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UNITED STATES DISTRICT COURT
DISTRICT OF IDAHO

LINDSAY HECOX et al.,

Plaintiffs,

v.

BRADLEY LITTLE et al.,

Defendants.

Case No. 1:20-cv-00184-DCN

INTERVENORS' [PROPOSED] MEMORANDUM IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION [Dkt. 22]

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PRELIMINARY STATEMENT

The State of Idaho has addressed multiple reasons why Plaintiffs' motion for preliminary injunction should be denied. Proposed Intervenor-Defendants Madison (Madi) Kenyon and Mary (MK) Marshall will not reiterate the legal authorities, standards, and arguments well covered by the State. Instead, Proposed Intervenors submit this brief to bring to the Court's attention additional facts that bear importantly on the "balance of the equities," and to unpack some basic flaws in the very foundations of Plaintiffs' Equal Protection claim.

As to the balance of the equities, Plaintiffs' depiction is wrong on both sides of the scale.

An injunction that blocks Idaho's Fairness in Women's Sports Act will inflict real harms on women and girls such as Intervenors. The Court does not face merely a balance between an abstract policy of the State and the tangible interests of individual plaintiffs. On the contrary, unfair competition in women's college athletics by male athletes *before* passage of the Fairness Act directly harmed Intervenors Madi and MK, who were denied equal athletic opportunities as a result.

The assertion by Plaintiffs' putative expert Helen Carroll that "I am not aware of any cisgender girls being harmed by the presence of a transgender student-athlete participating . . .in their league" (Carroll Declaration ¶ 25), reflects Ms. Carroll's ideological blinders, not facts. Recognizing what is really happening on the track to girls and young women like Intervenors, the Department of Education Office for Civil Rights has recently ruled that permitting males to compete in girls' and women's track competitions denies equal opportunities in athletics to girls and women and so violates Title IX. *See* Dep't of Educ. Office for Civil Rights, Letter of Impending Enforcement Action dated May 15, 2020 ("OCR Letter of Impending Enforcement Action"), attached as Appendix 1 to ECF No. 41, at 33-45. If the Fairness Act is enjoined,

Intervenors and other girls and young women will suffer concrete and irreparable harm in the coming fall season. *See* Section I.A below; *see also* Madison Kenyon Declaration, ECF No. 30-2, Mary Marshall Declaration, ECF No. 30-3, and Declaration of Chelsea Mitchell, submitted as Exhibit A hereto.

On the other side of the "balance of harms" scale, Plaintiffs cannot establish (as Plaintiffs' expert Dr. Deanna Adkins would have the Court believe) that Hecox will suffer severe psychological harm—and may commit suicide—unless permitted to compete in the women's division. On the contrary, in a detailed expert affidavit substantiated by extensive citations to the scientific literature, psychiatrist and expert in treatment of gender dysphoria Dr. Stephen Levine explains that there is no consensus among professionals that "social transition" (treating an individual as if he were of the opposite sex for all purposes, including athletic participation) is the only or most effective approach for young people who suffer from gender dysphoria. And there is no scientific basis at all to assert that "social transition" and "affirmation" lead to better long-term mental and physical health outcomes than other therapies. Instead, many studies document that those who persist in living in a transgender identity into adulthood suffer severely poor mental and physical health throughout their lifetimes, even after "transition," "affirmation," and cross-sex hormones, and even after so-called "sex-reassignment" surgery. *See* Section I.B below, and the expert affidavit of Dr. Stephen Levine attached as Exhibit B hereto. As a result, Hecox can show no likelihood of tangible harm absent an injunction.

As to the law, Plaintiffs' Equal Protection theory is defective at every turn. They do not complain because the Fairness Act protects separation of athletic competitions based on sex (which it does); rather they complain because it does *not* separate athletic competitions based on gender identity. They seek to invoke a novel category—gender identity—to declare

unconstitutional separation based on sex, which the Supreme Court and other courts have expressly sanctioned in circumstances that similarly turn on physical strength and capability. They ask this Court to invoke equal protection to *require* discrimination based on a category (gender identity) as a matter of Constitutional law, rather than to prohibit discrimination—an order that would be without precedent. And they seek to hijack a categorization that is justified only because of the physiological differences between the sexes, and convert it into a platform for a personal declaration of identity. In short, while Plaintiffs invoke the language of Equal Protection, their arguments and the remedy they seek have nothing to do with that body of law.

