (bgra) (Entered: 06/28/2016)
06/28/2016	71	MOTION to Stay re 69 Order, <i>Pending Appeal</i> by Gloucester County School Board. (Corrigan, David) (Entered: 06/28/2016)
06/28/2016	72	Memorandum in Support re 71 MOTION to Stay re 69 Order, <i>Pending Appeal</i> filed by Gloucester County School Board. (Corrigan, David) (Entered: 06/28/2016)
06/29/2016		Scheduling Conference - Rule 16b held on 6/29/2016 before District Judge Robert G. Doumar: Rebecca Glenberg and Joshua block present on behalf of the plaintiff; David Corrigan and Jeremy Capps present on behalf of the defendant; Comments of Court and Counsel; Court directed counsel to file a response to motion by 7/1/16. Trial date selected; Discovery schedule reviewed. Order to follow. Court adjourned. (Court Reporter Heidi Jeffreys.) (lhow,) (Entered: 06/30/2016)
06/30/2016	73	Rule 16(b) Scheduling Order - Pursuant to the Rule 16(b) Conference it is ordered that the Final Pretrial Conference set for 1/19/2017 at 10:00 AM in Norfolk. Bench Trial set for 1/31/2017 at 10:00 AM in Newport News. Signed by District Judge Robert G. Doumar & filed on 6/30/16. (ptom,) (Entered: 06/30/2016)
06/30/2016	74	USCA Case Number 16-1733 4CCA - Case Manager Jennifer Rice for 70 Notice of Appeal filed by Gloucester County School Board. [16-1733] (cchr) (Entered: 06/30/2016)
07/01/2016	75	RESPONSE to Motion re 71 MOTION to Stay re 69 Order, <i>Pending Appeal</i> filed by G. G.. (Glenberg, Rebecca) (Entered: 07/01/2016)
07/06/2016	76	ORDER denying 71 Motion to Stay. This Court is bound by the Judgment of the Court of Appeals. The Court of Appeals' actions in denying a rehearing en banc and a stay of its mandate indicate that it desires that its Judgment take effect immediately. The Court of Appeals itself is bound by its own prior precedents. Although Defendant has filed an appeal of the Preliminary Injunction, the Court of Appeals' prior opinion in this case will control in that appeal. This Court believes that based on the law as laid out in that opinion and the evidence submitted by declarations in this case, the Preliminary Injunction was warranted. There are no grounds for a stay. Accordingly, the Court DENIES the Motion for Stay Pending Appeal. ECF No. 71. Signed by District Judge Robert G. Doumar on 7/6/2016. (bgra) (Entered: 07/06/2016)
07/06/2016	77	ANSWER to 8 Complaint by Gloucester County School Board.(Corrigan, David) (Entered: 07/06/2016)
07/07/2016		

		Jury Trial set for 1/31/2017 at 10:00 AM in Newport News Courtroom 1 before District Judge Robert G. Doumar. (lbax,) (Entered: 07/07/2016)
07/12/2016	78	ORDER of USCA as to 70 : Upon consideration of submissions relative to the motion of appellant for stay pending appeal, the court denies the motion. Entered at the direction of Judge Floyd. Senior Judge Davis wrote an opinion concurring in the denial of a stay pending the filing of, and action on, a petition for certiorari. Judge Niemeyer wrote an opinion dissenting from the denial of a stay pending appeal. Notice of Appeal filed by Gloucester County School Board (16-1733) (bgra) (Entered: 07/14/2016)
08/03/2016	79	SUPREME COURT REMARK: The application to recall and stay the mandate of the United States Court of Appeals for the Fourth Circuit in case No. 152056, presented to THE CHIEF JUSTICE and by him referred to the Court, is granted and the preliminary injunction entered by the United States District Court for the Eastern District of Virginia on June 23, 2016, is hereby stayed pending the timely filing and disposition of a petition for a writ of certiorari. Should the petition for a writ of certiorari be denied, this stay shall terminate automatically. In the event the petition for a writ of certiorari is granted, the stay shall terminate upon the issuance of the judgment of this Court. (15-2056) (bgra) (Entered: 08/04/2016)
08/18/2016	80	MOTION to Stay by Gloucester County School Board. (Corrigan, David) (Entered: 08/18/2016)
08/18/2016	81	Brief in Support to 80 MOTION to Stay filed by Gloucester County School Board. (Corrigan, David) (Entered: 08/18/2016)
08/19/2016	82	ORDER of USCA as to 70 Notice of Appeal filed by Gloucester County School Board : Upon consideration of the joint motion to hold appeal in abeyance pending disposition of certiorari petition, the court grants the motion. (16-1733) (bgra) (Entered: 08/19/2016)
08/23/2016	83	Joint MOTION for Protective Order by G. G.. (Deady, Gail) (Entered: 08/23/2016)
08/23/2016	84	Memorandum in Support re 83 Joint MOTION for Protective Order filed by G. G.. (Attachments: # 1 Proposed Order Protective Order)(Deady, Gail) (Entered: 08/23/2016)
08/23/2016		MOTIONS REFERRED to Magistrate Judge: Douglas E. Miller. 83 Joint MOTION for Protective Order (bgra) (Entered: 08/23/2016)
08/24/2016	85	AGREED CONFIDENTIALITY PROTECTIVE ORDER: granting 83 Joint MOTION for Protective Order by G. G. Signed by Magistrate Judge Douglas E. Miller on 8/24/2016. (bgra) (Entered: 08/24/2016)
08/31/2016	86	ORDER granting 80 Motion to Stay. The Court hereby GRANTS the Motion to Stay and STAYS this matter pending the disposition of the School Board's petition for a writ of certiorari with the United States Supreme Court. ECF No. 80. Copy of Order provided to all Counsel of Record. Signed by District Judge Robert G. Doumar on 8/31/2016. (bgra) (Entered: 08/31/2016)
09/02/2016	87	

		SUPREME COURT REMARK: The petition for a writ of certiorari in the above entitled case was filed on August 29, 2016 and placed on the docket September 1, 2016 as No. 16-273. re 54 Notice of Appeal. [15-2056] (ldab,) (Entered: 09/02/2016)
10/31/2016	88	Supreme Court Remark re 54 Notice of Appeal : The petition for a writ of certiorari is granted limited to Questions 2 and 3 presented by the petition. (bgra) (Entered: 11/02/2016)
02/07/2017	89	Appeal Remark re 70 Notice of Appeal : RECORD requested by Supreme Court from court of appeals and district court/agency. Supreme Court Docket No.: 16-273 (15-2056)(bgra) (Entered: 02/08/2017)
02/07/2017	90	Appeal Remark re 70 Notice of Appeal : RECORD (4CCA) transmitted to Supreme Court. Supreme Court Docket No.: 16-273 (15-2056) (bgra) (Entered: 02/08/2017)
03/06/2017	91	SUPREME COURT REMARK--order remanding case received. 03/06/2017, REMANDED vacated. re 70 Notice of Appeal, 54 Notice of Appeal : [15-2056, 16-1733] (bgra) (Entered: 03/07/2017)
04/07/2017	92	SUPREME COURT REMARK--judgment remanding case received. REMANDED vacated, 04/07/2017. 70 Notice of Appeal, 54 Notice of Appeal. (15-2056) (16-1733) (bgra) (Entered: 04/11/2017)
04/07/2017	93	PUBLISHED OPINION of USCA (Copy): Upon consideration of the unopposed motion to vacate preliminary injunction, the court vacates the preliminary injunction entered by the district court on June 23, 2016. Senior Judge Davis wrote a concurring opinion in which Judge Floyd joined. Entered at the direction of Judge Floyd with the concurrence of Judge Niemeyer and Senior Judge Davis. re 70 Notice of Appeal attached copy of judgment will not take effect until issuance of the mandate. (16-1733) (bgra) (Entered: 04/11/2017)
04/07/2017	94	USCA JUDGMENT as to 70 Notice of Appeal: In accordance with the decision of this court, the district court preliminary injunction entered June 23, 2016 is vacated. This judgment shall take effect upon issuance of this court's mandate in accordance with Fed. R. App. P. 41. (16-1733) (bgra) (Entered: 04/11/2017)
04/13/2017	95	MOTION to Continue <i>Stay, Unopposed</i> by Gloucester County School Board. (Corrigan, David) (Entered: 04/13/2017)
04/13/2017	96	Brief in Support to 95 MOTION to Continue <i>Stay, Unopposed</i> filed by Gloucester County School Board. (Corrigan, David) (Entered: 04/13/2017)
04/13/2017	97	ORDER granting 95 Motion to Continue. The Court hereby GRANTS the Motion to Continue Stay and STAYS this matter pending the Fourth Circuit's ruling on the preliminary injunction and the dismissal of the Title IX claim. ECF No. 95.Copy of Order provided all counsel of record.Signed by District Judge Robert G. Doumar on 4/13/2017. (bgra) (Entered: 04/13/2017)
04/18/2017	98	AMENDED ORDER of USCA as to 70 Notice of Appeal filed by Gloucester County School Board. The Court amends its order filed April 7, 2017, as

		follows: On page 4, line 12, Shehab is corrected to read Shihab. [16-1733] (bgra) (Entered: 04/19/2017)
04/18/2017	99	AMENDED PUBLISHED ORDER of USCA (Copy) re 70 Notice of Appeal attached copy of judgment will not take effect until issuance of the mandate. Upon consideration of the unopposed motion to vacate preliminary injunction, the court vacates the preliminary injunction entered by the district court on June 23, 2016. Senior Judge Davis wrote a concurring opinion in which Judge Floyd joined. Entered at the direction of Judge Floyd with the concurrence of Judge Niemeyer and Senior Judge Davis. [16-1733] (bgra) (Entered: 04/19/2017)
05/01/2017	100	USCA Mandate: The judgment of this court, entered 4/7/2017, takes effect today. This constitutes the formal mandate of this court issued pursuant to Rule 41(a) of the Federal Rules of Appellate Procedure. re 70 Notice of Appeal. (16-1733) (bgra) (Entered: 05/01/2017)
05/03/2017	101	MOTION to Withdraw as Attorney by G. G.. (Attachments: # 1 Proposed Order)(Glenberg, Rebecca) (Entered: 05/03/2017)
05/03/2017	102	ORDER of USCA as to 54 Notice of Appeal filed by G. G. The court grants the motion to withdraw from further representation on appeal. (15-2056) (bgra) (Entered: 05/04/2017)
05/04/2017	103	MOTION to Amend/Correct 8 Complaint by G. G.. (Attachments: # 1 Memorandum of Law In Support of Plaintiff's Unopposed Motion to Amend Case Caption)(Deady, Gail) (Entered: 05/04/2017)
05/04/2017		Notice of Correction: The filing user is requested to refile the Memorandum in Support as a separate pleading, linking same back to Motion to Amend/Correct. re 103 MOTION to Amend/Correct 8 Complaint (bgra) (Entered: 05/04/2017)
05/04/2017	104	Memorandum in Support re 103 MOTION to Amend/Correct 8 Complaint <i>Caption</i> filed by G. G.. (Deady, Gail) (Entered: 05/04/2017)
05/16/2017	105	ORDER granting 101 Motion to Withdraw as Attorney. Upon consideration of Rebecca K. Glenberg's motion to withdraw as attorney in this case, it is hereby ORDERED that the motion to withdraw is GRANTED. Signed by District Judge Robert G. Doumar on 5/16/2017. (bgra) (Entered: 05/16/2017)
05/16/2017	106	ORDER granting 103 Motion to Amend/Correct. The Court finds that Plaintiff has reached the legal age of majority in Virginia. Accordingly, the Court hereby GRANTS Plaintiff's Motion. ECF No. 103. The Court ORDERS the Clerk of the Court to amend the docket by substituting "Gavin Grimm" as Plaintiff for "G.G., by his next friend and mother, Deirdre Grimm" in the case caption, and further ORDERS that all future filings in this matter employ this case styling. Signed by District Judge Robert G. Doumar on 5/16/2017. (bgra) (Entered: 05/16/2017)
06/06/2017		Case Reassigned to District Judge Arenda L. Wright Allen. District Judge Robert G. Doumar no longer assigned to the case. (afar) (Entered: 06/06/2017)
08/02/2017	107	

		Published Opinion and Order DIRECTING LIMITED REMAND [4CCA retains jurisdiction] re 54 Notice of Appeal attached copy of judgment will not take effect until issuance of the mandate. 15-2056 (ldab,) (Entered: 08/02/2017)
08/04/2017	108	ORDER re 107 Published Opinion and Order DIRECTING LIMITED REMAND [4CCA retains jurisdiction]. On August 25, 2017, each party shall submit a Response to the Position Statements. SEE ORDER FOR DETAILS. Signed by District Judge Arenda L. Wright Allen and filed on 8/4/17. Copies distributed to all parties 8/4/17.(ldab,) (Entered: 08/04/2017)
08/11/2017	109	Consent MOTION to Amend/Correct 8 Complaint by Gavin Grimm. (Attachments: # 1 Exhibit A)(Deady, Gail) (Entered: 08/11/2017)
08/17/2017	110	ORDER of USCA as to 54 Notice of Appeal filed by Gavin Grimm. The court grants the motion to withdraw from further representation on appeal. (15-2056) (epri) (Entered: 08/18/2017)
08/18/2017	111	STATUS REPORT <i>Joint Position Statement</i> by Gavin Grimm. (Deady, Gail) (Entered: 08/18/2017)
08/22/2017	112	ORDER granting 109 , the Consent Motion to Amend/Correct the Complaint, as follows: the Clerk is DIRECTED to lodge the Plaintiff's Amended Complaint; the Defendant shall file a responsive pleading or motion on or before September 15, 2017. If Defendant files a motion to dismiss, the parties' respective memoranda in support and opposition shall not exceed forty-five pages, exclusive of affidavits and supporting documentation. All briefs shall otherwise comply with the requirements of this Court's Local Rules. Signed by District Judge Arenda L. Wright Allen on 8/22/2017. (Allen, Arenda) (Entered: 08/22/2017)
08/22/2017	113	AMENDED COMPLAINT FILED AS DIRECTED against Gloucester County School Board, filed by Gavin Grimm.(ecav,) (Entered: 08/22/2017)
08/30/2017	114	ORDER of USCA as to 54 Notice of Appeal filed by Gavin Grimm Upon consideration of the motion to dismiss this appeal pursuant to Rule 42(b) of the Federal Rules of Appellate Procedure, and there appearing no opposition, the court grants the motion. Entered at the direction of Judge Niemeyer with the concurrence of Judge Duncan and Judge Floyd. 15-2056(ldab,) (Entered: 08/30/2017)
08/30/2017	115	USCA Rule 42(b) Mandate re 54 Notice of Appeal. This court's order dismissing this appeal pursuant to Local Rule 42(b) takes effect today. This constitutes the formal mandate of this court issued pursuant to Rule 41(a) of the Federal Rules of Appellate Procedure. 15-2056 (ldab,) (Entered: 08/30/2017)
08/30/2017	116	MOTION for Extension of Time to File Motion to Dismiss the Amended Complaint by Gloucester County School Board. (Attachments: # 1 Proposed Order Agreed)(Corrigan, David) (Entered: 08/30/2017)
08/31/2017	117	ORDER granting 116 Defendant's agreed Motion for Extension of Time to File a Motion to Dismiss the Amended Complaint as follows: Defendant's Motion

		shall be filed on or before September 22, 2017. Signed by District Judge Arenda L. Wright Allen on 08/31/2017. (Allen, Arenda) (Entered: 08/31/2017)
09/22/2017	118	MOTION to Dismiss for Failure to State a Claim by Gloucester County School Board. (Corrigan, David) (Entered: 09/22/2017)
09/22/2017	119	Brief in Support to 118 MOTION to Dismiss for Failure to State a Claim filed by Gloucester County School Board. (Corrigan, David) (Entered: 09/22/2017)
09/29/2017	120	Memorandum in Opposition re 118 MOTION to Dismiss for Failure to State a Claim filed by Gavin Grimm. (Deady, Gail) (Entered: 09/29/2017)
10/02/2017	121	ORDER deferring ruling on 118 , the Motion to Dismiss for Failure to State a Claim; under the circumstances presented by counsel jointly in a communication to the Court, the Court shall permit Defendant to file its Reply brief on or before Wednesday, October 11, 2017. The motion will be taken under advisement as of that date. If a hearing is deemed warranted by the Court, the Court will notify counsel for purposes of scheduling the hearing after October 11, 2017. Signed by District Judge Arenda L. Wright Allen on 10/2/2017. (Allen, Arenda) (Entered: 10/02/2017)
10/11/2017	122	RESPONSE in Support re 118 MOTION to Dismiss for Failure to State a Claim filed by Gloucester County School Board. (Attachments: # 1 Exhibit A) (Corrigan, David) (Entered: 10/11/2017)
10/26/2017	123	ORDER - The parties are ORDERED to file supplemental briefing on mootness pursuant to the directives herein. A ruling on Defendant's Motion to Dismiss for Failure to State a Claim 118 is DEFERRED pending resolution of the mootness issue. Before undertaking any jurisdictional discovery, the party seeking to undertake discovery is ORDERED to file a motion for jurisdictional discovery no later than 14 calendar days after the date of the entry of this Order. Defendant shall file its Supplemental Memorandum no later than 60 calendar days after the date of the entry of this Order. Plaintiff shall file its Response no later than 21 calendar days after service of the Defendant's Memorandum. Defendant may file a Reply no later than 7 calendar days after the service of the Response. Briefs shall not exceed 35 pages, excluding exhibits. Signed by District Judge Arenda L. Wright Allen on 10/26/17. (bpet,) (Entered: 10/26/2017)
11/01/2017	124	NOTICE by Gavin Grimm <i>Supplemental Authority in Opposition to Defendant's Motion to Dismiss</i> (Attachments: # 1 Exhibit A)(Deady, Gail) (Entered: 11/01/2017)
11/02/2017	125	NOTICE by Gavin Grimm <i>Consent to Dismissal of Requests for Relief (C) and (D)</i> (Deady, Gail) (Entered: 11/02/2017)
11/02/2017	126	MOTION to Vacate 123 Order,,, by Gavin Grimm. (Deady, Gail) (Entered: 11/02/2017)
11/02/2017	127	ORDER of USCA as to 54 Notice of Appeal filed by Gavin Grimm. The court grants the motion to withdraw from further representation on appeal. (15-2056) (bpet,) (Entered: 11/03/2017)
11/16/2017	128	

		Opposition to 126 MOTION to Vacate 123 Order,,, filed by Gloucester County School Board. (Corrigan, David) (Entered: 11/16/2017)
11/17/2017	129	REPLY to Response to Motion re 126 MOTION to Vacate 123 Order,,, filed by Gavin Grimm. (Deady, Gail) (Entered: 11/17/2017)
11/20/2017	130	NOTICE by Gavin Grimm re 126 MOTION to Vacate 123 Order,,, <i>Oral Argument</i> (Deady, Gail) (Entered: 11/20/2017)
11/28/2017	131	NOTICE by Gavin Grimm re 118 MOTION to Dismiss for Failure to State a Claim <i>Supplemental Authority</i> (Attachments: # 1 Exhibit A)(Deady, Gail) (Entered: 11/28/2017)
12/12/2017	132	ORDER GRANTING 126 Motion to Vacate, DISMISSING Requests for Relief (C) and (D). Defendant shall file an amended Motion to Dismiss within 45 days of this Order. Plaintiff shall file a Response to same within 21 days, and Defendant may file a Reply 7 days thereafter. Signed by District Judge Arenda L. Wright Allen on 12/12/17. (bpet,) (Entered: 12/13/2017)
01/05/2018	133	NOTICE of Appearance by David P. Corrigan on behalf of Gloucester County School Board (Corrigan, David) (Entered: 01/05/2018)
01/05/2018	134	NOTICE of Appearance by Douglas Edward Pittman on behalf of Gloucester County School Board (Pittman, Douglas) (Entered: 01/05/2018)
01/05/2018	135	Amended MOTION to Dismiss for Failure to State a Claim <i>Amended Complaint</i> by Gloucester County School Board. (Pittman, Douglas) (Entered: 01/05/2018)
01/05/2018	136	Brief in Support to 135 Amended MOTION to Dismiss for Failure to State a Claim <i>Amended Complaint</i> filed by Gloucester County School Board. (Pittman, Douglas) (Entered: 01/05/2018)
01/09/2018	137	MOTION to Withdraw , MOTION to Withdraw as Attorney by Gloucester County School Board. (Attachments: # 1 Exhibit A)(Fisher, Maurice) (Entered: 01/09/2018)
01/09/2018	138	Brief in Support of <i>Motion to Withdraw as Attorney</i> filed by Gloucester County School Board. (Fisher, Maurice) (Entered: 01/09/2018)
01/10/2018	139	Memorandum in Opposition re 135 Amended MOTION to Dismiss for Failure to State a Claim <i>Amended Complaint</i> filed by Gavin Grimm. (Deady, Gail) (Entered: 01/10/2018)
01/16/2018	140	REPLY to Response to Motion re 135 Amended MOTION to Dismiss for Failure to State a Claim <i>Amended Complaint</i> filed by Gloucester County School Board. (Attachments: # 1 Exhibit A)(Corrigan, David) (Entered: 01/16/2018)
03/02/2018	141	ORDER of USCA as to 54 Notice of Appeal filed by Gavin Grimm. The court grants the motion to withdraw from further representation on appeal. [15-2056] (bpet) (Entered: 03/05/2018)
03/06/2018	142	NOTICE of Supplemental Authority by Gavin Grimm re 135 Amended MOTION to Dismiss for Failure to State a Claim <i>Amended Complaint</i>

		(Attachments: # 1 Exhibit A) (Deady, Gail) Dkt text modified on 3/6/2018 (bpet). (Entered: 03/06/2018)
03/09/2018	143	ORDER granting 137 , the Motion to Withdraw as Attorney filed by M. Scott Fisher, as follows: Mr. Fisher, counsel of record for Defendant Gloucester County School Board, is granted permission to withdraw from this matter as counsel. Defendant will continue to be represented in this matter by Harman Claytor Corrigan & Wellman and David Corrigan, Jeremy Capps, and Douglas Pittman of that firm, who are also counsel of record. Signed by District Judge Arenda L. Wright Allen on 3/9/2018. (Allen, Arenda) (Entered: 03/09/2018)
03/13/2018	144	NOTICE of Supplemental Authority by Gavin Grimm re 135 Amended MOTION to Dismiss for Failure to State a Claim <i>Amended Complaint</i> (Attachments: # 1 Exhibit A)(Deady, Gail) Dkt text modified on 3/13/2018 (bpet). (Entered: 03/13/2018)
04/23/2018	145	NOTICE of Appearance by Claire Guthrie Gastanaga on behalf of Gavin Grimm (Gastanaga, Claire) (Entered: 04/23/2018)
04/23/2018	146	MOTION to Withdraw as Attorney by Gavin Grimm. (Attachments: # 1 Proposed Order)(Deady, Gail) (Entered: 04/23/2018)
04/28/2018	147	ORDER granting 146 , the Motion to Withdraw as Attorney filed by Gail Deady, as follows: Ms. Deady, counsel of record for Plaintiff Gavin Grimm, is granted permission to withdraw from this matter as counsel. Plaintiff will continue to be represented in this matter by Claire Gastanaga of the American Civil Liberties Union Foundation of Virginia, Inc., and Joshua Block and Leslie Cooper of the American Civil Liberties Union Foundation, who are all counsel of record. Signed by District Judge Arenda L. Wright Allen on 4/28/2018. (Allen, Arenda) (Entered: 04/28/2018)
05/22/2018	148	ORDER denying 135 Amended Motion to Dismiss for Failure to State a Claim, DISMISSING as moot 118 Motion to Dismiss for Failure to State a Claim. Counsel for the parties are DIRECTED to contact the Magistrate Courtroom Deputy within 30 days to schedule a settlement conference. Signed by District Judge Arenda L. Wright Allen on 5/22/18. (bpet) (Entered: 05/22/2018)
06/01/2018	149	Consent MOTION for Leave to Appeal <i>to the United States Fourth Circuit Court of Appeals</i> by Gloucester County School Board. (Corrigan, David) (Entered: 06/01/2018)
06/01/2018	150	Brief in Support to 149 Consent MOTION for Leave to Appeal <i>to the United States Fourth Circuit Court of Appeals</i> filed by Gloucester County School Board. (Corrigan, David) (Entered: 06/01/2018)
06/04/2018	151	Joint MOTION to Stay <i>All Proceedings in this Case Pending Appeal and for an Extension of Time for the School Board to File an Answer to Grimm's Amended Complaint</i> by Gloucester County School Board. (Corrigan, David) (Entered: 06/04/2018)
06/04/2018	152	Brief in Support to 151 Joint MOTION to Stay <i>All Proceedings in this Case Pending Appeal and for an Extension of Time for the School Board to File an</i>

		<i>Answer to Grimm's Amended Complaint</i> filed by Gloucester County School Board. (Corrigan, David) (Entered: 06/04/2018)
06/05/2018	153	ORDER: Defendant's 149 Consent Motion to Certify an Interlocutory Appeal to the 4th Circuit Court of Appeals is GRANTED. The Court's 5/22/18 148 Order is AMENDED as described in the instant Order. The parties' 151 Joint Motion to Stay All Proceedings in this Case Pending Appeal and for an Extension of Time for the School Board to File an Answer to Plaintiff's Amended Complaint is GRANTED. It is ORDERED that all proceedings in this case are stayed pending a ruling by the Fourth Circuit, and Defendant's deadline to file an Answer to Plaintiff's Amended Complaint is extended to 10 days after the entry of such ruling. Signed by District Judge Arenda L. Wright Allen on 6/5/18. (bpet) (Entered: 06/05/2018)
07/20/2018	154	ANSWER to Complaint by Gloucester County School Board.(Corrigan, David) (Entered: 07/20/2018)
07/23/2018		Refer for 16(b). (bpet) (Entered: 07/23/2018)
07/31/2018		Set Hearings Settlement Conference set for 10/4/2018 at 09:30 AM in Norfolk Judges Chamber before Magistrate Judge Douglas E. Miller. (cdod,) (Entered: 07/31/2018)
07/31/2018	155	RULE 26(f) PRETRIAL ORDER: Rule 16(b) Scheduling Conference set for 9/17/2018 at 10:00 AM in Norfolk Courtroom 3. Signed by Magistrate Judge Robert J. Krask and filed on 7/31/18. (lhow) (Entered: 07/31/2018)
08/02/2018	156	Settlement Conference Order entered. Settlement conference scheduled for October 4, 2018 at 9:30 a.m. at the United States District Court in Norfolk. The parties must submit a brief memorandum of five pages or less directly to the chambers of the undersigned via facsimile by noon on October 1, 2018. See order for further details. Signed by Magistrate Judge Douglas E. Miller on 08/02/18. (jjon) (Entered: 08/02/2018)
09/11/2018	157	NOTICE of Appearance by Nicole Gloria Tortoriello on behalf of Gavin Grimm (Tortoriello, Nicole) (Entered: 09/11/2018)
09/11/2018	158	Motion to appear Pro Hac Vice by Eden Heilman and Certification of Local Counsel Nicole Gloria Tortoriello Filing fee \$ 75, receipt number 0422-6266806. by Gavin Grimm. (Tortoriello, Nicole) (Main Document 158 replaced w/ ink-signed copy on 9/19/18) (bpet,). (Entered: 09/11/2018)
09/11/2018	159	Motion to appear Pro Hac Vice by Shayna Medley-Warsoff and Certification of Local Counsel Nicole Gloria Tortoriello Filing fee \$ 75, receipt number 0422-6266816. by Gavin Grimm. (Tortoriello, Nicole) (Entered: 09/11/2018)
09/12/2018	160	MOTION to Withdraw as Attorney by Gavin Grimm. (Gastanaga, Claire) Motion terminated on 9/18/18 (bpet,). (Entered: 09/12/2018)
09/17/2018		Scheduling Conference - Rule 16b held on 9/17/2018. Eden Heilman appeared on behalf of the plaintiff. (pro hac application pending) (lhow) (Entered: 09/17/2018)
09/18/2018	161	

		MOTION to Withdraw as Attorney by Gavin Grimm. (Attachments: # 1 Proposed Order)(Gastanaga, Claire) (Entered: 09/18/2018)
09/19/2018	162	ORDER granting 161 , the Motion to Withdraw as Attorney as follows: Ms. Gastanaga, counsel of record for Gavin Grimm, is granted permission to withdraw from this matter as counsel. The Plaintiff has consented, and remains fully represented. Signed by District Judge Arenda L. Wright Allen on 9/19/2018. (Allen, Arenda) (Entered: 09/19/2018)
09/19/2018		Notice of Correction re 158 Motion to appear Pro Hac Vice by Eden Heilman: the filing user has been advised to resubmit 158 via email with the proper signatures, and the Clerk's Office will substitute it for the existing document. (bpet,) (Entered: 09/19/2018)
09/19/2018	163	ORDER granting 159 , the Motion to appear Pro Hac Vice by Shayna Medley-Warsoff as certified by local counsel Nicole Gloria Tortoriello for Gavin Grimm. Signed by District Judge Arenda L. Wright Allen on 9/19/2018. (Allen, Arenda) (Entered: 09/19/2018)
09/19/2018	164	ORDER granting 158 , the Motion to appear Pro Hac Vice by Eden Heilman as certified by local counsel Nicole Gloria Tortoriello for Gavin Grimm. Signed by District Judge Arenda L. Wright Allen on 9/19/2018. (Allen, Arenda) (Entered: 09/19/2018)
09/26/2018	165	Order Rule 16(b) Scheduling Order - Pursuant to the Rule 16(b) Conference it is ordered that Final Pretrial Conference set for 7/12/2019 at 11:00 AM at the courthouse in Norfolk. Jury Trial set for 7/23/2019 at 10:00 AM at the courthouse in Newport News. Signed by District Judge Arenda L. Wright Allen on 9/25/18 and filed on 9/26/18. (lhow) (Entered: 09/26/2018)
10/04/2018	166	SECOND SETTLEMENT CONFERENCE ORDER. Settlement conference scheduled for 10/18/18 at 10:00 a.m. in the Richmond Courthouse ; any supplemental memoranda due by noon on 10/16/18; all other terms of the original 156 Settlement Conference Order remain in full force and effect; see Order for details. Signed by Magistrate Judge Douglas E. Miller on 10/4/18. (bpet,) (Entered: 10/04/2018)
10/18/2018		Settlement Conference held on 10/18/2018 before Magistrate Judge Douglas E. Miller. (lwoo) (Entered: 10/19/2018)
10/19/2018	167	ORDER Reassigning Case. Case reassigned to Magistrate Judge Robert J. Krask; Magistrate Judge Douglas E. Miller no longer assigned to case. Signed by Magistrate Judge Douglas E. Miller on 10/19/18. (bpet,) (Entered: 10/19/2018)
10/29/2018	168	Consent MOTION to Strike <i>Jury Demand and Set Case for Bench Trial</i> by Gavin Grimm. (Attachments: # 1 Proposed Order)(Tortoriello, Nicole) (Entered: 10/29/2018)
10/29/2018		MOTION REFERRED to Magistrate Judge Robert J. Krask: 168 Consent MOTION to Strike <i>Jury Demand and Set Case for Bench Trial</i> . (bpet,) (Entered: 10/29/2018)
10/29/2018	169	

		ORDER granting 168 Motion to Strike Jury Demand and Set Case for Bench Trial. Signed by Magistrate Judge Robert J. Krask on 10/29/18. (bpet,) (Entered: 10/29/2018)
10/29/2018		Bench Trial set for 7/23/2019 at 10:00 AM in Newport News Courtroom 1 before District Judge Arenda L. Wright Allen. (lhow) (Entered: 10/29/2018)
12/07/2018	170	MOTION for Leave to File <i>Second Amended Complaint</i> by Gavin Grimm. (Attachments: # 1 Exhibit A, # 2 Proposed Order)(Tortoriello, Nicole) (Entered: 12/07/2018)
12/21/2018	171	Memorandum in Opposition re 170 MOTION for Leave to File <i>Second Amended Complaint</i> filed by Gloucester County School Board. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Corrigan, David) (Entered: 12/21/2018)
12/27/2018	172	REPLY to Response to Motion re 170 MOTION for Leave to File <i>Second Amended Complaint</i> filed by Gavin Grimm. (Tortoriello, Nicole) (Entered: 12/27/2018)
02/13/2019	173	MOTION to Withdraw <i>as Counsel for Defendant</i> by Gloucester County School Board. (Attachments: # 1 Exhibit Proposed Order)(Pittman, Douglas) (Entered: 02/13/2019)
02/13/2019	174	Brief in Support to 173 MOTION to Withdraw <i>as Counsel for Defendant</i> filed by Gloucester County School Board. (Pittman, Douglas) (Entered: 02/13/2019)
02/14/2019	175	ORDER granting 173 , the Motion to Withdraw as Counsel for Defendant filed by Gloucester County School Board. Douglas E. Pittman is hereby granted leave to withdraw as counsel of record. Signed by District Judge Arenda L. Wright Allen on 2/14/2019. (Allen, Arenda) (Entered: 02/14/2019)
02/15/2019	176	ORDER granting 170 Motion for Leave to File <i>Second Amended Complaint</i> . The Clerk is DIRECTED to file the Second Amended Complaint. Signed by District Judge Arenda L. Wright Allen on 2/14/19. (bpet,) (Entered: 02/15/2019)
02/15/2019	177	SECOND AMENDED COMPLAINT against Gloucester County School Board, filed by Gavin Grimm. (bpet,) (Entered: 02/15/2019)
02/19/2019	178	MOTION for Extension of <i>Time to Serve Expert Disclosures</i> by Gloucester County School Board. (Capps, Jeremy) (Entered: 02/19/2019)
02/20/2019		MOTION REFERRED to Magistrate Judge Robert J. Krask: 178 MOTION for Extension of <i>Time to Serve Expert Disclosures</i> . (bpet,) (Entered: 02/20/2019)
02/21/2019	179	ORDER granting 178 Motion for Extension of Time to File expert disclosure by Gloucester County School Board. The defendant's expert disclosure responding to, contradicting, or rebutting plaintiff's expert disclosure shall be made on or before February 26, 2019. Signed by Magistrate Judge Robert J. Krask on 02/21/2019. (Krask, Robert) (Entered: 02/21/2019)
03/01/2019	180	ANSWER to Complaint (<i>Second Amended</i>) by Gloucester County School Board.(Corrigan, David) (Entered: 03/01/2019)
03/07/2019	181	

		NOTICE of Appearance by Jennifer Marie Safstrom on behalf of Gavin Grimm (Safstrom, Jennifer) (Entered: 03/07/2019)
03/19/2019	182	Consent MOTION for Leave to File Excess Pages by Gavin Grimm. (Attachments: # 1 Proposed Order)(Heilman, Eden) (Entered: 03/19/2019)
03/19/2019	183	ORDER granting 182 , Plaintiff's consent motion for leave to file summary judgment briefs in excess of the thirty-page limit on briefs imposed by Local Civil Rule 7(F)(3) as follows: for good cause shown, briefs filed in support of summary judgment, in opposition of summary judgment, and in reply shall be subject to a sixty-page limit. Signed by District Judge Arenda L. Wright Allen on 3/19/2019. (Allen, Arenda) (Entered: 03/19/2019)
03/26/2019	184	MOTION for Summary Judgment by Gavin Grimm. (Attachments: # 1 Proposed Order)(Heilman, Eden) (Entered: 03/26/2019)
03/26/2019	185	Memorandum in Support re 184 MOTION for Summary Judgment filed by Gavin Grimm. (Heilman, Eden) (Entered: 03/26/2019)
03/26/2019	186	EXHIBIT 1 Declaration of Gavin Grimm re 185 Memorandum in Support by Gavin Grimm. (Attachments: # 1 Exhibit A - Treatment Documentation Letter (Redacted), # 2 Exhibit B - DMV, # 3 Exhibit C - Court Order (Redacted), # 4 Exhibit D - Birth Certificate (Redacted), # 5 Exhibit E - Transcript (Redacted)) (Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	187	EXHIBIT 2 Declaration of Deirdre Grimm re 185 Memorandum in Support by Gavin Grimm.. (Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	188	MOTION Leave to File Brief in Support of Plaintiff <i>Unopposed Motion of Amicus Curiae Fairfax County School Board and Other Virginia School Boards for Leave to File Brief in Support of Plaintiff</i> by Fairfax County School Board, Alexandria City School Board, Arlington School Board, Falls Church City School Board. (Attachments: # 1 Proposed Amicus Brief, # 2 Proposed Order)(Cox, Trevor) (Entered: 03/26/2019)
03/26/2019	189	NOTICE of Appearance by Trevor Stephen Cox on behalf of Fairfax County School Board, Alexandria City School Board, Arlington School Board, Falls Church City School Board (Cox, Trevor) (Entered: 03/26/2019)
03/26/2019	190	NOTICE of Appearance by Stuart Alan Raphael on behalf of Fairfax County School Board, Alexandria City School Board, Arlington School Board, Falls Church City School Board (Raphael, Stuart) (Entered: 03/26/2019)
03/26/2019	191	MOTION for Summary Judgment by Gloucester County School Board. (Corrigan, David) (Entered: 03/26/2019)
03/26/2019	192	EXHIBIT 3 Declaration of Shayna Medley-Warsoff re 185 Memorandum in Support by Gavin Grimm. (Attachments: # 1 Exhibit 1 - Def.'s Response to First Set of Interrogatories, # 2 Exhibit 2 - Def.'s Supplemental Response to First Set of Interrogatories, # 3 Exhibit 3 - Penn Expert Rep. & Decl., # 4 Exhibit 4 - Penn CV, # 5 Exhibit 5 - WPATH Standards of Care, # 6 Exhibit 6 - Endocrine Society Guidelines, # 7 Exhibit 7 - Van Meter Expert Rep., # 8 Exhibit 8 - Penn Rebuttal Rep., # 9 Exhibit 9 - Collins Dep., # 10 Exhibit 10 -

		Clemons Dep., # 11 Exhibit 11 - Durr Dep., # 12 Exhibit 12 - Lord Dep., # 13 Exhibit 13 - Anderson Dep., # 14 Exhibit 14 - Van Meter Dep., # 15 Exhibit 15 - Collins memo dated 10/14/2014 (GCSB 894), # 16 Exhibit 16 - Clemons email dated 10/22/14 (WAVYTVFOIA 007), # 17 Exhibit 17 - Collins memo dated 10/23/14 (GCSB 4122), # 18 Exhibit 18 - Hook email dated 10/24/14 (GCSB-0854), # 19 Exhibit 19 - Hook email dated 10/31/14 (GCSB 0844), # 20 Exhibit 20 - Hook email to Board dated 11/4/14 (GCSB 0513), # 21 Exhibit 21 - Hook email to the Board dated 11/9/14 with attachment (GCSB 0507-08), # 22 Exhibit 22 - Press Release dated 12/3/14, # 23 Exhibit 23 - Recorded Minutes of the Gloucester County School Board, December 9, 2014, # 24 Exhibit 24 - Collins memo to Deirdre and David Grimm dated 12/10/2014 (GCSB 0893), # 25 Exhibit 25 - Email to Nate Collins dated 11/19/2014 (GCSB 3932), # 26 Exhibit 26 - Gavin transcript GCSB, # 27 Exhibit 27 - VSBA Presentation, # 28 Exhibit 28 - Map of Gloucester High School 17 (GCSB 1276), # 29 Exhibit 29 - Annotated Map of GHS, # 30 Exhibit 30 - List of Restrooms at GHS (GCSB 03944), # 31 Exhibit 31 - Ltr. from J. Block to D. Corrigan dated 12/23/16, # 32 Exhibit 32 - Ltr. from D. Corrigan to J. Block dated 1/18/17, # 33 Exhibit 33 - Ltr. from J. Block to D. McNerney dated 1/18/17, # 34 Exhibit 34 - Ltr. from K. Duncan to D. McNerney dated 1/19/17, # 35 Exhibit 35 - Press Release dated 02/13/2019, # 36 Exhibit 36 - Press Release dated 02/21/2019, # 37 Exhibit 37 - Recorded Minutes of the Gloucester County School Board, November 11, 2014, # 38 Exhibit 38 - AAP Amicus, # 39 Exhibit 39 - School Administrator Amicus, # 40 Exhibit 40 - Nat'l PTA Amicus, # 41 Exhibit 41 - APA & NASP Resolution, # 42 Exhibit 42 - Gender Spectrum Frequently Asked Questions (2016), # 43 Exhibit 43 - NASSP Statement)(Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	193	EXHIBIT 4 Declaration of Diana Bruce re 185 Memorandum in Support by Gavin Grimm. (Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	194	EXHIBIT 5 Declaration of Thomas Aberli re 185 Memorandum in Support by Gavin Grimm. (Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	195	EXHIBIT 6 Declaration of Janet M. Rainey re 185 Memorandum in Support by Gavin Grimm. (Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	196	Brief in Support to 191 MOTION for Summary Judgment filed by Gloucester County School Board. (Attachments: # 1 Exhibit 1, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D, # 6 Exhibit E, # 7 Exhibit F, # 8 Exhibit G, # 9 Exhibit H, # 10 Exhibit I, # 11 Exhibit J, # 12 Exhibit K, # 13 Exhibit L, # 14 Exhibit M, # 15 Exhibit N, # 16 Exhibit O)(Corrigan, David) (Entered: 03/26/2019)
03/26/2019	197	EXHIBIT 7 Declaration of James H. Loving re 185 Memorandum in Support by Gavin Grimm. (Attachments: # 1 Exhibit A - 1st multi user 1, # 2 Exhibit B - 1st multi user 2, # 3 Exhibit C - 1st multi user 3, # 4 Exhibit D - 2nd multi user 1, # 5 Exhibit E - 2nd multi user 2, # 6 Exhibit F - 2nd multi user 3, # 7

		Exhibit G - 2nd multi user 4, # 8 Exhibit H - single user 1, # 9 Exhibit I - single user 2, # 10 Exhibit J - single user 3, # 11 Exhibit K - single user 4, # 12 Exhibit L - single user 5)(Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/27/2019		Notice of Correction re 186 , 187 , 192 , 193 , 194 , 195 , 197 Exhibits: The exhibits are not linked back to the document to which they refer. Additionally, to the extent possible, exhibits should filed as attachments to the document they support. In the event that exhibits are too numerous to be contained in one docket entry, they should be filed as attachments to a Notice of Submission bearing the signature of the filing user, as outlined in the ECF Policies and Procedures Manual. The filing user has been advised to note same for future reference. No further action is required at this time. (bpet,) (Entered: 03/27/2019)
03/27/2019	198	ORDER granting 188 , the Unopposed Motion of Amici Curiae for Leave to File Brief in Support of Plaintiff, filed by Fairfax County School Board and other Virginia school boards. The Clerk is directed to please file the proposed amicus brief, ECF No. 188-1. Signed by District Judge Arenda L. Wright Allen on 3/27/2019. (Allen, Arenda) (Entered: 03/27/2019)
03/27/2019	199	Amicus Brief by Fairfax County School Board, Alexandria City School Board, Arlington School Board, Falls Church City School Board. (bpet,) (Entered: 03/27/2019)
04/09/2019	200	RESPONSE in Opposition re 184 MOTION for Summary Judgment filed by Gloucester County School Board. (Attachments: # 1 Exhibit 1 - Index of Exhibits, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D, # 6 Exhibit E, # 7 Exhibit F, # 8 Exhibit G, # 9 Exhibit H, # 10 Exhibit I, # 11 Exhibit J, # 12 Exhibit K, # 13 Exhibit L, # 14 Exhibit M, # 15 Exhibit N, # 16 Exhibit O, # 17 Exhibit P)(Corrigan, David) (Entered: 04/09/2019)
04/09/2019	201	RESPONSE in Opposition re 191 MOTION for Summary Judgment filed by Gavin Grimm. (Attachments: # 1 Exhibit 1, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D, # 6 Exhibit E)(Heilman, Eden) (Entered: 04/09/2019)
04/15/2019	202	REPLY to Response to Motion re 191 MOTION for Summary Judgment filed by Gloucester County School Board. (Attachments: # 1 List of Exhibits, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D, # 6 Exhibit E, # 7 Exhibit F, # 8 Exhibit G, # 9 Exhibit H, # 10 Exhibit I, # 11 Exhibit J) (Corrigan, David) (Entered: 04/15/2019)
04/16/2019	203	REPLY to Response to Motion re 184 MOTION for Summary Judgment filed by Gavin Grimm. (Attachments: # 1 Exhibit 1, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D, # 6 Exhibit E)(Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	204	MOTION to Seal by Gavin Grimm. (Attachments: # 1 Proposed Order) (Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	205	Notice of Filing Sealing Motion LCvR5(C) by Gavin Grimm re 204 MOTION to Seal (Heilman, Eden) (Entered: 04/16/2019)