I. The "balance of the equities" tips decidedly against enjoining operation of the Fairness in Women's Sports Act.

To obtain a preliminary injunction, a plaintiff must establish that "he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008) (collecting cases). Plaintiffs bear the burden of showing that each element weighs clearly and unequivocally in their favor. *Lopez v. Brewer*, 680 F.3d 1068, 1072 (9th Cir. 2012). The Court "must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief." *Winter*, 555 U.S. at 24; *see also Univ. of Haw. Prof'l Assembly v. Cayetano*, 183 F.3d 1096, 1108 (9th Cir. 1999) ("To determine which way the balance of the hardships tips, a court must identify the possible harm caused by the preliminary injunction against the possibility of the harm caused by not issuing it.").

In addition to the severe legal defects in Plaintiffs' arguments discussed in the State's opposition and in Section II below, Plaintiffs misdescribe both sides of the "balance of the equities" facing this Court.

A. Intervenor-Defendants and other women and girls will suffer immediate, identifiable harm and loss of rights if the Fairness in Women's Sports Act is enjoined.

Plaintiffs' putative expert Helen Carroll states that "I am not aware of any cisgender girls being harmed by the presence of a transgender student athlete participating . . . in their league" (Carroll Declaration ¶ 25), and Plaintiffs assert that enjoining the protections of the Fairness Act "would not harm Defendants," and that "Defendants . . . face no harm." Pls.' Mem. in Supp. of Prelim. Inj. ("Pl. PI Mem.") 28, ECF No. 22-1. This is mere say-so. In fact, as detailed in their declarations previously submitted in support of their motion to intervene (*see* Kenyon Decl., ECF No. 30-2; Marshall Decl., ECF No. 30-3), Intervenors themselves have already experienced harm from competition by males in women's and girls' athletics. And they and other girls and women in Idaho face further, direct harm if the Fairness Act's protection of women and girls from this unfair and unequal competition is enjoined. The State has a powerful interest in preventing this harm to its female citizens.

Madi and MK each have personally faced the disturbing and demoralizing experience of encountering male participation in their sport competitions, and must expect to compete against Plaintiff Hecox in the coming season if the Fairness in Women's Sports Act is enjoined. Kenyon Decl. ¶¶ 12, 14, 15, 29; Marshall Decl. ¶ 11, 14. As a result of this unfair competition, each of these young women lost placement opportunities and was denied a "level field" competitive experience in which effort and success enjoy a correlation. Kenyon Decl. ¶ 20. Madi found that "Fair competition pushes me to better myself and try harder; unfair competition [from a male] leaves me feeling frustrated and defeated"; watching a teammate lose her position on the championship podium because a male took first place was "heartbreaking." Kenyon Decl. ¶¶ 12, 16. MK similarly reports that while losing to another woman "drives me to work harder," losing to a male "feels completely different," "deflating." "It makes me think that no matter how hard I

try, my hard work and effort will not matter." Marshall Decl. ¶ 12. The experiences of Madi and MK closely echo the type of deprivation that the Second Circuit denounced when it wrote, in *McCormick v. School District of Mamaroneck*, 370 F.3d 275, 295 (2d Cir. 2004), that "[t]reating girls differently regarding a matter so fundamental to the experience of sports—the chance to be champions—is inconsistent with Title IX's mandate of equal opportunity for both sexes." And a subtler but perhaps deeper harm was the disturbing message implied by allowing male athletes to compete as "female"—a message that the Intervenors' distinctive identities as women are unrecognized and unimportant, to be casually brushed aside in favor of other priorities. Kenyon Decl. ¶ 24.

The experiences of Madi and MK are by no means unique. If Ms. Carroll is "unaware" of girls who have been "harmed by the presence of a transgender student athlete participating . . . in their league," it is because she chooses to be unaware. Nationwide attention has recently been given to the U.S. Department of Education Office for Civil Rights investigation and litigation in Connecticut, where opportunities for participation, advancement, victory opportunities, and public recognition have been taken from many girls as a result of the participation of just two male athletes in Connecticut girls' track competitions. *See* OCR Letter of Impending Enforcement Action, ECF No. 41 App'x 1 at 18-27. Chelsea Mitchell, one of the girls harmed in this way, and one of the complainants to the Office for Civil Rights, details the harms that she personally suffered in a declaration submitted as Exhibit A to this brief. Those harms included being denied "four state championship titles, two All New England awards, medals, points, and publicity"—all as a result of the state athletic conference policy that grants male athletes entrance to female competitions. Mitchell Decl. ¶6. And when a male athlete swept several female state championships and titles and was named "girls . . . athlete of the year" by the local

paper, Chelsea understandably felt the injustice this implied against those who are in fact female athletes. *Id.* at ¶ 33. She hopes that future female athletes may be spared the "anxiety, stress, and performance losses" that she suffered due to male competition in female events. *Id.* at ¶ 47. Chelsea's narrative documents the very real harm that is both predictable and experienced when males compete in girls' or women's leagues based on claims of gender identity.