04/16/2019	206	Sealed Attachment/Exhibit(s) B re 204 MOTION to Seal . (Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	207	Sealed Attachment/Exhibit(s) C re 204 MOTION to Seal . (Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	208	Sealed Attachment/Exhibit(s) D re 204 MOTION to Seal . (Attachments: # 1 Supplement Continuation of Sealed Filing, # 2 Supplement Continuation of Sealed Filing)(Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	209	Sealed Attachment/Exhibit(s) E re 204 MOTION to Seal . (Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	210	Memorandum in Support re 204 MOTION to Seal filed by Gavin Grimm. (Heilman, Eden) (Entered: 04/16/2019)
04/19/2019	211	RESPONSE to Motion re 204 MOTION to Seal filed by Gloucester County School Board. (Capps, Jeremy) (Entered: 04/19/2019)
04/22/2019	212	ORDER granting 204 Motion to Seal. Signed by Magistrate Judge Robert J. Krask on 4/22/19. (bpct,) (Entered: 04/22/2019)
04/30/2019	213	MOTION to Exclude <i>and Strike Exhibits Filed with Gavin Grimm's Motion for Summary Judgment and Reply in Support of Motion for Summary Judgment</i> by Gloucester County School Board. (Corrigan, David) (Entered: 04/30/2019)
04/30/2019	214	Brief in Support to 213 MOTION to Exclude <i>and Strike Exhibits Filed with Gavin Grimm's Motion for Summary Judgment and Reply in Support of Motion for Summary Judgment</i> filed by Gloucester County School Board. (Attachments: # 1 List of Exhibits, # 2 Exhibit A, # 3 Exhibit B)(Corrigan, David) (Entered: 04/30/2019)
05/01/2019	215	Request for Hearing by Gloucester County School Board re 191 MOTION for Summary Judgment , 213 MOTION to Exclude <i>and Strike Exhibits Filed with Gavin Grimm's Motion for Summary Judgment and Reply in Support of Motion for Summary Judgment</i> , 184 MOTION for Summary Judgment (Corrigan, David) (Entered: 05/01/2019)
05/06/2019	216	Memorandum in Opposition re 213 MOTION to Exclude <i>and Strike Exhibits Filed with Gavin Grimm's Motion for Summary Judgment and Reply in Support of Motion for Summary Judgment</i> filed by Gavin Grimm. (Safstrom, Jennifer) (Entered: 05/06/2019)
05/13/2019	217	RESPONSE in Support re 213 MOTION to Exclude <i>and Strike Exhibits Filed with Gavin Grimm's Motion for Summary Judgment and Reply in Support of Motion for Summary Judgment</i> filed by Gloucester County School Board. (Corrigan, David) (Entered: 05/13/2019)
05/21/2019	218	ORDER deferring ruling on 184 the Motion for Summary Judgment filed by Plaintiff, and the other pending motions; oral argument will be heard on these motions at 9 AM on Tuesday, July 23, 2019 in Norfolk. The trial date of July 23, 2019, the Pretrial Conference previously set for July 12, 2019, and all trial document filing deadlines are stricken, and will be rescheduled if necessary

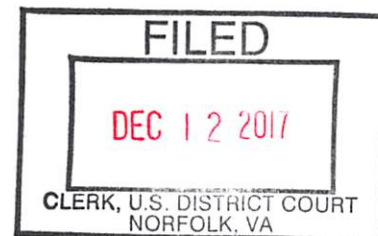
		after the pending motions are resolved. Signed by District Judge Arenda L. Wright Allen on 5/21/2019. (Allen, Arenda) (Entered: 05/21/2019)
05/21/2019	219	ORDER deferring ruling on 191 the Motion for Summary Judgment filed by the Defendant, as well as the other pending motions; oral argument will be heard on these motions at 9 AM on Tuesday, July 23, 2019 in Norfolk. The trial date of July 23, 2019, the Pretrial Conference previously set for July 12, 2019, and all trial document filing deadlines are stricken, and will be rescheduled if necessary after the pending motions are resolved. Signed by District Judge Arenda L. Wright Allen on 5/21/2019. (Allen, Arenda) (Entered: 05/21/2019)
05/21/2019	220	ORDER deferring ruling on 213 the Motion to Strike Exhibits filed by Defendant, as well as the other pending motions; oral argument will be heard on these motions at 9 AM on Tuesday, July 23, 2019 in Norfolk. The trial date of July 23, 2019, the Pretrial Conference previously set for July 12, 2019, and all trial document filing deadlines are stricken, and will be rescheduled if necessary after the pending motions are resolved. Signed by District Judge Arenda L. Wright Allen on 5/21/2019. (Allen, Arenda) (Entered: 05/21/2019)
05/24/2019	221	MOTION to Stay by Gloucester County School Board. (Corrigan, David) (Entered: 05/24/2019)
05/24/2019	222	Brief in Support to 221 MOTION to Stay filed by Gloucester County School Board. (Corrigan, David) (Entered: 05/24/2019)
05/31/2019	223	Memorandum in Opposition re 221 MOTION to Stay filed by Gavin Grimm. (Heilman, Eden) (Entered: 05/31/2019)
06/06/2019	224	REPLY Brief in Support re 221 MOTION to Stay filed by Gloucester County School Board. (Corrigan, David) Modified docket text on 6/6/2019 (jrin). (Entered: 06/06/2019)
06/18/2019	225	NOTICE of Supplemental Authority by Gavin Grimm re 201 Response in Opposition to Motion, 223 Memorandum in Opposition, 184 MOTION for Summary Judgment. (Attachments: # 1 Exhibit A)(Heilman, Eden) Modified text on 6/18/19 (bpet,) (Entered: 06/18/2019)
06/21/2019	226	ORDER denying 221 Motion to Stay. Signed by District Judge Arenda L. Wright Allen on 6/21/19. (bpet,) (Entered: 06/21/2019)
07/23/2019	228	Motions Hearing held before District Judge Arenda L. Wright Allen on 7/23/2019 re 184 MOTION for Summary Judgment 191 MOTION for Summary Judgment 213 MOTION to Exclude. Joshua Block, Nicole Tortoriello, Eden Heilman, Jennifer Safstrom and Shayna Medley-Warsoff present on behalf of the plaintiff. David Corrigan and Jeremy Capps present on behalf of the defendant. Arguments of counsel heard. Court to take the matter under advisement. (Court Reporter Jody Stewart.)(lhow) (Entered: 07/23/2019)
08/09/2019	229	ORDER. The Board's 213 Motion to Strike Exhibits is GRANTED IN PART andDENIED IN PART. Gavin Grimm's 184 Motion for Summary Judgment isGRANTED. The Board's 191 Motion for Summary Judgment is DENIED.

		Signed by District Judge Arenda L. Wright Allen on 8/9/19. (bpet,) (Entered: 08/09/2019)
08/09/2019	230	CLERK'S JUDGMENT. Signed by Clerk on 8/9/19. (bpet,) (Entered: 08/09/2019)
08/16/2019	231	Joint MOTION to Defer Filing of Bill of Costs and Petition for Fees by Gavin Grimm. (Heilman, Eden) (Entered: 08/16/2019)
08/19/2019	232	ORDER granting 231 , the Joint Motion to Defer Filing of Bill of Costs and Petition for Fees filed by Gavin Grimm, as follows: Plaintiff shall file his bill of costs and petition for fees within twenty-one days after the United States Court of Appeals for the Fourth Circuit issues its mandate on appeal. Signed by District Judge Arenda L. Wright Allen on 8/19/2019. (Allen, Arenda) (Entered: 08/19/2019)
08/21/2019	233	MOTION to Withdraw as Attorney <i>Shayna Medley-Warsoff</i> by Gavin Grimm. (Attachments: # 1 Proposed Order)(Heilman, Eden) (Entered: 08/21/2019)
08/22/2019	234	ORDER granting 233 , the Motion to Withdraw as Attorney filed by Shayna Medley-Warsoff for Gavin Grimm. Ms. Medley-Warsoff is terminated as counsel of record in this matter. Signed by District Judge Arenda L. Wright Allen on 8/22/2019. (Allen, Arenda) (Entered: 08/22/2019)
08/30/2019	235	NOTICE OF APPEAL by Gloucester County School Board. Filing fee \$ 505, receipt number 0422-6814437. (Corrigan, David) (Entered: 08/30/2019)
08/30/2019	236	Transmission of Notice of Appeal to US Court of Appeals re 235 Notice of Appeal (All case opening forms, plus the transcript guidelines, may be obtained from the Fourth Circuit's website at www.ca4.uscourts.gov). (Attachments: # 1 Notice of Appeal) (bpet,) (Entered: 08/30/2019)
09/03/2019	237	USCA Case Number 19-1952, 4CCA Case Manager Cathi Bennett for 235 Notice of Appeal filed by Gloucester County School Board. [19-1952] (bpet,) (Entered: 09/03/2019)
09/27/2019	238	TRANSCRIPT of proceedings held on 7-23-2019, before Judge Arenda W. Allen, Court Reporter/Transcriber Jody Stewart, Telephone number 757-222-7071. NOTICE RE REDACTION OF TRANSCRIPTS: The parties have thirty(30) calendar days to file with the Court a Notice of Intent to Request Redaction of this transcript. If no such Notice is filed, the transcript will be made remotely electronically available to the public without redaction after 90 calendar days. The policy is located on our website at www.vaed.uscourts.gov. Transcript may be viewed at the court public terminal or purchased through the court reporter/transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER Redaction Request due 10/28/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 12/26/2019. (stewart, jody) (Entered: 09/27/2019)

PACER Service Center

Transaction Receipt			
10/16/2019 10:34:54			
PACER Login:	HarmanClay1:2559815:0	Client Code:	0203.0276
Description:	Docket Report	Search Criteria:	4:15-cv-00054-AWA-RJK
Billable Pages:	20	Cost:	2.00

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division



GAVIN GRIMM,

Plaintiff,

v.

GLOUCESTER COUNTY SCHOOL
BOARD,

Defendant.

Civil No. 4:15-cv-54

ORDER

Currently before this Court are Plaintiff Gavin Grimm's Motion to Vacate Order for Supplemental Briefing and Plaintiff's Notice of Consent to Dismissal of Requests for Relief (C) and (D). ECF Nos. 125, 126. For the reasons stated herein, the Court dismisses Requests for Relief (C) and (D) in the Amended Complaint (ECF No. 113 at 17), and vacates its October 26, 2017 Order directing Supplemental Briefing (ECF No. 123).

I. BACKGROUND

The Court has recounted the procedural history of this case. *See* ECF No. 123 at 1–2.¹ On August 22, 2017, Plaintiff filed an Amended Complaint, alleging claims under Title IX of the

¹ Plaintiff Gavin Grimm, a transgender male teenager, commenced this action against the Gloucester County School Board in July 2015, alleging that the School Board's policy of assigning students to restrooms based on their biological sex violated Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681(a) and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. In September 2015, another judge of this Court issued a Memorandum Opinion and Order that (1) dismissed Grimm's claim under Title IX for failure to state a claim, and (2) denied his Motion for a Preliminary Injunction based on alleged violations of Title IX and the Equal Protection Clause. *G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.*, 132 F. Supp. 3d 736, 753 (E.D. Va. 2015).

An interlocutory appeal of those decisions followed, which led to an appellate review process by the United States Court of Appeals for the Fourth Circuit and the United States Supreme Court that lasted nearly two years. *Grimm v. Gloucester Cty. Sch. Bd.*, No. 15-2056, slip op. at 5–6 (4th Cir. Aug. 2, 2017). During this time, the district court case was re-assigned to the undersigned. In August 2017, the

Education Amendments of 1972, 20 U.S.C. § 1681(a), and under the Equal Protection Clause of the Fourteenth Amendment. ECF No. 113. The Amended Complaint sought: (1) a retrospective declaratory judgment and nominal damages, and (2) a prospective declaratory judgment and permanent injunctive relief. *Id.* at 17. Subsequently, Defendant filed a Motion to Dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6). ECF No. 118.

After the parties briefed the Motion to Dismiss, this Court issued an Order advising the parties that Plaintiff's graduation from high school raised threshold jurisdictional issues related to mootness. The Court further advised the parties that to the extent that the Motion to Dismiss questioned whether the case still presented a justiciable controversy, the Court would construe the Motion to Dismiss as brought pursuant to Rule 12(b)(1). The Court then ordered supplemental briefing regarding mootness. ECF No. 123. In response to the Court's Order, Plaintiff filed the Motions currently before the Court.

II. ANALYSIS

A. Plaintiff's Notice of Consent to Dismissal of Requests for Relief (C) and (D)

With respect to Plaintiff's Notice of Consent to Dismissal of Requests for Relief (C) and (D), Plaintiff has advised the Court that "[c]ontinuing to pursue claims for prospective

Fourth Circuit was again presented with the parties' original appeal of the September 2015 Memorandum Opinion and Order. *Id.* at 6.

During the pendency of the appeal, a potential mootness issue arose when Plaintiff graduated from high school. On August 2, 2017, the Fourth Circuit issued an Order remanding the case to this Court for a finding on the question of mootness and to develop a factual record on this issue. *Id.* at 6–8. This Court ordered the parties to submit a Joint Position Statement proposing procedures for developing this factual record and conducting proceedings on remand. ECF No. 108.

In their Joint Position Statement, the parties advised that they had filed a stipulation to voluntarily dismiss Plaintiff's interlocutory appeal regarding the Preliminary Injunction. ECF No. 111. Because of this, they believed that "there will be no need for additional fact-finding to determine whether the motion for preliminary injunction has become moot." *Id.* Instead, parties proposed that this Court grant Plaintiff's Motion to Amend the Complaint and set a schedule allowing Defendant to file a motion to dismiss. ECF Nos. 109, 111. This Court considered the Joint Position Statement, the record, and the history of the litigation, and granted the Consent Motion, allowing the parties to proceed with briefing in accordance with their proposed schedule. ECF No. 112.

declaratory and injunctive relief would require the parties and the court to expend time and resources resolving factual questions that would delay and distract from the central legal question of whether Defendant violated [Plaintiff's] rights under Title IX and the Fourteenth Amendment while he was a student at Gloucester High School.” ECF No. 125 at 2. Accordingly, the parties consent to dismissal of Requests for Relief (C) and (D), and ask that the Court dismiss such Requests pursuant to Federal Rule of Civil Procedure 12(b)(1). *Id.* at 3. Based on parties’ consent, the Court DISMISSES Requests for Relief (C) and (D), which seek a permanent injunction and a prospective declaratory judgment (ECF No. 113 at 17).

B. Plaintiff’s Motion to Vacate Order for Supplemental Briefing

The dismissals of the requests for prospective declaratory relief leave Requests for Relief (A) and (B), which seek retrospective relief. Plaintiff has advised that these remaining requests should not be subject to mootness challenges, but may be subject to dismissal pursuant to Federal Rule of Civil Procedure 12(b)(6). ECF No. 126 at 2.

Plaintiff argues that his graduation did not moot his request for nominal damages. “Even if a plaintiff’s injunctive relief claim has been mooted, the action is not moot if the plaintiff may be ‘entitled to at least nominal damages.’” *Rendelman v. Rouse*, 569 F.3d 182, 187 (4th Cir. 2009) (quoting *Covenant Media of S.C., LLC v. City of N. Charleston*, 493 F.3d 421, 429 n.4 (4th Cir. 2007)).

Plaintiff also argues that his request for a retrospective declaratory judgment is not moot because this request is intertwined with the damages claim. A “plaintiff’s request for declaratory relief is not moot [when] his ‘damages claim is contingent upon a finding by the court that the [complained of activity] is unconstitutional.’” *Marks v. City Council of City of Chesapeake, Va.*,

723 F. Supp. 1155, 1160 (E.D. Va. 1988) (second brackets in original), *aff'd* 883 F.2d 308 (4th Cir. 1989).

Defendant responds by acknowledging that “a claim is not moot when there is a claim for compensatory damages *and* nominal damages pending such that the plaintiff could at a minimum recover nominal damages.” ECF No. 128 at 3 (emphasis added). However, Defendant argues, because Plaintiff only seeks nominal damages in relation to his request for retroactive declaratory relief, but does not seek compensatory damages, Plaintiff’s case should be declared moot. *Id.*

“When students challenge the constitutionality of school policies, their claims for declaratory and injunctive relief generally become moot when they graduate.” *Mellen v. Bunting*, 327 F.3d 355, 364 (4th Cir. 2003) (internal citations omitted). After a student has graduated, “a case or controversy no longer exists between [the parties] with respect to the validity of the rules at issue.” *Bd. of Sch. Comm’rs v. Jacobs*, 420 U.S. 128, 129 (1975) (*per curiam*).

However, claims for damages may continue to present a live controversy. *Id.* at 365. That is, “even if a plaintiff’s injunctive relief claim has been mooted, the action is not moot if the plaintiff may be ‘entitled to at least nominal damages.’” *Rendelman*, 569 F.3d at 187. To be awarded nominal damages, a plaintiff need only show that a constitutional deprivation occurred, not proof of actual injury. *Chapin Furniture Outlet Inc. v. Town of Chapin*, 252 Fed. App’x 566, 572 (4th Cir. 2007).

The decision in *Mellen* is particularly instructive on this point. In *Mellen*, cadets at the Virginia Military Institute filed a complaint alleging that the Institute’s supper prayer violated federal and state constitutions and the Virginia Act for Religious Freedom. The cadets sought

declaratory and injunctive relief, as well as nominal damages. 327 F.3d at 363. The district court entered summary judgment in favor of the cadets, awarding declaratory relief and enjoining the defendant from sponsoring the supper prayer. However, as to the request for monetary damages, the district court concluded that the defendant was entitled to qualified immunity. The parties then filed cross-appeals. *Id.*

On appeal, the Fourth Circuit considered whether the case had become moot because the plaintiffs no longer attended the Institute. *Id.* The Fourth Circuit concluded that although the former cadets' claims for declaratory and injunctive relief were moot, "their damage claim"—that is, their claim for *nominal* damages—"continue[d] to present a live controversy." *Id.* at 365 (citing *Doe v. Madison Sch. Dist. No. 321*, 177 F.3d 789, 798 (9th Cir. 1999)).

Furthermore, "to the extent that . . . resolution [of a claim for declaratory relief] determines liability for damages to redress injuries alleged and proven," a plaintiff's claim for declaratory relief is not necessarily moot. *See Marks*, 723 F. Supp. at 1159 (citing *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432 n.7 (1985); *Lane v. Reid*, 559 F. Supp. 1047, 1048–51 (S.D.N.Y. 1983)). Accordingly, the Court finds that because Plaintiff's claim for damages rests upon a determination of the constitutionality of the complained-of action, his claim for retrospective declaratory relief is not moot. *See Powell v. McCormack*, 395 U.S. 486 (1969). That is, "this Court must decide the constitutional issue in order to make possible a decision on [plaintiff's] damages claim." *Marks*, 723 F. Supp. at 1160 (citing *Shifrin v. Wilson*, 412 F. Supp. 1282, 1292 (D.D.C. 1976)).

This Court concludes that Plaintiff's graduation did not moot either his request for nominal damages for the School Board's alleged past violations of his rights under Title IX and the Equal Protection Clause or his request for a declaratory judgment regarding these alleged

violations. This Court has jurisdiction over this case to the extent that Plaintiff seeks a retrospective declaratory judgment and nominal damages for past alleged violations of Title IX and the Equal Protection Clause. Defendant's Motion to Dismiss pursuant to Rule 12(b)(6) will be taken under advisement after additional briefing.

III. CONCLUSION

For the reasons stated herein, the Consent Motion for Dismissal of Requests for Relief (C) and (D) (ECF No. 125) and Plaintiff's Motion to Vacate Order for Supplemental Briefing (ECF No. 126) are GRANTED. Accordingly, Requests for Relief (C) and (D) of Plaintiff's Amended Complaint (ECF No. 113) are DISMISSED. The October 26, 2017 Order (ECF No. 123) directing the parties to file supplemental briefing on the question of mootness is VACATED.

The parties are DIRECTED to file amended briefing regarding Defendant's Motion to Dismiss (ECF No. 118) as follows: Defendant shall file an amended Motion to Dismiss regarding the remaining Requests for Relief no later than forty-five days after the date of entry of this Order. Plaintiff shall file a Response no later than twenty-one days after service of Defendant's amended Motion. Defendant may file a Reply no later than seven days after service of the Response.

IT IS SO ORDERED.

December 12th, 2017
Norfolk, Virginia



Arenda L. Wright Allen
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v.

GLOUCESTER COUNTY SCHOOL
BOARD,

Defendant.

Civil No. 4:15cv54

ORDER

Pending before the Court is an Amended Motion to Dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6) (ECF No. 135) filed by Defendant Gloucester County School Board (“Defendant” or “the Board”). For reasons set forth herein, the Motion is DENIED.

I. FACTUAL AND PROCEDURAL BACKGROUND

When ruling on a motion to dismiss for failure to state a claim, courts accept a complaint’s well-pled factual allegations as true, and draw any reasonable inferences in favor of the plaintiff. *See Wag More Dogs, LLC v. Cozart*, 680 F.3d 359, 365 (4th Cir. 2012). Accordingly, the Court reviews the facts as alleged by Plaintiff Gavin Grimm (“Plaintiff” or “Mr. Grimm”). *See* Am. Compl., ECF No. 113.

Mr. Grimm is an eighteen-year-old man who attended Gloucester High School, a public school in Gloucester County, Virginia, from September 2013 through his graduation in June 2017. *Id.* ¶¶ 1, 79. When Mr. Grimm was born, hospital staff identified him as female. *Id.* ¶ 17. However, Mr. Grimm has known from a young age that he has a male gender identity—that is, he has a “deeply felt, inherent sense of being a boy, a man, or male,” rather than a sense of being

“a girl, a woman, or a female.” *Id.* ¶ 18. Because his gender identity differs from the sex assigned to him at birth, he is transgender. *Id.* ¶¶ 17–19.

Like many of his transgender peers, after the onset of puberty, Mr. Grimm began suffering from “debilitating levels of distress” as the result of gender dysphoria, “a condition in which transgender individuals experience persistent and clinically significant distress caused by the incongruence between their gender identity and the sex assigned to them at birth.” *Id.* ¶ 19. There is a medical and scientific consensus that treatment for gender dysphoria includes allowing transgender individuals to live in accordance with their gender identity, including “use of names and pronouns consistent with their identity, grooming and dressing in a manner typically associated with that gender, and using restrooms and other sex-separated facilities that match their gender identity.”¹ *Id.* ¶¶ 20–21. Furthermore, when medically appropriate, treatment also includes hormone therapy and surgery so that transgender individuals “may develop physical sex characteristics typical of their gender identity.”² *Id.* ¶¶ 20, 25. In addition, under widely accepted standards of care, “boys who are transgender may undergo medically necessary chest-reconstruction surgery after they turn [sixteen years old].” *Id.* ¶ 27.

In 2014, by the end of his freshman year of high school, Mr. Grimm experienced such distress from his untreated gender dysphoria that he was unable to attend class. *Id.* ¶ 36. At this

¹ The consensus within medical and mental health communities is that excluding transgender individuals from using restrooms consistent with their gender identity “is harmful to their health and wellbeing. When excluded from the common restrooms, transgender [individuals] often avoid using the restroom entirely, either because the separate restrooms are too stigmatizing or too difficult to access.” *Id.* ¶ 28. As a result, they suffer from physical consequences, and their risk of depression and self-harm is increased. *Id.*; see also *id.* ¶ 29.

² “Hormone therapy affects bone and muscle structure, alters the appearance of a person’s genitals, and produces secondary sex characteristics such as facial and body hair in boys and breasts in girls.” *Id.* ¶ 25; see also Tim C. van de Grift et al., *Effects of Medical Interventions on Gender Dysphoria and Body Image: A Follow-Up Study*, 79:7 PSYCHOSOMATIC MED. 815 (2017) (“Overall, the levels of gender dysphoria . . . were significantly lower at follow-up [after medical intervention such as hormone therapy and genital or chest surgery] compared with clinical entry.”).

time, he informed his parents of his male gender identity. *Id.* He began treatment with a psychologist experienced in counseling transgender youth and, as part of the medically-necessary treatment for his gender dysphoria, commenced the process of transitioning to live in accordance with his male identity. *Id.* ¶¶ 1, 36–37. By the time he began his sophomore year, Mr. Grimm had legally changed his first name to Gavin and had begun using male pronouns. He wore clothing and a hairstyle in a manner consistent with other males, and used men’s restrooms in public venues without incident. *Id.* ¶¶ 2, 38. He also obtained a treatment documentation letter from his medical providers confirming that he was receiving treatment for gender dysphoria and was to be treated as a male in all respects—including restroom use. *Id.* ¶ 2.

In August 2014, prior to the beginning of his sophomore year, Mr. Grimm and his mother met with the Gloucester High School Principal and the Guidance Counselor, explaining that Mr. Grimm is a transgender boy and would be attending school as a boy. Mr. Grimm and his mother also provided the Principal and Counselor with the treatment documentation letter. *Id.* ¶ 39. At the time of the meeting, the Board lacked a policy addressing the restrooms that transgender students would use. *Id.* ¶ 41. Mr. Grimm initially requested the use of the restroom in the nurse’s office. However, that restroom was located remotely, and using it left Mr. Grimm feeling stigmatized and isolated. That restroom was also far from many of his classrooms, causing Mr. Grimm to be late for class when he used it. After a few weeks, Mr. Grimm sought permission to use the boys’ restrooms. With the Principal’s support, he began using the boys’ restrooms on October 20, 2014, and did so without incident for approximately seven weeks.³ *Id.* ¶¶ 42–47.

³ He also requested permission to complete his physical education requirements through a homebound program, bypassing any need to use the locker rooms at the school. *Id.* ¶ 45.

The Principal and Superintendent informed the Board that they had authorized Mr. Grimm to use the boys' restrooms, but otherwise kept the matter confidential. *Id.* ¶ 47. However, several adults in the community learned of a transgender student's use of the boys' restrooms. They contacted the Board, demanding that the transgender student be barred from the boys' restrooms. *Id.* The Board considered the matter in a private meeting and took no action for several weeks. However, one Board member proposed a policy regarding the use of restrooms by transgender students and submitted the policy for public debate at a Board meeting scheduled for November 11, 2014. In pertinent part, the policy proposed that "[i]t shall be the practice of the [Gloucester County Public Schools ("GCPS")] to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility."⁴ *Id.* ¶ 51.

At the meeting, Mr. Grimm decided to address the issue publicly, describing how he sought to use the restrooms "in peace" and had experienced "no problems from students" when using the boys' restrooms, "only from adults." *Id.* ¶ 55. The School Board deferred a vote on the proposed policy until its December 9, 2014 meeting. *Id.* ¶ 56. Before the next meeting, the

⁴ The entirety of the policy stated:

Whereas the GCPS recognizes that some students question their gender identities, and

Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and

Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore

It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

Id. ¶ 51.

Board announced plans to add or expand partitions between urinals in the male restrooms, add privacy strips to the doors of stalls in all restrooms, and to designate single-stall, unisex restrooms “to give all students the option for even greater privacy.” *Id.* ¶ 57.

Despite the announced plans, speakers at the December 9, 2014 meeting continued to demand that Mr. Grimm be excluded from using the boys’ restrooms immediately. *Id.* ¶ 59. The Board then passed the policy at the meeting by a six-to-one vote. The following day, Mr. Grimm was informed by the principal that he could no longer use the boys’ restrooms. *Id.* ¶¶ 61–62. The Board then installed three single-user restrooms, none of which was located near Mr. Grimm’s classes. Although any student was allowed to use them, no student besides Mr. Grimm did. *Id.* ¶¶ 65–66.

Because using the single-user restrooms underscored his exclusion and left him physically isolated, Mr. Grimm refrained from using any restroom at school. He developed a painful urinary tract infection and had difficulty concentrating in class because of his physical discomfort. *Id.* ¶¶ 67–70. When he attended school football games, no restroom was available for Mr. Grimm’s use. As a result, Mr. Grimm was forced to have his mother pick him up from games early. *Id.* ¶ 71.

Throughout his sophomore, junior, and senior years of high school, Mr. Grimm continued the process of transitioning to live in accordance with his male identity. In December 2014, the middle of his sophomore year, he had begun hormone therapy, which altered his bone and muscle structure, deepened his voice, and caused him to grow facial hair. *Id.* ¶¶ 72–73. In June 2015, prior to the beginning of his junior year, the Virginia Department of Motor Vehicles issued Mr. Grimm a state identification card designating his gender as male. *Id.* ¶ 74. A year later, prior to the beginning of his senior year, Mr. Grimm underwent chest-reconstruction

surgery, in accordance with the medical standards of care for treating gender dysphoria. *Id.* ¶ 75; *see id.* ¶ 27. Later that year, in September 2016, the Gloucester County Circuit Court issued an order changing his sex under Virginia state law and directing the Virginia Department of Health to issue Mr. Grimm a birth certificate listing his sex as male; this certificate was issued in October 2016. *Id.* ¶¶ 76–77. Throughout the process of these changes—up through Mr. Grimm’s graduation in June 2017—the School Board maintained that Mr. Grimm’s “biological gender” was female and prohibited administrators from permitting Mr. Grimm to use the boys’ restrooms. *Id.* ¶¶ 78–79.

Mr. Grimm commenced this action against the Gloucester County School Board in July 2015, alleging that the Board’s policy of assigning students to restrooms based on their biological sex violated Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681(a), as well as the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. In September 2015, another judge of this Court issued a Memorandum Opinion and Order (1) dismissing Mr. Grimm’s claim under Title IX for failure to state a claim and (2) denying his Motion for a Preliminary Injunction based on the alleged Title IX and Equal Protection Clause violations. *G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.*, 132 F. Supp. 3d 736, 753 (E.D. Va. 2015), *rev’d in part and vacated in part*, 822 F.3d 709 (4th Cir. 2016). An interlocutory appeal of those decisions followed, leading to appellate review by the United States Court of Appeals for the Fourth Circuit and by the United States Supreme Court. *See infra* III.A; *see also* ECF No. at 132 at 1–2. During this time, the district court suit was re-assigned to the undersigned. The case was remanded to this Court for consideration of the Title IX claim. The Equal Protection Claim also remains pending before this Court.

Following the filing of Mr. Grimm's Amended Complaint (ECF No. 113), the School Board filed the instant Motion to Dismiss (ECF No. 135). With respect to the Title IX claim (Count II, ECF No. 113 ¶¶ 90–92), the School Board argues that its policy of separating restrooms by physiological sex is valid under Title IX because (1) Title IX only allows for claims on the basis of sex, rather than gender identity, and (2) gender identity and sex, as addressed in Title IX, are not equivalent. *See* ECF No. 136 at 6, 12–26. With respect to the Equal Protection claim (Count I, ECF No. 113 ¶¶ 81–89), the School Board argues that its policy does not violate the Equal Protection Clause because transgender individuals are not members of a suspect class entitled to heightened scrutiny, and the Policy should be viewed as presumptively constitutional under both rational basis review and intermediate scrutiny. *Id.* at 28–36.

II. LEGAL STANDARD

A motion to dismiss under Rule 12(b)(6) tests the sufficiency of a complaint. “To survive a Rule 12(b)(6) motion to dismiss, a complaint must ‘state a claim to relief that is plausible on its face.’” *United States ex rel. Nathan v. Takeda Pharm. N. Am., Inc.*, 707 F.3d 451, 455 (4th Cir. 2013) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). “A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.” *Iqbal*, 556 U.S. at 678. “The plausibility standard is not akin to a ‘probability requirement,’ but it asks for more than a sheer possibility that a defendant has acted unlawfully.” *Id.* (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007)). “Facts that are ‘merely consistent with’ liability do not establish a plausible claim to relief.” *Takeda Pharm.*, 707 F.3d at 455 (quoting *Iqbal*, 556 U.S. at 678). Rather, the “[f]actual allegations must be enough to raise a right to relief above the speculative level,’ thereby ‘nudg[ing] [the plaintiff’s] claims across the line from conceivable to

plausible.” *Vitol, S.A. v. Primerose Shipping Co.*, 708 F.3d 527, 543 (4th Cir. 2013) (quoting *Twombly*, 550 U.S. at 555) (first and second alteration in original).

At this stage, “(1) the complaint is construed in the light most favorable to the plaintiff, (2) its allegations are taken as true, and (3) all reasonable inferences that can be drawn from the pleading are drawn in favor of the pleader.” 5B CHARLES A. WRIGHT ET AL., *FEDERAL PRACTICE & PROCEDURE* § 1357 & n.11 (3d ed.) (collecting cases); *accord Wag More Dogs*, 680 F.3d at 365.

However, courts “will not accept ‘legal conclusions couched as facts or unwarranted inferences, unreasonable conclusions, or arguments.’” *Takeda Pharm.*, 707 F.3d at 455 (quoting *Wag More Dogs*, 680 F.3d at 365). Additionally, a threadbare recitation of the “elements of a cause of action, and bare assertions devoid of further factual enhancement fail to constitute well-pled facts for Rule 12(b)(6) purposes.” *Nemet Chevrolet, Ltd. v. Consumeraffairs.com, Inc.*, 591 F.3d 250, 255 (4th Cir. 2009); *Iqbal*, 556 U.S. at 678 (noting that “the tenet that a court must accept a complaint’s allegations as true is inapplicable to threadbare recitals of a cause of action’s elements, supported by mere conclusory statements”).

III. ANALYSIS

A. Reconsideration of the Interlocutory Order

As a preliminary matter, this Court must consider whether it is bound by the previous dismissal of the Title IX claim. *See* ECF No. 57. Following Mr. Grimm’s interlocutory appeal of the dismissal, the Fourth Circuit reversed the dismissal. The reversal was based on the Fourth Circuit’s conclusion that deference should be given to a guidance letter issued by the Department of Education’s Office of Civil Rights that construed a Title IX regulation as generally requiring schools to treat transgender students consistent with their gender identity when electing to separate students on the basis of sex. *G.G. ex rel. Grimm v. Gloucester County Sch. Bd.* (*Grimm*

Id., 822 F.3d 709, 718–22 (4th Cir. 2016) (citing *Auer v. Robbins*, 519 U.S. 452 (1997)), *vacated and remanded*, 137 S. Ct. 1239 (2017). The United States Supreme Court granted a stay of the Fourth Circuit’s mandate and granted the Board’s writ of certiorari. After the guidance letter was rescinded as the result of a change in administration, the Supreme Court vacated the Fourth Circuit’s decision and remanded for reconsideration of the Title IX claim. ECF No. 91. The Fourth Circuit dismissed the appeal, and Mr. Grimm filed an Amended Complaint with this Court. ECF Nos. 113, 114.

The Board argues that this Court remains bound by the previous dismissal of the Title IX claim. In support of this position, the Board contends that because Mr. Grimm’s “current Title IX claim is virtually identical to the claim that [the previous judge] already dismissed, [Mr. Grimm] is essentially asking the Court to reconsider” the original decision. ECF No. 136 at 7. The Board contends that this Court need not reevaluate the previous dismissal of the Title IX claim because the prior decision analyzed the Title IX claim thoroughly without applying *Auer* deference to the letter and instead based its conclusion that Mr. Grimm had failed to state a Title IX claim on “valid precedent.” *Id.* at 6–7.

Such reconsiderations are governed by Federal Rule of Civil Procedure 54(b), which provides that:

any order or other decision, however designated, that adjudicates fewer than all the claims or rights and liabilities of fewer than all the parties does not end the action as to any of the claims or parties and may be revised at any time before the entry of a judgment adjudicating all the claims and all the parties’ rights and liabilities.

Both parties acknowledge that district courts retain the discretion to revise an interlocutory order at any time before the entry of a judgment adjudicating all the claims. *Carlson v. Boston Scientific Corp.*, 856 F.3d 320, 325 (4th Cir. 2017) (citing Fed. R. Civ. P. 54(b)).

Although courts have concluded that a successor judge should hesitate to overrule the earlier determination, *id.* (internal citation omitted), “whether rulings by one district judge become binding as ‘law of the case’ upon subsequent district judges is not a matter of rigid legal rule, but more a matter of proper judicial administration which can vary with the circumstances.” *Hill v. BASF Wyandotte Corp.*, 696 F.2d 287, 290 n.3 (4th Cir. 1982); *see also Stoffels ex rel. SBC Tel. Concession Plan v. SBC Commc’ns, Inc.*, 677 F.3d 720, 727 n.3 (5th Cir. 2012) (“When a successor judge is reviewing another judge’s interlocutory order, the law of the case doctrine requires only that the successor judge respect principles of comity when considering issues that have already been decided.”); *Am. Canoe Ass’n v. Murphy Farms, Inc.*, 326 F.3d 505, 515 (4th Cir. 2003) (noting that reconsideration of interlocutory orders “is committed to the discretion of the district court,” and that related doctrines such as law of the case “have evolved as a means of guiding that discretion” but “cannot limit the power of a court to reconsider an earlier ruling”). This Court’s primary responsibility—the responsibility of all federal courts—“is to reach the correct judgment under law.” *Am. Canoe Ass’n*, 326 F.3d at 515.

The Fourth Circuit has “cabined revision pursuant to Rule 54(b) by treating interlocutory rulings as law of the case.” *Carlson*, 856 F.3d at 325 (internal citations omitted). Accordingly, a “court may review an interlocutory order under the same circumstances in which it may depart from the law of the case: (1) a subsequent trial producing substantially different evidence; (2) a change in applicable law; or (3) clear error causing manifest injustice.” *Id.* (internal quotations and citations omitted). The Board argues that none of these requirements has been met, and that this Court should not depart from the previous adjudication of the Title IX claim. ECF No. 136 at 8.

This Court disagrees. First, there has been a significant change in the applicable law since the Motion to Dismiss the Title IX claim was initially considered in 2015. *See Carlson*, 856 F.3d at 325; *see also Bridger Coal Co. v. Dir., Office of Workers' Comp. Programs, U.S. Dep't of Labor*, 669 F.3d 1183, 1192 (10th Cir. 2012) (noting that the emergence of a circuit split can justify reconsideration). The Sixth and Seventh Circuits have since held that excluding boys and girls who are transgender from the restrooms that align with their gender identity may subject them to discrimination on the basis of sex under Title IX, the Equal Protection Clause, or both. *See Whitaker v. Kenosha Unified School Dist. No. 1 Board of Education*, 858 F.3d 1034, 1049–51 (7th Cir. 2017); *Dodds v. United States Dep't of Educ.*, 845 F.3d 217, 221 (6th Cir. 2016).

A number of district courts have also reached the same conclusion. *See A.H. by Handling v. Minersville Area Sch. Dist.*, No. 3:17cv391, 2017 WL 5632662, at *1, *3–*7 (M.D. Pa. Nov. 22, 2017) (denying school district's motion to dismiss a transgender student's Title IX and Equal Protection Claims based on school district's bathroom policy "dictating that children must use the bathroom corresponding to the sex listed on the student's birth certificate"); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288, 295 (W.D. Pa. 2017); *Bd. of Educ. of the Highland Local Sch. Dist. v. U.S. Dep't of Educ.*, 208 F. Supp. 3d 850, 865, 869, 871 (S.D. Ohio 2016).

Recently, the District of Maryland denied a strikingly similar Motion to Dismiss a transgender student's Title IX and Equal Protection claims stemming from his school's policy of barring him from using the boys' locker room. *M.A.B. v. Bd. of Educ. of Talbot Cty.*, 286 F. Supp. 3d 704, 711 (D. Md. 2018). Although these precedents are not binding upon this Court, the thorough analyses of analogous questions provided by the rulings proves persuasive.

Moreover, to the extent that the Fourth Circuit’s consideration of the Title IX claim provides meaningful guidance for this Court’s analysis of the Title IX regulation, the earlier dismissal of the Title IX claim lacked such guidance. *See infra* p. 15 and note 6.

Second, a number of factual developments warrant reconsideration of the original decision to dismiss the Title IX claim. When Mr. Grimm filed his initial complaint in 2015, he alleged that the Board’s policy violated his rights under Title IX on the day the policy was first issued, which occurred in the middle of his sophomore year. The Amended Complaint alleges that the Board violated his rights under Title IX when the policy was issued, and also throughout the remainder of his time as a student at Gloucester High School. Am. Compl., ECF No. 113 ¶ A. Since the previous dismissal of the Title IX claim, Mr. Grimm has received chest reconstruction surgery, obtained an order from Gloucester County Circuit Court legally changing his sex under Virginia law, and has received a new birth certificate from the Virginia Department of Health listing his sex as male. *Id.* ¶¶ 75–77. The previous decision was rendered without any opportunity to consider whether the Board’s policy violated Title IX throughout the remainder of Mr. Grimm’s time at Gloucester High School, and in light of these factual developments.

For these reasons, the Court concludes that revisiting the question of whether Mr. Grimm has stated a plausible Title IX claim is warranted. The Court now examines the claim’s merits. *See* ECF No. 113 ¶¶ 90–92.

B. Title IX Claim

Title IX provides that no person “shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance” 20 U.S.C. § 1681(a); *see also* 34 C.F.R. § 106.31. A covered institution may not, on the basis of sex, (1)

provide different aid, benefits, or services; (2) deny aid, benefits, or service, or (3) subject any person to separate or different rules, sanctions, or treatment. 34 C.F.R. § 106.31(b)(2)–(4).

However, “[n]ot all distinctions on the basis of sex are impermissible under Title IX.” *Grimm I*, 822 F.3d at 718. The statute’s regulations permit an institution to provide separate bathroom, shower, and locker facilities by sex, so long as the facilities are comparable. 34 C.F.R. § 106.33; *see also Whitaker*, 858 F.3d at 1047–48.

1. A Plaintiff’s Claim of Discrimination on the Basis of Transgender Status
Constitutes a Claim of Sex Discrimination Under Title IX

The parties dispute whether a transgender student’s allegation of discrimination based on his or her transgender status can constitute a claim of sex discrimination under Title IX. Neither Title IX nor its regulations defines the term “sex.” The Fourth Circuit has noted that because 34 C.F.R. § 106.33 permits separate toilets, locker rooms, and shower facilities on the basis of sex, “[b]y implication, the regulation also permits schools to exclude males from the female facilities and vice-versa.” *Grimm I*, 822 F.3d at 720.

The Board notes that § 106.33 permits schools to establish separate facilities on the basis of sex. The Board also contends that the term “sex” “at a minimum *includes* the physiological distinction between men and women.” ECF No. 136 at 13. Therefore, the Board argues, this Court must interpret Title IX as applying only to discrimination on the basis of physiological sex, rather than gender identity. *See id.* at 12–26.

Before evaluating whether discrimination on the basis of a plaintiff’s transgender status constitutes sex discrimination under Title IX, the Court must address the difficulties inherent in the Board’s view of “sex” under Title IX. That construction may be an appealingly simple way of interpreting the term “sex.” However, the Board argues that the Policy “distinguishes boys and girls based on physical sex characteristics alone,” ECF No. 136 at 21, but fails to

acknowledge that there are individuals who possess both male and female physical sex characteristics. As Mr. Grimm contends, attempting to draw lines based on physiological and anatomical characteristics proves unmanageable: how would the Board’s policy apply to individuals who have had genital surgery, individuals whose genitals were injured in an accident, or those with intersex traits who have genital characteristics that are neither typically male nor female? *See Grimm I*, 822 F.3d at 720–21;⁵ *Evancho*, 237 F. Supp. 3d at 279 (“[T]he Board has adopted a student bathroom policy that turns exclusively on the then-existing presence of a determinate external sex organ, no matter what other biological or gender markers may exist”). In Mr. Grimm’s situation, how would the Board have continued to implement the Policy after Mr. Grimm’s medical procedures? Mr. Grimm had attained some secondary male physical sex characteristics after hormone therapy and chest reconstruction surgery. Accordingly, acts of discrimination on the basis of physiological sex certainly could have occurred.

The Policy in question assigned restrooms based on “biological gender,” not physiological characteristics. This term has not been accepted by the medical community, because “sex”—the “attributes that characterize biological maleness or femaleness” (such as sex-determining genes, sex chromosomes, internal and external genitalia, and secondary sex characteristics)—is distinct from “gender,” or the “internal, deeply held sense” of being a man or a woman. *See* Wylie C. Hembree et al., *Endocrine Treatment of Gender-dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102(11) J. CLIN.

⁵ *Grimm I* specifically noted:

It is not clear to us how the regulation would apply in a number of situations—even under the Board’s own “biological gender” formulation. For example, which restroom would a transgender individual who had undergone sex reassignment surgery use? What about an intersex individual? What about an individual born with X-X-Y sex chromosomes? What about an individual who lost external genitalia in an accident?

822 F.3d at 720–21.

ENDOCRINOLOGY & METABOLISM 3869, 3875 (2017) (noting that the terms “biological male or female” should be avoided because not all individuals have physical attributes that align perfectly with biological maleness or femaleness, such as individuals with XY chromosomes who may have female-appearing genitalia). Given the Policy’s disregard for these distinctions, its use of the term “biological gender” functioned as a proxy for physiological characteristics that a student may or may not have had. The term allowed the Board to isolate, distinguish, and subject to differential treatment any student who deviated from what the Board viewed a male or female student *should* be, and from the physiological characteristics the Board believed that a male or female student *should* have.

The Court next turns to consideration of § 106.33. As the Fourth Circuit noted, the “inquiry is not ended” by § 106.33’s reference to males and females. *Grimm I*, 822 F.3d at 720.⁶ “Although the regulation may refer unambiguously to males and females, it is silent as to how a school should determine whether a transgender individual is a male or female for the purpose of access to sex-segregated restrooms.” *Id.* The Fourth Circuit initially determined that § 106.33 was ambiguous “as applied to transgender students,” and granted *Auer* deference to the guidance letter interpreting § 106.33 to generally require access to sex-segregated facilities on the basis of gender identity. *Id.* at 721–23. Following remand from the Supreme Court as the result of the withdrawal of the letter, the Fourth Circuit vacated its decision. Accordingly, *Grimm I* fails to

⁶ The District of Maryland recognized that although the Supreme Court vacated the Fourth Circuit’s judgment in *Grimm I* in light of the withdrawal of the guidance letter, the remainder of that decision remains binding law because (1) it has not overruled by a subsequent en banc opinion of the Fourth Circuit and (2) there has been no superseding contrary decision from the Supreme Court. See *United States v. Giddens*, 858 F.3d 870, 886 n.12 (4th Cir. 2017) (citing *United States v. Collins*, 415 F.3d 304, 311 (4th Cir. 2005)). “Thus, the Court will rely on [the Fourth Circuit’s previous *Grimm I* judgment] to the extent it offers guidance for deciding the Motions present.” *M.A.B.*, 286 F. Supp. 3d at 712 n.5.

inform this Court how § 106.33 is to be interpreted with respect to transgender students. The Fourth Circuit has not addressed this issue or Title IX’s application to transgender students since.

The Board asks this Court to resolve this issue by cabining the definition of sex to the “then-universal understanding of ‘sex’ as a binary term encompassing the physiological distinctions between men and women,” as understood during the passage of Title IX and the promulgation of § 106.33. *See* ECF No. 136 at 16. However, as noted above, this fails to address the question of how § 106.33 is to be interpreted regarding transgender students or other individuals with physiological characteristics associated with both sexes.

The Court has some guidance in resolving § 106.33’s ambiguity. Courts may “look to case law interpreting Title VII of the Civil Rights Act of 1964,” *as amended*, 42 U.S.C. §§ 2000e *et seq.* (2018)—which prohibits employment discrimination on the basis of, among other qualities, sex—“for guidance in evaluating a claim brought under Title IX.” *Id.* at 718 (citing *Jennings v. Univ. of N.C.*, 482 F.3d 686, 695 (4th Cir. 2007)); *see also M.A.B.*, 286 F. Supp. 3d at 713 (“[T]he Court turns to Title VII precedent for guidance [in interpreting a Title IX claim].”).

Neither the Fourth Circuit nor the Supreme Court has addressed how Title VII applies to transgender individuals. *See M.A.B.*, 286 F. Supp. 3d at 713. However, the Supreme Court has constructed a framework for addressing sex discrimination claims brought by individuals who fail to conform to social expectations for their gender group. In *Price Waterhouse v. Hopkins*, 490 U.S. 228, 235 (1989), the Supreme Court considered whether the plaintiff, a woman who was denied partnership in an accounting firm, had an actionable Title VII claim against the firm because the firm had allegedly denied her a promotion because she failed to conform to certain gender stereotypes related to women. *Id.* at 235, 250–53 (summarizing how firm partners

described the plaintiff as “macho” and a “tough-talking somewhat masculine hard-nosed manager”). Firm partners advised the plaintiff that her partnership chances would improve if she were to “walk more femininely, talk more femininely, dress more femininely, wear make-up, have her hair styled, and wear jewelry.” *Id.* at 235. Six Justices of the *Price Waterhouse* Court agreed that Title VII barred discrimination not only based on the plaintiff’s gender, but based on “sex stereotyping” because the plaintiff had failed to act in accordance with gender stereotypes associated with women. *Id.* at 250–51; *id.* at 258–61 (White, J., concurring); *id.* at 272–73 (O’Connor, J., concurring). In noting that “we are beyond the day when an employer could evaluate employees by assuming or insisting that they match[] the stereotype associated with their group,” the *Price Waterhouse* Court recognized that Title VII’s prohibition on sex discrimination necessarily includes a prohibition on gender stereotyping. *Id.* at 251.

Price Waterhouse, by its own terms, took an expansive view as to the forms of sex discrimination that Title VII was meant to reach, expressly leaving open the possibility of other forms of gender stereotyping. “By focusing on [gender stereotypes associated with appearance and behavior], however, we do not suggest a limitation on the possible ways of proving that stereotyping played a motivating role in an employment decision” *Id.* at 251–52.

The Supreme Court’s expansion recognizes that the prohibition on sex discrimination pursuant to Title VII also includes same-sex harassment claims. *Oncale v. Sundowner Offshore Services, Inc.*, 523 U.S. 75, 79 (1998) (noting that same-sex “sexual harassment in the workplace was assuredly not the principal evil Congress was concerned with when it enacted Title VII,” but that “statutory prohibitions often go beyond the principal evil to cover reasonably comparable

evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed”).⁷

The First, Second, Third, Seventh, and Ninth Circuits have all recognized that based on the logic of *Price Waterhouse*, a gender stereotyping allegation generally is actionable sex discrimination under Title VII. *Hively v. Ivy Tech Cmty. Coll.*, 854 F.3d 339, 351–52 (7th Cir. 2017 (en banc) (holding that a lesbian plaintiff could state a Title VII claim under a sex stereotyping theory); *Christiansen v. Omnicom Grp., Inc.*, 852 F.3d 195, 200–01 (2d Cir. 2017) (per curiam) (holding that a plaintiff had stated a plausible Title VII claim based on a gender stereotyping theory); *Prowel v. Wise Bus. Forms., Inc.*, 579 F.3d 285, 290 (3d Cir. 2009); *Nichols v. Azteca Rest. Enters., Inc.*, 256 F.3d 864, 874–75 (9th Cir. 2001); *Higgins v. New Balance Athletic Shoe, Inc.*, 194 F.3d 252, 261 n.4 (1st Cir. 1999).

Although the Fourth Circuit has yet to apply *Price Waterhouse* expressly to Title VII claims brought by transgender individuals,⁸ this Court joins the District of Maryland in concluding that “discrimination on the basis of transgender status constitutes gender stereotyping because ‘by definition, transgender persons do not conform to gender stereotypes.’” *M.A.B.*, 286 F. Supp. 3d at 714 (quoting *Finkle v. Howard Cty.*, 12 F. Supp. 3d 780, 787–88 (D. Md. 2014)). The Court also concludes that, pursuant to the logic of *Price Waterhouse*, transgender

⁷ For these reasons, the Court rejects the Board’s argument that Title IX should be cabined to its expressed purpose: ending discrimination against women in university admissions and appointments. *See* ECF No. 136 at 9, 24–25. The Court also finds unpersuasive the Board’s argument that other students’ privacy concerns—mentioned in the legislative history of Title IX regulations, *id.* at 10–12—should prevail in this context. *See infra* pp. 27–30 (rejecting such privacy concerns as a rationale for the Board’s Policy).

Relatedly, the Board also objects to this interpretation of Title IX because of hypothetical privacy concerns (rather than those found in legislative history). ECF No. 136 at 22–24. For the reasons discussed below, the Court finds these concerns—although worthy of consideration—are conjectural and abstract and fail to provide a basis for interpreting Title IX in the manner sought by the Board.

⁸ The Fourth Circuit also has not applied *Price Waterhouse* expressly to gender stereotyping claims brought under Title VII. *M.A.B.*, 286 F. Supp. 3d at 714.

discrimination is per se actionable sex discrimination under Title VII. *Id.*; see also *G.G. ex rel. Grimm (Grimm II)*, 654 Fed. App'x 606, 606–07 (4th Cir. 2016) (Davis, J., concurring) (internal citations omitted) (noting that “the Supreme Court has expressly recognized that claims based on an individual’s failure to conform to societal expectations based on that person’s gender constitute discrimination ‘because of sex’ under Title VII,” and noting that the First, Sixth, Ninth, and Eleventh Circuits have held that based on the logic of *Price Waterhouse*, discrimination against transgender individuals based on their transgender status is discrimination because of sex under federal civil rights statutes and the Equal Protection Clause).

This conclusion comports with decisions from the First, Sixth, Ninth, and Eleventh Circuits, all of which recognize that based on the gender-stereotyping theory from *Price Waterhouse*, claims of discrimination on the basis of transgender status are per se sex discrimination under Title VII or other federal civil rights laws. See *EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 574–75 (6th Cir. 2018) (confirming that claims of discrimination on the basis of transgender status is per se sex discrimination under Title VII);⁹ *Glenn v. Brumby*, 663 F.3d 1312, 1316–19 (11th Cir. 2011) (recognizing that a “person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes,” and holding that terminating an employee because she is transgender violates the prohibition on sex-based discrimination under the Title VII and the Equal Protection Clause following the reasoning of *Price Waterhouse*);¹⁰ *Smith v. City of Salem, Ohio*, 378 F.3d 566, 573–75 (6th Cir. 2004) (recognizing that discrimination against a transgender individual

⁹ The Sixth Circuit also reasoned (1) that “it is analytically impossible to fire an employee based on that employee’s status as a transgender person without being motivated, at least in part, by the employee’s sex,” 884 F. 3d at 575, and (2) that “discrimination against transgender persons necessarily implicates Title VII’s proscriptions against sex stereotyping,” *id.* at 576–77.

¹⁰ *Glenn* also held that “discrimination against a transgender individual because of her gender-nonconformity is sex discrimination, whether it’s described as being on the basis of sex or gender.” 663 F.3d at 1317.

because of his or her gender non-conformity amounts to gender stereotyping prohibited by Title VII and the Equal Protection Clause, and holding that a transgender employee had stated a claim under Title VII); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000) (holding that a transgender individual could state a claim for sex discrimination under the Equal Credit Opportunity Act based on *Price Waterhouse*); *Schwenk v. Hartford*, 204 F.3d 1187, 1201–03 (9th Cir. 2000) (holding that a transgender individual could state a claim under the Gender Motivated Violence Act under the reasoning of *Price Waterhouse*).

Numerous district courts have also concluded that a transgender individual can state a claim under Title VII for sex discrimination on the basis of a sex or gender-stereotyping theory. *See Roberts v. Clark Cty. Sch. Dist.*, 215 F. Supp. 3d 1001, 1014 (D. Nev. 2016), *reconsideration denied*, No. 2:15-cv-00388-JAD-PAL, 2016 WL 6986346 (D. Nev. Nov. 28, 2016); *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509, 527 (D. Conn. 2016); *Lopez v. River Oaks Imaging & Diagnostic Grp., Inc.*, 542 F. Supp. 2d 653, 660 (S.D. Tex. 2008); *Schroer v. Billington*, 577 F. Supp. 2d 293, 305 (D.D.C. 2008).

Accordingly, allegations of gender stereotyping are cognizable Title VII sex discrimination claims and, by extension, cognizable Title IX sex discrimination claims.¹¹ This Court joins the District of Maryland and several other appellate courts in concluding that “claims of discrimination on the basis of transgender status are per se actionable under a gender stereotyping theory” under Title IX, *M.A.B.*, 286 F. Supp. 3d at 715. Mr. Grimm has properly

¹¹ The Board’s argument that Title IX must explicitly refer to discrimination against transgender students to fulfill the notice requirements under *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), ECF No. 136 at 25–27, is unavailing. Title IX funding recipients “have been on notice that they could be subjected to private suits for intentional sex discrimination under Title IX since 1979,” when the Supreme Court decided *Cannon v. University of Chicago*, 441 U.S. 677, 691 (1979), and “have been put on notice by the fact that . . . cases since *Cannon* . . . have consistently interpreted Title IX’s private cause of action broadly to encompass diverse forms of intentional sex discrimination.” *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 182 (2005); *see also West Virginia Dep’t of Health & Human Resources v. Sebelius*, 649 F.3d 217, 223 (4th Cir. 2011).

brought a Title IX claim of discrimination “on the basis of sex”—that is, based on his transgender status.

2. Mr. Grimm Has Sufficiently Pled a Title IX Claim

Having concluded that Mr. Grimm may bring a Title IX claim based on his transgender status, this Court next turns to the question of whether he has pled his claim of discrimination on the basis of sex sufficiently. To state a claim under Title IX, a plaintiff must allege: (1) that he or she was excluded from participation in an education program because of his or her sex; (2) that the educational institution was receiving federal financial assistance at the time of his or exclusion; and (3) that the improper discrimination caused the plaintiff harm. *Grimm I*, 822 F.3d at 718 (citing *Preston v. Virginia ex rel. New River Cmty. Coll.*, 31 F.3d 203, 206 (4th Cir. 1994)); *but cf. M.A.B.*, 286 F. Supp. 3d at 716–17 (finding plaintiff had stated a Title IX claim under a gender stereotyping theory because he had alleged that he was denied access to the boys’ locker room on the basis of sex—that is, his transgender status); *Evancho*, 237 F. Supp. at 295 (describing the three requirements for stating a Title IX claim as (1) discrimination in an educational program that (2) receives federal assistance in which (3) such discrimination was on the basis of sex).

Before considering whether Mr. Grimm has stated a plausible Title IX claim, the Court recognizes the similarities between this case and *Whitaker*, in which a transgender male teenager was also subjected to a school policy in which he could use only the girls’ restrooms or gender-neutral restrooms that were far from his classrooms. 858 F.3d at 1040, 1041–42. This limitation was imposed despite the undisputed facts that the plaintiff had begun socially transitioning to life as a male during his freshman year, including changing his legal name and pronouns, and had been diagnosed with gender dysphoria by a therapist. As a result of the school policy, the plaintiff suffered from depression and anxiety; avoided water intake to avoid needing to use the

restroom, thereby exacerbating medical issues; and contemplated suicide. He also attempted to use the boys' restrooms in violation of the administration's decision. In response, administrators removed him from class on several occasions and instructed security guards to monitor his restroom use. *Id.* at 1040–41. Eventually, the school permitted him to use the boys' restrooms after a surgical transition. *Id.* at 1041. In reviewing the facts as alleged by the plaintiff, the Seventh Circuit concluded that the plaintiff had established a likelihood of success on the merits of his Title IX, and affirmed the district court's granting of a preliminary injunction on behalf of the plaintiff. *Id.* at 1050.

The Court now considers the first prong in determining if the Title IX claim is pled sufficiently: whether Mr. Grimm has sufficiently alleged that he was improperly discriminated against on the basis of his sex—that is, his transgender status. The Seventh Circuit concluded that a policy that requires transgender students to use bathrooms not in conformity with their gender identity subjects “a transgender student . . . to different rules, sanctions, and treatment than non-transgender students,” and amounts to discrimination on the basis of transgender status in violation of Title IX. *Whitaker*, 858 F.3d at 1049–50. This conclusion is sound. Furthermore, the provision of a gender-neutral alternative is insufficient to relieve a school board of liability, “as it is the policy itself which violates [Title IX].” *See id.* at 1050. Offering restroom alternatives that impose hardships like unreasonable distances to a student's classroom and increased stigma on a student is inadequate. *See id.*

In *M.A.B.*, the District of Maryland recognized that because the plaintiff had alleged that the school board had denied him access to the boys' locker rooms because of his transgender status, the policy subjected him to sex discrimination under a gender stereotyping theory. *M.A.B.* concluded that the plaintiff had sufficiently alleged discrimination under Title IX. 286 F. Supp.

3d at 716. Given the persuasive reasoning in *Whitaker* and *M.A.B.*, the Court concludes that Mr. Grimm has sufficiently pled that the Policy subjected him to sex discrimination under a gender stereotyping theory.

Having concluded that Mr. Grimm has properly alleged discrimination on the basis of sex, and finding the second pleading requirement is met because GCPS and Gloucester High School “are education programs receiving Federal financial assistance,” ECF No. 113 ¶ 91, the Court now turns to determining whether Mr. Grimm has sufficiently alleged that the discrimination harmed him. The location of the bathrooms, coupled with the stigmatization and physical and mental anguish inflicted upon Mr. Grimm, caused harm. “A policy that requires an individual to use a bathroom that does not conform with his or her gender identity punishes that individual for his or her gender non-conformance, which in turn violates Title IX.” *Whitaker*, 858 F.3d at 1049; *see also id.* at 1041 (noting that, among other harms, the plaintiff suffered from depression and anxiety because of the bathroom policy, and restricted his water intake to avoid restroom use, exacerbating his medical problems); *M.A.B.*, 286 F. Supp. 3d at 716–17 (applying *Whitaker* to conclude that the plaintiff had sufficiently pled a Title IX claim based on the school’s policy of excluding him from use of the boys’ locker room because of his transgender status). After full consideration of the facts presented and the compelling scope of relevant legal analyses, the Court concludes that Mr. Grimm has sufficiently pled a Title IX claim of sex discrimination under a gender stereotyping theory.

C. Equal Protection Claim

Mr. Grimm also brings a claim under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution (ECF No. 113 ¶¶ 81–89), which provides that “[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws.” U.S. Const. amend. XIV § 1. As *Whitaker* recognized, the Equal Protection Clause “is

essentially a directive that all persons similarly situated should be treated alike.” 858 F.3d at 1050 (quoting *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985)). Under “rational basis review,” state action will generally be presumed to be lawful and upheld if the classification drawn by the statute is rationally related to a legitimate state interest. *City of Cleburne*, 473 U.S. at 440. However, a state must not distinguish between classes of people in an “arbitrary or irrational” manner or out of a “bare . . . desire to harm a politically unpopular group.” *Id.* at 446–47 (internal citation omitted).

Under “rational basis review,” if a state classification of a group of people is rationally related to a legitimate state interest, courts will uphold the classifications. *Id.* at 440. However, when a state classifies a “suspect” or “quasi-suspect” group of people, courts will apply “heightened scrutiny.” *Id.* at 440–41.

Sex-based classifications are subject to heightened scrutiny. The state bears the burden of demonstrating that its proffered justification for the use of a sex-based classification is “exceedingly persuasive.” *United States v. Virginia*, 518 U.S. 515, 533 (1996). That is, the state is required to demonstrate that the classification “serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives.” *Id.* at 524 (internal citation omitted). Hypothesized or *post hoc* justifications created in response to litigation are insufficient to meet this burden, as are justifications based on overbroad generalizations about sex. *Id.* at 533. Furthermore, “[i]f a state actor cannot defend a sex-based classification by relying upon overbroad generalizations, it follows that sex-based stereotypes are also insufficient sustain a classification.” *Kenosha*, 858 F.3d at 1051 (internal citation omitted).

1. The Board's Policy Warrants Intermediate Scrutiny

The parties dispute which level of scrutiny is warranted. The Board contends that rational basis review should apply because transgender individuals do not constitute a quasi-suspect class under the Equal Protection Clause. ECF No. 136 at 28. Mr. Grimm contends that classification based upon transgender status amounts to classification based on sex, and so warrants heightened scrutiny. ECF No. 139 at 37–38.

The Fourth Circuit has not considered the question of whether transgender classifications are sex-based. *See M.A.B.*, 286 F. Supp. 3d at 718. The Seventh and Eleventh Circuits have considered the issue and have concluded that heightened scrutiny applies. *See Whitaker*, 858 F.3d at 1051; *Glenn*, 663 F.3d at 1321. This Court agrees and concludes that intermediate scrutiny is warranted for at least two reasons.

First, transgender individuals constitute at least a quasi-suspect class, and the Policy classified Mr. Grimm on the basis of his transgender status. *See M.A.B.*, 286 F. Supp. 3d at 718–20. Four factors are used to determine whether a group of people who have been classified by a state amount to a suspect or quasi-suspect class: (1) whether the class has historically been subject to discrimination, *Bowen v. Gilliard*, 483 U.S. 587, 602 (1987); (2) whether the class has a defining characteristic that bears a relation to ability to perform or contribute to society, *Cleburne*, 473 U.S. at 440–41; (3) whether the class exhibits obvious, immutable, or distinguishing characteristics that define the class as a discrete group, *Bowen*, 483 U.S. at 602; and (4) whether the class is a minority or politically powerless. *Id.* This Court joins the District of Maryland in concluding that transgender individuals meet all four factors and constitute at least a quasi-suspect class.

As to the first factor, there is no doubt that transgender individuals historically have been subjected to discrimination on the basis of their gender identity, including high rates of violence

and discrimination in education, employment, housing, and healthcare access. *See Whitaker*, 858 F.3d at 1051; *M.A.B.*, 286 F. Supp. 3d at 720; *see also Evancho*, 237 F. Supp. 3d at 288; *Highland*, 208 F. Supp. 3d at 874; *Adkins v. City of New York*, 143 F. Supp. 3d 134, 139 (S.D.N.Y. 2015).

The second factor is also met because transgender status has no bearing on a transgender individual's ability to contribute to society. *See M.A.B.*, 286 F. Supp. 3d at 720.

As to the third factor, "transgender status is immutable." *Id.* at 720–21. Furthermore, transgender individuals have distinguishing characteristics—the disparity between the gender they were assigned at birth and the gender they identify with—that define them as a discrete group. *Id.* at 721.

As to the fourth factor, there can be no doubt that transgender individuals are a minority and are politically powerless, comprising just a fraction of the population and frequently subjected to discriminatory federal policies and state laws. *Id.* at 721. This Court joins the District of Maryland, as well as a host of other district courts, in concluding that because transgender individuals are part of a quasi-suspect class, classifications based on transgender status are per se entitled to heightened scrutiny. *Id.* at 720–22; *see also Doe 1 v. Trump*, 275 F. Supp. 3d 167, 208–09 (D.D.C. 2017); *Evancho*, 237 F. Supp. 3d at 288; *Highland*, 208 F. Supp. 3d at 874; *Adkins*, 143 F. Supp. 3d at 139–40; *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015).

Second, intermediate scrutiny is also warranted because, as Mr. Grimm has pled the matter, the Board Policy at issue relies on sex stereotypes. Accordingly, Mr. Grimm's claims amount to an allegation of a sex-based classification and, therefore, an allegation of sex-based

discrimination in violation of the Equal Protection Clause. *See M.A.B.*, 286 F. Supp. 3d at 718–19.

In *Whitaker*, the Seventh Circuit declined to conclude whether “transgender status is per se entitled to heightened scrutiny,” but recognized that “it is enough to say that, just as in *Price Waterhouse*,” that the record demonstrated that the plaintiff had been subject to sex stereotyping and therefore had experienced sex discrimination. *Whitaker*, 858 F.3d at 1051. The court reasoned that because “the School District decides which bathroom a student may use based upon the sex listed on the student’s birth certificate,” the policy could not be stated without referencing sex. *Id.* Accordingly, *Whitaker* concluded, “[t]his policy is inherently based upon a sex-classification,” and “heightened review applies.” *Id.*; *see also Glenn*, 663 F.3d at 1319–20 (recognizing that the consistent purpose of applying intermediate scrutiny to sex-based classifications has been to eliminate discrimination on the basis of gender stereotypes, and concluding that discrimination against a transgender individual because of his or her gender non-conformity constitutes sex discrimination under the Equal Protection Clause).

This Court joins other courts that have concluded that because the Policy relies on sex-based stereotypes, it is a sex-based classification. *See M.A.B.*, 286 F. Supp. 3d at 718–19. The Policy classified Mr. Grimm differently on the basis of his transgender status and, accordingly, subjected him to sex stereotyping. The Equal Protection Clause protects Mr. Grimm from impermissible sex stereotypes—just as Title IX does, for the reasons articulated previously—and the Court need only find that the Board’s Policy demonstrated sex stereotyping under the Equal Protection Clause. *Cf. Price Waterhouse*, 490 U.S. 250–52. Mr. Grimm was subjected to sex discrimination because he was viewed as failing to conform to the sex stereotype propagated by

the Policy. Because the Policy relies on sex-based stereotypes, the Court finds that review of the Policy is subject to intermediate scrutiny.

2. As Pled by Mr. Grimm, the Policy was Not Substantially Related to Achieving an Important Governmental Objective

The Court next turns to whether the Policy survives review under heightened scrutiny. To survive, the Board must demonstrate that the classification serves an important governmental objective, and that the discriminatory means employed are substantially related to the achievement of those objectives. *Virginia*, 518 U.S. at 533 (internal citation omitted).

The Board argues that the Policy is substantially related to an important governmental objective: protecting the privacy rights of its students. *See* ECF No. 136 at 35–37. The Board expands this argument by contending that concerns over student privacy extend to protecting students like Mr. Grimm who, for whatever reason, may be uncomfortable using a restroom corresponding with their physiological sex. The Board argues that by permitting such students to use a single-user restroom, the Board is also protecting the privacy of students like Mr. Grimm. *Id.* at 36.

The Board’s argument rings hollow. In *Whitaker*, the Seventh Circuit concluded that although the school’s privacy justification may be a legitimate and important interest, the policy was not genuine because it is “based upon sheer conjecture and abstraction.” *Whitaker*, 858 F.3d at 1052; *see also Grimm I*, 822 F.3d at 723.

Such conjecture is obvious. First, the plaintiff in *Whitaker*—like Mr. Grimm—used the boys’ bathrooms for *weeks* without incident before *other adults in the community—not students*—complained of this use. Second, as the Seventh Circuit observed, a “transgender student’s presence in a restroom provides no more of a risk to other students’ privacy rights than the presence of an overly curious student of the same biological sex who decides to sneak

glances at his or her classmates performing their bodily functions.” *Whitaker*, 858 F.3d at 1052. Third, if school districts were genuinely concerned with protecting the privacy of students who have different-looking anatomies, “then it would seem that separate bathrooms also would be appropriate for pre-pubescent and post-pubescent children who do not look alike anatomically,” which the school district had not provided. *Id.* at 1052–53. This Court declines to further evaluate the legitimacy of the purported privacy concerns. The record here is less developed than it was in *Whitaker*. However, the Court underscores that, as pled by Mr. Grimm, Mr. Grimm used the boys’ bathrooms for weeks without incident.

The Court concludes that, as pled by Mr. Grimm, the policy at issue was not substantially related to protecting other students’ privacy rights. *See M.A.B.*, 286 F. Supp. 3d at 724–26.¹² There were many other ways to protect privacy interests in a non-discriminatory and more effective manner than barring Mr. Grimm from using the boys’ restrooms. For example, the Board had taken steps “to give all students the option for even greater privacy” by installing partitions between urinals and privacy strips for stall doors. ECF No. 113 ¶ 57. Additionally, students who wanted greater privacy for any reason could have used one of the new single-stall restrooms made available upon implementation of the policy. *See Grimm I*, 822 F.3d at 728–29 (Davis, J., concurring). Furthermore, as the *M.A.B.* court recognized, it is significant when a

¹² The Court emphasizes that *M.A.B.* rejected the defendants’ argument that single-use restrooms and stalls in the boys’ locker room would be insufficient to assuage privacy concerns, because “if M.A.B. changing clothes in the designated restrooms makes him feel humiliated and embarrassed . . . then students who use those restrooms for greater privacy will feel the same way.” 286 F. Supp. 3d at 724.

M.A.B. rejected that argument for four reasons: (1) the policy interfered with M.A.B.’s health and well-being because it prevented him from social transition, as required for treating his gender dysphoria; (2) M.A.B. was *required* to use the designated restrooms, unlike the students who had the *option* to do so if they desired greater privacy; (3) the policy singled out M.A.B. “and marks him as different for being transgender,” again in contrast to students for whom using a single-stall restroom carried no stigma; and (4) “even if some boys feel humiliated, embarrassed, or alienated for deciding to change clothes in a single-use restroom or stall, changing there still serves [the defendants’] privacy concerns because those boys still enjoy greater privacy.” *Id.* at 724–25. The Court agrees with *M.A.B.*’s reasoning.

school board fails to provide “any explanation for why completely barring [the transgender student] from the boys’ [segregated facility] protects the privacy of other boys,” “while the availability of single-use restrooms or locker stalls does not.” *M.A.B.*, 286 F. Supp. 3d at 725. As in *Whitaker* and *M.A.B.*, preventing Mr. Grimm from using the boys’ restrooms did nothing to protect the privacy rights of other students, but certainly singled out and stigmatized Mr. Grimm. *Id.*

Similarly, the Board’s argument that the policy should not be construed as violating the Equal Protection Clause because the policy treated all boys and girls the same is unavailing. ECF No. 136 at 26–37. The Policy singled out Mr. Grimm for differing treatment because it “treat[ed] transgender students . . . who fail to conform to the sex-based stereotypes associated with their assigned sex at birth[] differently,” whereas a boy making the personal choice to change clothes in or use a single-stall restroom would not have been singled out by the school policy. *Whitaker*, 858 F.3d at 1051; *see also Grimm I*, 822 F.3d at 729 (Davis, J., concurring) (“For other students, using the single-stall restrooms carries no stigma whatsoever, whereas for G.G., using those same restrooms is tantamount to humiliation and a continuing mark of difference among his fellow students.”).

For these reasons, the Court concludes that Mr. Grimm has sufficiently pled that the Policy was not substantially related to protecting other students’ privacy rights, because there were many other ways to protect privacy interests in a non-discriminatory and more effective manner than barring Mr. Grimm from using the boys’ restrooms. The Board’s argument that the policy did not discriminate against any one class of students is resoundingly unpersuasive. Accordingly, the Court declines to dismiss his Equal Protection Claim.

IV. CONCLUSION

For the reasons set forth herein, the Amended Motion to Dismiss (ECF No. 135) is DENIED. The Motion to Dismiss (ECF No. 118) is DISMISSED as moot.

Counsel for the parties are DIRECTED to contact the Courtroom Deputy for the United States Magistrate Judges at (757) 222-7222 within thirty days of entry of this Order to schedule a settlement conference.

IT IS SO ORDERED.

May 22nd, 2018
Norfolk, Virginia



Arenda L. Wright Allen
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v.

GLOUCESTER COUNTY
SCHOOL BOARD,

Defendant.

Civil No. 4:15cv54

ORDER

This matter comes before the Court on Plaintiff Gavin Grimm's ("Mr. Grimm") Motion for Leave to File Second Amended Complaint, ECF No. 170. For the reasons stated herein, Mr. Grimm's Motion is **GRANTED**.

Mr. Grimm filed his original Complaint on June 11, 2015 against Defendant Gloucester County School Board ("the Board"). ECF No. 8. Mr. Grimm filed a First Amended Complaint on August 22, 2017 after graduating from Gloucester High School. ECF No. 113. The original Complaint and the First Amended Complaint asserted that the Board violated Mr. Grimm's rights under Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681(a), and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, when it assigned him a restroom based on his biological sex rather than on his gender identity.

The Board filed a motion to dismiss the First Amended Complaint, which this Court denied on May 22, 2018. ECF No. 148. The Board filed an Answer to the First Amended Complaint on July 20, 2018. ECF No. 154.

Mr. Grimm now requests leave to file a Second Amended Complaint, attached as Exhibit A to his Motion. The proposed Second Amended Complaint contains new allegations against the Board.¹ Specifically, Mr. Grimm alleges that the Board continues to discriminate against him “by refusing to update his official school transcript to match the male sex on his birth certificate, despite [Mr. Grimm’s] repeated requests.” ECF No. 170-1, ¶ 12. Mr. Grimm alleges that he is stigmatized and humiliated whenever he is required to provide a high school transcript to a college or potential employer that declares his sex to be different than his gender identity. *Id.*

Federal Rule of Civil Procedure 15(a) provides that leave to amend “shall be freely given when justice so requires.” F.R.C.P. 15(a). “[L]eave to amend a pleading should be denied only when the amendment would be prejudicial to the opposing party, there has been bad faith on the part of the moving party, or the amendment would have been futile.” *Laber v. Harvey*, 438 F.3d 404, 426 (4th Cir. 2006) (en banc).

The Board opposes Mr. Grimm’s request to file the Second Amended Complaint. The Board does not assert any prejudice or bad faith. Instead, the Board argues that the Second Amended Complaint would be futile because Mr. Grimm’s new allegations do not constitute a violation of Mr. Grimm’s rights under Title IX or the Equal Protection Clause.

The Board first argues that statutes and regulations passed by the Virginia General Assembly govern the amendment of vital records and that “matters of state law are not properly considered under Title IX or the Equal Protection Clause.” ECF No. 171 at 3 (citing Va. Code Ann. § 32.1-269; 12 VAC 5-550-320; 12 VAC 5-550-460). The Board’s argument is unpersuasive. The cited regulations do not support the Board’s position. For example, 12 VAC

¹ The proposed Second Amended Complaint also contains several minor changes and removes requests for injunctive relief that the Court previously dismissed as moot.

5-550-320 states that a certificate of birth is to be amended upon presentation of acceptable evidence, such as a court order that the name or sex on the certificate be changed. Mr. Grimm obtained a court order from the Virginia Circuit Court and used that court order to obtain a birth certificate indicating his gender as male. He presented that birth certificate to the Board in support of his request to change his transcript. According to the regulations, Mr. Grimm presented acceptable evidence for his request. ECF No. 171-1. If the Board decided to treat Mr. Grimm differently than similarly situated students, that could be evidence of a violation of federal law, a fact that is not altered by the Board's citations to Virginia law.

Second, the Board argues that the Family Educational Rights and Privacy Act ("FERPA"), 20 U.S.C. § 1232g; 34 C.F.R. Part 99, provides the appropriate framework for relief. FERPA provides parents or students the opportunity to request an amendment to educational records. 34 C.F.R. § 99.20(a). If a request is denied, FERPA grants parents and students the right to be notified of the reasons and the right to a hearing to contest the decision. 34 C.F.R. § 99.20(b)–(c). Finally, FERPA grants parents and students the right to "place a statement in the record commenting on the contested information in the record or stating why he or she disagrees with the decision of the agency or institution, or both." 34 C.F.R. § 99.21(b)(1)(ii)(2).

There is no indication that FERPA was intended to be the sole remedy for students contesting information in their vital records. To the contrary, FERPA explicitly provides that "[n]othing in this chapter shall be construed to affect the applicability of . . . title IX of the Education Amendments of 1972 . . . or other statutes prohibiting discrimination." 20 U.S.C. § 1221(d). This language makes clear that FERPA does not preclude a suit pursuant to Title IX.

Nor does FERPA displace equal protection claims under 42 U.S.C. § 1983. In *Fitzgerald v. Barnstable Sch. Comm.*, the United States Supreme Court held that Title IX did not preclude

students from bringing equal protection claims under section 1983 because Title IX does not include “an express private means of redress” and “the protections guaranteed by the two sources of law diverge.” 555 U.S. 246, 256 (2009). This line of reasoning applies with even greater force to FERPA, which does not create any private cause of action, expressly or impliedly. *Gonzaga University v. Doe*, 536 U.S. 273, 287 (2002). Moreover, the protection guaranteed by FERPA is that vital records are to be accurate, and the law provides procedural protections to accomplish that end. The protection guaranteed by the Equal Protection Clause, however, is that individuals are to be free from discrimination. In other words, “the protections guaranteed by the two sources of law diverge.”

For these reasons, the proposed Second Amended Complaint would not be futile, and the Board has not asserted any other reason to deny Mr. Grimm’s Motion for Leave. That Motion, ECF No. 170, is **GRANTED**. The Clerk is **DIRECTED** to file the Second Amended Complaint, ECF No. 170-1.

The Clerk is **REQUESTED** to forward a copy of this Order to all counsel of record.

IT IS SO ORDERED.



Arenda L. Wright Allen
United States District Judge


_____, 2019
Norfolk, Virginia

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Case No. 4:15-cv-54
	)	
GLOUCESTER COUNTY SCHOOL	)	
BOARD,	)	
	)	
Defendant.	)	
_____	)	

SECOND AMENDED COMPLAINT

1. Gavin Grimm (“Gavin”) is a 19-year-old young man who is transgender. When Gavin was 15, he came out to his family as a boy and, with the help of his medical providers, transitioned to living in accordance with his male identity as part of medically necessary treatment for gender dysphoria.

2. By the time Gavin began his sophomore year at Gloucester High School, he had legally changed his name to Gavin and begun using male pronouns. Gavin wore his clothing and hairstyles in a manner typical of other boys and used the men’s restrooms in public venues, including restaurants, libraries, and shopping centers, without encountering any problems. Gavin’s medical providers also gave him a “treatment documentation letter,” which confirmed that Gavin was receiving treatment for gender dysphoria and stated that he should be treated as a boy in all respects, including when using the restroom.

3. With the support of the school principal and superintendent, Gavin used the boys’ restrooms at Gloucester High School for approximately seven weeks without incident.

4. But in response to complaints from some adults in the community, the Gloucester County School Board (the “Board”) overruled its own administrators and enacted a new policy prohibiting boys and girls “with gender identity issues” from using the same restrooms as other boys and girls. The new policy directed students who are transgender to an “alternative appropriate private facility.”

5. The Board continued to exclude Gavin from using the same restrooms as other boys, even after he began receiving hormone therapy, obtained a Virginia state I.D. card listing his sex as male, underwent chest reconstruction surgery, obtained a court order legally changing his sex to male under Virginia law, and received a new Virginia birth certificate reflecting that his sex is male.

6. Throughout the rest of high school, Gavin was forced to use separate restrooms that no other student was required to use. That degrading and stigmatizing policy singled Gavin out as unfit to use the same restrooms that are available to every other student.

7. The Board’s policy conflicts with the views of every major medical and mental health organization and school counselors’, teachers’, and administrators’ organizations across the country.

8. In every part of the country, including Virginia, boys and girls who are transgender are already using sex-separated restroom and locker room facilities at school, participating in interscholastic athletic teams in both high school and college, and joining girl-scout and boy-scout troops.

9. Ignoring these realities, the Gloucester County School Board has adhered to its categorical ban, which prohibits the Board’s own school administrators from ever allowing any

student who is transgender to use the common facilities that are available to every other boy and girl.

10. Gavin is recognized by his family, his medical providers, the Virginia Department of Health, and the world at large as a boy. Allowing him to use the same restrooms as other boys is the only way to provide him access to sex-separated restrooms without discrimination.

11. By segregating Gavin from his peers, excluding him from using the same restrooms that every other boy is allowed to use, and relegating him to separate restroom facilities, the Board discriminated against Gavin, in violation of the Equal Protection Clause of the Fourteenth Amendment and Title IX of the Education Amendments of 1972.

12. The Board also continues to discriminate against Gavin by refusing to update his official school transcript to match the male sex on his birth certificate, despite Gavin's repeated requests. As a result, every time Gavin is required to provide a high school transcript to a college or potential employer, he must provide a transcript that—unlike all his other identification documents—declares that his sex is “female.” The Board thus continues to stigmatize and humiliate Gavin by treating Gavin differently from every other graduating student with a male birth certificate, in violation of Title IX and the Fourteenth Amendment.

13. Gavin seeks redress from this Court.

JURISDICTION AND VENUE

14. This action arises under Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, *et seq.*, the Constitution of the United States, and 42 U.S.C. § 1983. This Court has jurisdiction pursuant to Article III of the United States Constitution and 28 U.S.C. § 1331. Declaratory relief is authorized by 28 U.S.C. §§ 2201 and 2202.

15. Venue lies with this Court pursuant to 28 U.S.C. §§ 1391(b)(1)-(2), because the defendant resides in this District and a substantial part of the events or omissions giving rise to the claim occurred in this District.

PARTIES

16. Plaintiff Gavin Grimm (“Gavin”) is nineteen years old. From September 2013 to June 2017, he attended Gloucester High School, a public high school in Gloucester County, Virginia.

17. The Gloucester County School Board (the “School Board” or “Board”) is an elected body responsible for the operation of the Gloucester County Public Schools (“GCPS”), including the promulgation of policies. At all times relevant, the School Board has acted and continues to act under color of state law.

FACTUAL ALLEGATIONS

Transgender youth and gender dysphoria

18. Gavin was born in Gloucester County and has lived in Gloucester County his entire life. Gavin is a typical teenager who is articulate and intelligent, reads broadly, loves his dog and cats, and enjoys hanging out with his friends.

19. When Gavin was born, the hospital staff identified him as female, but from a young age, Gavin knew that he was a boy. Although the sex assigned to Gavin at birth was female, Gavin has a male gender identity.

20. Everyone has a gender identity. It is an established medical concept, referring to a person’s deeply felt, inherent sense of one’s gender. Most people have a gender identity that matches the sex they are identified as at birth. But people who are transgender have a gender identity that differs from the sex they are assigned at birth.

21. Like many students who are transgender, Gavin succeeded at school until the onset of puberty, when he began to suffer debilitating levels of distress from gender dysphoria, a condition in which individuals who are transgender experience persistent and clinically significant distress caused by the incongruence between their gender identity and the sex assigned to them at birth. Although gender dysphoria is a serious medical condition recognized by the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders (5th ed. 2013), being transgender is not a mental disorder and "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities." Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender & Gender Variant Individuals* (2012).

22. There is a medical and scientific consensus that the treatment for gender dysphoria is for boys who are transgender to live as boys and for girls who are transgender to live as girls. When medically appropriate, treatment also includes hormone therapy and surgery. This medical consensus is embraced by the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the National Endocrine Society, and every other major medical and mental health organization in the United States.

23. The ability of individuals who are transgender to live consistently with their identity is critical to their health and well-being. That includes using names and pronouns consistent with their identity, grooming and dressing in a manner typically associated with that gender, and using restrooms and other sex-separated facilities that match their gender identity. Preventing students who are transgender from living in a manner that is consistent with their gender identity puts them at increased risk of debilitating depression and suicide. By contrast,

when gender dysphoria is properly treated, individuals who are transgender experience profound relief and can go on to lead healthy, happy, and successful lives.

24. Boys and girls who are transgender are people who consistently, persistently, and insistently do not identify with the sex assigned to them at birth, and who can experience the debilitating distress of gender dysphoria when they are not able to live as the boys and girls that they are. The gender identity of these adolescents is stable and fixed.

25. Boys and girls who are transgender are attending schools across the country. While students who are transgender have long been part of school communities, it is only in the last couple decades that there has been more widespread access to the medical and psychological support that they need. Beginning in the early 2000s, as a result of advances in medical and psychological treatment, students who are transgender finally began to receive the treatment necessary to alleviate the devastating pain of gender dysphoria and live their lives in accordance with who they really are.

26. Many students who are transgender attend school without classmates and peers knowing they are transgender. For example, many students have already transitioned before beginning school and many others transfer to a new school after transitioning.

27. With hormone therapy, students who are transgender develop physical sex characteristics typical of their gender identity—not the sex they were identified as at birth. Hormone therapy affects bone and muscle structure, alters the appearance of a person's genitals, and produces secondary sex characteristics such as facial and body hair in boys and breasts in girls.

28. In addition, children who are transgender who receive puberty blockers never go through puberty as their birth-designated sex. They will be exposed to the same levels of

testosterone or estrogen as other boys and girls during puberty, and those hormones will affect every major body system.