Indeed, it was the harms that Chelsea describes that caused the Office for Civil Rights to conclude recently that "by permitting the participation of biologically male students in girls' interscholastic track in the state of Connecticut, [the Connecticut league and member schools] denied female student-athletes benefits and opportunities" including equal opportunities "to place higher in . . . events; to receive awards and other recognition; and possibly to obtain greater visibility to colleges and other benefits," and so violated Title IX. OCR Letter of Impending Enforcement Action, ECF No. 41 App'x 1 at 33.

B. Plaintiff Hecox's claims of psychological harm are speculative and unsupported by science. [1]

Plaintiffs have alleged that "[t]he only treatment to avoid [suicide among transgender individuals] is . . . to affirm gender identity." (Compl. ¶ 103.) Plaintiffs' putative expert Dr. Adkins repeats this assertion verbatim (Adkins Decl. ¶ 22, ECF No. 22-2), and in their preliminary injunction brief Plaintiffs repeat this theme (Pl. PI Mem. 5, 28). Somewhat mysteriously, Plaintiffs do *not* include the purported risk that Hecox will commit suicide in their list of purported "irreparable injury" (Pl. PI Mem. 26-27), but then work it back into their cursory discussion of the "balance of equities" (*id.* at 27-28).

[1] Plaintiffs do not assert that Plaintiff Jane Doe, a female who lives under a gender identity consistent with her sex, is subject to any of the risks attributed to individuals who suffer from gender dysphoria. The State has amply highlighted the wildly speculative nature of Jane Doe's supposedly anticipated "injuries," and Intervenors will not take the Court's time repeating those points.

Any claim of likely psychological harm or suicide risk with respect to Plaintiff Hecox is entirely speculative and unsupported by any facts in the record. More broadly, the claim that permitting males who identify as female to compete in female athletics will reduce suicide and reduce psychological damage among that group is unsupported by science. On this point, Intervenor-Defendants bring essential information and expertise to this litigation through the accompanying expert affidavit of Dr. Stephen B. Levine, Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine, who has worked with individuals suffering from gender dysphoria for over 45 years.

Plaintiffs' expert Dr. Deanna Akins has, essentially, opined that fairness in athletic opportunities to girls and women including Intervenors must take a back seat to the interests of males who identify as female, because (she claims) the only accepted therapy for individuals suffering from gender dysphoria demands "social transition"—treating those individuals in all circumstances as if they were in fact of the opposite sex. Dr. Adkins suggests that those individuals are likely to commit suicide or suffer severe psychological distress unless they are permitted to compete on girls' teams. Adkins Decl. 6-8.

Dr. Adkins cites almost no scientific literature to support her opinions. Dr. Levine, by contrast, cites extensive literature in his affidavit to explain that "social transition" is by no means universally accepted as the only correct therapy by practitioners in the field. Levine Aff. 11-21. He explains that there are no studies whatsoever that demonstrate that "social transition"—including participation in girls' or women's athletics—decreases suicide or suicide attempts in children, adolescents, or young adults who suffer from gender dysphoria, or will produce better physical or mental health outcomes for these individuals over the long run as compared to other therapeutic approaches. Levine Aff. 28-34. Instead, multiple studies from

respected centers have shown that individuals who persist in living in a transgender identity experience severely worse mental and physical health outcomes as adolescents and adults—including severely worse incidence of suicide and suicide attempts—than the general population, even after administration of cross-sex hormones and even "sex-reassignment surgery." Levine Aff. 34-42. Meanwhile, multiple studies suggest that a very large majority of children who suffer from gender dysphoria will "desist" from experiencing that dysphoria, and will revert to comfort with their biological sex by the time they reach young adulthood, so long as they are *not* subjected to "gender affirming" social transition such as participating in opposite-sex athletics. "Social transition and affirmation," however, may radically reduce the percentage of young people who revert to comfort with their biological sex. Levine Aff. 24-28.