29. Under widely accepted standards of care developed by the World Professional Association of Transgender Health (“WPATH”), genital surgery is not recommended for minors, but boys who are transgender may undergo medically necessary chest-reconstruction surgery after they turn 16.

30. According to every major medical and mental health organization, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association, excluding boys and girls who are transgender from using the same restrooms as other boys and girls is harmful to their health and wellbeing. When excluded from the common restrooms, students who are transgender often avoid using the restroom entirely, either because the separate restrooms are too stigmatizing or too difficult to access. They suffer infections and other negative health consequences as a result of avoiding restroom use. The exclusion also increases their risk of depression and self-harm.

31. Educators and school administrators across the country also recognize that excluding boys and girls who are transgender from using the common restrooms interferes with their ability to learn and thrive at school. It impairs their ability to develop a healthy sense of self, peer relationships, and the cognitive skills necessary to succeed in adult life. In light of these harms, the National Association of School Psychologists, National Association of Secondary School Principals, National Association of Elementary School Principals, and the American School Counselor Association have all called upon schools to allow boys and girls who are transgender to use the same restrooms as other boys and girls.

32. According to the American Academy of Pediatrics and other major medical and mental health organizations, there is no evidence that allowing boys and girls who are transgender to use the same restrooms as other boys and girls causes any harm to the physical or mental health of students who are not transgender.

33. Schools can provide accommodations for all students—whether transgender or not—to enhance their own privacy without discriminating against students who are transgender by excluding them from common spaces.

34. In schools across the country, including Virginia, boys and girls who are transgender already use the same restrooms and locker rooms as other boys and girls.

35. In high school athletic associations across the country, including Virginia, boys and girls who are transgender already play on the same sports teams as other boys and girls.

36. Institutions ranging from the Girl Scouts and Boy Scouts to the Seven Sisters colleges to the National Collegiate Athletic Association already recognize boys who are transgender as boys and recognize girls who are transgender as girls.

37. Treating boys who are transgender as boys, and treating girls who are transgender as girls, is the only way they can equally participate in school, work, or society at large.

Gavin's experience at Gloucester High School

38. In 2014, near the end of his first year of high school, the distress caused by Gavin's untreated gender dysphoria became so great that he was unable to attend class. At that point, Gavin came out to his parents as a boy and, at his request, began seeing a psychologist with experience counseling youth who are transgender.

39. With the help of his medical providers, Gavin transitioned to living in accordance with his male identity as part of medically necessary treatment for gender dysphoria.

40. Gavin legally changed his name to Gavin and began using male pronouns. Gavin wore his clothing and hairstyles in a manner typical of other boys and began using the men's restrooms in public venues, including restaurants, libraries, and shopping centers, without encountering any problems. His medical providers also referred Gavin to an endocrinologist to begin hormone therapy.

41. Gavin and his mother met with the school guidance counselor in August 2014, before the beginning of his sophomore year, to explain that Gavin is a boy who is transgender and would be attending school as a boy.

42. Gavin and his mother gave the guidance counselor a "treatment documentation letter" from his psychologist, which confirmed that Gavin was receiving treatment for gender dysphoria and stated that he should be treated as a boy in all respects, including when using the restroom.

43. At the time Gavin and his mother met with the guidance counselor, the School Board did not have policies addressing which restrooms students who are transgender should use.

44. Gavin initially agreed to use the restroom in the nurse's office, but he soon felt stigmatized and isolated using a different restroom from everyone else. The restroom in the nurse's office was also located far away from many of his school classes, and Gavin was often unable to use the restroom without being late for class.

45. After a few weeks of using the restroom in the nurse's office, Gavin sought permission to use the boys' restrooms.

46. On October 20, 2014, with the school principal's support, Gavin began using the boys' restrooms, and did so for seven weeks without incident.

47. Gavin also requested permission to complete his physical-education requirements through a home-bound program. As a result, he never needed to use the locker rooms at school.

48. The principal of Gloucester High School and the superintendent of Gloucester County Public Schools informed the Board that they had authorized Gavin to use the same restrooms as other boys, but otherwise kept the matter confidential.

49. Although the principal and superintendent treated the matter as confidential, some adults in the community learned that a boy who is transgender was using the boys' restrooms at Gloucester High School. They contacted the Board to demand that the transgender student (who was not publicly identified as Gavin until later) be barred from the boys' restrooms.

50. On information and belief, at least some of the complaints came from a Gloucester High School employee who runs the school Bible club and is a pastor at a local church. That employee told the Washington Post that he spoke out against Gavin's use of the boys' restroom because "God puts us on this Earth as who we are."

51. The Board considered the matter at a private meeting and took no action for several weeks.

52. Unsatisfied with the results of the private meeting, one member of the Board alerted the broader community by proposing the following policy for public debate at the Board's meeting on November 11, 2014:

Whereas the GCPS recognizes that some students question their gender identities, and

Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and

Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore

It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding

biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

53. The policy categorically prohibits administrators from allowing any boy who is transgender to use any boys' restroom (or allowing any girl who is transgender to use any girls' restroom) in any school within the Gloucester County School District, regardless of the student's individual circumstances.

54. The policy does not define "biological gender," and the term has no common or accepted meaning. There are many biological components of sex, including chromosomal, anatomical, hormonal, and reproductive elements, some of which could be ambiguous or in conflict within an individual, either because that individual has intersex traits or because that individual has undergone medical care for gender dysphoria.

55. After learning about the meeting through social media, Gavin and his parents decided to speak against the proposed policy. In order to speak against the policy, Gavin was forced to reveal himself to the entire community and the local media as the boy whose restroom use was at issue.

56. Gavin told the Board:

I use the public restroom, the men's public restroom, in every public space in Gloucester County and others. I have never once had any sort of confrontation of any kind.

...

All I want to do is be a normal child and use the restroom in peace, and I have had no problems from students to do that—only from adults.

...

I did not ask to be this way, and it's one of the most difficult things anyone can face.

...

I am just a human. I am just a boy.

A recording of his remarks can be viewed online at <https://goo.gl/CYh4gd>

57. By a vote of 4-3, the School Board voted to defer a vote on the policy until its meeting on December 9, 2014.

58. Before its next meeting, the Board issued a press release announcing plans for “adding or expanding partitions between urinals in male restrooms, and adding privacy strips to the doors of stalls in all restrooms.” In addition, the press release announced “plans to designate single stall, unisex restrooms ... to give all students the option for even greater privacy.”

59. Speakers at the December 9, 2014 Board meeting nonetheless demanded that Gavin be excluded from the boys’ restrooms immediately, and many threatened to vote Board members out of office if they refused to pass the new policy.

60. With Gavin in attendance, several speakers pointedly referred to him as a “young lady.” One speaker called Gavin a “freak” and compared him to a person who thinks he is a “dog” and wants to urinate on fire hydrants. “Put him in a separate bathroom if that’s what it’s going to take,” said another.

61. The Board meeting made Gavin feel that he had been turned into a public spectacle in front of the entire community.

62. The Board passed the policy on December 9, 2014, by a 6-1 vote.

63. The following day, the principal told Gavin he could no longer use the same restrooms as other boys.

64. The Board’s new policy did not affect the restroom usage of any other student at Gloucester High School. Every other student was allowed to continue using the same restrooms they had been using before the new policy was adopted. The only person who had to use a different restroom was Gavin.

65. The Board subsequently installed three single-user restrooms. One of the restrooms had previously been designated as a restroom for teachers and staff. The other two restrooms were converted from old utility closets.

66. None of the single-user restrooms was located near Gavin's classes.

67. Although any student was allowed to use the single-user restrooms, no one else did so. Everyone knew they were created for Gavin as part of the policy prohibiting him from using the same restrooms as other boys.

68. Being relegated to the separate restrooms was demeaning and shameful for Gavin. It signaled to Gavin and the entire school community that he is different, and it sent a public message to all his peers that he is not fit to be treated like everyone else.

69. Gavin did everything he could to avoid using the restroom at school. As a result, he developed painful urinary tract infections and was often distracted and uncomfortable in class.

70. When Gavin absolutely had to use the restroom, he used the nurse's restroom, but he still felt ashamed doing so. Every time he had to walk to the other side of school to use the nurse's restroom, Gavin felt like he was taking a "walk of shame." It was a constant reminder to Gavin—and to anyone who saw him—that Gavin is transgender and had been barred from using the same restrooms as other boys.

71. Being excluded from the common boys' restroom and forced to use separate restroom facilities also physically isolated Gavin from the rest of his peers by requiring him to travel to a separate part of the school if he had to use the restroom between classes.

72. When Gavin attended school football games, there was no restroom for him to use at all. The Gloucester High School building was locked after school, and there are no single-user

restroom facilities in the stadium. When he had to use the restroom, Gavin's only option was to call his mother to pick him up and take him home early.

Enforcement of the policy

73. The Board continued to exclude Gavin from the same restrooms as other boys throughout the remainder of his sophomore, junior, and senior years of high school.

74. In December 2014, Gavin began hormone therapy, which has altered his bone and muscle structure, deepened his voice, and caused him to grow facial hair.

75. In June 2015, the Virginia Department of Motor Vehicles issued Gavin a state I.D. card identifying him as male.

76. In June 2016, Gavin underwent chest-reconstruction surgery, in accordance with the medical standards of care for treating gender dysphoria.

77. On September 9, 2016, the Gloucester County Circuit Court issued an order changing Gavin's sex under Virginia state law and directing the Virginia Department of Health to issue Gavin a birth certificate listing his sex as male.

78. On October 27, 2016, the Virginia Department of Health issued Gavin a birth listing his sex as male.

79. Despite all of this, the Board disregarded Gavin's medical treatment, his Virginia I.D. card, his new Virginia birth certificate, and the court order changing his sex under Virginia state law. The Board maintained that Gavin's "biological gender" remains female and continued to prohibit its administrators from allowing Gavin to use the boys' restrooms.

Refusal to update gender designation on Gavin's official transcript

80. During his senior year, Gavin received an updated Virginia birth certificate reflecting that his sex is male and provided that birth certificate to school administrators. But

despite Gavin's repeated requests, the Board refused to update his official school transcript to match the male sex on his birth certificate. In doing so, the Board once again singled out Gavin for different treatment from every other student at Gloucester High School with a male birth certificate.

81. Every time Gavin is required to provide a high school transcript to a college or employer, he must provide a transcript that—unlike all his other identification documents—declares that his sex is “female.”

82. Gavin graduated high school on June 10, 2017. But by refusing to update Gavin's official school transcript, the Board continues to stigmatize and humiliate Gavin to this day.

CLAIMS FOR RELIEF

COUNT I

Fourteenth Amendment to the United States Constitution

83. The Board is the final policymaker for Gloucester County Public Schools, acting under color of state law.

84. By excluding Gavin from using the same restrooms that every other boy is allowed to use and relegating him to separate restroom facilities, the Board treated Gavin differently from similarly situated students in violation of the Equal Protection Clause of the Fourteenth Amendment.

85. By excluding Gavin from using the same restrooms that every other boy is allowed to use and relegating him to separate restroom facilities, the Board discriminated against Gavin on the basis of gender, which is subject to heightened scrutiny under the Equal Protection Clause.

86. By excluding Gavin from using the same restrooms that every other boy is allowed to use and relegating him to separate restroom facilities, the Board discriminated against

Gavin on the basis of transgender status, which is also subject to heightened scrutiny under the Equal Protection Clause.

- a. People who are transgender as a class have historically been subject to discrimination.
- b. People who are transgender as a class have a defining characteristic that frequently bears no relation to an ability to perform or contribute to society.
- c. People who are transgender as a class exhibit immutable or distinguishing characteristics that define them as a discrete group.
- d. People who are transgender as a class are a minority with relatively little political power.

87. By excluding Gavin from using the same restrooms that every other boy is allowed to use and relegating him to separate restroom facilities, the Board discriminated against Gavin based on invidious stereotypes, moral disapproval, and unfounded fears about people who are different.

88. By refusing to update Gavin's official school transcript to match the male designation on his updated birth certificate, the Board has discriminated—and continues to discriminate—against Gavin.

89. The Board's discrimination against Gavin is not narrowly tailored to advance a compelling government interest.

90. The Board's discrimination against Gavin is not substantially related to any important government interest.

91. The Board's discrimination against Gavin is not rationally related to any legitimate government interest.

92. The Board is liable for its violation of Gavin’s Fourteenth Amendment rights under 42 U.S.C. § 1983.

COUNT II
Title IX of the Education Amendments of 1972
20 U.S.C. § 1681 *et seq.*

93. Title IX provides that “[n]o person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.” 20 U.S.C. § 1681(a).

94. Gloucester County Public Schools and Gloucester High School are education programs receiving Federal financial assistance.

95. By prohibiting Gavin from using the same restrooms that every other boy is allowed to use and relegating him to separate restroom facilities, the Board violated his rights under Title IX.

96. By refusing to update Gavin’s official school transcript to match the male designation on his updated birth certificate, the Board violated—and continues to violate—his rights under Title IX.

REQUEST FOR RELIEF

For the foregoing reasons, Plaintiff respectfully requests that the Court grant the following relief:

A. A declaration that the Board’s policy violated Gavin’s rights under the Fourteenth Amendment to the United States Constitution and Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, *et seq.*, on the day the policy was first issued and throughout the remainder of his time as a student at Gloucester High School;

- B. A declaration that the Board’s refusal to update Gavin’s official school transcript to match the “male” designation on his updated birth certificate violated—and continues to violate—Gavin’s rights under the Fourteenth Amendment to the United States Constitution and Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, *et seq.*
- C. Nominal damages in an amount determined by the Court;
- D. A permanent injunction requiring the Board to update Gavin’s official school records to match the male designation on his updated birth certificate;
- E. Plaintiff’s reasonable costs and attorneys’ fees pursuant to 42 U.S.C. § 1988; and
- F. Such other relief as the Court deems just and proper.

Dated: February 15, 2019

Respectfully submitted,

AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF VIRGINIA, INC.

/s/

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**Admission pending, notice of appearance forthcoming

Counsel for Plaintiff Gavin Grimm

CERTIFICATE OF SERVICE

I hereby certify that on the 15th day of February 2019, I electronically filed the foregoing with the Clerk of the Court for the U.S. District Court for the Eastern District of Virginia 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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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v.

Case No. 4:15-cv-54

GLOUCESTER COUNTY SCHOOL
BOARD,

Defendant.

ANSWER TO SECOND AMENDED COMPLAINT

Defendant Gloucester County School Board (“School Board”) states as follows for its Answer to the Second Amended Complaint filed by Plaintiff Gavin Grimm (“Grimm”):

1. The School Board admits that Grimm is 19 years old, asserts that he is transgender, but is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 1 of Grimm’s Second Amended Complaint. As such, those allegations are hereby denied.

2. Upon information and belief, the School Board admits that Grimm changed his name to Gavin and that Gavin received a document entitled “treatment documentation letter,” which speaks for itself. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 2 of Grimm’s Second Amended Complaint in the manner and form alleged. As such, those allegations are hereby denied.

3. The School Board admits that Grimm used the boys’ restrooms at Gloucester High School for a period of time; however, the School Board denies the remaining allegations

contained in Paragraph 3 of Grimm's Second Amended Complaint in the manner and form alleged.

4. The School Board admits that it received complaints and inquiries from students, parents of students, and other adults, but denies the remaining allegations contained in Paragraph 4 of Grimm's Second Amended Complaint in the manner and form alleged.

5. The School Board denies the allegations contained in Paragraph 5 of Grimm's Second Amended Complaint in the manner and form alleged.

6. The School Board denies the allegations contained in Paragraph 6 of Grimm's Second Amended Complaint in the manner and form alleged.

7. The School Board denies the allegations contained in Paragraph 7 of Grimm's Second Amended Complaint in the manner and form alleged.

8. The School Board denies the allegations contained in Paragraph 8 of Grimm's Second Amended Complaint in the manner and form alleged.

9. The School Board denies the allegations contained in Paragraph 9 of Grimm's Second Amended Complaint in the manner and form alleged.

10. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in the first sentence of Paragraph 10 of Grimm's Second Amended Complaint. The School Board denies the allegations contained in the second sentence of Paragraph 10 of Grimm's Second Amended Complaint in the manner and form alleged.

11. The School Board denies the factual allegations contained in Paragraph 11 of Grimm's Second Amended Complaint in the manner and form alleged, and further denies that it has violated the Equal Protection Clause of the Fourteenth Amendment or Title IX of the Educational Amendments of 1972.

12. The School Board denies the allegations contained in Paragraph 12 of Grimm's Second Amended Complaint in the manner and form alleged.

13. The School Board denies that Grimm is entitled to the relief requested or any relief.

JURISDICTION AND VENUE

14. Paragraph 14 of Grimm's Second Amended Complaint contains legal conclusions to which no response is required. The School Board, however, denies that it has violated the Equal Protection Clause of the Fourteenth Amendment or Title IX of the Educational Amendments of 1972.

15. Paragraph 15 of Grimm's Second Amended Complaint contains legal conclusions to which no response is required. The School Board, however, denies it took any act in violation of the Equal Protection Clause of the Fourteenth Amendment or Title IX of the Educational Amendments of 1972.

PARTIES

16. The School Board admits the allegations contained in Paragraph 16 of Grimm's Amended Complaint.

17. The School Board admits the allegations contained in Paragraph 17 of Grimm's Amended Complaint.

FACTUAL ALLEGATIONS

18. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 18 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

19. The School Board admits that at birth Grimm's gender was identified as female in conformity with his biological sex. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 19 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied in the manner and form alleged.

20. The allegations contained in Paragraph 20 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

21. The School Board does not possess sufficient information to form a belief as to the truth or falsity of the factual allegations contained in Paragraph 21 of Grimm's Second Amended Complaint pertaining specifically to Grimm. As such, those allegations are hereby denied. Further, the remaining allegations in Paragraph 21 are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

22. The allegations contained in Paragraph 22 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

23. The allegations contained in Paragraph 23 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

24. The allegations contained in Paragraph 24 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

25. The allegations contained in Paragraph 25 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

26. The allegations contained in Paragraph 26 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

27. The allegations contained in Paragraph 27 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as

stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

28. The allegations contained in Paragraph 28 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

29. The allegations contained in Paragraph 29 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

30. The allegations contained in Paragraph 30 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

31. The allegations contained in Paragraph 31 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

32. The allegations contained in Paragraph 32 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

33. Paragraph 33 of Grimm's Second Amended Complaint contains legal conclusions to which no response is required. The School Board denies any factual allegations contained in Paragraph 33 in the manner and form alleged, and further denies that it has discriminated against Grimm.

34. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 34 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

35. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 35 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

36. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 36 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

37. The allegations contained in Paragraph 37 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

38. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 38 of Grimm's Second Amended Complaint.

39. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 39 of Grimm's Second Amended Complaint.

40. The School Board admits, upon information and belief, that Grimm changed his name to Gavin and began using male pronouns. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 40 of Grimm's Second Amended Complaint.

41. The School Board admits that Grimm and his mother met with a guidance counselor near the beginning of the 2014-2015 school year; however, the School Board denies the remaining allegations contained in Paragraph 41 of Grimm's Second Amended Complaint in the manner and form alleged.

42. The School Board admits that, at a later time, the school principal was shown a copy of the "treatment documentation letter," which speaks for itself, and at some point a copy of that letter was given to the guidance counselor; however, the School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 42 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

43. In answer to Paragraph 43 of Grimm's Second Amended Complaint, the School Board avers that its policy related to student restroom use applied equally to all students and did not violate the Equal Protection Clause or Title IX. The School Board denies all remaining allegations contained in Paragraph 43 of Grimm's Second Amended Complaint in the manner and form alleged.

44. In response to the allegations contained in Paragraph 44 of Grimm's Second Amended Complaint, the School Board admits that Gavin requested to use the restroom in the nurse's office; however, the School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in that paragraph; and therefore those allegations are hereby denied.

45. The School Board admits the allegations contained in Paragraph 45 of Grimm's Second Amended Complaint.

46. The School Board admits that on or about October 20, 2014, Grimm began using the male restrooms with the principal's permission; however, the School Board denies the remaining allegations contained in Paragraph 46 in the manner and form alleged.

47. The School Board admits that Grimm requested to complete his physical-education requirements through virtual classes, but is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 47 of Grimm's Second Amended Complaint; and therefore those allegations are hereby denied.

48. In response to the allegations contained in Paragraph 48 of Grimm's Second Amended Complaint, the School Board admits that the principal authorized Grimm to use the boys' restrooms, the superintendent informed the School Board of that decision, and both the principal and the superintendent otherwise kept the matter confidential; however, the School Board denies the remaining allegations contained in that paragraph in the manner and form alleged.

49. The School Board denies the allegations contained in Paragraph 49 of Grimm's Second Amended Complaint in the manner and form alleged.

50. Upon information and belief, the School Boards admits that a pastor in the community who is a Gloucester High School employee made statements, not in his capacity as a school employee, to the Washington Post as set forth in Paragraph 50 of the Second Amended Complaint.

51. The School Board denies the allegations contained in Paragraph 51 of Grimm's Second Amended Complaint in the manner and form alleged.

52. The School Board admits a board member proposed the quoted resolution, which speaks for itself, at the School Board's November 11, 2014, but denies the remaining allegations contained in Paragraph 52 of Grimm's Second Amended Complaint in the manner and form alleged.

53. The School Board denies the allegations contained in Paragraph 53 of Grimm's Second Amended Complaint in the manner and form alleged. The School Board avers that, in a December 9, 2014 Board meeting, it enacted a resolution, which speaks for itself, concerning the use of restroom facilities by all students, including those students that question their gender identities.

54. In response to the allegations contained in Paragraph 54 of Grimm's Second Amended Complaint, the School Board avers that the resolution speaks for itself. The remaining allegations contained in that paragraph are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

55. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in the first sentence of Paragraph 55 of Grimm's Second

Amended Complaint; however, the School Board denies the allegations contained in the second sentence of that paragraph in the manner and form alleged.

56. The School Board admits that an excerpt of Grimm's comments is set forth in Paragraph 56 of Grimm's Second Amended Complaint.

57. The School Board admits the allegations contained in Paragraph 57 of Grimm's Second Amended Complaint.

58. The School Board admits that it issued a press release on December 3, 2014, which speaks for itself.

59. The School Board denies the allegations contained in Paragraph 59 of the Second Amended Complaint in the manner and form alleged.

60. The School Board denies the allegations contained in Paragraph 60 of Grimm's Second Amended Complaint in the manner and form alleged. The School Board avers that any allegations related to the comments of public attendees to the School Board's meeting are not properly directed to the School Board. The School Board further avers that those comments speak for themselves.

61. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 61 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

62. The School Board admits the allegations contained in Paragraph 62 of Grimm's Second Amended Complaint.

63. The School Board admits that after the December 9, 2014 School Board meeting, the principal told Gavin he could not use the boys' restroom; however, the School Board denies

the remaining allegations contained in Paragraph 63 of Grimm's Second Amended Complaint in the manner and form alleged.

64. The School Board denies the allegations contained in Paragraph 64 of Grimm's Second Amended Complaint in the manner and form alleged. The School Board avers that, in a December 9, 2014 Board meeting, it enacted a resolution, which speaks for itself, concerning the use of restroom facilities by all students, including those students that question their gender identities.

65. In response to the allegations contained in Paragraph 65 of the Second Amended Complaint, the School Board admits that it made three single-user restrooms available to all students and that these restrooms included a restroom that had previously been designated for teacher and staff use; however, the School Board denies the remaining allegations contained in that paragraph in the manner and form alleged.

66. The School Board denies the allegations contained in Paragraph 66 of Grimm's Second Amended Complaint in the manner and form alleged.

67. The School Board denies the allegations contained in Paragraph 67 of Grimm's Second Amended Complaint in the manner and form alleged.

68. The School Board denies the allegations contained in Paragraph 68 of Grimm's Second Amended Complaint in the manner and form alleged.

69. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 69 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

70. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 70 of Second Grimm's Amended Complaint. As such, those allegations are hereby denied.

71. The School Board denies the allegations in Paragraph 71 of Grimm's Second Amended Complaint in the manner and form alleged.

72. The School Board admits that there were no single-user restrooms in the Gloucester High School football stadium; however, the School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 72 of Grimm's Second Amended Complaint, and therefore denies those allegations.

73. The School Board denies the allegations contained in Paragraph 73 of Grimm's Second Amended Complaint in the manner and form alleged. The School Board avers that, in a December 9, 2014 Board meeting, it enacted a resolution concerning the use of restroom facilities by all students, including those students that question their gender identities.

74. The School Board does not possess sufficient information to form a belief as to the truth or falsity of the allegations contained in Paragraph 74 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

75. The School Board does not possess sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 75 of Grimm's Second Amended Complaint.

76. The School Board does not possess sufficient information to form a belief as to the truth or falsity of the allegations contained in Paragraph 76 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied. Further, the allegations contained in

Paragraph 76 of Grimm's Second Amended Complaint improperly call for an expert opinion, and the School Board calls for strict proof of those allegations.

77. The School Board, upon information and belief, admits that an Order was entered by the Gloucester County Circuit Court which speaks for itself. The School Board denies the remaining allegations contained in Paragraph 77 of Grimm's Second Amended Complaint in the manner and form alleged.

78. The School Board denies the allegations contained in Paragraph 78 of Grimm's Second Amended Complaint in the manner and form alleged.

79. In response to Paragraph 79 of Grimm's Second Amended Complaint, the School Board admits that Plaintiff's biological sex is female, but denies the remaining allegations contained therein in the manner and form alleged.

80. In response to Paragraph 80 of Grimm's Second Amended Complaint, the School Board admits that in November of 2016, Grimm provided a different Virginia birth certificate listing Grimm's sex as male; however, the School Board denies that the birth certificate was issued in conformity with Virginia law based upon the School Board's understanding of the Code of Virginia and applicable administrative regulations. The School Board admits that Grimm's official school transcript was not altered and is consistent with Grimm's original birth certificate and sex upon enrolling in high school. The School Board denies the remaining allegations contained therein in the manner and form alleged.

81. The School Board is without sufficient information to form a belief as to the truth or falsity of the allegations contained in Paragraph 81 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

82. The School Board admits that Grimm graduated high school on June 10, 2017. The School Board denies the remaining allegations contained in Paragraph 82 of Grimm's Second Amended Complaint.

CLAIMS FOR RELIEF

COUNT I

Fourteenth Amendment to the United States Constitution

83. Paragraph 83 of Grimm's Second Amended Complaint contains legal conclusions to which no response is required.

84. The School Board denies the allegations contained in Paragraph 84 of Grimm's Second Amended Complaint.

85. The School Board denies the allegations contained in Paragraph 85 of Grimm's Second Amended Complaint.

86. The School Board denies the allegations contained in Paragraph 86 of Grimm's Second Amended Complaint, including all subparts.

87. The School Board denies the allegations contained in Paragraph 87 of Grimm's Second Amended Complaint.

88. The School Board denies the allegations contained in Paragraph 88 of Grimm's Second Amended Complaint.

89. The School Board denies the allegations contained in Paragraph 89 of Grimm's Second Amended Complaint.

90. The School Board denies the allegations contained in Paragraph 90 of Grimm's Second Amended Complaint.

91. The School Board denies the allegations contained in Paragraph 91 of Grimm's Second Amended Complaint.

92. The School Board denies the allegations contained in Paragraph 92 of Grimm's Second Amended Complaint.

COUNT II

Title IX of the Education Amendments of 1972 20 U.S.C. § 1681 *et seq.*

93. Paragraph 93 of Grimm's Second Amended Complaint contains a quotation of 20 U.S.C. § 1681(a) and does not require a response.

94. The School Board admits the allegations contained in Paragraph 94 of Grimm's Second Amended Complaint.

95. The School Board denies the allegations contained in Paragraph 95 of Grimm's Second Amended Complaint.

96. The School Board denies the allegations contained in Paragraph 96 of Grimm's Second Amended Complaint.

REQUEST FOR RELIEF

97. The School Board denies any factual allegations contained in the unnumbered paragraph, including all subparts, related to Grimm's request for relief, and further denies that Grimm is entitled to the remaining requested relief or any other relief.

DEFENSES

98. The School Board denies all allegations contained in Grimm's Second Amended Complaint not specifically admitted herein.

99. The School Board denies any wrongdoing and further denies that it violated Grimm's Constitutional Rights or Title IX (20 U.S.C. § 1681 *et seq.*) in any way.

100. The School Board avers that Grimm's claims are moot and fail for that reason.

101. The School Board avers that the notice requirement of the Spending Clause of the United States Constitution (Art. I, § 8, cl. 1) precludes a finding that the School Board violated Title IX, and Grimm's Title IX claims fail for that reason.

102. The School Board avers that it has an interest in protecting the privacy rights of all of its students, that the resolution adopted during the December 9, 2014 School Board meeting serves this important governmental objective, and that any alleged discriminatory conduct of the School Board is substantially related to achieving that objective. For these reasons, the School Board avers that Grimm's Equal Protection Clause claims fail.

103. The School Board denies that Grimm suffered a compensable injury caused by the School Board.

104. The School Board avers that it acted lawfully and with legal justification at all times referenced in Grimm's Second Amended Complaint.

105. The School Board denies that it is liable to Grimm in the amount claimed or any amount, for the reasons stated or for any other reasons.

106. The School Board reserves the right to amend this Answer at any time, including not limited to, any amendment necessary in the event that evidence becomes available during the course of discovery or at trial that may warrant assertion of a new defense, including affirmative defenses.

WHEREFORE, for the foregoing reasons, Defendant Gloucester County School Board, by counsel, respectfully requests judgment in its favor together with costs expended herein.

**GLOUCESTER COUNTY SCHOOL
BOARD**

By Counsel

/s/

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C E R T I F I C A T E

I hereby certify that on the 1st day of March, 2019, I filed a copy of the foregoing document with the Clerk of the Court using the CM/ECF system, which will automatically send a Notice of Electronic Filing to all counsel of record.

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,	)	
	)	
	)	
Plaintiff,	)	
	)	Civil Case No. 4:15-cv-54
v.	)	
	)	
GLOUCESTER COUNTY SCHOOL	)	
BOARD,	)	
	)	
Defendant.	)	

DECLARATION OF GAVIN GRIMM

1. I am the plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. My name is Gavin Elliot Grimm.

3. I was born in Gloucester County on May 4, 1999, and lived in Gloucester County all my life until January 2018.

4. I currently reside in Berkeley, California where I attend school at Berkeley City College and engage in community activism work.

5. I was a student at Gloucester High School and graduated on June 5, 2017.

My Early Childhood Before Transition

6. I have always known that I am a boy. I always saw myself as a boy, identified with male cartoons, and related to male characters. During imaginary play as a young child, I always cast myself in a male role with a traditionally male or gender-neutral name.

7. Around the time that I reached school age, I first started to understand that others perceived me as a girl. I also began to recognize that society perceives large differences between

men and women, including different expectations about their social roles. In part, this realization developed as I expressed interest in activities that were not available to me because I was seen by others as a girl. At that point, I had an understanding that the female physical and social role I was assigned were inaccurate. But I did not have the language at the time to vocalize those feelings.

8. Starting in elementary school, I was bullied throughout my entire school career, in part because I did not conform to traditionally feminine gender expectations. Peers threw things at me, called me horrible names, refused to sit near me, and excluded me from activities. I was called names frequently, at least once or twice a day. Students would call me “faggot,” “dyke,” “homo,” “weirdo,” and make references to my weight.

9. I recall one instance when students were asked to line up boy, girl, boy, girl. I remember the person assigning students placed me in one of the “boy” positions. This was a moment of great joy for me.

10. Throughout my childhood I would request boys’ clothing, but was told it was not appropriate for me. As I grew older, I would fight with my mom to let me shop in the boys’ aisle. I remember a particularly distressing experience when my sister got married and my mother insisted I wear a dress. That was a painful, drawn-out process. For every store we went to, I would walk in, take one look, and say I hated them all. I really fought hard not to wear a dress and eventually, after a lot of tears, I wore one that was very plain and black, like a square with straps. I was incredibly distressed, and the first thing I greeted my relatives with was “please don’t call me pretty,” because I did not want to be perceived as feminine in any way.

11. At around age 12, I was able to exercise more control over my clothing and hairstyle. I cut my hair short in a style traditionally associated with boys, and wore clothing exclusively from the boys' section of stores.

12. When I was 13, I also began using a compression garment, often referred to as a chest binder, to flatten my breasts. I never left the house without wearing the compression garment.

13. Everyone who knew me still assumed that I was a girl because I had not at that time discovered the word transgender and how that related to who I was. But, outwardly, I presented very masculine, and that was not something that was unnoticed by peers and friends. When I went in women's restrooms, I was chased out or yelled at by girls or women saying "you are not supposed to be in here," or telling me that I was in the wrong place and needed to leave.

My Gender Transition and Coming Out

14. Around the same time, I first learned about the term "transgender" from the internet, and realized that there was a word for the feelings I had felt all my life. I had not known about gender transition before, and I was ecstatic to discover it was something a person could do.

15. I had very few friends when I was younger, but as I acknowledged my male gender identity to myself and began to feel more comfortable with who I am, I began to form a group of close friends. One time in ninth grade, before I had revealed to any of my friends that I was transgender, I remember a friend saw another student and remarked, "that looks like the male version of Gavin." My other friend said in response, "Gavin is the male version of Gavin." (This was before I changed my name, so they actually used said my old name instead of "Gavin" when they talked.) I was elated that one of my closest friends perceived me as male, even before I had revealed my gender identity to them.

16. During ninth grade, I gradually began disclosing to friends that I was a boy. Since the reactions of my friends were generally positive and supportive, I disclosed my gender identity to more friends. By the end of ninth grade, most of my friends were aware of my gender identity, and I lived openly as a boy when socializing with friends away from home and school.

17. But I was still afraid to reveal to my family or teachers that I was transgender. My home and community environment was very conservative and also religious. The teachings of the churches in our community were that being gay or transgender was wrong and evil.

18. This made my ninth grade year very difficult for me. Continuing to be seen by others as a girl was incredibly distressing to me. When I would raise my hand to answer a question in class, teachers would say “yes, ma’am.” Teachers continued to refer to me by a female name. Using the girls’ restrooms was also a constant source of anxiety, so I began avoiding the restrooms at school.

19. The cumulative stress of being constantly misgendered caused depression and anxiety so severe that I could not attend school during the spring semester of my freshman year. My ability to function at school became so diminished that it was not possible for me to continue going to school. My social anxiety related to being gendered incorrectly was so bad that I was afraid to go outside, where I might encounter other people. I was miserable, and as a result, could not focus academically. Instead, I took classes through a home-bound program that follows the public high school curriculum through online classes.

20. In April 2014 I finally came out to my mother as a boy. I had previously downloaded a PDF on a reading tablet with information about what it means to be transgender, but I had been too nervous to show it to her. That day, we were in the kitchen talking about something else, and she said the word “transgender.” I did not think she was aware of that word.

When she said the word “transgender,” I ran off to find the tablet—but I couldn’t find it. So I came back and told her that I am transgender, and a boy.

21. My mom told me she loved me and would support me, but she told me not to tell the rest of my family yet. She also helped pick a new name for me: Gavin.

22. We ended up telling the rest of my family a few weeks later at a party for my fifteenth birthday. The morning of the party I was overwhelmed by grief and anxiety. I had locked myself in my bedroom, deeply traumatized by the thought of experiencing another birthday as a “birthday girl.” My father knocked, and he asked me what the problem was. I told him, “Mom said I wasn’t allowed to tell you.” So he asked my mom, and she told him I was a boy. My mom then called the rest of my relatives who were on the way to the party to tell them that I was a boy. She wiped off my old name from the birthday cake, and wrote “Gavin” in its place.

23. My mother made clear to my dad and my brother that she expected them to respect that I am a boy and to use my correct name and pronouns. That was not a point of negotiation in our household. It took a few months for my father and brother to get used to it. But they eventually shifted from tacitly accepting my identity to fully supporting me. My father and brother would comfortably say to other people “he’s my son,” or “he’s my brother.”

24. At my request, I began therapy with a psychologist who had experience with working with transgender patients. The psychologist diagnosed me with gender dysphoria. The psychologist recommended that I immediately begin living as a boy in all respects. That included using a male name and pronouns and using boys’ restrooms. The psychologist gave me a “treatment documentation letter” to confirm I was receiving treatment for gender dysphoria and that, as part of that treatment, I should be treated as a boy. A copy of that treatment

documentation letter is attached as Exhibit A. In addition, the psychologist recommended that I see an endocrinologist to begin hormone treatment for gender dysphoria.

25. In July 2014, I petitioned the Circuit Court of Gloucester County to change my legal name to Gavin Elliot Grimm, and the court granted the petition.

Starting Tenth Grade as a Boy

26. Before the beginning of tenth grade, my mother and I met with Gloucester High School guidance counselor Tiffany Durr to explain that I was a boy and needed to socially transition at school as part of my medical treatment. Ms. Durr expressed support for me and a willingness to ensure a welcoming environment for me at school.

27. Ms. Durr and I agreed that I would send an email to teachers explaining that I was to be addressed using the name Gavin and to be referred to with male pronouns. This was to avoid the potential of misgendering (a practice of unintentionally or maliciously misidentifying my gender) or deadnaming (a practice of using a transgender person's birth name, instead of their chosen name).

28. I did not personally experience malicious misgendering from staff, but there were small groups of students who would make a point to greet me by my dead name, and deliberately identify me as a girl. I recall one instance where my name, "Gavin," was called for attendance, and a classmate started laughing. I heard him tell everyone, "that's a chick, that's a chick," and repeatedly tried to call my attention by yelling my old name. But after I complained to the teacher, she made sure that the student did not harass me in class again.

29. I initially agreed to use a separate restroom in the nurse's office, but once I began school, I soon found it stigmatizing to use a separate restroom. I began to feel anxiety and shame surrounding my travel to the nurse's office. The location of the nurse's office made it difficult

for me to use the restroom between classes, as it was located in a different part of the building and was very inconvenient to reach from my classrooms. I recall my frustration with missing instructional time in class.

30. I was also embarrassed by how long it would take for me to get to and return from the nurse's office. On at least one occasion a teacher commented on my lengthy disappearance when I reentered the classroom. The teacher made a big public point about how long I had been gone in a way that I felt was humiliating. Other times, students would say, "what took you so long," and other snide remarks.

31. I was allowed to use a faculty restroom that was closer to my classes, but I was even more embarrassed to use the faculty restroom than the restroom in the nurse's office. I was worried that another student would see me go into a faculty restroom, which would have been even more uncommon than my going to the nurse's office.

32. After a few weeks, I asked Ms. Durr and Principal Nate Collins to be allowed to use the boys' restrooms. I expressed to Mr. Collins that it was stigmatizing and embarrassing to have to travel to a separate restroom, and that it was also detrimental to my instructional time to have to travel so far to use the restroom. I said that it identified me as different and as a target for harassment.

33. I did not need to use the locker rooms because I had elected to continue completing my physical education classes through an online program.

34. I also informed Mr. Collins that I was expecting to begin hormone therapy. My family and I had met with a pediatric endocrinologist at Virginia Commonwealth University to begin hormone therapy treatment. But my initial blood tests revealed that my body was already producing an unusually high amount of testosterone. Before I could begin hormone therapy I had

to wait several weeks while the doctors made sure that I did not have an endocrine disorder that was incompatible with hormone therapy.

35. Mr. Collins told me he would check with others. A few weeks later, Mr. Collins met with me again and said that I could use the same restrooms as other boys.

36. I started using the restrooms on October 20, 2014. For approximately the next seven weeks, I used the boys' restrooms at school. During the time I used the boys' restrooms, I never encountered any problems from other students. Over the course of those seven weeks, I had a single conversation with a student in the restroom. He asked me if I liked his socks, and I said yes.

37. At the time I was granted permission to use the boys' restroom at school, I had already been using the boys' restroom in public places in Gloucester and outside of Gloucester, so this was very natural to me.

38. After being respected as a boy and allowed to use the same restrooms as other boys, I was excited about the prospect of living out the rest of my school year as just another student. The seven weeks when I had been respected and treated like other boys were the most comfortable I ever felt at school.

The School Board's New Policy

39. On November 10, 2014, my mother and I learned that the School Board would be discussing my use of the boys' restrooms at its meeting on November 11, 2014. No one from the Gloucester High School administration or the School Board informed us of this discussion. We learned about it through a Facebook post encouraging people to attend and speak out against me using the boys' restrooms, with many vile comments about a girl being in the boys' restroom.

My mom and I were frustrated, and we felt it was wrong that we were not given advanced notice that the question of my bathroom use was going to be debated at a public school board meeting.

40. My parents and I attended the meeting to speak against the policy. After having the experience of being treated just like other boys, I could not sit on the sidelines and let the School Board take it away from me. If I did not speak up, the conversation would have been held without me and with no one to support me. Since it was a conversation about my future, I wanted to be included.

41. I also attended the School Board's meeting on December 9, 2014.

42. Members of the public who spoke at the meetings made openly hostile comments about me, calling me "a freak," "a dog," and all sorts of hateful horrible language. Many of these individuals went to great lengths to refer to me with female pronouns or honorifics such as young lady, little miss, ma'am, or missus.

43. As a result of the school board meetings and the new transgender restroom policy, I felt like I had been stripped of my privacy and dignity. Having the entire community discuss my genitals and my medical condition in a public setting has made me feel like a public spectacle. Everyone could now identify me as "the transgender student who wants to use the boys' restroom," which made me incredibly anxious and fearful.

44. The day after the school board meeting, Mr. Collins told me that I would no longer be allowed to use the boys' restrooms and that there would be disciplinary consequences if I tried to do so.

45. After having had the opportunity to live consistent with my gender identity, I was devastated when it was taken away from me. It was humiliating for the School Board to take the

position that there was something wrong with me, and that I should not be allowed to be with my peers in common spaces.

46. Although the Board had announced that it would construct three new single-user restrooms, those restrooms were not completed until about a week after the policy went into effect. At one point during that week, I stayed after school for an event and realized that the nurse's office was locked and it would be several hours before my parents could pick me up. I was very distraught—totally devastated—that I had nowhere to use the restroom in my own school, so I broke down and went sobbing to the library to ask for help. One of the librarians drove me home so that I could use the restroom.

47. After the three single-stall restrooms were constructed at Gloucester High School, I looked inside the restrooms once or twice just to see what they looked like, but I never used them. The single-stall restrooms made me feel even more stigmatized and isolated than using the nurse's office because everyone knew that they were installed for me in particular, so that other boys would not have to share the same restroom as me.

48. Although the school said that all students could use the single-stall restrooms, I was the only student mandated to use them. I never saw any other student use the single-stall restrooms either. Two of the restrooms were near the lunchroom, and when my friends and I sat down for lunch we could see the restrooms, but I never saw any student use them.

49. Unlike some of the boys' restrooms, none of the new single stall restrooms were located near my classes. Only one of the single-stall restrooms is located anywhere near the restrooms used by other students. Because all three facilities are clustered near each other, they were not much closer or more convenient than the nurse's restroom.

50. Instead of using the separate restrooms, I tried to avoid using the restrooms entirely while at school. When that was not possible, I used the nurse's restroom. Every time I had to walk to the nurse's room, I felt like I was doing a walk of shame. I was embarrassed that everyone who saw me enter the nurse's office knew exactly why I was there: because I am transgender, and I was prohibited from using the same restrooms as other boys.

51. I tried to limit the amount of liquids I drank and tried to "hold it" when I needed to urinate during the school day. Avoiding the restroom was distracting when I was trying to focus in class. And, as a result of trying to avoid using the restroom, I repeatedly developed painful urinary tract infections. The only time I developed these infections was during the school year when I had to avoid using the restroom; I did not develop infections during summer vacations, and now that I have graduated from Gloucester High School, that problem has disappeared.

52. The restroom policy also interfered with my involvement in school events and activities, making me feel even more targeted and isolated. There was no restroom I could use when attending football games because there were no single-user facilities by the athletic field and school buildings were locked after-hours, so I tried very hard to plan ahead so that I would not have to use the restroom during the game. But there were a few occasions when I needed to use the restroom, and I had to leave the game early. One time, a friend had to drive me down the road to use a restroom at a nearby Lowe's or Home Depot. Another time, my mother just came and took me home.

53. Shortly after the policy went into effect, I met with Ms. Durr and told her that I felt humiliated and distressed by the Board's policy. But I knew that she could not do anything to change it. After that, I realized that talking to school counselors and administrators was pointless

because the Board had already decided that it didn't care about my wellbeing. Counselors and administrators could not give me permission to use the boys' restroom, and I did not have faith in the school system to protect me.

54. By the time I started eleventh grade, the stress was unbearable. I was in an environment every single day, five days a week, where I felt unsafe, anxious, and disrespected. I told my mom that I was having suicidal thoughts, and I was hospitalized briefly at Virginia Commonwealth University (VCU) Medical Center Critical Care Hospital for mental health treatment for suicidality, depression, and anxiety.

55. Instead of returning to Gloucester High School to resume classes, I completed the rest of eleventh grade in an independent study program at the "T.C. Walker" building, which is a separate location where students could complete course credits through an online computer program. At the "T.C. Walker" building, all the students in the independent study program used a single-stall restroom that was near the classroom. I was able to use this restroom without being singled out and treated differently from everyone else.

56. When I was in twelfth grade, the independent study program was no longer offered at "T.C. Walker." I returned to Gloucester High School, but I had stored up enough credit from online courses that I had a reduced course load. For all of twelfth grade, I continued to use the nurse's restroom when I absolutely had to, and I stayed away from campus as much as possible.

57. I graduated Gloucester High School on June 5, 2017.

58. Living through this experience has made me stronger than I ever thought I could be, but I am still deeply hurt and upset about what the School Board put me through for all those years. At the beginning of tenth grade, I finally had a chance to have a normal high school

experience just like any other boy. The School Board took that away from me, and I will never get it back.

Additional Medical and Legal Steps in My Gender Transition

59. During tenth, eleventh, and twelfth grade, I also continued to take medical and legal steps as part of my gender transition.

60. In December 2014, shortly after the Board's policy went into effect, I began hormone therapy, which has deepened my voice, increased my growth of facial hair, and given me a more masculine appearance.

61. In June 2015—at the end of tenth grade—the Virginia Department of Motor Vehicles issued a state I.D. card for me identifying me as male with an “M” gender marker. A copy of the DMV letter confirming my gender marker change is identified as Exhibit B.

62. In June 2016—at the end of eleventh grade—I underwent chest-reconstruction surgery, as part of my treatment for gender dysphoria.

63. On September 9, 2016—at the beginning of twelfth grade—the Gloucester County Circuit Court issued an order declaring that my sex is male and directed the Virginia Department of Health to issue me a birth certificate listing my sex as male. A copy of that court order is attached as Exhibit C.

64. On October 27, 2016, the Virginia Department of Health issued a birth certificate listing my sex as male. A copy of that birth certificate is attached as Exhibit D.

65. Despite all of this, I was still not allowed to use the same restrooms as other boys at Gloucester High School.

66. After I received my updated birth certificate, my mother and I provided the school with a copy and asked them to update my school records to match the gender marker on my birth certificate. I was planning to apply to colleges, and I wanted my school transcript to be updated so that it identified me as “male” instead of “female.”

67. I went to the guidance office several times to ask when my school records would be updated, but I never received an answer. Finally, someone from the guidance office told me that they had been instructed to tell me: “We have received your request. Thank you.”

68. As a result of Gloucester County Public Schools’ refusal to update my school records, my official school transcript still identifies my sex as “female” even though all of my other identification documents identify me as male. A copy of my transcript is attached as Exhibit E.

69. I am currently attending community college at Berkley City College, but I plan to eventually transfer to a four-year school. Every time I have to provide a copy of my transcript to a new school or employer, I will have to show them a document that negates my male identity and marks me as different from other boys. I am still tethered to high school by this document, and I think it is unfair that a high school that put me through so much is able to wield that much negative influence over my adult life.

70. I was shocked and angry when I learned the School Board recently testified that their policy turned on students’ current birth certificate. If the Board really is interpreting its policy this way, then it makes what they did to me even worse. Under what they now say the

policy means, I should have been allowed to use the same restrooms as other boys starting in late October 2016 when I provided them with my new birth certificate. I could have had a normal high school experience for most of my senior year. I jumped through hoop after hoop, and I did everything I was supposed to do even under the Board's discriminatory policy. If the Board really thought something was wrong with my documents, why didn't they just tell me what the problem was so I could address it? It feels like they were playing games with my life, and I do not understand how a group of adults could treat a high school student that way.

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:

3/19/19

A handwritten signature in black ink, appearing to read 'Gavin Grimm', written over a horizontal line.

Gavin Grimm



Lisa Griffin, Ph.D.
Clinical Psychologist

14 S. Auburn Av. • Richmond, VA 23221
(704) 458-0433 • lisa@drisagriffin.com
www.drlisagriffin.com

Treatment Documentation Letter

Name: Gavin [REDACTED] Grimm
Date of birth: REDACTED 1999
Date of letter: 5-26-2014

I am a clinical psychologist licensed in Virginia (#0810004568) and North Carolina (#2072) and a specialist in gender identity and gender dysphoria in children and teens.

The purpose of this letter is to certify that Gavin Grimm, assigned female at birth, is under my care for gender dysphoria. Best mental health/medical practices recommend that he present as a male in all activities of daily living.

Gavin should be afforded all the rights of a natal male and be considered and treated as male in every respect. This includes restroom usage and ability to express himself in gender-specific manners. His male name and male pronouns should be used exclusively.

Lisa Griffin, Ph.D.



COMMONWEALTH of VIRGINIA

Department of Motor Vehicles
2300 West Broad Street

Richard D. Holcomb
Commissioner

Post Office Box 27412
Richmond, VA 23269-0001

June 5, 2015

Dear

The Department of Motor Vehicles (DMV) has approved your request to have the gender indicator on your credential changed from F to M.

Please visit your local DMV to complete this transaction. Please present this letter to the Customer Service Representative (CSR) as it will help to expedite your request. You will then be issued a new credential with the new gender indicator.

Please retain this letter in the event you need to return to a Customer Service Center for a replacement or reissue credential.

If you or the CSR has any questions regarding the re-issuance of your credential or our gender change policy, you may contact us Monday-Friday from 8:15 a.m. until 5:00 p.m. at (804) 367-6203.

Sincerely,

A handwritten signature in cursive script that reads "R. Smalls".

R. Smalls
Medical Evaluator Senior
Medical Review Services

VIRGINIA:

IN THE CIRCUIT COURT OF GLOUCESTER COUNTY

In Re: Amendment of a Vital Record
for Gavin Elliot Grimm Pursuant to 32.1-269 of the Code of Virginia

Change of Gender: from Female to Male
Date of Birth [REDACTED]

CL16-326

ORDER

This matter comes before the court based on the petition of Gavin Elliot Grimm, a minor, by and through his parents David Wayne Grimm and Deirdre Anne Grimm. The petition requests that the court enter an order that amends a vital record in accordance with Virginia Code Section 32.1-269. Specifically, the petitioners ask the court to enter an order directing the State Registrar to amend the birth certificate of Gavin Elliot Grimm to show a change of sex from female to male.

The court finds that the petitioner resides in Gloucester County, Virginia and that the Gloucester County Circuit Court is a court of competent jurisdiction to hear this matter. The court also finds that an order was previously entered by the Gloucester County Circuit Court on July 25, 2014 in case number [REDACTED] that changed the petitioner's name to Gavin Elliot Grimm to comport with his gender. The court finds that Gavin Elliot Grimm underwent gender reassignment surgery in June 2016; that the surgery was successful; and that Gavin Elliot Grimm is now functioning fully as a male. Therefore, the court finds that the sex of Gavin Elliot Grimm has been properly changed by a medical procedure and that it is in his best interests to amend his birth certificate.

As a result of the foregoing, the court does hereby ORDER that the State Registrar be and hereby is authorized and directed to amend the birth certificate of Gavin Elliot Grim to show the change of sex from female to male.



The clerk shall send a copy of this order to the petitioner and to the State Registrar.

This cause is ended and shall be stricken from the Court's docket.

ENTER: 9 / 9 / 2016

JUDGE

Jeffrey W. Shaw

WE ASK FOR THIS:

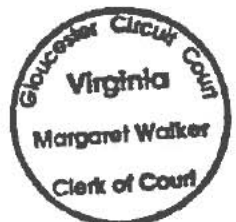
Gavin Elliot Grimm
Gavin Elliot Grimm

David Wayne Grimm
David Wayne Grimm

Deirdre Anne Grimm
Deirdre Anne Grimm

Bary W. Hausrath, Esq. (VSB #77013)
The Law Office of Bary W. Hausrath, PLLC
P.O. Box 13890, Richmond, VA 23225
122 Granite Avenue, Richmond, VA 23226
(T) 804-482-1649
(F) 888-583-4991

I certify that the document(s) to which this authentication is affixed are true copies of a record in the Gloucester County Circuit Court, that I have custody of the record and that I am the custodian of that record.
Margaret Walker, Clerk
By [Signature] Dep. Clerk



CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

CERTIFICATE OF LIVE BIRTH

STATE FILE NUMBER: [REDACTED]

NAME OF REGISTRANT: GAVIN ELLIOT GRIMM

DATE OF BIRTH: [REDACTED] SEX: MALE

PLACE OF BIRTH: NEWPORT NEWS, VIRGINIA

MAIDEN NAME OF MOTHER: DEIRDRE ANNE SMITH

AGE OF MOTHER: 34

MOTHER'S PLACE OF BIRTH: VIRGINIA

NAME OF FATHER: DAVID WAYNE GRIMM

AGE OF FATHER: 38

FATHER'S PLACE OF BIRTH: PENNSYLVANIA

DATE RECORD FILED: MAY 17, 1999



This is to certify that this is a true and correct reproduction or abstract of the official record filed with the Virginia Department Of Health, Richmond, Virginia

DATE ISSUED **October 27, 2016**

Janet M. Rainey
Janet M. Rainey, State Registrar

Do not accept unless on security paper with the seal of Virginia Department of Health, Vital Statistics in the lower left hand corner.
Section 32.1-272, Code of Virginia, as amended.

VS 15B

VOID WITHOUT WATERMARK OR IF ALTERED OR ERASED

SEE REVERSE SIDE FOR OPENING INSTRUCTIONS

Graduation date: 06/10/2017
Diploma type: Standard

Student State ID: [REDACTED] Birth Date: [REDACTED] Gender: Female Grade Level: Graduated	Student Address [REDACTED]	School Gloucester High School Gloucester County Public Schools 6680 Short Lane Gloucester, VA 23061 804-693-2526 (Tel) 804-693-7685 (Fax) Virginia School ID: 036-0260

Year: 2011-2012			Grade Level: 7		
Peasley Middle School					
2885 Hickory Fork Road Gloucester VA, 23061 804-693-1499 tlawson@gc.k12.va.us					
ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
12005	KEYBOARDING			0.50	
Totals:				0.50	

Summary	
GPA (Cumulative Weighted):	[REDACTED]
Rank (Cumulative Weighted):	
Credits Attempted:	23.00
Credits Earned:	22.00
Verified Credits Earned:	7.00
2011 Absences:	6
2013 Absences:	7
2014 Absences:	32
2015 Absences:	96
2016 Absences:	24

Year: 2013-2014			Grade Level: 9		
Gloucester High School					
6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us					
ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01001	VLC ENGLISH 9	DL		1.00	
02052	VLC ALGEBRA I	DL		0.00	
03001	VLC EARTH SCI	DL		1.00	1.00
04052	VLC WORLD I	DL		1.00	1.00
08001	VLA PE 9	DL		0.50	
08051	VLA HEALTH 9	DL		0.50	
Totals:				4.00	2.00

Standardized Tests			
Test	Subtest	Date	Score

Credentials	
Code Name	Date
9303 Workplace Readiness Skills	02/27/2017

Year: 2014-2015 Gloucester High School 6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us			Grade Level: 10		
ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01002	ENGLISH 10			1.00	
02052	ALGEBRA I			1.00	1.00
03051	BIOLOGY I			1.00	1.00
04052	WORLD HIST II			1.00	1.00
05052	THEATER I			1.00	
05154	ART FOUNDATION			1.00	
08016	VLC PE 10	DL		0.50	
08201	HEALTH PE DR ED 10			1.00	
Totals:				7.50	3.00

Year: 2015-2016 Gloucester High School 6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us			Grade Level: 11		
ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01003	VLC ENG 11	DL		1.00	2.00
01104	CREAT WRITING			1.00	
02072	VLC GEOMETRY	DL		1.00	
03005	VLC OCEANOGRAPHY	DL		1.00	
04102	VLC US HISTORY	DL		1.00	
04254	VLC PSYCH	DL		1.00	
Totals:				6.00	2.00

Year: 2016-2017 Gloucester High School 6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us			Grade Level: 12		
ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01004	ENGLISH 12			1.00	
02902	ALG FUN DATA			1.00	
04151	US GOVERNMENT			1.00	
19262	ECON PERS FIN			1.00	
Totals:				4.00	

Official Signature and Title (Required): _____	Date: _____

(A) Advanced (AC) Accelerated (AP) Advanced Placement (DE) Dual Enrollment (IB) International Baccalaureate (CC) Commonwealth College Course Collaborative (H) Honors (S) Summer (SC) Credits earned by substitution (DL) Distance Learning

07/19/2018 12:43:06 EDT

GCSB - 04283

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,	)	
	)	
Plaintiff,	)	
	)	Civil No. 4:15-cv-00054
v.	)	
	)	
GLOUCESTER COUNTY SCHOOL	)	
BOARD,	)	
	)	
Defendant.	)	

DECLARATION OF DEIRDRE GRIMM

1. I am the mother of Plaintiff Gavin Grimm in the above-captioned action. I have actual knowledge of the matters stated in this declaration.
2. My name is Deirdre Anne Grimm.
3. I live in Gloucester County, Virginia.
4. I have been a Licensed Practical Nurse (“LPN”) for 30 years. I currently work for the American Addiction Treatment Center and Sentara Wound Care Center.
5. I understood for most of Gavin’s early life that he struggled with something, but he wasn’t able to put a name to it until later.
6. As a child Gavin was anxious. He never felt fully comfortable around people, and he had trouble being around big crowds at parties and events. Gavin’s demeanor changed noticeably when he transitioned and started to live authentically as a boy. He is now confident and comfortable with himself. He is not that shy, anxious kid anymore.
7. In April 2014, Gavin came out to me as transgender. I inadvertently opened the door by telling him about a conversation that I had recently had with another adult about their

transgender child. Gavin seized the moment, and said he had to tell me something. He was very nervous when he came out to me as transgender.

8. Gavin's coming out did not change a thing about my love and support. I told him it didn't change anything about how I felt about him. But I know it was a big deal for him because he wasn't sure what to expect.

9. I was committed to supporting Gavin from day one. The first thing I did was spend three days and nights reading about transgender children and how I could support Gavin. My husband took a longer time to deal with it and really understand what Gavin was going through. He tried very hard to show support from the beginning, and his support for Gavin really transformed over several months.

10. At Gavin's request, I took him to see a psychologist who specialized in treating transgender youth. She diagnosed him with gender dysphoria and gave us a treatment documentation letter advising that he should be treated as a boy in all respects.

11. Before Gavin began tenth grade in the fall of 2014, Gavin and I met with the school guidance counselor, Ms. Tiffany Durr, about Gavin's transition. I presented her with Gavin's legal name change order and his treatment documentation letter. Ms. Durr was very supportive of Gavin and was fully "on board" with using Gavin's correct name and pronouns.

12. Gavin used the nurse's bathroom for some time that fall, but he expressed concerns to me. Gavin said that it took him a long time to walk across the school to the nurse's bathroom from his classes in D-hall. He also said he felt singled out and embarrassed, and that other students made comments pointing out that he was using a separate restroom, saying things like "what took you so long?" Gavin and I met with Ms. Durr and Principal Nate Collins and discussed Gavin's concerns. Mr. Collins was very open to allowing Gavin to use the boys'

restroom. We all had a very reassuring conversation about Gavin's safety, and I felt fully supported by Mr. Collins.

13. Gavin, Mr. Collins, and I all set a date on which Gavin would begin using the boys' restrooms at school. Gavin began using the boys' restrooms in October 2014.

14. On November 10, 2014, a friend of mine sent me a Facebook message, in which someone was urging people to go the Gloucester County School Board meeting the following evening, on November 11th. The message said that the School Board would be discussing and voting on Gavin using the boys' restrooms.

15. I don't remember if the message named Gavin, but I remember it was clear they were talking about my child and whether he should be allowed in the boys' restroom. The post was clearly rallying people to go to the meeting and oppose a transgender student using the restrooms. Some of the comments were really terrible.

16. No one on the School Board ever contacted me or Gavin about the meeting. The first time I became aware of any problem was from the Facebook message I received.

17. After seeing the Facebook post, I started making a booklet of educational materials on what it means to be transgender. I included medical literature, information on suicide rates for transgender children, and information pulled from transgender equality websites. I made one booklet for every School Board member and took those booklets to the meeting and gave them to the members.

18. When Gavin and I spoke about it, we never considered not going to the School Board meeting. They were going to be talking about Gavin, my child, and I had no doubt that I had to be there. Gavin was also set on going. He has always been the kind of kid who will fight for himself if people are going to be making decisions about his life.

19. Prior to the meeting I knew nothing about the School Board's proposal. All I knew was that they were discussing my son and whether or not he should be allowed to use the boys' restroom. I was not aware of any plans to restrict boys' and girls' restrooms by "biological sex," or to create a third restroom option for "unisex" usage.

20. I didn't really know what to expect at the School Board meeting, but I really didn't expect it to be as brutal as it was. Gavin and I sat and listened to adult members of our community stand up and insult Gavin. I remember them calling my child an "it" and a "freak," and I remember thinking I worked in this community for 17 years as a nurse. I have been at many of these people's houses taking care of their moms and dads. I loved my community, and I remember thinking, how could people be calling my kid these names?

21. I remember one adult after another getting up there and talking about things that I don't even think were appropriate for them to be talking about. These people were talking about his private body parts. I just remember how appalled I felt for Gavin and how scared it made me that he wouldn't be able to struggle and live through all of this. Based on what I had read about transgender youth and the suicide risks, I was already scared for Gavin's life. Then we went to this horror show of a school board meeting, and it just made me even more fearful of the impact on him of his community not accepting him.

22. When the School Board said it would be installing separate single-stall restrooms Gavin and I talked about the new restrooms, and he was very upset about it. He didn't want to use them because he is not "unisex;" he is a boy. I remember him saying they may as well put a flashing light that says "Gavin" above the new restrooms, because everyone knew they were created for him, and only he was forced to use them.

23. The School Board voted on December 9, 2014, to issue a policy preventing Gavin from using the boys' restrooms. Gavin was seriously distressed by this policy. He felt so validated when he was allowed to use the boys' bathroom at school, just like a normal boy. He had never felt like a normal boy up to that point because he hadn't been validated that way. They gave him that validation, and then they took it away.

24. From that point, high school was especially difficult for Gavin. One night at the beginning of his year in eleventh grade, I found him sobbing on the bathroom floor, and he begged me to take him somewhere because he was having thoughts of suicide. So I took him to Virginia Commonwealth University Medical Center to get him help. They put him on the boys' ward, which was very validating to him. He was treated like any other boy.

25. One time, Gavin called me and asked me to pick him up from a football game because there was no bathroom for him to use after school. There was no single-user restroom at the football field, and he wasn't allowed to use the men's room. Gavin told me he felt like his bladder was about to burst. It was like a gut punch to me, as a mom. If you don't have an issue accessing bathrooms, you don't think about how hard it is for somebody who does. But Gavin lived that reality every day in high school.

26. Gavin had frequent urinary tract infections during his high school years. He would hold his urine during the day and have to use the restroom as soon as he got home. We kept boxes of AZO, an over-the-counter medication for urinary tract infections, always stocked at home to in order to give him some relief from the pain.

27. Not only has the School Board ruined my son's high school years, but now they're affecting his college years too. Gavin wanted to have the gender marker on his school records changed to "male" before he applied to college. When Gavin was issued an updated birth

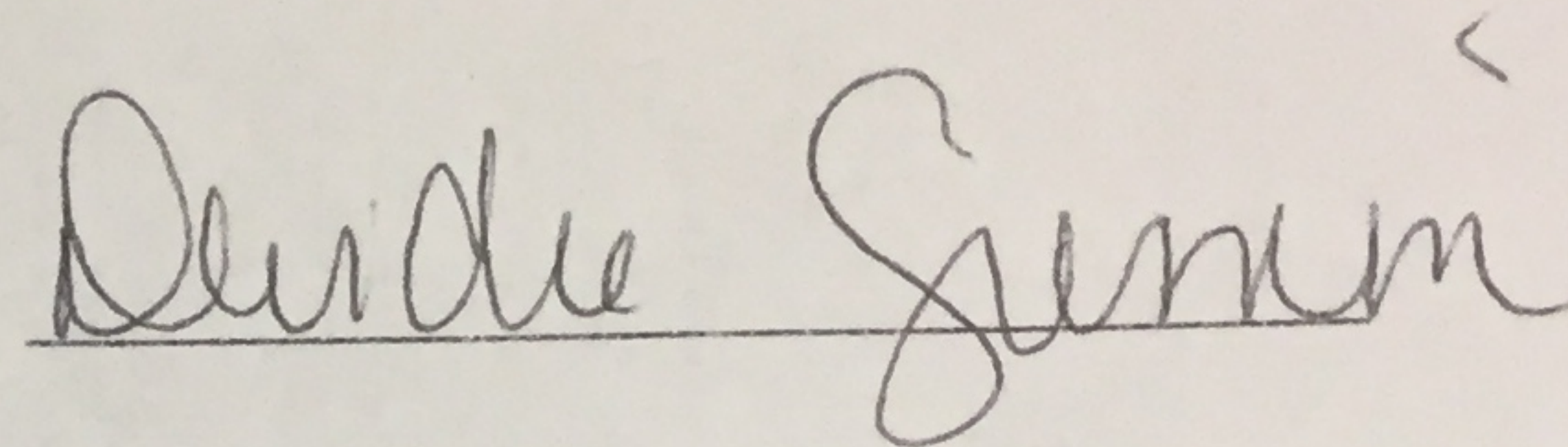
certificate listing his gender as male, it was a celebration for us because we thought he could finally get his school records changed too. I personally walked an official copy of that document into the Gloucester High School guidance department and handed it to the office secretary. They gave me the impression it would be no problem for them to update Gavin's records, but when Gavin started requesting his transcript to apply to colleges, he realized they had refused to list his gender as male.

28. When I learned the Board is now saying Gavin could have used the boys' restroom his senior year if they thought he had presented a valid birth certificate, I was furious. In all these years, no one from the High School or the School Board ever said a word to me or Gavin indicating there was any problem with his birth certificate. For them to come back and say that now feels like a slap in the face. It makes me so upset that they have treated my kid this way.

29. Gavin is a strong kid, but this whole experience has taken a big toll on him and on our entire family. As a parent, you want to protect your child and keep him from harm. It broke my heart to watch him suffer and not be able to do anything to stop it. And he was being hurt by his own School Board, which should have been protecting him.

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: 3-21-19

A handwritten signature in cursive script, reading "Deirdre Grimm", written over a horizontal line.

Deirdre Grimm

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, ,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Case No. 4:15-cv-54
	)	
GLOUCESTER COUNTY SCHOOL	)	
BOARD,	)	
	)	
Defendant.	)	
_____	)	

DECLARATION OF SHAYNA MEDLEY-WARSOFF

I, Shayna Medley-Warsoff, submit the following declaration in support of Plaintiff Gavin Grimm's motion for summary judgment. I am one of the attorneys for Gavin Grimm, and I have personal knowledge of the facts in this attorney declaration. If called upon to testify, I could competently testify to the matters set forth in this declaration.

1. A copy of Defendant's Answers to Plaintiff's First Set of Interrogatories is attached to this Declaration as Exhibit 1.
2. A copy of Defendant's Supplemental Answer to Plaintiff's Interrogatory No. 1. is attached to this Declaration as Exhibit 2.
3. A copy of the Expert Report and Declaration of Dr. Melinda Penn is attached to this Declaration as Exhibit 3.
4. A copy of Dr. Melinda Penn's curriculum vitae, which was originally attached as Exhibit A to the Expert Report and Declaration of Dr. Melinda Penn, is attached to this Declaration as Exhibit 4.

5. A copy of the World Professional Association for Transgender Health (“WPATH”) Standards of Care, which was originally attached as Exhibit B to the Expert Report and Declaration of Dr. Melinda Penn, is attached to this Declaration as Exhibit 5.

6. A copy of the Endocrine Society’s Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, which was originally attached as Exhibit C to the Expert Report and Declaration of Dr. Melinda Penn, is attached to this Declaration as Exhibit 6.

7. A copy of the Expert Report of Dr. Quentin Van Meter is attached to this Declaration as Exhibit 7.

8. A copy of the Rebuttal Expert Report and Declaration of Dr. Melinda Penn is attached to this Declaration as Exhibit 8.

9. A copy of the deposition of Nathan Collins in this case is attached to this Declaration as Exhibit 9.

10. A copy of the deposition of Walter Clemons in this case is attached to this Declaration as Exhibit 10.

11. A copy of the deposition of Tiffany Durr in this case is attached to this Declaration as Exhibit 11.

12. A copy of the deposition of Matthew Lord in this case is attached to this Declaration as Exhibit 12.

13. A copy of the 30(b)(6) deposition of Troy Anderson in this case is attached to this Declaration as Exhibit 13.

14. A copy of the deposition of Quentin Van Meter is attached to this Declaration as Exhibit 14.

15. A copy of Mr. Collins's memorandum to Deirdre Grimm dated October 14, 2014, which was originally produced as GCSB 0894 and attached as Exhibit 8 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 15.

16. A copy of Dr. Clemons's email to the School Board dated October 22, 2014, originally produced as WAVY TV FOIA 007 and attached as Exhibit 5 to the Deposition of Walter Clemons, is attached to this Declaration as Exhibit 16.

17. A copy of Mr. Collins's memorandum to Dr. Clemons dated October 23, 2014, which was originally produced as GCSB 4121-22 and attached as Exhibit 2 to the Deposition of Dr. Clemons, is attached to this Declaration as Exhibit 17.

18. A copy of the emails from Carla Hook to a constituent dated October 24-27, 2014, which were originally produced as GCSB 0853-55, is attached to this Declaration as Exhibit 18.

19. A copy of the email from Carla Hook to a constituent dated October 31, 2014, which was originally produced as GCSB 0844, is attached to this Declaration as Exhibit 19.

20. A copy of the email from Carla Hook to the School Board dated November 4, 2014, which was originally produced as GCSB 0513, is attached to this Declaration as Exhibit 20.

21. A copy of the email and attachment from Carla Hook to the School Board dated November 9, 2014, which was originally produced as GCSB 0507-08, is attached to this Declaration as Exhibit 21.

22. A copy of the School Board's press release dated December 3, 2014, which was originally produced as GCSB 0592-94 and attached as Exhibit 10 to the Deposition of Dr. Clemons, is attached to this Declaration as Exhibit 22.

23. A copy of the Recorded Minutes of Gloucester County School Board meeting on December 9, 2014, which is available online at

<http://gets.gc.k12.va.us/Portals/Gloucester/District/docs/SBAgenda2014/Minutes2014/MIN-12-09-2014.pdf>, is attached to this Declaration as Exhibit 23.

24. A copy of the Mr. Collins's memorandum to Deirdre and David Grimm dated December 10, 2014, which was originally produced as GCSB 0893 and attached as Exhibit 15 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 24.

25. A copy of an email from Amy Bergh to Mr. Collins dated November 14, 2014, which was originally produced as GCSB 3932 and attached as Exhibit 12 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 25.

26. A copy of Gavin's final transcript, which was originally produced as GCSB 4283 and attached as Exhibit 22 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 26.

27. A copy of the presentation given at the 2014 Virginia School Board Association conference, originally produced as GCSB 4221-31 and attached as Exhibit 9 to the Deposition of Walter Clemons, is attached to this Declaration as Exhibit 27.

28. A copy of the map of Gloucester High School, originally produced as GCSB 1276 and attached as Exhibit 4 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 28.

29. An annotated copy of the Gloucester High School map, on which I have marked the locations of school restrooms based on pages 33-36 and 94-108 of the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 29.

30. A copy of the list of restrooms at Gloucester High School, which was originally produced as GCSB 03944 and attached as Exhibit 5 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 30.

31. A copy of the letter from Joshua Block to David Corrigan dated December 23, 2016, is attached to this Declaration as Exhibit 31.

32. A copy of the letter from David Corrigan to Joshua Block dated January 18, 2017, is attached to this Declaration as Exhibit 32.

33. A copy of the letter from Joshua Block to Denise McNerney dated January 18, 2017, is attached to this Declaration as Exhibit 33.

34. A copy of the letter from Kyle Duncan to Denise McNerney dated January 19, 2017, is attached to this Declaration as Exhibit 34.

35. A copy of the Gloucester County School Board press release dated February 13, 2019, is attached to this Declaration as Exhibit 35.

36. A copy of the Gloucester County School Board press release dated February 21, 2019, is attached to this Declaration as Exhibit 36.

37. A copy of the Recorded Minutes of Gloucester County School Board meeting on November 11, 2014, which is available online at <http://gets.gc.k12.va.us/Portals/Gloucester/District/docs/SBAgenda2014/Minutes2014/MIN-11-11-2014.pdf>, is attached to this Declaration as Exhibit 37.

38. A copy of the Amicus Brief of American Academy of Pediatrics, et al. in support of Plaintiff-Appellant, *G.G. v. Gloucester Cty. Sch. Bd.*, No. 15-2056, ECF No. 244 (4th Cir.), is attached to this Declaration as Exhibit 38.

39. A copy of the Amicus Brief of School Administrators from Thirty-Three States and the District of Columbia in support of Plaintiff-Appellant, *G.G. v. Gloucester Cty. Sch. Bd.*, No. 15-2056, ECF No. 155 (4th Cir.), is attached to this Declaration as Exhibit 39.

40. A copy of the Amicus Brief of the National PTA, et al. in support of Plaintiff-Appellant, *G.G. v. Gloucester Cty. Sch. Bd.*, No. 15-2056, ECF No. 145-1 (4th Cir.), is attached to this Declaration as Exhibit 40.

41. A copy of the American Psychological Association & National Association of School Psychologists' 2015 *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools*, available online at <https://goo.gl/AcXES2>, is attached to this Declaration as Exhibit 41.

42. A copy of Gender Spectrum's 2016 *Transgender Students and School Bathrooms: Frequently Asked Questions*, available online at <https://goo.gl/Z4xejp>, is attached to this Declaration as Exhibit 42.

43. A copy of the National Association of Secondary School Principals' 2016 *Position Statement on Transgender Students*, available online at <https://goo.gl/kcfImn>, is attached to this Declaration as Exhibit 43.

44. I have reviewed the video recording of the Gloucester County School Board meeting dated December, 9, 2014, which is available online at http://gloucester.granicus.com/MediaPlayer.php?view_id=10&clip_id=1090. At 42:20, a person identified as Savannah Williams says, "I just filled out my voter's registration card a week ago and I can tell you that you can make any decision you want but if you don't vote to protect your constituents you will not be reelected. I can certainly say that my vote will go to someone else. Fact. If you choose to vote that Gloucester County public school restrooms

should be made coed, you will be replaced and we the citizens of Gloucester will reverse your decision with a new School Board.”

45. At 50:53, a person identified as Andrew Palas says, “We do have the power to vote you out of office and we will do that.”

46. At 59:53, a person identified as Karen Pauley says, “And like many have said, I also have a voter’s card and I’m not afraid to use it. And I will vote every single one of you off of this Board if you do not protect our children.”

47. At 1:18:00, a person identified as Janet West says, “I have a voter’s card and all will lose their job.”

48. At 1:17:40, Janet West says, “Now we’re here talking about this young lady, where’s my child respect?”

49. At 1:22:55, a person identified as Don Mitchell says, “Here we have a thousand students versus one freak.”

50. At 1:23:25, Don Mitchell says, “If you want to consider yourself a dog, must we use tax dollars to install fire hydrants where you can publicly relieve yourselves?”

51. At 58:56, Karen Pauley says, “Put him in a separate bathroom if that’s what it’s going to take.”

52. I have reviewed the video recording of the Gloucester County School Board meeting dated February 19, 2019, which is available online at http://gloucester.granicus.com/MediaPlayer.php?view_id=10&clip_id=2043. At 10:34, David Corrigan, attorney for the Gloucester County School Board, says, “the proposed resolution would allow those students to use the restroom consistent with their new gender identity as long as they meet three criteria: First, the student must have a medical diagnosis

from a health care provider, with expertise in the gender identity field. Second the student must have been living as the new gender identity for a period of at least 6 months, and third, the student must have been receiving treatment in the form of social transition or hormones for a period of 6 months.”

53. At 11:20, Corrigan says, “The proposed resolution comes as result of discussions that have occurred between representatives of the school board, along with me as the school board attorney for Gloucester County in this litigation, the plaintiff and legal counsel for the plaintiff, under the supervision of a federal magistrate judge from Newport News named Douglas Miller. Judge Miller is not seeking to force a settlement or enforce a settlement, but he’s been instrumental in helping the parties develop language which the plaintiff has agreed to and which the school board has agreed to present here tonight.”

54. At 11:57, Corrigan says, “A significant issue raised previously was that a student could just, on a whim, decide for a day to use the restroom of the opposite sex. This resolution eliminates that possibility.”

55. At 12:10, Corrigan says, “With the changes already made to existing restrooms ensuring greater privacy and the creation of the single-stall restrooms throughout the high school, the issue of individual privacy is also addressed.”

56. At 1:59:35, an individual identified as Brian Bird says, “our sons are being demasculinated by this country. Our daughters are being defeminized. I don’t want to see us promote that.”

57. At 59:24, an individual identified as Kenny Smith says, “when we talk about social transition and gender identity we’re talking about issues that we’ve created. God didn’t create those.”

58. At 47:53, an individual identified as a current Gloucester High School student named Elizabeth S. says, "I've heard some transgender students say that they have to wait till they get home in order to use the restroom because they're scared of what the security guards are going to say."

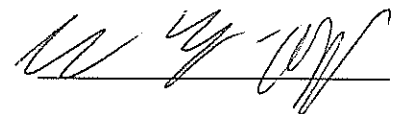
59. At 1:05:52, an individual identified as a Gloucester High School student named Marie Hutchins says, "I see every single day people that are afraid to use the bathroom and that do not want to due to discrimination, and I just don't think that's right."

60. At 1:05:15, an individual identified as a transgender student at Gloucester High School named Vincent Staples says, "I'm in favor of the current proposition that is being discussed tonight so that I can feel like I belong in my school."

61. At 1:36:07, an individual identified as Jonathan Hargis says he is the "proud parent of a transgender child" in the Gloucester public schools. At 1:37:00, he says, "I'm quite certain that I will never be able to convince those of you that think that it's a mental disorder. I can tell you there's no medication for it, there's no praying it out of them, and there's no beating it out of them. They are who they are, and they deserve the opportunity to be treated with respect and dignity."

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

Dated: March 25, 2019

A handwritten signature in black ink, appearing to read 'Shayna Medley-Warsoff', written over a horizontal line.

Shayna Medley-Warsoff

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v.

Case No. 4:15-cv-00054

GLOUCESTER COUNTY SCHOOL
BOARD,

Defendant.

**DEFENDANT'S ANSWERS TO
PLAINTIFF'S FIRST INTERROGATORIES**

Comes now the defendant, Gloucester County School Board ("School Board"), and for its
Answers to Plaintiff's First Interrogatories, states as follows:

GENERAL OBJECTIONS

A. Defendant objects to the Instructions contained in Plaintiff's interrogatories to the
extent they alter, amend, or exceed the scope of the Federal Rules of Civil Procedure.

B. The information supplied in these answers is not based solely on the knowledge of
the executing party but includes knowledge of the party, its agents, representatives, and attorneys,
unless privileged. Such knowledge may or may not be known to the Defendant other than as
provided.

C. The word usage and sentence structure may be that of the attorney and staff
assisting in the preparation of these answers and thus do not necessarily purport to be the precise
language of the executing party.

D. These answers will be supplemented in accordance with the Rule 33 of the Federal Rules of Civil Procedure, the Local Rules of the Eastern District of Virginia, and any Orders regarding discovery.

E. Defendant objects to interrogatories, etc., that invade or attempt to invade the attorney/client, work product, or any other applicable privilege.

ANSWERS TO INTERROGATORIES

1. Identify all complaints received by Gloucester County School Board (“the Board”) or its employees related to transgender students’ use of restrooms during the 2014-2015 school year, and for each complaint identify the date of the complaint, the recipient of the complaint, the content of the complaint, how the complaint was communicated or transmitted, whether the complainant was from a Gloucester High School student or parent of a Gloucester High School student, and whether the complaint related to any incident in which a student reported being in the restroom at the same time as Plaintiff.

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term “complaint” is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection,¹ Gloucester County High School Principal Nate Collins gave Grimm permission to use the male restroom on October 20, 2014. Two to three days later, Superintendent Dr. Walter Clemons received two complaints from parents regarding a transgender student using the restroom inconsistent with that student's biological sex. Dr. Clemons does not recall the identity of those parents. The parents indicated that they did not approve of a biologically female student using the male restroom. Additionally, a male student met with Collins in person and expressed concern about a biologically female student using the male restroom and a lack of privacy. Collins does not recall the specific identity of this student.

Moreover, after Grimm began to use the male restroom, Dr. Clemons, Collins and the individual members of the School Board received numerous complaints via email, which are listed below.

Emails sent to all members of the School Board

- On October 23, 2014, Kathryn Lindsay, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On October 23, 2014, Stacie and Paul Martin, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

¹ The School Board specifically reasserts its objection that Plaintiff's use of the term "complaint" in this Interrogatory is vague and ambiguous. The School Board has included in its Answer communications with individuals who generally opposed a transgender student using a restroom inconsistent with that student's biological sex. The School Board's Answer includes communications with individuals who did not agree with Gloucester High School allowing a transgender student to use a restroom inconsistent with that student's biological sex and communications with individuals who supported the School Board's December 9, 2014 resolution and the School Board's litigation of this matter.

- On October 27, 2014, Susannah Hogge sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On October 27, 2014, Jennifer Spears, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On October 28, 2014, Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 10, 2014, Elisa Nelson, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 10/11, 2014, Stuart and Seth Bunting, parents of student(s) enrolled in Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 11, 2014, Mary Diggs, upon information and belief a resident of Gloucester County, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 11, 2014, David Turner sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 12, 2014, Haley Poulson, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 12, 2014, Kelly Williams, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 13, 2014, Melissa Alexander, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 17, 2014, Kelly Cooper, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 7, 2014, Jenny Poole, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 8, 2014, Mike Enz, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 8, 2014, Heather Schott, a parent of student(s) enrolled in the Gloucester County Public School System, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 10, 2014, Tommie Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 10, 2014, Paul Martin, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 20, 2014, Chuck Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 20, 2014, Clayton Rogers sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On January 2, 2015, an individual named Jena sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On July 10, 2015, Tim Tompkins sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On April 21, 2016, Kathryn Lindsay, a parent of students(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On April 21, 2016, Paul Martin, parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On May 12, 2016, Kenneth Larson sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Troy Anderson

In addition to receiving emails sent to the entire School Board, Mr. Anderson received the following communications:

- On December 7, 2014, Ginger Enz, parent of student(s) enrolled in Gloucester High School, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On July 27, 2015, Leland Pike, a resident of Kentucky, sent Mr. Anderson an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On July 14, 2016, Florence Alpert, a resident of New York, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Randy Burak

In addition to receiving emails sent to the entire School Board, Mr. Burak received the following communications:

- On November 12, 2014, Gina Thayer, a parent of student(s) enrolled in Gloucester High School, sent Mr. Burak an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 3, 2014, Lisa Wood, a resident of the Abingdon District, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 7, 2014, Mike Enz, a parent of student(s) who attended Gloucester High School, sent the Mr. Burak an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 8, 2014, a resident of Gloucester County named Ginger emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 11, 2014, Sharon Kass, a resident of Washington D.C., emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Kimberly Hensley

In addition to receiving emails sent to the entire School Board, Ms. Hensley received the following communications:

- On November 19, 2014, Tracey Parks Carter, a parent of student(s) at Gloucester High School, emailed Ms. Hensley regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 13, 2014, Cliff and Brandi Blackwood, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, emailed Ms. Hensley regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Carla Hook

In addition to receiving emails sent to the entire School Board, Ms. Hook received the following communications:

- On December 7, 2014, Steven Davis, a parent of high school student(s) in the York District, sent an email to Ms. Hook regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Charles Records

In addition to receiving emails sent to the entire School Board, Mr. Records received the following communications:

- On April 21, 2016, Jean Lassiter sent an email to Mr. Records regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Dr. Clemons

In addition to receiving some of the emails sent to the entire Board, Dr. Clemons received the following communications:

- On October 22, 2016 Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent Dr. Clemons an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On November 7, 2016, Ralph VanNess sent Dr. Clemons an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Additionally, the following School Board members received complaints via telephone, which are listed below.

Telephone Complaints made to Carla Hook

- Upon information and belief, before October 28, 2014, Ms. Hook spoke with Season and Andrew Palas, whose children were enrolled in Gloucester County Public Schools, regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Additionally, the issue of transgender bathroom use was discussed at public School Board meetings on November 11, 2014 and December 9, 2014. Video links to those meetings are available at: <http://www.gloucesterva.info/640/Meeting-Portal>.

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the November 11, 2014 meeting:

- Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)
- Eddie Aliff
- Savannah Williams (student at Gloucester High School)
- Terry Brennan
- Joy Sampson (parent of student(s) enrolled in Gloucester County Public Schools)
- Kelly Williams (parent of student(s) enrolled in Gloucester County Public Schools)
- Marc Jenkins (parent of student(s) enrolled in Gloucester County Public Schools)

- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Brian Byrd (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Tricia Ray**
- **Kim Ward (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Melissa Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Ray Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Season Palas (parent of student(s) enrolled in Gloucester County Public Schools)**

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the December 9, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Scott Williams (student at Gloucester High School)**
- **Savannah Williams (student at Gloucester High School)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Karen Pauly**
- **Mike Enz (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Katherine Foley (parent of student(s) enrolled at Gloucester High School)**
- **Howard Mowry**
- **Janet West (parent of student(s) enrolled at Gloucester High School)**
- **Linda Walk**
- **Don Mitchell**

- Terry Brennan
- Marista Cooper (grandparent of student(s) enrolled in Gloucester County Public Schools)
- Kelly Williams

The School Board also incorporates by reference any additional “complaints” not described herein that are contained in the documents the School Board has produced in response to Plaintiff’s First Request for Production of Documents.

2. State whether any of the complaints identified in Interrogatory No. 1 were from the student (or the parent of the same student) identified in GCSB 03541 in the email subject “Gavin and [redacted].”

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term “complaint” is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection, upon information and belief, neither the student nor the parent of the student referenced in this Interrogatory made a “complaint” to the School Board.

3. State whether any of the complaints identified in Interrogatory No. 1 were from the student (or the parent of the student) identified in GCSB 03541 as “[redacted] – NOT reliable.”

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds

that the use of the term “complaint” is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection, upon information and belief, neither the student nor the parent of the student referenced in this Interrogatory made a “complaint” to the School Board.

4. State whether any of the complaints identified in Interrogatory No. 1 were from a student (or the parent of a student) named Austin.

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term “complaint” is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection, upon information and belief, the School Board does not know whether a student named Austin, or the parent of a student named Austin, made a “complaint” as is referenced above.

5. State whether there is an “alternative appropriate private facility” available for “students with gender identity issues” within 200 feet of the most remote location of Gloucester High School.

OBJECTION: The School Board objects on the grounds that the phrase “within 200 feet of the most remote location of Gloucester High School” is vague and ambiguous. The School Board further objects on the grounds that the Interrogatory is overly broad, vague, and ambiguous because it does not set forth a time frame for the School Board’s Answer.

ANSWER: Without waiving and subject to the foregoing objection, there are locations of Gloucester High School that are farther than 200 feet away from the single-user restrooms installed at Gloucester High School.

6. Identify all documents and resources relied upon by Defendants in creating the “biological gender” restroom policy passed by the School Board in 2014.