Dr. Levine's expert affidavit is extensive, detailed, and thoroughly documented. But a key take-away is that there is good reason to believe, based on extensive peer-reviewed literature in the field, that social transition and "affirmation" of transgender identity in children and adolescents—which Plaintiffs would have this Court mandate in the context of athletics as a matter of law—steers those young people on a path that leads to severely negative mental and physical health outcomes. Of course, the opinions of Dr. Levine like those of Dr. Adkins will have to be tested by cross-examination at trial. But meanwhile, an awareness of this science will be critical to this Court's evaluation of Plaintiff Hecox's baseless claim that the "balance of the equities" requires that this Court enjoin the Fairness Act's requirement that only females play in athletics designated for girls or women.

II. Plaintiffs' invocation of "equal protection" turns the law and logic of equal protection on its head, and would deny equal protection to Intervenors and similarly situated women and girls.

A. Basic principles of Equal Protection law relative to classifications by sex

In most contexts, the Equal Protection Clause prohibits governmental action that treats one class of individuals differently, unless that classification and distinction is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 440 (1985). "The Equal Protection Clause does not forbid classifications. It simply keeps governmental decisionmakers from treating differently persons who are in all relevant respects alike." *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992). The Court's "traditional view of the core concern of the Equal Protection Clause" is "as a shield against arbitrary classifications." *Engquist v. Oregon Dep't of Agric.*, 553 U.S. 591, 598 (2008). Legislation is presumed valid against an Equal Protection challenge. *Cleburne*, 473 U.S. at 440.

Some classifications, however—and in particular "race, alienage, or national origin"—are so seldom relevant to the capabilities of individuals and any state interest that they are deemed "suspect," and laws that turn on these classifications are subject to "strict scrutiny." They are constitutional "only if they are suitably tailored to serve a compelling state interest," *Cleburne*, 473 U.S. at 440. The Supreme Court has strongly cautioned lower courts against creating new "suspect categories." *Id.* at 441 (noting that "respect for the separation of powers" should make courts reluctant to establish new suspect classes). Neither the Supreme Court nor the Ninth Circuit has recognized "gender identity" as a "suspect class."

Classification and separate treatment based on sex falls somewhere in the middle. While the Supreme Court has cautioned that sex "frequently bears no relation to ability to perform or contribute to society," *Cleburne*, 473 U.S. at 440, quoting *Frontiero v. Richardson*, 411 U.S.

677, 686 (1973), it remains true that "[g]ender has never been rejected as an impermissible classification in all instances." *Kahn v. Shevin*, 416 U.S. 351, 356 n.10 (1974). Instead, the Supreme Court has recognized that that "the sexes are not similarly situated in certain circumstances," *Michael M. v. Superior Court of Sonoma County*, 450 U.S. 464, 469 (1981), and that "[p]hysical differences between men and women … are enduring: '[T]he two sexes are not fungible; a community made up exclusively of one is different from a community composed of both.'" *United States v. Virginia*, 518 U.S. 515, 533 (1996) ("*VMI*"). In *Nguyen v. INS*, 533 U.S. 53, 73 (2001), the Court condemned an artificial and blinkered analysis that would "fail to acknowledge even our most basic biological differences—such as the fact that a mother must be present at birth but the father need not be," while in the *VMI* case the Court volunteered that the admission of women to VMI "would undoubtedly require" adjustments to VMI's physical training program. *VMI*, 518 U.S. at 550 n.19.

The biological and physiological differences between men and women are real, relevant, and "enduring," and as a result sex-separated teams and competition have been the rule in most sports since competitive women's athletics became accepted, and have repeatedly been approved by courts. Thus, the Ninth Circuit approved a state policy that forbade male student participation on female high school sports teams, concluding that there is "no question that the Supreme Court allows for these average real differences between the sexes to be recognized" in the context of athletics. *Clark ex rel. Clark v. Arizona Interscholastic Ass'n*, 695 F.2d 1126, 1131 (9th Cir. 1982). For the same reason, the Fourth Circuit recently upheld—against a Title VII challenge brought by a male applicant—the FBI's "gender normed" physical fitness benchmarks that set different requirements for "male and female Trainees" (with males facing more rigorous requirements) "in order to account for their innate physiological differences." *Bauer v. Lynch*,

812 F.3d 340, 343 (4th Cir. 2016). That court's reasoning was clear; the fact that it comports with common sense is not a mark against it: "Men and women simply are not physiologically the same for the purposes of physical fitness programs. . . . [T]he physiological differences between men and women impact their relative abilities to demonstrate the same levels of physical fitness. In other words, equally fit men and women demonstrate their fitness differently." *Id.* at 350, 351.