OBJECTION: The School Board objects on the grounds that Plaintiff’s Interrogatory is vague and ambiguous. Further, the School Board objects to the extent this Interrogatory seeks information and/or materials protected from disclosure by the attorney-client privilege, the attorney work-product doctrine, and/or as materials prepared in anticipation of litigation.

ANSWER: Without waiving and subject to the foregoing objection, Carla Hook prepared the resolution at issue in this litigation. Upon information and belief, Ms. Hook did not rely on any documents or resources in preparing the resolution.

7. Identify all persons consulted in creating the “biological gender” restroom policy passed by the School Board in 2014.

OBJECTION: The School Board objects on the grounds that Plaintiff’s Interrogatory is vague and ambiguous. Further, the School Board objects to the extent this Interrogatory

seeks information and/or materials protected from disclosure by the attorney-client privilege, the attorney work-product doctrine, and/or as materials prepared in anticipation of litigation.

ANSWER: Without waiving and subject to the foregoing objection, Carla Hook prepared the resolution at issue in this litigation. Upon information and belief, Ms. Hook did not consult with any persons in preparing the resolution.

**GLOUCESTER COUNTY SCHOOL
BOARD**

By _____



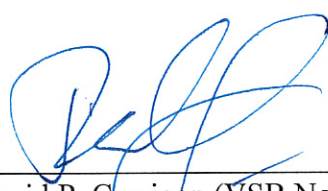
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CERTIFICATE

I hereby certify that on the 13th day of December, 2018, I emailed the document to the following:

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v.

Case No. 4:15-cv-00054

GLOUCESTER COUNTY SCHOOL
BOARD,

Defendant.

**DEFENDANT'S SUPPLEMENTAL ANSWER TO
PLAINTIFF'S INTERROGATORY NO. 1**

Comes now the defendant, Gloucester County School Board ("School Board"), and for its Supplemental Answer to Plaintiff's Interrogatory, states as follows:

GENERAL OBJECTIONS

A. Defendant objects to the Instructions contained in Plaintiff's interrogatories to the extent they alter, amend, or exceed the scope of the Federal Rules of Civil Procedure.

B. The information supplied in these answers is not based solely on the knowledge of the executing party but includes knowledge of the party, its agents, representatives, and attorneys, unless privileged. Such knowledge may or may not be known to the Defendant other than as provided.

C. The word usage and sentence structure may be that of the attorney and staff assisting in the preparation of these answers and thus do not necessarily purport to be the precise language of the executing party.

D. These answers will be supplemented in accordance with the Rule 33 of the Federal Rules of Civil Procedure, the Local Rules of the Eastern District of Virginia, and any Orders regarding discovery.

E. Defendant objects to interrogatories, etc., that invade or attempt to invade the attorney/client, work product, or any other applicable privilege.

ANSWERS TO INTERROGATORIES

1. Identify all complaints received by Gloucester County School Board (“the Board”) or its employees related to transgender students’ use of restrooms during the 2014-2015 school year, and for each complaint identify the date of the complaint, the recipient of the complaint, the content of the complaint, how the complaint was communicated or transmitted, whether the complainant was from a Gloucester High School student or parent of a Gloucester High School student, and whether the complaint related to any incident in which a student reported being in the restroom at the same time as Plaintiff.

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term “complaint” is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection,¹ Gloucester County High School Principal Nate Collins gave Grimm permission to use the male restroom on October 20, 2014. Two to three days later, Superintendent Dr. Walter Clemons received two complaints from parents regarding a transgender student using the restroom inconsistent with that student's biological sex. Dr. Clemons does not recall the identity of those parents. The parents indicated that they did not approve of a biologically female student using the male restroom. Additionally, a male student met with Collins in person and expressed concern about a biologically female student using the male restroom and a lack of privacy. Collins does not recall the specific identity of this student.

Moreover, after Grimm began to use the male restroom, Dr. Clemons, Collins and the individual members of the School Board received numerous complaints via email, which are listed below.

Emails sent to all members of the School Board

- On October 23, 2014, Kathryn Lindsay, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On October 23, 2014, Stacie and Paul Martin, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

¹ The School Board specifically reasserts its objection that Plaintiff's use of the term "complaint" in this Interrogatory is vague and ambiguous. The School Board has included in its Answer communications with individuals who generally opposed a transgender student using a restroom inconsistent with that student's biological sex. The School Board's Answer includes communications with individuals who did not agree with Gloucester High School allowing a transgender student to use a restroom inconsistent with that student's biological sex and communications with individuals who supported the School Board's December 9, 2014 resolution and the School Board's litigation of this matter.

- On October 27, 2014, Susannah Hogge sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On October 27, 2014, Jennifer Spears, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On October 28, 2014, Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 10, 2014, Elisa Nelson, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 10/11, 2014, Stuart and Seth Bunting, parents of student(s) enrolled in Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 11, 2014, Mary Diggs, upon information and belief a resident of Gloucester County, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 11, 2014, David Turner sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 12, 2014, Haley Poulson, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 12, 2014, Kelly Williams, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 13, 2014, Melissa Alexander, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On November 17, 2014, Kelly Cooper, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 7, 2014, Jenny Poole, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On December 8, 2014, Mike Enz, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On December 8, 2014, Heather Schott, a parent of student(s) enrolled in the Gloucester County Public School System, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On December 10, 2014, Tommie Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On December 10, 2014, Paul Martin, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On December 20, 2014, Chuck Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On December 20, 2014, Clayton Rogers sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On January 2, 2015, an individual named Jena sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On July 10, 2015, Tim Tompkins sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On April 21, 2016, Kathryn Lindsay, a parent of students(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On April 21, 2016, Paul Martin, parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On May 12, 2016, Kenneth Larson sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Troy Anderson

In addition to receiving emails sent to the entire School Board, Mr. Anderson received the following communications:

- On December 7, 2014, Ginger Enz, parent of student(s) enrolled in Gloucester High School, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On July 27, 2015, Leland Pike, a resident of Kentucky, sent Mr. Anderson an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On July 14, 2016, Florence Alpert, a resident of New York, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Randy Burak

In addition to receiving emails sent to the entire School Board, Mr. Burak received the following communications:

- On November 12, 2014, Gina Thayer, a parent of student(s) enrolled in Gloucester High School, sent Mr. Burak an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On December 3, 2014, Lisa Wood, a resident of the Abingdon District, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On December 7, 2014, Mike Enz, a parent of student(s) who attended Gloucester High School, sent the Mr. Burak an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On December 8, 2014, a resident of Gloucester County named Ginger emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 11, 2014, Sharon Kass, a resident of Washington D.C., emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Kimberly Hensley

In addition to receiving emails sent to the entire School Board, Ms. Hensley received the following communications:

- On November 19, 2014, Tracey Parks Carter, a parent of student(s) at Gloucester High School, emailed Ms. Hensley regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.
- On December 13, 2014, Cliff and Brandi Blackwood, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, emailed Ms. Hensley regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Carla Hook

In addition to receiving emails sent to the entire School Board, Ms. Hook received the following communications:

- On December 7, 2014, Steven Davis, a parent of high school student(s) in the York District, sent an email to Ms. Hook regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Charles Records

In addition to receiving emails sent to the entire School Board, Mr. Records received the following communications:

- On April 21, 2016, Jean Lassiter sent an email to Mr. Records regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Dr. Clemons

In addition to receiving some of the emails sent to the entire Board, Dr. Clemons received the following communications:

- On October 22, 2016 Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent Dr. Clemons an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On November 7, 2016, Ralph VanNess sent Dr. Clemons an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Additionally, the following School Board members received complaints via telephone, which are listed below.

Telephone Complaints made to Carla Hook

- Upon information and belief, before October 28, 2014, Ms. Hook spoke with Season and Andrew Palas, whose children were enrolled in Gloucester County Public Schools, regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Additionally, the issue of transgender bathroom use was discussed at public School Board meetings on November 11, 2014 and December 9, 2014. Video links to those meetings are available at: <http://www.gloucesterva.info/640/Meeting-Portal>.

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the November 11, 2014 meeting:

- Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)
- Eddie Aliff
- Savannah Williams (student at Gloucester High School)
- Terry Brennan
- Joy Sampson (parent of student(s) enrolled in Gloucester County Public Schools)
- Kelly Williams (parent of student(s) enrolled in Gloucester County Public Schools)
- Marc Jenkins (parent of student(s) enrolled in Gloucester County Public Schools)

- Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)
- Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)
- Brian Byrd (parent of student(s) enrolled in Gloucester County Public Schools)
- Tricia Ray
- Kim Ward (parent of student(s) enrolled in Gloucester County Public Schools)
- Melissa Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)
- Ray Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)
- Season Palas (parent of student(s) enrolled in Gloucester County Public Schools)

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the December 9, 2014 meeting:

- Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)
- Scott Williams (student at Gloucester High School)
- Savannah Williams (student at Gloucester High School)
- Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)
- Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)
- Karen Pauly
- Mike Enz (parent of student(s) enrolled in Gloucester County Public Schools)
- Katherine Foley (parent of student(s) enrolled at Gloucester High School)
- Howard Mowry
- Janet West (parent of student(s) enrolled at Gloucester High School)
- Linda Walk
- Don Mitchell

- Terry Brennan
- Marista Cooper (grandparent of student(s) enrolled in Gloucester County Public Schools)
- Kelly Williams

The School Board also incorporates by reference any additional “complaints” not described herein that are contained in the documents the School Board has produced in response to Plaintiff’s First Request for Production of Documents.

SUPPLEMENTAL ANSWER:

In its Answers to Plaintiff’s First Interrogatories, the School Board provided a list of email communications between board members and various individuals regarding the use of restrooms by transgender students. Further, the School Board provided the emails identified in those Answers in response to Plaintiff’s First Requests for Production of Documents. The emails speak for themselves, and each School Board member’s knowledge of any “complaint” sent by email relating to the use of restrooms by transgender students is consistent with the contents of those emails.

Further, in addition to the information provided in the School Board’s Answers to Plaintiff’s First Interrogatories, the following School Board members recall receiving non-email communications from individuals concerning the use of school restrooms by transgender students:

- Carla Hook received approximately five (5) telephone calls from parents of students enrolled in Gloucester County Public Schools who said their children were uncomfortable with a girl using the boys’ restroom. Ms. Hook does not recall the names of either the parents with whom she spoke or their children. To Ms. Hook’s knowledge, the children had no direct interaction with Grimm in the boys’ restroom.
- Kevin Smith received dozens of communications before the December 9, 2014, School Board meeting regarding a transgender student using the restroom

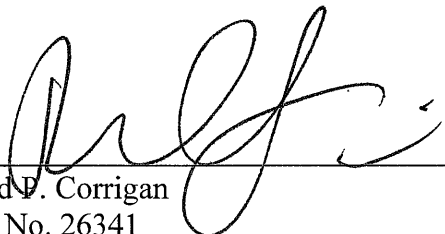
inconsistent with that student's biological sex. To Mr. Smith's best recollection, approximately seventy-five (75) percent of those communications came from parents of students enrolled in Gloucester County Public Schools. Mr. Smith does not recall the names of either the individuals with whom he spoke or their children. The individuals indicated that they were not in favor of a transgender student using the restroom inconsistent with that student's biological sex. Additionally, parents indicated that they did not want their children using the same bathroom as a member of the opposite sex. To Mr. Smith's knowledge, the children had no direct interaction with Grimm in the boys' restroom.

- Troy Andersen received approximately five (5) telephone calls from parents of students at Gloucester County Public Schools regarding a transgender student using the restroom inconsistent with that student's biological sex. Mr. Andersen does not recall the names of either the parents or their children. The parents did not want their children using the same bathroom as a member of the opposite sex, and they were concerned about the privacy and safety of students, including their children. Mr. Andersen believes that he followed any telephone conversation on this issue with an email to the parent, and that the telephone conversations were substantively similar to the email exchanges. To the best of Mr. Andersen's knowledge, the children had no direct interaction with Grimm in the boys' restroom.
- Randy Burak received two telephone calls on October 20, 2014, from parents of students at Gloucester County Public Schools regarding a transgender student using the restroom inconsistent with that student's biological sex. One telephone call came from "Mr. Wood," a parent of two boys enrolled in Gloucester County Public Schools. Mr. Burak does not recall the first name of Mr. Wood. Mr. Wood indicated that he and his children were not in favor of a girl using the same restroom as boys. The other telephone call came from a parent, whose name Mr. Burak cannot recall, who likewise did not approve of a transgender student using the restroom inconsistent with that student's biological sex. This parent expressed concern that young male students would be uncomfortable with a student who was biologically female using the male restroom. Mr. Burak does not know whether or not the children of the two parents had any direct interaction with Grimm in the boys' restroom.

This Answer will be supplemented further as additional information is received.

**GLOUCESTER COUNTY SCHOOL
BOARD**

By _____



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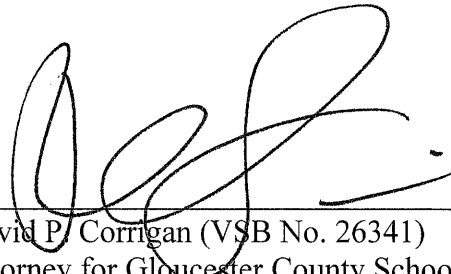
CERTIFICATE

I hereby certify that on the 11th day of January, 2019, I mailed and emailed the document to the following:

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil No. 4:15-cv-00054-AWA-RJK
	)	
GLOUCESTER COUNTY SCHOOL	)	
BOARD,	)	
	)	
Defendant.	)	

**EXPERT REPORT AND DECLARATION OF
DR. MELINDA PENN, M.D.**

1. I, Melinda Penn, M.D., have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

PROFESSIONAL BACKGROUND

2. My professional background, experience, and publications are detailed in my curriculum vitae (“CV”), attached as Exhibit A.

3. I am a pediatric endocrinologist currently practicing at Children’s Hospital of the King’s Daughters in Norfolk, Virginia. I am board certified in pediatric endocrinology by the American Board of Pediatrics, and I specialize in transgender health and Type-1 diabetes.

4. After graduating from Eastern Virginia Medical School in 2004, I completed my residency at Medical University of South Carolina in 2007, followed by a fellowship at Children’s Hospital of Philadelphia in 2010.

5. After completing my medical training, I returned to Virginia and worked for 8 years as a practicing pediatric endocrinologist at Virginia Commonwealth University (“VCU”) in

Richmond. I began treating transgender patients in 2013, and I founded and co-directed VCU's Pediatric and Adolescent Transgender Clinic in 2016 with an adolescent psychiatrist.

6. In July 2018, I moved to the Hampton Roads area to practice at the Children's Hospital of the King's Daughters.

7. As part of my practice, I provide transition-related endocrine care to transgender adolescents in accordance with the World Professional Association for Transgender Health ("WPATH") Standards of Care (attached as Exhibit B) and the Endocrine Society's Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons (attached as Exhibit C).

8. I am a member of WPATH and the Pediatric Endocrine Society. I am also a member of the Pediatric Endocrinology Society's Special Interest Group for Transgender Health and have attended several of their meetings at the annual Pediatric Endocrinology Society conferences, and stay involved in communications among members. I currently serve as a part of my hospital's Transgender Working Group which is made up of health professionals committed to increasing compassionate and knowledgeable care for transgender patients.

9. Over the past 5 years, I have treated over 100 transgender youth and adolescents in Virginia.

10. In my work with transgender youth, I collaborate closely with mental health professionals to provide comprehensive care. My clinic at VCU was a multidisciplinary clinic with a pediatric psychiatrist who specializes in transgender care, and we frequently collaborated with a psychologist who specializes in pediatric and adolescent LGBT care. Currently, I work with a social worker who is available to see my patients and can offer mental health resources and referrals.

11. I regularly keep up to date with the professional literature on the treatment of children and adolescents with gender dysphoria.

12. In preparing this report, I relied on my scientific education and training, my professional experience, clinical guidelines that represent the contemporary standard of care for treating transgender youth, and scientific literature on the topic.

13. The materials I have relied upon in preparing this report are the same types of materials that experts in my field regularly rely upon when forming professional opinions.

14. I may supplement these opinions in response to information produced by Defendants in discovery or in response to Defendant's expert disclosures.

15. I have not testified as an expert at a trial or deposition in the last four years.

16. I am being compensated at an hourly rate of \$300 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

OPINIONS

17. The term "gender identity" refers to a person's innate sense of belonging to a particular gender. Although the precise etiology of gender identity is unknown, biological and environmental factors are believed to contribute to this fundamental aspect of human development.

18. A person's gender identity usually matches the sex they were designated at birth based on their external genitalia. The terms "sex designated at birth" or "sex assigned at birth" are more precise than the term "biological sex" because all of the physiological aspects of a person's sex are not always aligned with each other. For example, some people with intersex characteristics may have chromosomes typically associated with males but genitalia typically

associated with females. For these reasons the Endocrine Society warns practitioners that the terms “biological sex” and “biological male or female” are imprecise and should be avoided.

19. Most boys were designated male at birth based on their external genital anatomy, and most girls were designated female at birth based on their external genital anatomy. But transgender children have a gender identity that differs from the sex assigned to them at birth. A transgender boy is someone who was assigned a female sex at birth but persistently, consistently, and insistentlly identifies as male. A transgender girl is someone who was assigned a male sex at birth but persistently, consistently, and insistentlly identifies as female.

20. Gender identity is a deeply rooted early in life. For some children, a transgender identity presents early in childhood. For others, the onset of puberty, and the resulting physical changes in their bodies, may lead them to recognize that their gender identity is not aligned with their sex assigned at birth.

21. According the American Psychiatric Association’s Diagnostic & Statistical Manual of Mental Disorders (“DSM V”), “gender dysphoria” is the diagnostic term for the condition experienced by some transgender people of clinically significant distress resulting from the lack of congruence between their gender identity and the sex assigned to them at birth. In order to be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

22. Being transgender is not itself a mental disorder or a medical condition to be cured. But gender dysphoria is a serious medical condition that, if left untreated, can result in crippling anxiety, severe depression, self-harm, and suicidality. Spack NP, Edwards-Leeper L, Feldmain HA, et al. *Children and adolescents with gender identity disorder referred to a*

pediatric medical center. Pediatrics. 2012; 129(3):418-425. Olson KR, Durwood L, DeMeules M, McLaughlin KA. *Mental health of transgender children who are supported in their identities*. Pediatrics 2016/137:1-8.

23. WPATH and the National Endocrine Society have published widely accepted standards of care for treating gender dysphoria. The medical treatment for gender dysphoria is to eliminate the clinically significant distress by helping a transgender person live in alignment with their gender identity. This treatment is sometimes referred to as “gender transition,” “transition related care,” or “gender affirming care.” The American Academy of Pediatrics agrees that this care is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria.

24. The precise treatment for gender dysphoria depends on each person’s individualized need, and the medical standards of care differ depending on whether the treatment is for a pre-pubertal child, an adolescent, or an adult.

25. Before puberty, gender transition does not include any drug or surgical intervention and is limited to “social transition,” which means allowing a transgender child to live and be socially recognized in accordance with their gender identity. Typically, social transition can include allowing children to wear clothing, to cut or grow their hair, to use names and pronouns and restrooms and other sex-separated facilities in line with their gender identity instead of the sex assigned to them at birth.

26. Under the Endocrine Society Clinical Guidelines, hormone therapy may become medically necessary and appropriate as transgender youth reach puberty. In providing hormone therapy pediatric endocrinologists must work in close consultation with qualified mental health professionals experienced in diagnosing and treating gender dysphoria.

27. For many transgender adolescents, going through puberty in accordance with the sex assigned to them at birth can cause extreme distress. Puberty blocking hormone treatment allows transgender youth to avoid going through puberty in accordance with the sex assigned to them at birth, along with the heightened gender dysphoria and permanent physical changes that puberty would cause.

28. Under the Endocrine Society Clinical Guidelines, transgender adolescents may be eligible for puberty-blocking hormone therapy if:

- A qualified mental health professional has confirmed that:
 - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
 - gender dysphoria worsened with the onset of puberty,
 - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
- The adolescent:
 - has sufficient mental capacity to give informed consent to this (reversible) treatment, and
 - has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility, and
 - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
 - agrees with the indication for GnRH agonist treatment,

- has confirmed that puberty has started in the adolescent, and
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

29. Once a transgender adolescent establishes maturity and competence to make decisions about treatment, often around the age of 14, it may then be medically necessary and appropriate to provide gender-affirming hormone therapy to allow them to go through puberty consistently with their gender identity.

30. Under Endocrine Society Clinical Guidelines, transgender adolescents may be eligible for gender-affirming hormone therapy if:

- A qualified mental health professional has confirmed:
 - the persistence of gender dysphoria,
 - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
 - the adolescent has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
- And the adolescent:
 - has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
 - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
 - agrees with the indication for sex hormone treatment,

- has confirmed that there are no medical contraindications to sex hormone treatment.

31. Adolescents who receive gender-affirming hormones after puberty blockers never go through puberty in accordance with the sex assigned to them at birth and, instead, go through puberty that matches their gender identity. Pre-pubertal boys and girls are indistinguishable with respect to secondary sex characteristics. If a pre-pubertal child receives puberty blockers, they will never develop the secondary sex characteristics of the sex assigned to them at birth, and when they are provided hormones in accordance with their gender identity, they will develop only the secondary sex characteristics that match their gender identity.

32. For example, transgender boys treated with puberty blockers and gender affirming hormones will receive the same amount of testosterone during puberty that non-transgender boys generate with their gonads or testes. They will develop the phenotypic features of non-transgender boys such as muscle mass, fat distribution, facial and body hair, along with lower vocal pitch. Likewise, transgender girls treated with puberty blockers and gender affirming hormones will receive the same amount of estrogen during puberty that non-transgender girls generate endogenously. They will develop the same muscle mass, fat distribution, skin and female hair patterns, and breasts typically associated with other girls.

33. Under the WPATH standards of care, boys and girls who are transgender may also receive medically necessary chest reconstructive surgeries once they turn 16 and genital surgery once they reach the age of majority.

34. When provided medical treatments in accordance with the standards of care before and during puberty, transgender boys do not resemble and are not perceived as girls in

their day to day life, and transgender girls do not resemble and are not perceived as boys in their day to day life.

35. Blocking a transgender youth from going through puberty in accordance with the sex assigned to them at birth and providing gender-affirming hormones can be lifesaving treatment and change the short and long term health outcomes for transgender youth.

36. Offering safe, healthy, medically supervised gender transition is critical to the healthy growth and development of many transgender children and adolescents who experience gender dysphoria. Transgender youth are a high risk population with increased risk for poor mental health outcomes including suicide, homelessness and becoming a victim of violence. Psychological functioning has been shown to improve with hormone and surgical therapy. Guss, Carly, Shumer, Daniel; Katz-Wise, Sabra L. *Transgender and gender nonconforming adolescent care: psychosocial and medical considerations*. Current Opinions in Pediatrics: August 2015-Volume 27-Issue 4. p 421-426; Lopez, Ximena; Marinkovic, Maja; Eimicke, Toni; Rosenthal, Stephen; Olshan, Jerrold. *Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health*. Current Opinions in Pediatrics: August 2017-Volume 29, Issue 4. 475-480; Cohen-Kettenis PT, Schagn SEE, Steensma TD, de Vries ALC, Delemarre-van de Waal HA; *Puberty suppression in a gender dysphoric adolescent: a 22-year follow-up*. Arch Sex Behav. 2011;40(4): 843-847.

37. I have seen these dramatically improved health outcomes in my own practice as a pediatric endocrinologist. Many of my patients with gender dysphoria have a history of significant depression and anxiety requiring medications and often hospitalizations prior to initiating endocrine care. My patients and their parents have all reported improvement—often dramatic improvement—in the adolescent's functioning and reduction in their gender dysphoria

after initiating care. Many are able to stop or reduce their psychiatric medications and report improved socialization and increased participation in school and other activities. Adolescents who had previously been withdrawn open up and start having goals and making plans for their futures. Parents describe having their happy kid back.

38. The well-being of adolescents with gender dysphoria depends on more than access to medical care to medically transition: The patients who have the most positive outcomes are those who are supported and respected as the gender they identify with by their families, peers, and school. This includes being referred to by the name and gender pronouns that match their identity and being able to participate in activities and access facilities consistent with their gender identity. deVries AL, McGuire JK, Steensma TD, et al. *Young adult psychological outcome after puberty suppression and gender reassignment*. Pediatrics 2014; 134:696-704.

39. Many of my patients wish to use the restroom for their affirmed gender and do not want to be singled out as different or inconvenienced by having to go to a separate restroom that other students are not required to use. While some students – particularly those who are early in their transition – feel safer or more comfortable using a private restroom, forcing transgender students to do so can be harmful to their wellbeing by calling them out as different and rejecting their gender. Many of my patients express that it is important to them to be seen as the boys and girls that they are and not be singled out as transgender. For some, being required to use a separate restroom is a constant reminder that they are different and not accepted as the boy or girl they know they are.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 1/18/2019



Melinda Penn, M.D.

Eastern Virginia Medical School Curriculum Vitae

Melinda Penn, MD

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Education

Fellow, Pediatric Endocrinology Children's Hospital of Philadelphia Philadelphia, PA	7/2007-8/2010
Resident, General Pediatrics Medical University of South Carolina Charleston, SC	7/2004-7/2007
Degree: MD Eastern Virginia Medical School Norfolk, VA	8/2000-5/2004
Degree: BS, Biology Virginia Commonwealth University Richmond, VA	8/1996-5/2000

Professional Experience

Physician, Pediatric Endocrinology Children's Specialty Group Norfolk, VA	7/2018-present

Academic Appointments

Assistant Professor, Department of Pediatrics Virginia Commonwealth University Richmond, VA	9/2010-7/2018
Associate Program Director, Pediatric Residency Virginia Commonwealth University Richmond, VA	7/2013- 7/2018

Certification and Licensure

American Board of Pediatrics - General Pediatrics	10/2007

Melinda Penn, 7/2018
Page 2 of 5

American Board of Pediatrics- Pediatric Endocrinology	11/2011
South Carolina Limited Training Medical License	7/2004-7/2007
Pennsylvania Medical License	7/2007-8/2010
Pennsylvania Medical Training License	7/2007-8/2010
Virginia Medical License	6/2010-present

Professional Memberships and Activities

Lawson Wilkins Pediatric Endocrinology Society	2007-present
World Professional Association for Transgender Health	2014-present
Endocrine Society	2007-2010

Honors and Awards

Virginia Commonwealth University Presidential Scholarship	8/1996-5/2000
Virginia Commonwealth University, University Honors	5/2000
LWPES Fellow Travel Grant	2008,2009,2010
Ruth L. Kirschstein National Research Service Award Institutional Training Grant Recipient Children's Hospital of Philadelphia	7/2008-7/2009
Novo Nordisk Research Fellowship Grant Recipient Lawson Wilkins Pediatric Endocrine Society	7/2009-7/2010
Marilyn Fishman Grant for Diabetes Research Recipient Endocrine Fellows Foundation	7/2009-7/2010
Richmond Magazine "Top Doc"- Pediatric Endocrinology	2014- 2017

Committee Assignments and Administrative Services

Transgender Working Group CHKD	7/2018-present
Diabetes Center Team CHKD	7/2018-present
Laboratory Utilization Committee VCU Health System	7/2017-7/2018
DREAM Team- Inpatient Diabetes Committee VCU Health System	2011

Central Virginia JDRF Board of Directors 2011-2017

Educational Activities

Pediatric Endocrinology Resident Lecture 12/2018
Transgender Medicine
CHKD

Pediatric Endocrinology Fellowship Lecturer 2011-2018
Children's Hospital of Richmond at VCU

Pediatric Resident Lecturer 2011-2017
Pediatric Endocrinology lectures
Children's Hospital of Richmond at VCU

Endocrinology Grand Rounds 2012, 2015
Virginia Commonwealth University

MS2 Lecturer 2015, 2016
Puberty
Virginia Commonwealth University School of Medicine

ACGME Residency Orientation 2016
Walk the Walk
Virginia Commonwealth University School of Medicine

Medical Student Interest Group Lecturer 2016
Pediatric Transgender Medicine
Virginia Commonwealth University School of Medicine

Pediatric Endocrinology Fellow Clinical Mentor 2011-2018
Virginia Commonwealth University School of Medicine

Clinical Educator for Pediatric Endocrinology Fellows, 2010-2018
Pediatric Residents and Medical students
Children's Hospital of Richmond at VCU

Clinical Activities

Director of Pediatric Transgender Health Clinic 2014-2018
Children's Hospital of Richmond at Virginia Commonwealth University

Grants and Contract Awards

Ruth L. Kirschstein National Research Service Award 2008-2009
Institutional Training Grant Recipient
Children's Hospital of Philadelphia

Novo Nordisk Research Fellowship Grant Recipient, \$10,000 2009-2010
Lawson Wilkins Pediatric Endocrine Society

Marilyn Fishman Grant for Diabetes Research Recipient, \$10,000 2009-2010
Endocrine Fellows Foundation

Publications

Kameswaran V, Bramswig NC, McKenna LB, **Penn M**, Schug J, Hand NJ, Chen Y, Choi I, Vourekas A, Won KJ, Liu C, Vivek K, Naji A, Friedman JR, Kaestner KH. [Epigenetic regulation of the DLK1-MEG3 microRNA cluster in human type 2 diabetic islets](#). Cell Metab. 2014 Jan 7;19(1):135-45.
PMID: 24374217

Book Chapters

Penn, M. *Type 1 Diabetes*. Encyclopedia of inflammatory Disease. Springer Online Publication, 2014

Penn, M, Grimberg A. *Patient Encounters: The Inpatient Pediatrics Work-Up. Chapter 11: Diabetic Ketoacidosis*. Lippincott Williams and Wilkins, 2009.

Abstracts and Presentations

National

Oral Platform Presentation, LWPES/ESPE 2010
MicroRNA Profile in Type 2 diabetes.

Regional

JDRF TypeOneNation Summit 10/2017
Expert Panel

Virginia TIES Conference 10/2017
Transgender Medical Care for Children and Adolescents

Peds at the Beach 7/2016
Transgender Healthcare for Children and Adolescents

Animas Diabetes Family Conference 4/2011
Expert Panel

Poster Presentations

Penn M, Hsu Y, Hughes N, DeLeon D. *Transitioning Infants with Monogenic Diabetes to Oral Sulfonylurea Therapy*. Abstract for poster presentation, University of Pennsylvania, Institute of Diabetes and Metabolism Research Day, March 2009.

Penn M, Hsu Y, Hughes N, DeLeon D. *Transitioning Infants with Monogenic Diabetes to Oral Sulfonylurea Therapy*. Abstract for poster presentation, LWPES/ESPE, New York, NY 2009.

Penn M, Koren D, Hughes N, Kelly A, DeLeon D. *Neonatal diabetes due to KCNJ11 Mutations*. Abstract for poster presentation, Pediatric Academic Society, Honolulu, HI 2008.

Penn M, Koren D, Hughes N, Kelly A, DeLeon D. *Neonatal diabetes due to KCNJ11 Mutations*. Abstract for poster presentation, CHOP Fellows Research Day, February 2008.

Professional Development

Diabetes Technology Society- Certified Diabetes Technology Clinician 2013

Community Service

Camp Adam Fisher 2005, 2006
Diabetes Camp- Medical staff volunteer
Marion, SC

Setebaid Diabetes Camp- Medical staff volunteer 2008
Shickshinny, PA

ADA Diabetes Camp Donovan McNabb- Medical Supervisor 2008-2010
Philadelphia, PA

Camp WannaCure- Medical Director 2011-2018
Richmond, VA

Central Virginia JDRF Board of Directors 2011-2017



Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health



Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version¹ | www.wpath.org

¹ This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

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Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)¹ is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The SOC are based on the best available science and expert professional consensus.² Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the SOC to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the SOC.

The overall goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the SOC may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

¹ Formerly the Harry Benjamin International Gender Dysphoria Association

² *Standards of Care (SOC)*, Version 7 represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The SOC are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the SOC, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the SOC – to evolve.

The SOC articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the SOC recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the SOC to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.



Global Applicability of the Standards of Care

While the SOC are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the SOC to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the SOC according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The SOC are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the SOC. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the SOC are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.



The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that “the expression of gender characteristics, including identities, that are not stereotypically associated with one’s assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative.”

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in “minority stress” (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one’s relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases (ICD)* (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV Epidemiologic Considerations

Formal epidemiologic studies on the incidence³ and prevalence⁴ of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

³ **incidence**—the number of new cases arising in a given period (e.g., a year)

⁴ **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.



Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a “transition,” because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one’s gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the SOC offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.⁵ Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

⁵ Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;
2. Trained in childhood and adolescent developmental psychopathology;
3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).
2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.
3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.
4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.
5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).
6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.
2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).
3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.
2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.
3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.
4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.
5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions.* These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.
2. *Partially reversible interventions.* These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).
3. *Irreversible interventions.* These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
2. Gender dysphoria emerged or worsened with the onset of puberty;
3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;
4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII

Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the SOC focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.
2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.
3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.
4. Documented supervised training and competence in psychotherapy or counseling.
5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.
6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess gender dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called “a qualified mental health professional”) are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider’s health care team.

2. Provide information regarding options for gender identity and expression and possible medical interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If applicable, assess eligibility, prepare, and refer for hormone therapy

The SOC provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

5. If applicable, assess eligibility, prepare, and refer for surgery

The SOC also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The SOC do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).
- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy is not an absolute requirement for hormone therapy and surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The SOC do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

2. Goals of psychotherapy for adults with gender concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing

gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family therapy or support for family members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).

5. Follow-up care throughout life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. Etherapy, online counseling, or distance counseling

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

Other Tasks of the Mental Health Professional**1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents**

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide information and referral for peer support

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the SOC have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII

Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the SOC. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *Standards of Care* outlined in section VI);
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the SOC, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship between the Standards of Care and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The SOC are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the SOC). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.
- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fat compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES ^A

Effect	Expected Onset ^B	Expected Maximum Effect ^B
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months ^C	variable
Increased muscle mass/strength	6-12 months	2-5 years ^D
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

^A Adapted with permission from Hembree et al.(2009). Copyright 2009, The Endocrine Society.

^B Estimates represent published and unpublished clinical observations.

^C Highly dependent on age and inheritance; may be minimal.

^D Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES ^A

Effect	Expected Onset ^B	Expected Maximum Effect ^B
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years ^C
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years ^D
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

^A Adapted with permission from Hembree et al. (2009). Copyright 2009, The Endocrine Society.

^B Estimates represent published and unpublished clinical observations.

^C Significantly dependent on amount of exercise.

^D Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaber, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease^A Gallstones Elevated liver enzymes Weight gain Hypertriglyceridemia	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors ^B	Cardiovascular disease	
Possible increased risk	Hypertension Hyperprolactinemia or prolactinoma ^A	Elevated liver enzymes Hyperlipidemia
Possible increased risk with presence of additional risk factors ^B	Type 2 diabetes^A	Destabilization of certain psychiatric disorders^C Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

^A Risk is greater with oral estrogen administration than with transdermal estrogen administration.

^B Additional risk factors include age.

^C Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.
2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).
3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.
4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.
5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.
6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the SOC (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens*, below).

4. Initiating hormonal feminization/masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk assessment and modification for masculinizing hormone therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Catrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and risk monitoring during feminizing hormone therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and risk monitoring during masculinizing hormone therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or economic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for feminizing hormone therapy (MtF)Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications (“anti-androgens”)

A combination of estrogen and “anti-androgens” is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.
- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).
- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadotropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.
- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for masculinizing hormone therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and compounded hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX

Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignancies that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.



Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.
2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the SOC; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI

Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the SOC. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve “ideal” results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversible, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);
2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;
3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;
2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered “aesthetic” surgery or “reconstructive” surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the SOC, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the SOC allow for an individualized approach to best meet a patient’s health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one’s gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The SOC do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for breast/chest surgery (one referral)Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the SOC for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the SOC for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. 12 continuous months of living in a gender role that is congruent with their gender identity;

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dysphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called “chest reconstruction”) is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or “male chest contouring” procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled “purely aesthetic,” these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII

Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long

distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII

Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such

as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hildebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the Standards of Care to People Living in Institutional Environments

The SOC in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the SOC can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the SOC. A “freeze frame” approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the SOC) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the SOC, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the SOC (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the Standards of Care to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPE1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the “disorder” label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the SOC, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the SOC

Previously, individuals with a DSD who also met the *DSM-IV-TR*'s behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a “Gender Identity Disorder - Not Otherwise Specified.” They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the SOC.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the SOC. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).



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APPENDIX A

GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the SOC are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones: Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Crossdressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the “disorder” label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B

OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely increased risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible increased risk:Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other side effects of feminizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of anti-androgen medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the SOC. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely increased risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible increased risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing, may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other side effects of masculinizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C

SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the SOC, the criteria put forth in the SOC for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the SOC – to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the SOC for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the SOC for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the SOC for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);
6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D

EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically been doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p < .001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which “almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning” (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E

DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial SOC “work group” was established in 2006. Members were invited to examine specific sections of SOC, *Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the SOC as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of SOC, *Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of SOC, *Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader SOC Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader SOC Revision Committee and the International Advisory Group. Upon completion of these three iterations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the SOC and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the SOC.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;
2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;
3. Working meeting of the Writing Group;
4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;
5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

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Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

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***Cosponsoring Associations:** American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society-appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

professional for adults (recommended)—should be knowledgeable about the diagnostic criteria and criteria for gender-affirming treatment, have sufficient training and experience in assessing psychopathology, and be willing to participate in the ongoing care throughout the endocrine transition. We recommend treating gender-dysphoric/gender-incongruent adolescents who have entered puberty at Tanner Stage G2/B2 by suppression with gonadotropin-releasing hormone agonists. Clinicians may add gender-affirming hormones after a multidisciplinary team has confirmed the persistence of gender dysphoria/gender incongruence and sufficient mental capacity to give informed consent to this partially irreversible treatment. Most adolescents have this capacity by age 16 years old. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age. For the care of peripubertal youths and older adolescents, we recommend that an expert multidisciplinary team comprised of medical professionals and mental health professionals manage this treatment. The treating physician must confirm the criteria for treatment used by the referring mental health practitioner and collaborate with them in decisions about gender-affirming surgery in older adolescents. For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient. We suggest maintaining physiologic levels of gender-appropriate hormones and monitoring for known risks and complications. When high doses of sex steroids are required to suppress endogenous sex steroids and/or in advanced age, clinicians may consider surgically removing natal gonads along with reducing sex steroid treatment. Clinicians should monitor both transgender males (female to male) and transgender females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, clinicians should persistently monitor adverse effects of sex steroids. For gender-affirming surgeries in adults, the treating physician must collaborate with and confirm the criteria for treatment used by the referring physician. Clinicians should avoid harming individuals (via hormone treatment) who have conditions other than gender dysphoria/gender incongruence and who may not benefit from the physical changes associated with this treatment. (*J Clin Endocrinol Metab* 102: 3869–3903, 2017)

Summary of Recommendations

1.0 Evaluation of youth and adults

- 1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

- 1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)
- 1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

- 1.4. We recommend against puberty blocking and gender-affirming hormone treatment in pre-pubertal children with GD/gender incongruence. (1 ⊕⊕○○)
- 1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 ⊕⊕⊕○)

2.0 Treatment of adolescents

- 2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 ⊕⊕○○)
- 2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 ⊕⊕○○)
- 2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 ⊕⊕○○)
- 2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 ⊕⊕○○).
- 2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 ⊕○○○)
- 2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 ⊕⊕○○)

3.0 Hormonal therapy for transgender adults

- 3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and

- the criteria for the endocrine phase of gender transition before beginning treatment. (1 ⊕⊕⊕○)
- 3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 ⊕⊕⊕○)
- 3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 ⊕⊕○○)
- 3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 ⊕○○○)

4.0 Adverse outcome prevention and long-term care

- 4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 ⊕⊕○○)
- 4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 ⊕⊕○○)
- 4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 ⊕⊕○○)
- 4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 ⊕⊕○○)
- 4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 ⊕⊕○○)
- 4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 ⊕○○○)
- 4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

5.0 Surgery for sex reassignment and gender confirmation

- 5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕○○)
- 5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)
- 5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)
- 5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕○○○)
- 5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕○○)
- 5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕○○○)

Changes Since the Previous Guideline

Both the current guideline and the one published in 2009 contain similar sections. Listed here are the sections contained in the current guideline and the corresponding number of recommendations: Introduction, Evaluation of Youth and Adults (5), Treatment of Adolescents (6), Hormonal Therapy for Transgender Adults (4), Adverse Outcomes Prevention and Long-term Care (7), and Surgery for Sex Reassignment and Gender Confirmation (6). The current introduction updates the diagnostic classification of "gender dysphoria/gender incongruence." It also reviews the development of "gender identity" and summarizes its natural development. The section on

clinical evaluation of both youth and adults, defines in detail the professional qualifications required of those who diagnose and treat both adolescents and adults. We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional. We recommend against puberty blocking followed by gender-affirming hormone treatment of prepubertal children. Clinicians should inform pubertal children, adolescents, and adults seeking gender-confirming treatment of their options for fertility preservation. Prior to treatment, clinicians should evaluate the presence of medical conditions that may be worsened by hormone depletion and/or treatment. A multidisciplinary team, preferably composed of medical and mental health professionals, should monitor treatments. Clinicians evaluating transgender adults for endocrine treatment should confirm the diagnosis of persistent gender dysphoria/gender incongruence. Physicians should educate transgender persons regarding the time course of steroid-induced physical changes. Treatment should include periodic monitoring of hormone levels and metabolic parameters, as well as assessments of bone density and the impact upon prostate, gonads, and uterus. We also make recommendations for transgender persons who plan genital gender-affirming surgery.

Method of Development of Evidence-Based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee (CGS) of the Endocrine Society deemed the diagnosis and treatment of individuals with GD/gender incongruence a priority area for revision and appointed a task force to formulate evidence-based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines (1). A detailed description of the grading scheme has been published elsewhere (2). The task force used the best available research evidence to develop the recommendations. The task force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕○○○ denotes very low-quality evidence; ⊕⊕○○, low quality; ⊕⊕⊕○, moderate quality; and ⊕⊕⊕⊕, high quality. The task force has confidence that persons who receive care according to the strong recommendations will derive, on average, more benefit than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each recommendation is a description of the evidence and the

values that the task force considered in making the recommendation. In some instances, there are remarks in which the task force offers technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the task force and their preferences; therefore, one should consider these remarks as suggestions.

In this guideline, the task force made several statements to emphasize the importance of shared decision-making, general preventive care measures, and basic principles of the treatment of transgender persons. They labeled these “Ungraded Good Practice Statement.” Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles.

The Endocrine Society maintains a rigorous conflict-of-interest review process for developing clinical practice guidelines. All task force members must declare any potential conflicts of interest by completing a conflict-of-interest form. The CGS reviews all conflicts of interest before the Society’s Council approves the members to participate on the task force and periodically during the development of the guideline. All others participating in the guideline’s development must also disclose any conflicts of interest in the matter under study, and most of these participants must be without any conflicts of interest. The CGS and the task force have reviewed all disclosures for this guideline and resolved or managed all identified conflicts of interest.

Conflicts of interest are defined as remuneration in any amount from commercial interests; grants; research support; consulting fees; salary; ownership interests [e.g., stocks and stock options (excluding diversified mutual funds)]; honoraria and other payments for participation in speakers’ bureaus, advisory boards, or boards of directors; and all other financial benefits. Completed forms are available through the Endocrine Society office.

The Endocrine Society provided the funding for this guideline; the task force received no funding or remuneration from commercial or other entities.

Commissioned Systematic Review

The task force commissioned two systematic reviews to support this guideline. The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes. The review identified 29 eligible studies at moderate risk of bias. In transgender males (female to male), sex steroid therapy was associated with a statistically significant increase in serum triglycerides and low-density lipoprotein cholesterol levels. High-density lipoprotein cholesterol levels decreased significantly across all follow-up time periods. In transgender females (male to female), serum triglycerides were significantly higher without any changes in other parameters. Few myocardial infarction, stroke, venous thromboembolism (VTE), and death events were reported. These events were more frequent in transgender females. However, the

quality of the evidence was low. The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals and identified 13 studies. In transgender males, there was no statistically significant difference in the lumbar spine, femoral neck, or total hip BMD at 12 and 24 months compared with baseline values before initiating masculinizing hormone therapy. In transgender females, there was a statistically significant increase in lumbar spine BMD at 12 months and 24 months compared with baseline values before initiation of feminizing hormone therapy. There was minimal information on fracture rates. The quality of evidence was also low.

Introduction

Throughout recorded history (in the absence of an endocrine disorder) some men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism. In modern history, there have been numerous ongoing biological, psychological, cultural, political, and sociological debates over various aspects of gender variance. The 20th century marked the emergence of a social awakening for men and women with the belief that they are “trapped” in the wrong body (3). Magnus Hirschfeld and Harry Benjamin, among others, pioneered the medical responses to those who sought relief from and a resolution to their profound discomfort. Although the term transsexual became widely known after Benjamin wrote “The Transsexual Phenomenon” (4), it was Hirschfeld who coined the term “transsexual” in 1923 to describe people who want to live a life that corresponds with their experienced gender vs their designated gender (5). Magnus Hirschfeld (6) and others (4, 7) have described other types of trans phenomena besides transsexualism. These early researchers proposed that the gender identity of these people was located somewhere along a unidimensional continuum. This continuum ranged from all male through “something in between” to all female. Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience themselves as having both a male and female gender identity, whereas others completely renounce any gender classification (8, 9). There are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity (10) or men who do not experience themselves as men but do not want to live as women (11, 12). In some countries, (e.g., Nepal, Bangladesh, and Australia), these nonmale or nonfemale genders are officially recognized (13). Specific treatment protocols, however, have not yet been developed for these groups.

Instead of the term transsexualism, the current classification system of the American Psychiatric Association uses the term gender dysphoria in its diagnosis of persons who are not satisfied with their designated gender (14). The current version of the World Health Organization's ICD-10 still uses the term transsexualism when diagnosing adolescents and adults. However, for the ICD-11, the World Health Organization has proposed using the term "gender incongruence" (15).

Treating persons with GD/gender incongruence (15) was previously limited to relatively ineffective elixirs or creams. However, more effective endocrinology-based treatments became possible with the availability of testosterone in 1935 and diethylstilbestrol in 1938. Reports of individuals with GD/gender incongruence who were treated with hormones and gender-affirming surgery appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association was founded in September 1979 and is now called the World Professional Association for Transgender Health (WPATH). WPATH published its first Standards of Care in 1979. These standards have since been regularly updated, providing guidance for treating persons with GD/gender incongruence (16).

Prior to 1975, few peer-reviewed articles were published concerning endocrine treatment of transgender persons. Since then, more than two thousand articles about various aspects of transgender care have appeared.

It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable treating physicians to maximize benefit and minimize risk when caring for individuals diagnosed with GD/gender incongruence.

In the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols. Specifically, endocrine treatment protocols for GD/gender incongruence should include the careful assessment of the following: (1) the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development); (2) the effects of treatment in adults on sex hormone levels; (3) the requirement for and the effects of progestins and other agents used to suppress endogenous sex steroids during treatment; and (4) the risks and benefits of gender-affirming hormone treatment in older transgender people.

To successfully establish and enact these protocols, a commitment of mental health and endocrine investigators is required to collaborate in long-term, large-scale

studies across countries that use the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools (*e.g.*, the European Network for the Investigation of Gender Incongruence) (17, 18).

Terminology and its use vary and continue to evolve. Table 1 contains the definitions of terms as they are used throughout this guideline.

Biological Determinants of Gender Identity Development

One's self-awareness as male or female changes gradually during infant life and childhood. This process of cognitive and affective learning evolves with interactions with parents, peers, and environment. A fairly accurate timetable exists outlining the steps in this process (19). Normative psychological literature, however, does not address if and when gender identity becomes crystallized and what factors contribute to the development of a gender identity that is not congruent with the gender of rearing. Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression (20) likely reflect a complex interplay of biological, environmental, and cultural factors (21, 22).

With respect to endocrine considerations, studies have failed to find differences in circulating levels of sex steroids between transgender and nontransgender individuals (23). However, studies in individuals with a disorder/difference of sex development (DSD) have informed our understanding of the role that hormones may play in gender identity outcome, even though most persons with GD/gender incongruence do not have a DSD. For example, although most 46,XX adult individuals with virilizing congenital adrenal hyperplasia caused by mutations in *CYP21A2* reported a female gender identity, the prevalence of GD/gender incongruence was much greater in this group than in the general population without a DSD. This supports the concept that there is a role for prenatal/postnatal androgens in gender development (24–26), although some studies indicate that prenatal androgens are more likely to affect gender behavior and sexual orientation rather than gender identity *per se* (27, 28).

Researchers have made similar observations regarding the potential role of androgens in the development of gender identity in other individuals with DSD. For example, a review of two groups of 46,XY persons, each with androgen synthesis deficiencies and female raised, reported transgender male (female-to-male) gender role changes in 56% to 63% and 39% to 64% of patients, respectively (29). Also, in 46,XY female-raised individuals with cloacal

Table 1. Definitions of Terms Used in This Guideline

<i>Biological sex, biological male or female:</i> These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.
<i>Cisgender:</i> This means not transgender. An alternative way to describe individuals who are not transgender is "non-transgender people."
<i>Gender-affirming (hormone) treatment:</i> See "gender reassignment"
<i>Gender dysphoria:</i> This is the distress and unease experienced if gender identity and designated gender are not completely congruent (see Table 2). In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, which replaced "gender identity disorder" with "gender dysphoria" and changed the criteria for diagnosis.
<i>Gender expression:</i> This refers to external manifestations of gender, expressed through one's name, pronouns, clothing, haircut, behavior, voice, or body characteristics. Typically, transgender people seek to make their gender expression align with their gender identity, rather than their designated gender.
<i>Gender identity/experienced gender:</i> This refers to one's internal, deeply held sense of gender. For transgender people, their gender identity does not match their sex designated at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression (see below), gender identity is not visible to others.
<i>Gender identity disorder:</i> This is the term used for GD/gender incongruence in previous versions of DSM (see "gender dysphoria"). The ICD-10 still uses the term for diagnosing child diagnoses, but the upcoming ICD-11 has proposed using "gender incongruence of childhood."
<i>Gender incongruence:</i> This is an umbrella term used when the gender identity and/or gender expression differs from what is typically associated with the designated gender. Gender incongruence is also the proposed name of the gender identity-related diagnoses in ICD-11. Not all individuals with gender incongruence have gender dysphoria or seek treatment.
<i>Gender variance:</i> See "gender incongruence"
<i>Gender reassignment:</i> This refers to the treatment procedure for those who want to adapt their bodies to the experienced gender by means of hormones and/or surgery. This is also called gender-confirming or gender-affirming treatment.
<i>Gender-reassignment surgery (gender-confirming/gender-affirming surgery):</i> These terms refer only to the surgical part of gender-confirming/gender-affirming treatment.
<i>Gender role:</i> This refers to behaviors, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or that society associates with or considers typical of the social role of men or women.
<i>Sex designated at birth:</i> This refers to sex assigned at birth, usually based on genital anatomy.
<i>Sex:</i> This refers to attributes that characterize biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics.
<i>Sexual orientation:</i> This term describes an individual's enduring physical and emotional attraction to another person. Gender identity and sexual orientation are not the same. Irrespective of their gender identity, transgender people may be attracted to women (gynephilic), attracted to men (androphilic), bisexual, asexual, or queer.
<i>Transgender:</i> This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment.
<i>Transgender male (also: trans man, female-to-male, transgender male):</i> This refers to individuals assigned female at birth but who identify and live as men.
<i>Transgender woman (also: trans woman, male-to-female, transgender female):</i> This refers to individuals assigned male at birth but who identify and live as women.
<i>Transition:</i> This refers to the process during which transgender persons change their physical, social, and/or legal characteristics consistent with the affirmed gender identity. Prepubertal children may choose to transition socially.
<i>Transsexual:</i> This is an older term that originated in the medical and psychological communities to refer to individuals who have permanently transitioned through medical interventions or desired to do so.

exstrophy and penile agenesis, the occurrence of transgender male changes was significantly more prevalent than in the general population (30, 31). However, the fact that a high percentage of individuals with the same conditions did not change gender suggests that cultural factors may play a role as well.

With respect to genetics and gender identity, several studies have suggested heritability of GD/gender incongruence (32, 33). In particular, a study by Heylens *et al.* (33) demonstrated a 39.1% concordance rate for gender identity disorder (based on the DSM-IV criteria) in 23 monozygotic twin pairs but no concordance in 21 same-sex dizygotic or seven opposite-sex twin pairs. Although numerous investigators have sought to identify

specific genes associated with GD/gender incongruence, such studies have been inconsistent and without strong statistical significance (34–38).

Studies focusing on brain structure suggest that the brain phenotypes of people with GD/gender incongruence differ in various ways from control males and females, but that there is not a complete sex reversal in brain structures (39).

In summary, although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development.

Natural History of Children With
GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called “desisters”). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood (41, 42). With the newer, stricter criteria of the DSM-5 (Table 2), persistence rates may well be different in future studies.

1.0 Evaluation of Youth and Adults

Gender-affirming treatment is a multidisciplinary effort. After evaluation, education, and diagnosis, treatment may include mental health care, hormone therapy, and/or surgical therapy. Together with an MHP, hormone-prescribing clinicians should examine the psychosocial impact of the potential changes on people’s lives, including mental health, friends, family, jobs, and their role in society. Transgender individuals should be encouraged to experience living in the new gender role and assess whether

this improves their quality of life. Although the focus of this guideline is gender-affirming hormone therapy, collaboration with appropriate professionals responsible for each aspect of treatment maximizes a successful outcome.

Diagnostic assessment and mental health care

GD/gender incongruence may be accompanied with psychological or psychiatric problems (43–51). It is therefore necessary that clinicians who prescribe hormones and are involved in diagnosis and psychosocial assessment meet the following criteria: (1) are competent in using the DSM and/or the ICD for diagnostic purposes, (2) are able to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (e.g., body dysmorphic disorder), (3) are trained in diagnosing psychiatric conditions, (4) undertake or refer for appropriate treatment, (5) are able to do a psychosocial assessment of the patient’s understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) regularly attend relevant professional meetings.

Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, an MHP who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex.

During assessment, the clinician obtains information from the individual seeking gender-affirming treatment. In the case

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

- A. A marked incongruence between one’s experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following:

1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)

2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated 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 different from one’s designated gender)

5. A strong desire to be treated as the other gender (or some alternative gender different from one’s designated gender)

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s designated gender)
- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

1. The condition exists with a disorder of sex development.

2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

Reference: American Psychiatric Association (14).

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of adolescents, the clinician also obtains information from the parents or guardians regarding various aspects of the child’s general and psychosexual development and current functioning. On the basis of this information, the clinician:

- decides whether the individual fulfills criteria for treatment (see Tables 2 and 3) for GD/gender incongruence (DSM-5) or transsexualism (DSM-5 and/or ICD-10);
- informs the individual about the possibilities and limitations of various kinds of treatment (hormonal/surgical and nonhormonal), and if medical treatment is desired, provides correct information to prevent unrealistically high expectations;
- assesses whether medical interventions may result in unfavorable psychological and social outcomes.

In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues. Literature on postoperative regret suggests that besides poor quality of surgery, severe psychiatric comorbidity and lack of support may interfere with positive outcomes (52–56).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family’s ability to endure stress, give support, and deal with the complexities of the adolescent’s situation should be part of the diagnostic phase (58).

Social transitioning

A change in gender expression and role (which may involve living part time or full time in another gender role that is consistent with one’s gender identity) may test the person’s resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports. It assists both the individual and the clinician in their judgments about how to proceed (16). During social transitioning, the person’s feelings about the social transformation (including coping with the responses of others) is a major focus of the counseling. The optimal timing for social transitioning may differ between individuals. Sometimes people wait until they

start gender-affirming hormone treatment to make social transitioning easier, but individuals increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment.

Criteria

Adolescents and adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding (16). Criteria for gender-affirming hormone therapy for adults are in Table 4, and criteria for gender-affirming hormone therapy for adolescents are in Table 5. Follow-up studies in adults meeting these criteria indicate a high satisfaction rate with treatment (59). However, the quality of evidence is usually low. A few follow-up studies on adolescents who fulfilled these criteria also indicated good treatment results (60–63).

Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence

- 1.1. We advise that only trained MHPs who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person’s understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)
- 1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or ICD for diagnostic

Table 3. ICD-10 Criteria for Transsexualism

Transsexualism (F64.0) has three criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
2. The transsexual identity has been present persistently for at least 2 y.
3. The disorder is not a symptom of another mental disorder or a genetic, DSD, or chromosomal abnormality.

Table 4. Criteria for Gender-Affirming Hormone Therapy for Adults

1. Persistent, well-documented gender dysphoria/gender incongruence
2. The capacity to make a fully informed decision and to consent for treatment
3. The age of majority in a given country (if younger, follow the criteria for adolescents)
4. Mental health concerns, if present, must be reasonably well controlled

Reproduced from World Professional Association for Transgender Health (16).

purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

Evidence

Individuals with gender identity issues may have psychological or psychiatric problems (43–48, 50, 51, 64, 65). It is therefore necessary that clinicians making the diagnosis are able to make a distinction between GD/gender incongruence and conditions that have similar features. Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate) (66), or certain forms of eunuchism (in which a person is preoccupied with or engages in castration and/or penectomy for

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

1. A qualified MHP has confirmed that:
 - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
 - gender dysphoria worsened with the onset of puberty,
 - any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
 - the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment,
2. And the adolescent:
 - has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
 - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment
 - agrees with the indication for GnRH agonist treatment,
 - has confirmed that puberty has started in the adolescent (Tanner stage $\geq$ G2/B2),
 - has confirmed that there are no medical contraindications to GnRH agonist treatment.

Adolescents are eligible for subsequent sex hormone treatment if:

1. A qualified MHP has confirmed:
 - the persistence of gender dysphoria,
 - any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
 - the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
2. And the adolescent:
 - has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
 - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:
 - agrees with the indication for sex hormone treatment,
 - has confirmed that there are no medical contraindications to sex hormone treatment.

Reproduced from World Professional Association for Transgender Health (16).

reasons that are not gender identity related) (11). Clinicians should also be able to diagnose psychiatric conditions accurately and ensure that these conditions are treated appropriately, particularly when the conditions may complicate treatment, affect the outcome of gender-affirming treatment, or be affected by hormone use.

Values and preferences

The task force placed a very high value on avoiding harm from hormone treatment in individuals who have conditions other than GD/gender incongruence and who may not benefit from the physical changes associated with this treatment and placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the good practice statement.

- 1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).
- 1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 ⊕⊕○○)

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that children should be discouraged from showing gender-variant behaviors or should be punished for exhibiting such behaviors. In individual cases, an early complete social transition may result in a more favorable outcome, but there are currently no criteria to identify the

GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty.

Values and preferences

The task force placed a high value on avoiding harm with gender-affirming hormone therapy in prepubertal children with GD/gender incongruence. This justifies the strong recommendation in the face of low-quality evidence.

- 1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 ⊕⊕⊕○)

Remarks

Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision (67, 68). Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormonal interventions, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment.

Treating early pubertal youth with GnRH analogs will temporarily impair spermatogenesis and oocyte maturation. Given that an increasing number of transgender youth want to preserve fertility potential, delaying or temporarily discontinuing GnRH analogs to promote gamete maturation is an option. This option is often not preferred, because mature sperm production is associated with later stages of puberty and with the significant development of secondary sex characteristics.

For those designated male at birth with GD/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient for the cryopreservation of sperm. However, prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression. This can be accomplished by spontaneous gonadotropin recovery after

cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production, as stated above. Note that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In males treated for precocious puberty, spermarche was reported 0.7 to 3 years after cessation of GnRH analogs (69). In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6 to 12 months of gonadotropin treatment. However, sperm numbers when partners of these patients conceive are far below the “normal range” (70, 71).

In girls, no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation (72, 73). Clinicians should inform adolescents that no data are available regarding either time to spontaneous ovulation after cessation of GnRH analogs or the response to ovulation induction following prolonged gonadotropin suppression.

In males with GD/gender incongruence, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. *In vitro* spermatogenesis is currently under investigation. Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In females with GD/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain. There have been reports of an increased incidence of polycystic ovaries in transgender males, both prior to and as a result of androgen treatment (74–77), although these reports were not confirmed by others (78). Pregnancy has been reported in transgender males who have had prolonged androgen treatment and have discontinued testosterone but have not had genital surgery (79, 80). A reproductive endocrine gynecologist can counsel patients before gender-affirming hormone treatment or surgery regarding potential fertility options (81). Techniques for cryopreservation of oocytes, embryos, and ovarian tissue continue to improve, and oocyte maturation of immature tissue is being studied (82).

2.0 Treatment of Adolescents

During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with GD/gender incongruence. In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with GD/gender incongruence, the pubertal physical changes are unbearable. As early medical intervention may prevent

psychological harm, various clinics have decided to start treating young adolescents with GD/gender incongruence with puberty-suppressing medication (a GnRH analog). As compared with starting gender-affirming treatment long after the first phases of puberty, a benefit of pubertal suppression at early puberty may be a better psychological and physical outcome.

In girls, the first physical sign of puberty is the budding of the breasts followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, and menarche occurs ~2 years later. In boys, the first physical change is testicular growth. A testicular volume ≥ 4 mL is seen as consistent with the initiation of physical puberty. At the beginning of puberty, estradiol and testosterone levels are still low and are best measured in the early morning with an ultrasensitive assay. From a testicular volume of 10 mL, daytime testosterone levels increase, leading to virilization (83). Note that pubic hair and/or axillary hair/odor may not reflect the onset of gonadarche; instead, it may reflect adrenarche alone.

- 2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment (Table 5), and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 $\oplus\oplus\oplus\oplus$)
- 2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2). (2 $\oplus\oplus\oplus\oplus$)

Evidence

Pubertal suppression can expand the diagnostic phase by a long period, giving the subject more time to explore options and to live in the experienced gender before making a decision to proceed with gender-affirming sex hormone treatments and/or surgery, some of which is irreversible (84, 85). Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains (86).

Another reason to start blocking pubertal hormones early in puberty is that the physical outcome is improved compared with initiating physical transition after puberty has been completed (60, 62). Looking like a man or woman when living as the opposite sex creates difficult

barriers with enormous life-long disadvantages. We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics. However, adolescents with GD/gender incongruence should experience the first changes of their endogenous spontaneous puberty, because their emotional reaction to these first physical changes has diagnostic value in establishing the persistence of GD/gender incongruence (85). Thus, Tanner stage 2 is the optimal time to start pubertal suppression. However, pubertal suppression treatment in early puberty will limit the growth of the penis and scrotum, which will have a potential effect on future surgical treatments (87).

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Values and preferences

These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.

Remarks

Table 6 lists the Tanner stages of breast and male genital development. Careful documentation of hallmarks of pubertal development will ensure precise timing when initiating pubertal suppression once puberty has started. Clinicians can use pubertal LH and sex steroid levels to confirm that puberty has progressed sufficiently before starting pubertal suppression (88). Reference

ranges for sex steroids by Tanner stage may vary depending on the assay used. Ultrasensitive sex steroid and gonadotropin assays will help clinicians document early pubertal changes.

Irreversible and, for GD/gender-incongruent adolescents, undesirable sex characteristics in female puberty are breasts, female body habitus, and, in some cases, relative short stature. In male puberty, they are a prominent Adam’s apple; low voice; male bone configuration, such as a large jaw, big feet and hands, and tall stature; and male hair pattern on the face and extremities.

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 ⊕⊕○○)

Evidence

Clinicians can suppress pubertal development and gonadal function most effectively via gonadotropin suppression using GnRH analogs. GnRH analogs are long-acting agonists that suppress gonadotropins by GnRH receptor desensitization after an initial increase of gonadotropins during ~10 days after the first and (to a lesser degree) the second injection (89). Antagonists immediately suppress pituitary gonadotropin secretion (90, 91). Long-acting GnRH analogs are the currently preferred treatment option. Clinicians may consider long-acting GnRH antagonists when evidence on their safety and efficacy in adolescents becomes available.

During GnRH analog treatment, slight development of secondary sex characteristics may regress, and in a later phase of pubertal development, it will stop. In girls, breast tissue will become atrophic, and menses will stop. In boys, virilization will stop, and testicular volume may decrease (92).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploration of his/her transition wish, the individual no longer desires transition, they can discontinue pubertal suppression. In subjects with

Table 6. Tanner Stages of Breast Development and Male External Genitalia

The description of Tanner stages for breast development:

- 1. Prepubertal
- 2. Breast and papilla elevated as small mound; areolar diameter increased
- 3. Breast and areola enlarged, no contour separation
- 4. Areola and papilla form secondary mound
- 5. Mature; nipple projects, areola part of general breast contour

For penis and testes:

- 1. Prepubertal, testicular volume <4 mL
- 2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 mL
- 3. Penis longer, testes larger (8–12 mL)
- 4. Penis and glans larger, including increase in breadth; testes larger (12–15 mL), scrotum dark
- 5. Penis adult size; testicular volume > 15 ml

Adapted from Lawrence (56).

precocious puberty, spontaneous pubertal development has been shown to resume after patients discontinue taking GnRH analogs (93).

Recommendations 2.1 to 2.3 are supported by a prospective follow-up study from The Netherlands. This report assessed mental health outcomes in 55 transgender adolescents/young adults (22 transgender females and 33 transgender males) at three time points: (1) before the start of GnRH agonist (average age of 14.8 years at start of treatment), (2) at initiation of gender-affirming hormones (average age of 16.7 years at start of treatment), and (3) 1 year after “gender-reassignment surgery” (average age of 20.7 years) (63). Despite a decrease in depression and an improvement in general mental health functioning, GD/gender incongruence persisted through pubertal suppression, as previously reported (86). However, following sex hormone treatment and gender-reassignment surgery, GD/gender incongruence was resolved and psychological functioning steadily improved (63). Furthermore, well-being was similar to or better than that reported by age-matched young adults from the general population, and none of the study participants regretted treatment. This study represents the first long-term follow-up of individuals managed according to currently existing clinical practice guidelines for transgender youth, and it underscores the benefit of the multidisciplinary approach pioneered in The Netherlands; however, further studies are needed.

Side effects

The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development. Few data are available on the effect of GnRH analogs on BMD in adolescents with GD/gender incongruence. Initial data in GD/gender-incongruent subjects demonstrated no change of absolute areal BMD during 2 years of GnRH analog therapy but a decrease in BMD z scores (85). A recent study also suggested suboptimal bone mineral accrual during GnRH analog treatment. The study reported a decrease in areal BMD z scores and of bone mineral apparent density z scores (which takes the size of the bone into account) in 19 transgender males treated with GnRH analogs from a mean age of 15.0 years (standard deviation = 2.0 years) for a median duration of 1.5 years (0.3 to 5.2 years) and in 15 transgender females treated from 14.9 (± 1.9) years for 1.3 years (0.5 to 3.8 years), although not all changes were statistically significant (94). There was incomplete catch-up at age 22 years after sex hormone treatment from age 16.6 (± 1.4)

years for a median duration of 5.8 years (3.0 to 8.0 years) in transgender females and from age 16.4 (± 2.3) years for 5.4 years (2.8 to 7.8 years) in transgender males. Little is known about more prolonged use of GnRH analogs. Researchers reported normal BMD z scores at age 35 years in one individual who used GnRH analogs from age 13.7 years until age 18.6 years before initiating sex hormone treatment (65).

Additional data are available from individuals with late puberty or GnRH analog treatment of other indications. Some studies reported that men with constitutionally delayed puberty have decreased BMD in adulthood (95). However, other studies reported that these men have normal BMD (96, 97). Treating adults with GnRH analogs results in a decrease of BMD (98). In children with central precocious puberty, treatment with GnRH analogs has been found to result in a decrease of BMD during treatment by some (99) but not others (100). Studies have reported normal BMD after discontinuing therapy (69, 72, 73, 101, 102). In adolescents treated with growth hormone who are small for gestational age and have normal pubertal timing, 2-year GnRH analog treatments did not adversely affect BMD (103). Calcium supplementation may be beneficial in optimizing bone health in GnRH analog-treated individuals (104). There are no studies of vitamin D supplementation in this context, but clinicians should offer supplements to vitamin D-deficient adolescents. Physical activity, especially during growth, is important for bone mass in healthy individuals (103) and is therefore likely to be beneficial for bone health in GnRH analog-treated subjects.

GnRH analogs did not induce a change in body mass index standard deviation score in GD/gender-incongruent adolescents (94) but caused an increase in fat mass and decrease in lean body mass percentage (92). Studies in girls treated for precocious puberty also reported a stable body mass index standard deviation score during treatment (72) and body mass index and body composition comparable to controls after treatment (73).

Arterial hypertension has been reported as an adverse effect in a few girls treated with GnRH analogs for precocious/early puberty (105, 106). Blood pressure monitoring before and during treatment is recommended.

Individuals may also experience hot flashes, fatigue, and mood alterations as a consequence of pubertal suppression. There is no consensus on treatment of these side effects in this context.

It is recommended that any use of pubertal blockers (and subsequent use of sex hormones, as detailed below) include a discussion about implications for fertility (see recommendation 1.3). Transgender adolescents may

want to preserve fertility, which may be otherwise compromised if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones.

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function (107), but animal data suggest there may be an effect of GnRH analogs on cognitive function (108).

Values and preferences

Our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved (as compared with the alternatives) and a relatively lower value on limiting the cost of therapy. Of the available alternatives, depot and oral progestin preparations are effective. Experience with this treatment dates back prior to the emergence of GnRH analogs for treating precocious puberty in papers from the 1960s and early 1970s (109–112). These compounds are usually safe, but some side effects have been reported (113–115). Only two recent studies involved transgender youth (116, 117). One of these studies described the use of oral lynestrenol monotherapy followed by the addition of testosterone treatment in transgender boys who were at Tanner stage B4 or further at the start of treatment (117). They found lynestrenol safe, but gonadotropins were not fully suppressed. The study reported metrorrhagia in approximately half of the individuals, mainly in the first 6 months. Acne, headache, hot flashes, and fatigue were other frequent side effects. Another progestin that has been studied in the United States is medroxyprogesterone. This agent is not as effective as GnRH analogs in lowering endogenous sex hormones either and may be associated with other side effects (116). Progestin preparations may be an acceptable treatment for persons without access to GnRH analogs or with a needle phobia. If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see adult section).

Remarks

Measurements of gonadotropin and sex steroid levels give precise information about gonadal axis suppression, although there is insufficient evidence for any specific short-term monitoring scheme in children treated with GnRH analogs (88). If the gonadal axis is not completely suppressed—as evidenced by (for example) menses, erections, or progressive hair growth—the interval of GnRH analog treatment can be shortened or the dose increased. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone mineral accretion. Table 7 illustrates a suggested clinical protocol.

Anthropometric measurements and X-rays of the left hand to monitor bone age are informative for evaluating growth. To assess BMD, clinicians can perform dual-energy X-ray absorptiometry scans.

- 2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule (see Table 8) after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years (Table 5). (1 ⊕⊕○○)
- 2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 ⊕○○○)
- 2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment (Table 9). (2 ⊕⊕○○)

Table 7. Baseline and Follow-Up Protocol During Suppression of Puberty

Every 3–6 mo
Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
Laboratory: LH, FSH, E2/T, 25OH vitamin D
Every 1–2 y
Bone density using DXA
Bone age on X-ray of the left hand (if clinically indicated)

Adapted from Hembree *et al.* (118).
Abbreviations: DXA, dual-energy X-ray absorptiometry; E2, estradiol; FSH, follicle stimulating hormone; LH, luteinizing hormone; T, testosterone;

Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β-estradiol, increasing the dose every 6 mo: 5 μg/kg/d 10 μg/kg/d 15 μg/kg/d 20 μg/kg/d Adult dose = 2–6 mg/d <i>In postpubertal transgender female adolescents, the dose of 17β-estradiol can be increased more rapidly:</i> 1 mg/d for 6 mo 2 mg/d
Induction of female puberty with transdermal 17β-estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d): 6.25–12.5 μg/24 h (cut 25-μg patch into quarters, then halves) 25 μg/24 h 37.5 μg/24 h Adult dose = 50–200 μg/24 h <i>For alternatives once at adult dose, see Table 11.</i> <i>Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).</i>
Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC): 25 mg/m ² /2 wk (or alternatively, half this dose weekly, or double the dose every 4 wk) 50 mg/m ² /2 wk 75 mg/m ² /2 wk 100 mg/m ² /2 wk Adult dose = 100–200 mg every 2 wk <i>In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:</i> 75 mg/2 wk for 6 mo 125 mg/2 wk <i>For alternatives once at adult dose, see Table 11.</i> <i>Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).</i>

Adapted from Hembree et al. (118).
Abbreviations: IM, intramuscularly; SC, subcutaneously.

Evidence

Adolescents develop competence in decision making at their own pace. Ideally, the supervising medical professionals should individually assess this competence, although no objective tools to make such an assessment are currently available.

Many adolescents have achieved a reasonable level of competence by age 15 to 16 years (119), and in many countries 16-year-olds are legally competent with regard to medical decision making (120). However, others believe that although some capacities are generally achieved before age 16 years, other abilities (such as good risk

assessment) do not develop until well after 18 years (121). They suggest that health care procedures should be divided along a matrix of relative risk, so that younger adolescents can be allowed to decide about low-risk procedures, such as most diagnostic tests and common therapies, but not about high-risk procedures, such as most surgical procedures (121).

Currently available data from transgender adolescents support treatment with sex hormones starting at age 16 years (63, 122). However, some patients may incur potential risks by waiting until age 16 years. These include the potential risk to bone health if puberty is suppressed

Table 9. Baseline and Follow-up Protocol During Induction of Puberty

Every 3–6 mo •Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo •In transgender males: hemoglobin/hematocrit, lipids, testosterone, 25OH vitamin D •In transgender females: prolactin, estradiol, 25OH vitamin D
Every 1–2 y •BMD using DXA •Bone age on X-ray of the left hand (if clinically indicated) <i>BMD should be monitored into adulthood (until the age of 25–30 y or until peak bone mass has been reached).</i> <i>For recommendations on monitoring once pubertal induction has been completed, see Tables 14 and 15.</i>

Adapted from Hembree et al. (118).
Abbreviation: DXA, dual-energy X-ray absorptiometry.

for 6 to 7 years before initiating sex hormones (*e.g.*, if someone reached Tanner stage 2 at age 9-10 years old). Additionally, there may be concerns about inappropriate height and potential harm to mental health (emotional and social isolation) if initiation of secondary sex characteristics must wait until the person has reached 16 years of age. However, only minimal data supporting earlier use of gender-affirming hormones in transgender adolescents currently exist (63). Clearly, long-term studies are needed to determine the optimal age of sex hormone treatment in GD/gender-incongruent adolescents.

The MHP who has followed the adolescent during GnRH analog treatment plays an essential role in assessing whether the adolescent is eligible to start sex hormone therapy and capable of consenting to this treatment (Table 5). Support of the family/environment is essential. Prior to the start of sex hormones, clinicians should discuss the implications for fertility (see recommendation 1.5). Throughout pubertal induction, an MHP and a pediatric endocrinologist (or other clinician competent in the evaluation and induction of pubertal development) should monitor the adolescent. In addition to monitoring therapy, it is also important to pay attention to general adolescent health issues, including healthy life style choices, such as not smoking, contraception, and appropriate vaccinations (*e.g.*, human papillomavirus).

For the induction of puberty, clinicians can use a similar dose scheme for hypogonadal adolescents with GD/gender incongruence as they use in other individuals with hypogonadism, carefully monitoring for desired and undesired effects (Table 8). In transgender female adolescents, transdermal 17 β -estradiol may be an alternative for oral 17 β -estradiol. It is increasingly used for pubertal induction in hypogonadal females. However, the absence of low-dose estrogen patches may be a problem. As a result, individuals may need to cut patches to size themselves to achieve appropriate dosing (123). In transgender male adolescents, clinicians can give testosterone injections intramuscularly or subcutaneously (124, 125).

When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion. Gonadotropin secretion and endogenous production of testosterone may resume and interfere with the effectiveness of estrogen treatment, in transgender female adolescents (126, 127). Therefore, continuation of GnRH analog treatment is advised until gonadectomy. Given that GD/gender-incongruent adolescents may opt not to have gonadectomy, long-term studies are necessary to examine the potential risks of prolonged GnRH analog treatment. Alternatively, in transgender male adolescents, GnRH analog treatment can be discontinued once an

adult dose of testosterone has been reached and the individual is well virilized. If uterine bleeding occurs, a progestin can be added. However, the combined use of a GnRH analog (for ovarian suppression) and testosterone may enable phenotypic transition with a lower dose of testosterone in comparison with testosterone alone. If there is a wish or need to discontinue GnRH analog treatment in transgender female adolescents, they may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see section 3.0 "Hormonal Therapy for Transgender Adults").

Values and preferences

The recommendation to initiate pubertal induction only when the individual has sufficient mental capacity (roughly age 16 years) to give informed consent for this partly irreversible treatment places a higher value on the ability of the adolescent to fully understand and oversee the partially irreversible consequences of sex hormone treatment and to give informed consent. It places a lower value on the possible negative effects of delayed puberty. We may not currently have the means to weigh adequately the potential benefits of waiting until around age 16 years to initiate sex hormones vs the potential risks/harm to BMD and the sense of social isolation from having the timing of puberty be so out of sync with peers (128).

Remarks

Before starting sex hormone treatment, effects on fertility and options for fertility preservation should be discussed. Adult height may be a concern in transgender adolescents. In a transgender female adolescent, clinicians may consider higher doses of estrogen or a more rapid tempo of dose escalation during pubertal induction. There are no established treatments yet to augment adult height in a transgender male adolescent with open epiphyses during pubertal induction. It is not uncommon for transgender adolescents to present for clinical services after having completed or nearly completed puberty. In such cases, induction of puberty with sex hormones can be done more rapidly (see Table 8). Additionally, an adult dose of testosterone in transgender male adolescents may suffice to suppress the gonadal axis without the need to use a separate agent. At the appropriate time, the multidisciplinary team should adequately prepare the adolescent for transition to adult care.

3.0 Hormonal Therapy for Transgender Adults

The two major goals of hormonal therapy are (1) to reduce endogenous sex hormone levels, and thus reduce

the secondary sex characteristics of the individual’s designated gender, and (2) to replace endogenous sex hormone levels consistent with the individual’s gender identity by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with the sex hormones of the chosen gender is codetermined in collaboration with both the person pursuing transition and the health care providers. The treatment team should include a medical provider knowledgeable in transgender hormone therapy, an MHP knowledgeable in GD/gender incongruence and the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being (129, 130).

- 3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 ⊕⊕⊕⊕)
- 3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment (Table 10). (1 ⊕⊕⊕⊕)
- 3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 ⊕⊕⊕⊕)

Evidence

It is the responsibility of the treating clinician to confirm that the person fulfills criteria for treatment. The treating clinician should become familiar with the terms and criteria presented in Tables 1–5 and take a thorough history from the patient in collaboration with the other members of the treatment team. The treating clinician must ensure that the desire for transition is appropriate; the consequences, risks, and benefits of treatment are well understood; and the desire for transition persists. They also need to discuss fertility preservation options (see recommendation 1.3) (67, 68).

Transgender males

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in transgender males (Appendix A) (113, 114, 131–134). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (135). Clinicians can use either parenteral or transdermal preparations to achieve testosterone values in the normal male range (this is dependent on the specific assay, but is typically 320 to 1000 ng/dL) (Table 11) (136). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions (see section 4.0 “Adverse Outcome Prevention and Long-Term Care”) and should be avoided.

Similar to androgen therapy in hypogonadal men, testosterone treatment in transgender males results in increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire (137).

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen
Very high risk of adverse outcomes:
•Thromboembolic disease
Moderate risk of adverse outcomes:
•Macroprolactinoma
•Breast cancer
•Coronary artery disease
•Cerebrovascular disease
•Cholelithiasis
•Hypertriglyceridemia
Transgender male: testosterone
Very high risk of adverse outcomes:
•Erythrocytosis (hematocrit > 50%)
Moderate risk of adverse outcomes:
•Severe liver dysfunction (transaminases > threefold upper limit of normal)
•Coronary artery disease
•Cerebrovascular disease
•Hypertension
•Breast or uterine cancer

Table 11. Hormone Regimens in Transgender Persons

Transgender females ^a	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch	0.025–0.2 mg/d
(New patch placed every 3–5 d)	
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate ^b	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate ^c	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6% ^d	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.
^aEstrogens used with or without antiandrogens or GnRH agonist.
^bNot available in the United States.
^cOne thousand milligrams initially followed by an injection at 6 wk then at 12-wk intervals.
^dAvoid cutaneous transfer to other individuals.

In transgender males, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, clinicians may consider the addition of a progestational agent or endometrial ablation (138). Clinicians may also administer GnRH analogs or depot medroxyprogesterone to stop menses prior to testosterone treatment.

Transgender females

The hormone regimen for transgender females is more complex than the transgender male regimen (Appendix B). Treatment with physiologic doses of estrogen alone is insufficient to suppress testosterone levels into the normal range for females (139). Most published clinical studies report the need for adjunctive therapy to achieve testosterone levels in the female range (21, 113, 114, 132–134, 139, 140). Multiple adjunctive medications are available, such as progestins with antiandrogen activity and GnRH agonists (141). Spironolactone works by directly blocking androgens during their interaction with the androgen

receptor (114, 133, 142). It may also have estrogenic activity (143). Cyproterone acetate, a progestational compound with antiandrogenic properties (113, 132, 144), is widely used in Europe. 5 α -Reductase inhibitors do not reduce testosterone levels and have adverse effects (145). Dittrich *et al.* (141) reported that monthly doses of the GnRH agonist goserelin acetate in combination with estrogen were effective in reducing testosterone levels with a low incidence of adverse reactions in 60 transgender females. Leuprolide and transdermal estrogen were as effective as cyproterone and transdermal estrogen in a comparative retrospective study (146). Patients can take estrogen as oral conjugated estrogens, oral 17 β -estradiol, or transdermal 17 β -estradiol. Among estrogen options, the increased risk of thromboembolic events associated with estrogens in general seems most concerning with ethinyl estradiol specifically (134, 140, 141), which is why we specifically suggest that it not be used in any transgender treatment plan. Data distinguishing among other estrogen options are less well established although there is some thought that oral routes of administration are more thrombogenic due to the “first pass effect” than are transdermal and parenteral routes, and that the risk of thromboembolic events is dose-dependent. Injectable estrogen and sublingual

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estrogen may benefit from avoiding the first pass effect, but they can result in more rapid peaks with greater overall periodicity and thus are more difficult to monitor (147, 148). However, there are no data demonstrating that increased periodicity is harmful otherwise.

Clinicians can use serum estradiol levels to monitor oral, transdermal, and intramuscular estradiol. Blood tests cannot monitor conjugated estrogens or synthetic estrogen use. Clinicians should measure serum estradiol and serum testosterone and maintain them at the level for premenopausal females (100 to 200 pg/mL and <50 ng/dL, respectively). The transdermal preparations and injectable estradiol cypionate or valerate preparations may confer an advantage in older transgender females who may be at higher risk for thromboembolic disease (149).

Values

Our recommendation to maintain levels of gender-affirming hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharmacologic doses. Those patients receiving endocrine treatment who have relative contraindications to hormones should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

Remarks

Clinicians should inform all endocrine-treated individuals of all risks and benefits of gender-affirming hormones prior to initiating therapy. Clinicians should strongly encourage tobacco use cessation in transgender females to avoid increased risk of VTE and cardiovascular complications. We strongly discourage the unsupervised use of hormone therapy (150).

Not all individuals with GD/gender incongruence seek treatment as described (e.g., male-to-eunuchs and individuals seeking partial transition). Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach including mental health. No evidence-based protocols are available for these groups (151). We need prospective studies to better understand treatment options for these persons.

- 3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 ⊕○○○)

Evidence

Transgender males

Physical changes that are expected to occur during the first 1 to 6 months of testosterone therapy include

cessation of menses, increased sexual desire, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice (152, 153), clitoromegaly, and male pattern hair loss (in some cases) (114, 144, 154, 155) (Table 12).

Transgender females

Physical changes that may occur in transgender females in the first 3 to 12 months of estrogen and anti-androgen therapy include decreased sexual desire, decreased spontaneous erections, decreased facial and body hair (usually mild), decreased oiliness of skin, increased breast tissue growth, and redistribution of fat mass (114, 139, 149, 154, 155, 161) (Table 13). Breast development is generally maximal at 2 years after initiating hormones (114, 139, 149, 155). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in transgender females has been studied (150), precise information about other changes induced by sex hormones is lacking (141). There is a great deal of variability among individuals, as evidenced during pubertal development. We all know that a major concern for transgender females is breast development. If we work with estrogens, the result will be often not what the transgender female expects.

Alternatively, there are transgender females who report an anecdotal improved breast development, mood, or sexual desire with the use of progestogens. However, there have been no well-designed studies of the role of progestogens in feminizing hormone regimens, so the question is still open.

Our knowledge concerning the natural history and effects of different cross-sex hormone therapies on breast

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	— ^a
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	— ^b
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Assche-man *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

^aPrevention and treatment as recommended for biological men.

^bMenorrhagia requires diagnosis and treatment by a gynecologist.

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Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y ^a
Scalp hair	Variable	— ^b
Voice changes	None	— ^c

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

^aComplete removal of male sexual hair requires electrolysis or laser treatment or both.

^bFamilial scalp hair loss may occur if estrogens are stopped.

^cTreatment by speech pathologists for voice training is most effective.

development in transgender females is extremely sparse and based on the low quality of evidence. Current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect. This prevents us from drawing any firm conclusion at this moment and demonstrates the need for further research to clarify these important clinical questions (162).

Values and preferences

Transgender persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.*, breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone-induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse Outcome Prevention and Long-Term Care

Hormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons. The risks arise from and are worsened by inadvertent or intentional use of supraphysiologic doses of sex hormones, as well as use of inadequate doses of sex hormones to maintain normal physiology (131, 139).

- 4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every

3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 ⊕⊕○○)

Evidence

Pretreatment screening and appropriate regular medical monitoring are recommended for both transgender males and females during the endocrine transition and periodically thereafter (26, 155). Clinicians should monitor weight and blood pressure, conduct physical exams, and assess routine health questions, such as tobacco use, symptoms of depression, and risk of adverse events such as deep vein thrombosis/pulmonary embolism and other adverse effects of sex steroids.

Transgender males

Table 14 contains a standard monitoring plan for transgender males on testosterone therapy (154, 159). Key issues include maintaining testosterone levels in the physiologic normal male range and avoiding adverse events resulting from excess testosterone therapy, particularly erythrocytosis, sleep apnea, hypertension, excessive weight gain, salt retention, lipid changes, and excessive or cystic acne (135).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with parenteral or transdermal testosterone use (163, 164). Past concerns regarding liver toxicity with testosterone have been alleviated with subsequent reports that indicate the risk of serious liver disease is minimal (144, 165, 166).

Transgender females

Table 15 contains a standard monitoring plan for transgender females on estrogens, gonadotropin suppression, or antiandrogens (160). Key issues include avoiding supraphysiologic doses or blood levels of estrogen that may lead to increased risk for thromboembolic disease, liver dysfunction, and hypertension. Clinicians should monitor serum estradiol levels using laboratories participating in external quality control, as measurements of estradiol in blood can be very challenging (167).

VTE may be a serious complication. A study reported a 20-fold increase in venous thromboembolic disease in a large cohort of Dutch transgender subjects (161). This increase may have been associated with the use of the synthetic estrogen, ethinyl estradiol (149). The incidence decreased when clinicians stopped administering ethinyl estradiol (161). Thus, the use of synthetic estrogens and conjugated estrogens is undesirable because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease. In a German gender clinic, deep vein thrombosis occurred in 1 of 60 of transgender females treated with a GnRH analog and oral

Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:^a
 - a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
 - b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
 - c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

^aAdapted from Lapauw *et al.* (154) and Ott *et al.* (159).

estradiol (141). The patient who developed a deep vein thrombosis was found to have a homozygous C677 T mutation in the methylenetetrahydrofolate reductase gene. In an Austrian gender clinic, administering gender-affirming hormones to 162 transgender females and 89 transgender males was not associated with VTE, despite an 8.0% and 5.6% incidence of thrombophilia (159). A more recent multinational study reported only 10 cases of VTE from a cohort of 1073 subjects (168). Thrombophilia screening of transgender persons initiating hormone treatment should be restricted to those with a personal or family history of VTE (159). Monitoring D-dimer levels during treatment is not recommended (169).

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕○○)

Evidence

Estrogen therapy can increase the growth of pituitary lactotroph cells. There have been several reports of prolactinomas occurring after long-term, high-dose

estrogen therapy (170–173). Up to 20% of transgender females treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (156). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy or discontinuation of cyproterone acetate (157, 174, 175).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Clinicians should measure prolactin levels at baseline and then at least annually during the transition period and every 2 years thereafter. Given that only a few case studies reported prolactinomas, and prolactinomas were not reported in large cohorts of estrogen-treated persons, the risk is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in transgender females, clinicians may perform radiologic examinations of the pituitary in those patients whose prolactin levels persistently increase despite stable or reduced estrogen levels. Some transgender individuals receive psychotropic medications that can increase prolactin levels (174).

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
 - a. Serum testosterone levels should be <50 ng/dL.
 - b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

- 4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 ⊕⊕○○)

Evidence

Transgender males

Administering testosterone to transgender males results in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride and low-density lipoprotein cholesterol values (176–179). Studies of the effect of testosterone on insulin sensitivity have mixed results (178, 180). A randomized, open-label uncontrolled safety study of transgender males treated with testosterone undecanoate demonstrated no insulin resistance after 1 year (181, 182). Numerous studies have demonstrated the effects of sex hormone treatment on the cardiovascular system (160, 179, 183, 184). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (161). Likewise, a meta-analysis of 19 randomized trials in nontransgender males on testosterone replacement showed no increased incidence of cardiovascular events (185). A systematic review of the literature found that data were insufficient (due to very low-quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or VTE in transgender males (176). Future research is needed to ascertain the potential harm of hormonal therapies (176). Clinicians should manage cardiovascular risk factors as they emerge according to established guidelines (186).

Transgender females

A prospective study of transgender females found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (178). However, increased weight, blood pressure, and markers of insulin resistance attenuated these favorable lipid changes. In a meta-analysis, only serum triglycerides were higher at ≥24 months without changes in other parameters (187). The largest cohort of transgender females (mean age 41 years, followed for a mean of 10 years) showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (161).

Thus, there is limited evidence to determine whether estrogen is protective or detrimental on lipid and glucose metabolism in transgender females (176). With aging, there is usually an increase of body weight. Therefore, as with nontransgender individuals, clinicians should

monitor and manage glucose and lipid metabolism and blood pressure regularly according to established guidelines (186).

- 4.4. We recommend that clinicians obtain BMD measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 ⊕⊕○○)

Evidence

Transgender males

Baseline bone mineral measurements in transgender males are generally in the expected range for their pre-treatment gender (188). However, adequate dosing of testosterone is important to maintain bone mass in transgender males (189, 190). In one study (190), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels in the normal range may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol, both systemically and locally in the bone.

Transgender females

A baseline study of BMD reported T scores less than −2.5 in 16% of transgender females (191). In aging males, studies suggest that serum estradiol more positively correlates with BMD than does testosterone (192, 193) and is more important for peak bone mass (194). Estrogen preserves BMD in transgender females who continue on estrogen and antiandrogen therapies (188, 190, 191, 195, 196).

Fracture data in transgender males and females are not available. Transgender persons who have undergone gonadectomy may choose not to continue consistent sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss. There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (e.g., when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be

reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).

- 4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for those designated female at birth. (2 ⊕⊕○○)
- 4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 ⊕○○○)

Evidence

Studies have reported a few cases of breast cancer in transgender females (197–200). A Dutch study of 1800 transgender females followed for a mean of 15 years (range of 1–30 years) found one case of breast cancer. The Women's Health Initiative study reported that females taking conjugated equine estrogen without progesterone for 7 years did not have an increased risk of breast cancer as compared with females taking placebo (137).

In transgender males, a large retrospective study conducted at the U.S. Veterans Affairs medical health system identified seven breast cancers (194). The authors reported that this was not above the expected rate of breast cancers in cisgender females in this cohort. Furthermore, they did report one breast cancer that developed in a transgender male patient after mastectomy, supporting the fact that breast cancer can occur even after mastectomy. Indeed, there have been case reports of breast cancer developing in subareolar tissue in transgender males, which occurred after mastectomy (201, 202).

Women with primary hypogonadism (Turner syndrome) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (203, 204). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short term (<20 to 30 years). We need long-term studies to determine the actual risk, as well as the role of screening mammograms. Regular examinations and gynecologic advice should determine monitoring for breast cancer.

Prostate cancer is very rare before the age of 40, especially with androgen deprivation therapy (205). Childhood or pubertal castration results in regression of the prostate and adult castration reverses benign prostate hypertrophy (206). Although van Kesteren *et al.* (207) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostates of

transgender females, studies have reported cases of benign prostatic hyperplasia in transgender females treated with estrogens for 20 to 25 years (208, 209). Studies have also reported a few cases of prostate carcinoma in transgender females (210–214).

Transgender females may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for transgender females who transitioned after age 20 years to have annual screening digital rectal examinations after age 50 years and prostate-specific antigen tests consistent with U.S. Preventive Services Task Force Guidelines (215).

- 4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Evidence

Although aromatization of testosterone to estradiol in transgender males has been suggested as a risk factor for endometrial cancer (216), no cases have been reported. When transgender males undergo hysterectomy, the uterus is small and there is endometrial atrophy (217, 218). Studies have reported cases of ovarian cancer (219, 220). Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender-affirming surgery to prevent reproductive tract cancer (221).

Values

Given the discomfort that transgender males experience accessing gynecologic care, our recommendation for the medical necessity of total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecologic care required following transition. Additionally, in certain countries, the approval required to change the sex in a birth certificate for transgender males may be dependent on having a complete hysterectomy. Clinicians should help patients research nonmedical administrative criteria and

provide counseling. If individuals decide not to undergo hysterectomy, screening for cervical cancer is the same as all other females.

5.0 Surgery for Sex Reassignment and Gender Confirmation

For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not. Those that change fertility (previously called sex reassignment surgery) include genital surgery to remove the penis and gonads in the male and removal of the uterus and gonads in the female. The surgeries that effect fertility are often governed by the legal system of the state or country in which they are performed. Other gender-conforming surgeries that do not directly affect fertility are not so tightly governed.

Gender-affirming surgical techniques have improved markedly during the past 10 years. Reconstructive genital surgery that preserves neurologic sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (187). Additionally, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender-affirming treatment that includes hormones and surgery (130, 144) (Table 16).

Surgery that affects fertility is irreversible. The World Professional Association for Transgender Health Standards of Care (222) emphasizes that the “threshold of 18 should not be seen as an indication in itself for active intervention.” If the social transition has not been satisfactory, if the person is not satisfied with or is ambivalent about the effects of sex hormone treatment, or if the person is ambivalent about surgery then the individual should not be referred for surgery (223, 224).

Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina (225, 226). Surgeons often invert the skin of the penis to form the wall of the vagina, and several literatures reviews have

reported on outcomes (227). Sometimes there is inadequate tissue to form a full neovagina, so clinicians have revisited using intestine and found it to be successful (87, 228, 229). Some newer vaginoplasty techniques may involve autologous oral epithelial cells (230, 231).

The scrotum becomes the labia majora. Surgeons use reconstructive surgery to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Some surgeons are also creating a sensate pedicled-spot adding a G spot to the neovagina to increase sensation (232). Most recently, plastic surgeons have developed techniques to fashion labia minora. To further complete the feminization, uterine transplants have been proposed and even attempted (233).

Neovaginal prolapse, rectovaginal fistula, delayed healing, vaginal stenosis, and other complications do sometimes occur (234, 235). Clinicians should strongly remind the transgender person to use their dilators to maintain the depth and width of the vagina throughout the postoperative period. Genital sexual responsivity and other aspects of sexual function are usually preserved following genital gender-affirming surgery (236, 237).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. Voice therapy by a speech language pathologist is available to transform speech patterns to the affirmed gender (148). Spontaneous voice deepening occurs during testosterone treatment of transgender males (152, 238). No studies have compared the effectiveness of speech therapy, laryngeal surgery, or combined treatment.

Breast surgery is a good example of gender-confirming surgery that does not affect fertility. In all females, breast size exhibits a very broad spectrum. For transgender females to make the best informed decision, clinicians should delay breast augmentation surgery until the patient has completed at least 2 years of estrogen therapy, because the breasts continue to grow during that time (141, 155).

Another major procedure is the removal of facial and masculine-appearing body hair using either electrolysis or

Table 16. Criteria for Gender-Affirming Surgery, Which Affects Fertility

1. Persistent, well-documented gender dysphoria
2. Legal age of majority in the given country
3. Having continuously and responsibly used gender-affirming hormones for 12 mo (if there is no medical contraindication to receiving such therapy)
4. Successful continuous full-time living in the new gender role for 12 mo
5. If significant medical or mental health concerns are present, they must be well controlled
6. Demonstrable knowledge of all practical aspects of surgery (e.g., cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation)

laser treatments. Other feminizing surgeries, such as that to feminize the face, are now becoming more popular (239–241).

In transgender males, clinicians usually delay gender-affirming genital surgeries until after a few years of androgen therapy. Those surgeries that affect fertility in this group include oophorectomy, vaginectomy, and complete hysterectomy. Surgeons can safely perform them vaginally with laparoscopy. These are sometimes done in conjunction with the creation of a neopenis. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (242, 243). Radial forearm flap seems to be the most satisfactory procedure (228, 244). Other flaps also exist (245). Surgeons can make neopenile erections possible by reinnervation of the flap and subsequent contraction of the muscle, leading to stiffening of the neopenis (246, 247), but results are inconsistent (248). Surgeons can also stiffen the penis by imbedding some mechanical device (*e.g.*, a rod or some inflatable apparatus) (249, 250). Because of these limitations, the creation of a neopenis has often been less than satisfactory. Recently, penis transplants are being proposed (233).

In fact, most transgender males do not have any external genital surgery because of the lack of access, high cost, and significant potential complications. Some choose a metaoidioplasty that brings forward the clitoris, thereby allowing them to void in a standing position without wetting themselves (251, 252). Surgeons can create the scrotum from the labia majora with good cosmetic effect and can implant testicular prostheses (253).

The most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility. Breast size only partially regresses with androgen therapy (155). In adults, discussions about mastectomy usually take place after androgen therapy has started. Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual. There are now newer approaches to mastectomy with better outcomes (254, 255). These often involve chest contouring (256). Mastectomy is often necessary for living comfortably in the new gender (256).

- 5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically

necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕○○)

- 5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)
- 5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)
- 5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕○○○)
- 5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕○○)
- 5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕○○○)

Evidence

Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult. However, one systematic review including a large numbers of studies reported satisfactory cosmetic and functional results for vaginoplasty/neovagina construction (257). For transgender males, the outcomes are less certain. However, the problems are now better understood (258). Several postoperative studies report significant long-term psychological and psychiatric pathology (259–261). One study showed satisfaction with breasts, genitals, and femininity increased significantly and showed the importance of surgical treatment as a key therapeutic option for transgender females (262). Another analysis demonstrated that, despite the young average age at death following surgery and the relatively larger number of individuals with somatic morbidity, the study does not allow for determination of

causal relationships between, for example, specific types of hormonal or surgical treatment received and somatic morbidity and mortality (263). Reversal surgery in regretful male-to-female transsexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcomes. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

When a transgender individual decides to have gender-affirming surgery, both the hormone prescribing clinician and the MHP must certify that the patient satisfies criteria for gender-affirming surgery (Table 16).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or following surgery (176). For this reason, the surgeon and the hormone-prescribing clinician should collaborate in making a decision about the use of hormones before and following surgery. One study suggests that preoperative factors (such as compliance) are less important for patient satisfaction than are the physical postoperative results (56). However, other studies and clinical experience dictate that individuals who do not follow medical instructions and do not work with their physicians toward a common goal do not achieve treatment goals (264) and experience higher rates of postoperative infections and other complications (265, 266). It is also important that the person requesting surgery feels comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (223).

An endocrinologist or experienced medical provider should monitor transgender individuals after surgery. Those who undergo gonadectomy will require hormone replacement therapy, surveillance, or both to prevent adverse effects of chronic hormone deficiency.

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v.

Case No. 4:15-cv-54

GLOUCESTER COUNTY SCHOOL
BOARD,

Defendant.

GLOUCESTER COUNTY SCHOOL BOARD'S
RULE 26(a)(2) DISCLOSURE

NOW COMES the Defendant Gloucester County School Board ("School Board"), by counsel, and hereby discloses the following expert in accordance with Rule 26(a)(2) of the Federal Rules of Civil Procedure.

The School Board submits this disclosure without conceding that expert testimony is appropriate or needed with regard to the claims against the School Board, and without prejudice to or waiving the School Board's right to summary judgment and/or a judgment as a matter of law at the conclusion of plaintiff's evidence.

The following information is offered only as a summary of the respective expert's opinions and the grounds underlying those opinions. The School Board reserves the right to supplement, modify and/or change this expert disclosure as the expert continues to review this matter on behalf of the School Board and as additional discovery is conducted. The expert opinion is based on the expert's training, education and experience, as well as his review of the documents and other relevant materials noted in the reports. All opinions expressed will be offered to a reasonable degree of certainty in the witness' field of expertise unless stated

otherwise. The expert witness may render additional opinions or expound on the opinions listed in the reports at his depositions. The report and opinion testimony of the expert is incorporated in this Disclosure by reference.

Quentin L. Van Meter, M.D.
1800 Howell Mill Road NW
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The School Board reserves the right to call as a witness, Dr. Quentin L. Van Meter, an expert in the field of pediatric endocrinology. Dr. Van Meter's expert report and CV are attached to this Disclosure and incorporated by reference as if fully set forth herein. (Exhibit 1).

**GLOUCESTER COUNTY SCHOOL
BOARD**

By Counsel



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CERTIFICATE

I hereby certify that a true copy of the foregoing was emailed and mailed this 26th day of February, 2019 to:

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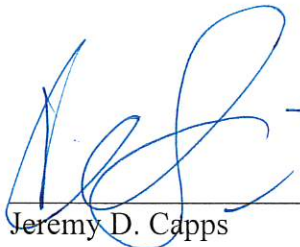
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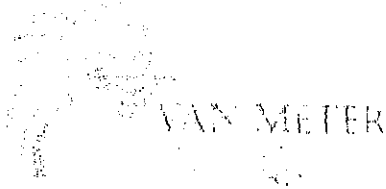
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26 February, 2019

1. I have been retained by counsel for the Gloucester County School Board as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this report. My professional background, experience, and publications are detailed in my curriculum vitae, which is attached as Exhibit A.
2. I received my B.A. in Science at the College of William and Mary, and my M.D. from the Medical College of Virginia, Virginia Commonwealth University.
3. I am currently a pediatric endocrinologist in private practice in Atlanta Georgia. I am the President of Van Meter Pediatric Endocrinology, P.C. I am on the clinical faculties of Emory University School of Medicine and Morehouse College of Medicine, in the role of adjunct Associate Professor of Pediatrics.
4. I am board certified in Pediatrics and Pediatric Endocrinology. I have been licensed to practice medicine in Georgia since 1991. I have been previously licensed to practice medicine in California, Louisiana, and Maryland.
5. I did my Pediatric Endocrine fellowship at Johns Hopkins Hospital from 1978-1980. The faculty present at that time had carried on the tradition of excellence established by Lawson Wilkins, M.D. Because of the reputation of the endocrine program as a center for exceptional care for children with disorders of sexual differentiation, I had well-above average exposure to such patients. As a Pediatric Fellow, I was also exposed to adults with Gender Identity Disorder, then called Trans-Sexuality, and received training from John Money, Ph.D., in his Psychohormonal Division.
6. I have maintained a continued interest in gender discordance since my fellowship years and have read extensively the literature in scientific peer-reviewed journals and have attended national and international pediatric endocrine conferences where this subject is presented and discussed. I am also familiar with the wide array of commentary on the subject.
7. My professional memberships include The Pediatric Endocrine Society, the Endocrine Society, the American Association of Clinical Endocrinologists where I held a position on the Pediatric Scientific Committee until it was disbanded one year ago, the American Diabetes Association, and I am a fellow of the American College of Pediatricians, currently serving on the Board of Directors as President. I am on the Advisory Board of Camp Kudzu, a non-profit organization which provides diabetes camp experience in Georgia.
8. My opinions expressed in this report are based upon my education, training, and experience in the subject matters discussed. The materials that I have relied upon are the same types of materials that

EXHIBIT

1

other experts in my field rely upon when forming opinions. Specific sources upon which I rely in this report are footnoted.

9. Over my career, I have served as an expert witness in medical malpractice cases for both plaintiff and defense. I have testified at Georgia State Legislative Committee hearings. In the past six years, I have testified by deposition in *Harlen Schneider v. J. Enrique Lujan, M.D. et al.*, in the circuit court of the first judicial circuit of Okaloosa County, FL, Civil Division, on 7 Feb 2014; and in the case of plaintiff Kimora Gilmer, represented by attorneys at the Birmingham, AL, firm of Pittman Dutton on 22 May 2014.

10. I provided an expert declaration in the case of *Carcano v McCorey* and *US vs North Carolina* on 12 August 2016. I testified in Springfield, Illinois as a plaintiff's expert witness in the case of *Cooley v. Paul* for the firm of Kanoski Bresney, 3 Nov 2017. I testified in court in Hamilton County Ohio in February 2018 in regard to Jessica Siefert, a transgender teen who had been removed from the custody of her biologic parents. I testified via skype in Alberta Province, Canada on 14 June 2018 in regard to the matter of parents suing the school systems there for withholding information about transgender-promoting programs in the public schools from the parents. My publications include a textbook chapter, case studies, and articles generated by clinical research studies. I serve on the speaker's bureau of major pharmaceutical companies.

11. I am being compensated at an hourly rate for actual time devoted, at the rate of \$350 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

Sexual Differentiation in the Fetus

12. From the moment of conception, a fetus is determined to be either a male (XY), female (XX), or in rare cases, to have a combination of sex-determining chromosomes, many of which are not compatible with life, and some of which are the cause of identifiable clinical syndromes. The presence of a Y chromosome in the developing fetus directs the developing gonadal tissue to develop as a testicle. The absence of a functional Y chromosome allows the gonadal tissue to develop as an ovary. Under the influence of the mother's placental hormones, the testicle will produce testosterone which directs the genital tissue to form a penis and a scrotum. Simultaneously, the testicle produces anti-Müllerian Hormone (AMH) which regresses development of the tissue that would otherwise develop into the uterus, fallopian tubes, and upper third of the vagina.

13. This combination of actions in early fetal development is responsible for what we subsequently see on fetal sonograms, and what we observe at birth as male or female genitalia. It is only when the genital structures are ambiguous in appearance that sex assignment is withheld until a thorough expert team evaluation has occurred.

14. For reasons most often occurring as random events, there are malfunctions of the normal differentiation. These aberrations of normal development are responsible for what we classify as Disorders of Sexual Differentiation (DSD) and they represent a very small fraction of the human population. The incidence of such circumstances occurs in 1:4500 to 1:5500 births¹

1 Lee PA et al, Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care, 2016 *Horm Res Paediatr*

15. Sex is binary, male or female, and is determined by chromosomal complement and corresponding reproductive role. The exceedingly rare DSDs are all medically identifiable deviations from the human binary sexual norm. The 2006 consensus statement of the Intersex Society of North America and the 2015 revision of the Statement does not endorse DSD as a third sex.²

16. DSD outcomes range from appearance of female external genitalia in an XY male (complete androgen insensitivity syndrome) to appearance of male external genitalia in an XX female (severe congenital adrenal hyperplasia). As one would expect, there are variations of the degree of hormonally driven changes that create ambiguous genital development that prevent assigning of a specific classification as either male or female at birth.

17. DSD patients are not "transgender"; they have an objective, physical, medically verifiable, physiologic condition. Transgender people generally do not have intersex conditions or any other verifiable physical anomaly. People who identify as "feeling like the opposite sex" or "somewhere in between" do not comprise a third sex. They remain biological men or biological women.

18. "Gender" is a term that refers to the psychological and cultural characteristics associated with biological sex. It is a psychological concept and sociological term, not a biological one. The term gender possessed solely a linguistic meaning prior to the 1950s. This changed when sexologists of the 1950s and 1960s manipulated the term to conceptualize cross-dressing and transsexualism in their psychological practice.

19. "Gender identity" is a term coined by my former endocrine faculty member John Money in the 1970s and has come to refer to an individual's mental and emotional sense of being male or female. The norm is for individuals to have a gender identity that aligns with one's biological sex.

20. Gender discordance (formerly Gender Identity Disorder) is used to describe a psychological condition in which a person experiences marked incongruence between his experienced gender and the gender associated with his biological sex. He will often express the belief that he is the opposite sex.

21. Gender discordance occurs in 0.001% of biological females and in 0.0033% of biological males.³ Exact numbers are hard to document since reporting is often anecdotal. Gender discordance is not considered a normal developmental variation.

22. "Gender Dysphoria" is a diagnostic term to describe the emotional distress caused by gender incongruity.⁴

² Lee PA et al, Consensus Statement on Management of Intersex Disorders, Pediatrics 2006; 118 e488-e500.

³ Seaborg E, About Face, Endocrine News 2014 (May) 16-19.

⁴ American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed; 2013:451-459.

Etiology of Gender Disorders

23. Transgender affirming professionals claim transgender individuals have a "feminized brain" trapped in a male body at birth and vice versa based upon various brain studies. Diffusion-weighted MRI scans have demonstrated that the pubertal testosterone surge in boys increases white matter volume. A study by Rametti and colleagues found that the white matter microstructure of the brains of female-to-male (FtM) transsexual adults, who had not begun testosterone treatment, more closely resembled that of men than that of women.⁵ Other diffusion-weighted MRI studies have concluded that the white matter microstructure in both FtM and male-to-female (MtF) transsexuals falls halfway between that of genetic females and males.⁶ These studies, however, are of limited clinical significance due to the small number of subjects and failure to account for neuroplasticity.

24. Neuroplasticity is the well-established phenomenon in which long-term behavior alters brain microstructure. For example, the MRI scans of experienced cab drivers in London are distinctly different from those of non-cab drivers, and the changes noted are dependent on the years of experience.⁷ There is no evidence that people are born with brain microstructures that are forever unalterable, but there is significant evidence that experience changes brain microstructure.^{8,9} Therefore, any transgender brain differences would more likely be the result of transgender behavior than its cause.

25. Furthermore, infants' brains are imprinted prenatally by their own endogenous sex hormones, which are secreted from their gonads beginning at approximately eight weeks' gestation.^{10,11,12} There are no published studies documenting MRI-verified differences in the brains of gender-disordered children or adolescents. The DSD guidelines also specifically state that current MRI technology cannot be used to identify those patients who should be raised as males or raised as females.¹³

5 Rametti G, Carrillo B, Gomez-Gil E, et al. White matter microstructure in female to male transsexuals before cross-sex hormonal treatment. A diffusion tensor imaging study. *J Psychiatr Res* 2011;45:199-204.

6 Kranz GS, Hahn A, Kaufmann U, et al. White matter microstructure in transsexuals and controls investigated by diffusion tensor imaging. *J Neurosci* 2014;34(46):15466-15475.

7 Maguire EA et al, Navigation-related structural change in the hippocampi of taxi drivers, *PNAS* 2000;97:4398- 4403.

8 Gu J, Kral R. What contributes to individual differences in brain structure? *Front Hum Neurosci* 2014;8:262.

9 Sale A, Eierardi N, Maffei L, Environment and Brain Plasticity: Towards an Endogenous Pharmacotherapy, *Physiol Rev* 2014; 94: 189 –234.

10 Reyes FI, Winter JS, Faiman C. Studies on human sexual development fetal gonadal and adrenal sex steroids. *J Clin Endocrinol Metab* 1973; 37(1):74-78.

11 Lombardo M. Fetal testosterone influences sexually dimorphic gray matter in the human brain. *J Neurosci* 2012; 32:674-680.

12 Campano A. [ed]. Geneva Foundation for Medical Education and Research. Human Sexual Differentiation;2016Availableat:www.gfmer.ch/Books/Reproductive_health/Human_sexual_differentiation.html. Accessed May 11, 2016.

13 Lee PA et al, Consensus Statement on Management of Intersex Disorders, *Pediatrics* 2006; 118 e488-e500.

26. Behavior geneticists have known for decades that while genes and hormones influence behavior, they do not hard-wire a person to think, feel, or behave in a particular way. The science of epigenetics has established that genes are not analogous to rigid "blueprints" for behavior. Rather, humans "develop traits through the dynamic process of gene-environment interaction. ... [genes alone] don't determine who we are."¹⁴

27. Regarding transgenderism, twin studies of adults prove definitively that prenatal genetic and hormone influence is minimal. The largest twin study of transgender adults found that only 10 percent of identical twins were both transgender-identified.¹⁵ Since identical twins contain 100 percent of the same DNA from conception and develop in exactly the same prenatal environment exposed to the same prenatal hormones, if genes and/or prenatal hormones contributed to a significant degree to transgenderism, the concordance rates would be close to 100 percent. Instead, 80 percent of identical twin pairs were discordant. This would indicate that at least 80 percent of what contributes to transgenderism as an adult in one co-twin consists of one or more non-shared post-natal experiences including but not limited to non-shared family experiences.

28. These findings also mean that persistent GD is due predominately to the impact of nonshared environmental influences. These studies provide compelling evidence that discordant gender is not hard-wired genetically.

Gender Dysphoria vs. Gender Identity Disorder

29. Up until the recent revision of the DSM-IV criteria, the American Psychological Association (APA) held that Gender Identity Disorder (GID) was the mental disorder described as a discordance between the natal sex and the gender identity of the patient.

30. Dr. Kenneth Zucker, who is a highly respected clinician and researcher from Toronto carried on evaluation and treatment of GID patients for forty years. His works, widely published, found that the vast majority of boys and girls with GID identify with their biological sex by the time they emerge from puberty to adulthood, through either watchful waiting or family and individual counseling.¹⁷ His results were mirrored in studies from Europe.^{18,19} When the DSM-V revision of the diagnosis of GID was proposed by the APA committee responsible for revision, Dr. Zucker insisted that there be a medical term to replace Gender Identity Disorder, removing gender discordance as a mental disorder apart from the presence of significant emotional distress. With this revision, Gender Dysphoria describes the mental anguish which is experienced by the gender discordant patient.

14 Shenk, D. *The Genius in All of Us: Why everything you've been told about genetics, talent, and IQ is wrong.* (2010) New York, NY: Doubleday; p. 18.

15 Diamond, M. "Transsexuality Among Twins: identity concordance, transition, rearing, and orientation." *International Journal of Transgenderism*, 14(1), 24-38.

17 Zucker KJ, Gender Identity Disorder, in Rutter M, Taylor EA, editors. *Child and Adolescent psychiatry*, 4th ed, Malden Mass: Blackwell, 2006: 737-753.

18 Wallieri MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. *J Am Academy Child Adolescent Psychiatry* 2008; 47:1413-1423.

19 Schechner T. Gender Identity Disorder: A Literature Review from a Developmental Perspective. *Isr J Psychiatry Related Sci* 2010; 47:42-48.

31. The theory that societal rejection is the root cause of Gender dysphoria was validly questioned by a study from Sweden which showed that the dysphoria was not eliminated by hormones and sex reassignment surgery even with widespread societal acceptance.²⁰

Treatment of Gender Dysphoria

32. The treatment of the child and adolescent with gender discordance and accompanying gender dysphoria should include an in-depth evaluation of the child and family dynamics. This provides a basis on which to proceed with psychologic therapy. The entire biologic and social family should be involved in psychological therapy designed to assist the patient, if at all possible, to align gender identity with natal sex. Psychological support by competent counselors with an intent of resolving the gender conflict should be provided as long as the patient continues to suffer emotionally. Given the high degree of eventual desistance of gender discordance/dysphoria by the end of puberty, it would be ethical and logical to counsel the patient and family to rear the child in conformity with natal sex.

33. Erikson described the stage of adolescence as "Identity versus Role Confusion" during which the teen works at developing a sense of self by testing roles then integrating them into a single identity.²¹ This process is often unpleasant regardless of the presence or absence of gender identity conflicts. The major benefit of enduring puberty in a GD patient is that it provides a strong likelihood of alignment of his gender identity with his natal sex. There is no doubt that these patients need compassionate care to get them through their innate pubertal changes. Scientific evidence shows that 80%-95% of pre-pubertal children with GD will come to identify with their biological sex by late adolescence. Some will require lifelong supportive counseling, and others will not.²²

Science vs. Pseudoscience

34. The advent of "centers of excellence" for gender-disordered patients²³ combined with sociologic agenda in academia has created the impression that there is scientific validity to gender discordance as a variation of normal. There has been a flurry of non-peer-reviewed articles in journals and newsletters circulated to general pediatricians that promote the ideology of transgenderism without scientific support.^{24,25,26,27} Mainstream clinicians and scientists who consider gender discordance to be a mental disorder have been deliberately excluded in the makeup of the steering committees of academic and medical professional societies which are promulgating guidelines that were previously unheard of.

20 Dhejne, Cecilia et al. Long-term Follow-up of transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden *PLoS One* February 2011 Vol 6 Issue 2, e16885

21 Erikson, E. H. (1993). *Childhood and society*. WW Norton & Company. Erikson, E. H. (1993). *Childhood and society*. WW Norton & Company.

22 Zucker KJ, Gender Identity Disorder, in Rutter M, Taylor EA, editors. *Child and Adolescent psychiatry*, 4th ed, Malden Mass: Blackwell, 2006: 737-753.

23 Hsieh S and Leninger J, Resource List: Clinical Care Programs for Gender-Nonconforming Children and Adolescents, *Pediatr Ann* 2014;43:238-244.

24 Prager, LM, A boy who wants to be a girl, *Contemporary Pediatrics* 2008; 25:56-58.

25 Garafolo R Tipping points in caring for the gender-non-conforming child and adolescent, *Pediatr Ann* 2014;43:227-229.

26 Steever J, Cross-gender Hormone therapy in adolescents, *Pediatr Ann* 2014;43: e-138-e-144.

27 Simons LK et al, Understanding gender variance in Children and Adolescents, *Pediatr Ann* 2014;43:e-126-e131.

35. The Endocrine Society published such a document in 2009.²⁸ Its recommendations promoted the use of psychological evaluation, counseling, blocking of pubertal maturation at the onset of puberty, the subsequent use of cross-sex hormones, and possible surgical intervention at the age of consent. Of the 22 recommendations contained in the document, only three were supported by scientific proof. These three warned of potential adverse effects of hormonal manipulation. The remaining 19 recommendations were nearly evenly split into a group that was based on very limited scientific evidence and a group that was based on no scientific evidence at all. The response to these guidelines was a burgeoning of Gender Identity Clinics in the United States from three to over forty-five in a period of seven years. Subsequently, the Endocrine Society revised the guidelines and the modifications were more permissive with the younger ages at which cross-sex hormones and surgical treatment could be recommended. They did add a concern that counseling regarding induced infertility should be included.²⁹

The Pediatric Endocrine Society created their own guidelines³⁰ as did the American Academy of Pediatrics.³¹ Each of these subsequent guidelines were more lenient and the AAP actually suggested that initial evaluation for undercurrent psychological issues be abandoned altogether.

36. WPATH is an agenda-driven advocacy organization whose membership consists of anyone who has an interest in the transgender social and political agenda. There are no requirements for specialty training or certification. Its guidelines and standards of care are not scientifically supported.

37. WPATH promotes "expert witnesses" and provides them with a bibliography replete with self-confirming references to opinion pieces and anecdotal case reports along with clinical case reviews with inherent selection bias.

38. WPATH's "peer-reviewed" journal is not reviewed by anyone with an opinion that is not in keeping with the philosophy of the organization itself.

39. I reviewed the legal complaint filed on behalf of the plaintiff, Gavin Grimm as well as the deposition of Gavin Grimm and the declaration by expert witness, Dr. Melinda Penn. I direct my strongest criticism at the information that was presented to support the affirmation of the gender incongruence through counseling, medical and surgical intervention. Statements were made that such action is clearly the only scientifically valid way to proceed, when the breadth of medical literature does not support this concept.

28 Hembree WC et al, Endocrine Treatment of Transsexual Persons: and Endocrine Society Clinical Practice Guideline, *J Clin Endo Metab* 2009; 94:3132-3154.

29. Hembree WC et al, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: an Endocrine Society Clinical Practice Guideline, *J Clin Endo Metab* 2017 ;102:3869-3903.

30. https://www.pedsendo.org.../TG_SIG_%20Statement_10_220_15.pdf

31. Rafferty J, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, *Pediatrics* 2018;142:320182161

40. There are no scientifically validated gender incongruence training programs at universities in the United States. Under the guise of compassion for the bullied, endocrinologists are promoting chemical treatment that forever creates medical suffering, introducing complications such as sterility, increased stroke and cancer risk all to supposedly save the gender-incongruent person from taking his/her life to end the suffering imposed upon them by society. The suicide risk is hyper-inflated to as high as 50% when in reality it is actually 5%, as reported by the Williams Institute.³² The mantra of "insistent, persistent and consistent" as a means to diagnose the entity of gender incongruence is not scientifically supported. The Nuremberg Guidelines are an established framework that have been overlooked by WPATH, the Endocrine Society, the Pediatric Endocrine Society and the American Academy of Pediatrics.

41. The requirement that society at large, and school systems in particular, should grant special regulatory privileges to a gender-incongruent person which is intended to further a student's belief that they are born into the body of the wrong sex is an endorsement of a form of medical "treatment" which has no scientific basis. Allowing a biologic female to use a male-designated bathroom facility is one of several "gender affirming" care options, but it is creating harm to at least two parties. The harm to the gender incongruent person is that it promotes a pathway to inevitable long-term medical and psychological morbidity. The premise of gender affirming care can be managed through other methods without requiring school systems to permit transgender students to use the restroom associated with their new gender identity. The second party harmed is the student without gender incongruence who must suffer emotionally while being told they must tolerate the presence of an opposite sex individual in a sexually segregated space and embrace the regulation which gives the gender incongruent person special privileges as if they were based on a civil right founded on immutable biology.



Quentin L. Van Meter, M.D.
Pediatric Endocrinologist

32. Wilson BDM et al, Characteristics and Mental Health of Gender Nonconforming Adolescents in California, Health Policy Fact Sheet, The Williams Institute UCLA School of Law December 2017

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M.D. – 1973

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Institution: Johns Hopkins University
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President, Uniformed Services West Chapter, 1987 – 1990
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Editor, The Georgia Pediatrician, 1994 – 1998

Chairman, Georgia Chapter Legislative Committee, 1996 – 2006

Fellow: The American College of Pediatricians, 2007 – present
Member of the Board of Directors, 2008- present
Vice President/President, 2015-present

Member: Pediatric Endocrine Society, 1989 – present

Member: American Diabetes Association Professional Section, 1988 – present

Member: Endocrine Society, 1994-present

Member: Southern Pediatric Endocrine Society, 1992 – Present

Member: American Association of Clinical Endocrinologists, 2005 – present

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Institution: University of California, San Francisco
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Institution: University of California, San Diego, School of Medicine
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Peachtree City, Georgia 30269
September 1991 – October 2003

Pediatric Endocrinologist Peer Reviewer 2006 – present
MCMC, LLC, Boston, MA
IMEDECS, Lansdale PA

Speaker's Bureau
Novo Nordisk, Pfizer, Endo, Abbvie
AAP Equipp course on Growth- development committee- 2012

PUBLICATIONS: (Articles in Peer Reviewed Journals)

Riddick, JR, Flora R., Van Meter, QL:
"Computerized Preparation of Two-Way Analysis of Variance
Control Charts for Clinical Chemistry," Clinical Chemistry,
18:250, March 1972.

Van Meter, QL, Gareis FJ, Hayes, JW, Wilson, CB:
"Galactorrhea in a 12 Year Old Boy with Chromophobe Adenoma,"
J. Pediatrics 90:756, May 1977.

Plotnick, LP, Van Meter, QL, Kowarski, AA, "Human Growth Hormone
Treatment of Children with Growth Failure and Normal Growth
Hormone Levels by Immunoassay: Lack of Correlation with
Somatomedin Generation: Pediatrics 71:324, March 1983.

Brawley, RW, Van Meter, QL, "Mebendazole Ascaris Migration," W.J.
Med, 145:514015, October 1986.

Van Meter, QL, "The Role of the Primary Care Physician in Caring for
Patients with Type-1 Diabetes," Comp Ther 1998; 24(2):93-101

Midyett LK, Rogol AD, Van Meter QL, Frane J, and Bright GM,
"Recombinant Insulin-Like Growth factor (IGF)-I Treatment in Short
Children with Low IGF-I Levels: First-Year Results from a Randomized
Clinical Trial," J Clin Endocrinol Metab, 2010;95:611-619.

ABSTRACTS:

Van Meter, Q L, & Lee, PA: "Evaluation of Puberty in Male and Female
Patients with Noonan Syndrome," Pediatric Research 14:485, 1980.

Van Meter, QL, et al: "Characterization of Pituitary Function in
Double Bolus GnRH Infusion as a Diagnostic Tool," Pediatric Research
32:111, 1984.

Van Meter, QL, Felix, SD, Lin, FL: "Evaluation of the Pituitary-Adrenal
Axis in Patients Treated with nasal Beclomethasone," (Presented at the
1991 Annual Meeting of the Endocrine Society and the 6th Annual Naval
Academic Research Competition, Bethesda, MD, 17 May, 1991).

Rogol AD Midyett LK Van Meter Q, Frane J, Bailly J, and Bright GM,
Recombinant Human IGF-1 for Children with Primary IGF-1 Deficiency
(IGFD): Safety Data from Ongoing Clinical Trials (presented at the PAS
2007, Toronto).

Van Meter Q, Midyett LK, Deeb L et al, Prevalence of primary IGFD among untreated children with short stature in a prospective, multicenter study (Poster POO715) ICE Rio de Janeiro, Brazil 2008.

G.M. Bright¹, W.V. Moore², J. Nguyen³, G. Kletter⁴, B. S. Miller⁵, Q. L. Van Meter⁶, E. Humphriss¹, J.A. Moore⁷ and J.L. Cleland¹ Results of a Phase 1b Study of a new long-acting human growth hormone (VRS-317) in pediatric growth hormone deficiency (PGHD). PAS 2014 May 2014

Van Meter Q, Welstead B and Low J, Characteristics of a Population of Obese Children and Adolescents: Suggesting a New Paradigm, presented at ESPE meeting, Dublin 2014.

Wayne V. Moore¹, Patricia Y. Fechner², Huong Jil Nguyen³, Quentin L. Van Meter⁴, John S. Fuqua⁵, Bradley S. Miller⁶, David Ng⁷, Eric Humphriss⁸, R. W. Charlton⁸, George M. Bright⁸, Safety and Efficacy of Somavaratan (VRS-317), a Long-Acting rhGH, in Children with Growth Hormone Deficiency (GHD): 3-Year Update of the VERTICAL & VISTA Trials, presented at the 2017 Endocrine Society meeting in Orlando FL

Bradley S. Miller¹, Wayne V. Moore², Patricia Y. Fechner³, Huong Jil Nguyen⁴, Quentin L. Van Meter⁵, John S. Fuqua⁶, David Ng⁷, Eric Humphriss⁸, R. W. Charlton⁸, George M. Bright⁸, 3-Year Update of the Phase 2a and Long-term Safety Studies (VERTICAL and VISTA) of Somavaratan (VRS-317), a Long-acting rhGH for the Treatment of Pediatric Growth Hormone Deficiency, presented at the 2017 IMPE meeting in Washington D.C.

Laidlaw MK, Van Meter QL, Hruz PW, Von Mol A, and Malone WJ, Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," J CLin Endo Metab 2019;104: 1-2.

ADDITIONAL PRESENTATIONS/LECTURES:

Pediatrics Update, CME Associates, San Diego – Orlando Annual Conferences: Lectures on Pediatric Endocrine Subjects – 1986 – 2001. Course Moderator, 1997, 1998, 1999, 2000, 2001

Endocrine and Gastroenterology Update, CME Associates, Maui HI Nov 2001, Lecturer and Course Moderator

Lecture on Panhypopituitarism, Pharmacia Conference, Nashville TN April 2002.

Family Medicine Review Course, Orlando, FL, 1992 – 2001

Pediatric Grand Rounds, Tanner Medical Center, October 1997

Pediatric Grand Rounds, Hughes Spaulding Children's Hospital, September, 2003

Pediatrics in the Park, Fall CME meeting for the Georgia Chapter of the American Academy of Pediatrics, November 2003

Pediatric Grand Rounds, Columbus Regional Medical Center, January 2004

Frontiers in Pediatrics CME Course, sponsored by the Atlanta Children's Health Network, Atlanta, March 2004.

Pediatric Grand Rounds, Eggleston Children's Hospital, May 2004.

Sue Schley Matthews Pediatric Conference, Columbus Regional Medical Center, September 2004

56th Annual Scientific Assembly and Exhibition of the Georgia Academy of Family Physicians, Nov 2004

Program Co-Chairman: Southern Pediatric Endocrine Society Annual meeting, Nov 2004, November 2014

Presentations on Diabetes, Growth Failure, and Thyroid Disease to the Postgraduate Pediatric Nurse Practitioner Program, Georgia State University, Nov 2005, June 2006, May 2007

Issues in Medicine, US Medical Congress Conference and Exhibition, Las Vegas, meeting planner and speaker, June, 2006

CME Presentations for the Georgia Chapter of the American Academy of Pediatrics Spring and Fall Meetings 2004-present

Quentin L. Van Meter, M.D.

Pediatric Grand Rounds, Columbus Regional Medical Center, Columbus, GA, 2011-present

Human Growth Foundation Regional CME Conference, Atlanta GA
March 2013, February 2014 Columbus Georgia

International Federation of Therapeutic Counseling Choice: Transgender Medicine, IFTCC Launch, October 15, 2018 London, Third International Congress, October 25 2018 Budapest.

Audio Digest Pediatrics - ① v. 41, no. 4; ② v. 41, no. 20; ③ v. 43, no. 17

Audio Digest Family Practice - ① v. 42, no. 5; ② v. 44, no. 11; ③ v. 44, no. 44; ④ v. 45, no 15

Audio Digest Otolaryngology - ① v. 32, no. 14

CURRENT HOSPITAL APPOINTMENTS:

Eggleston/Scottish Rite Children's Hospitals, active
staff, Pediatric Endocrinology

PAST AND CURRENT CLINICAL RESEARCH:

2006	Sanofi-Aventis HMR1964D/3001	study completed 2007
2006	Tercica MS301-	study completed 2008
2007	Tercica MS310-	study completed 2008
2007	Tercica MS306-	study completed 2010
2007	Tercica MS316-	study completed 2012
2008	EMD Serono 28358	study completed 2009
2012	Versartis 12VR2	study completed 2014
2012	Debiopharm 8206-CPP-301	study started July 2012
2013	Versartis 13 VR3	study started Dec 2013
2014	Novo-Nordisk Elipse	study started 2014
2015	Versartis 14 VR4	study completed 2017
2017	Mannkind MKC-TI-155	study started 2017

LEGAL EXPERT WITNESS:

2017	North Carolina Legislature- transgender bathroom bill
2018	Jessica Siefert transgender case, Cincinnati, OH
2018	Alberta, Canada school system transgender case
2018	Decatur GA School Board transgender case

Quentin L. Van Meter, M.D.

Customary charges for medical legal review, deposition and court testimony for
Quentin L. Van Meter, M.D.

Retainer- \$1500

Record review- \$350/h

Deposition and Testimony- \$450/h

If testimony requires travel, lodging, and meals- reimbursement for full receipted cost

If testimony requires days away from the medical practice, flat fee of \$3500 per day involved.