B. What the Fairness in Women's Sports Act does

Against the background of universal practice since the advent of women's sports and this legal precedent, Idaho's Fairness in Women's Sports Act is hardly a novelty. What it does is to ensure that in Idaho, if sports teams and competitions are separated by sex, then those teams and competitions designated for females are in fact reserved for females. The law protects women and girls such as Intervenors from competition that is both unfair and insuperable, and thus helps ensure equal opportunities in athletic experiences for girls and boys, women and men, in Idaho. *See* legislative purpose set forth in Idaho Code § 33-6202.

The justification for this law is simple and physical—it is "because of physiological differences between male and female individuals." *VMI*, 518 U.S. at 550 n.19. As reviewed above, courts as well as common sense recognize these differences. The Legislature made well-supported legislative findings concerning some of these "physiological differences." Idaho Code § 33-6202. If anything further were necessary, Dr. Gregory Brown has extensively detailed physiological differences between the sexes that impact athletic performance in his declaration submitted by the State. Expert Decl. of Dr. Gregory Brown, ECF 41-1. As to the real-world impact of these differences when males compete in female divisions, Dr. Brown—like the legislative findings—references the published work of Duke Law School Professor Doriane Lambelet Coleman who concluded, based on an extensive review of performance times in running events:

> [D]epending on the sport and event, the gap between the best male and female performances remains somewhere between 7 to 14 percent; and even the best female is consistently surpassed by many elite and non-elite males, including both boys and men. If elite sport were co-ed or competition were open, even the best female would be rendered invisible by the sea of men and boys who would surpass her.[2]

In other sports, physiological differences are respected by different equipment height or weight for men and women.[3] These biological and physiological realities provide an "exceedingly persuasive justification," *VMI*, 518 U.S. at 531, for protecting female athletes from dominating competition from males. Indeed, because of these same considerations, the Department of Education, in a 1979 Policy Interpretation regarding Title IX that has been held to be "both persuasive and not unreasonable" and so entitled to judicial deference, *McCormick*, 370 F.3d at 289-91, has declared that Title IX may not only permit but *require* provision of single-sex athletic teams when "[m]embers of the excluded sex [almost always women] do not possess

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[2] Doriane Lambelet Coleman et al., *Re-Affirming the Value of the Sports Exception to Title IX's General Non-Discrimination Rule*, 27 DUKE JOURNAL OF GENDER LAW & POLICY 69, 88-89 (2020), https://scholarship.law.duke.edu/djglp/vol27/iss1/7. Professor Coleman has publicly disagreed with the Fairness Act as it applies to males who have undergone puberty blocking since the very beginning of puberty (a category that neither Plaintiff claims to occupy), but she has not disavowed any of the extensive data or detailed findings contained in this very recent publication.

[3] Publicly available official sport standards, for example, show that:

• The net height used for women's volleyball is more than 7 inches lower than that used for men's volleyball. Federation Internationale de Volleyball (FIVB), *Official Volleyball Rules* 2017-2020, https://www.fivb.org/EN/Refereeing-Rules/documents/FIVB-Volleyball_Rules_2017-2020-EN-v06.pdf (last visited June 3, 2020).

• The hurdle height used for the high school girls' 100-meter hurdle event is 33 inches, while the standard height used for boys' high school 110-meter hurdle is 39 inches. USA Track and Field (USATF) *2020 Competition Rules*, https://www.usatf.org/governance/rule-books, (last visited June 3, 2020).

• The standard women's basketball has a circumference of 28.5 to 29 inches and a weight of between 18 and 20 oz, while a standard basketball used in a men's game has a circumference between 29.5 to 30 inches and a weight of between 20 and 22 oz. International Basketball Federation (FIBA) *2018 Official Basketball Rules*, http://www.fiba.basketball/OBR-2018-Basketball-Equipment-Yellow-Version-2.pdf (last visited June 8, 2020); *Women's National Basketball Association, Official Rules 2020*, https://ak-static.cms.nba.com/wp-content/uploads/sites/27/2020/05/2020-WNBA-Rule-Book-Final.pdf (last visited June 8, 2020).

sufficient skill to be selected for a single integrated team, or to compete actively on such a team if selected." 44 Fed. Reg. 71,413, 71,418 (Dec. 11, 1979).

Thus, while sex is not a suspect classification, the Fairness Act could easily meet the requirement applicable to such classifications: it is "narrowly tailored to serve a compelling state interest," *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 227 (1995). The Fairness Act draws the line exactly where both logic and these precedents require: based on biology. The Act defines no categories, asks no questions, draws no lines, and excludes no individuals based on subjective or non-physical criteria such as sexual orientation or gender identity. Indeed, to divide individuals into separate athletic competitions according to such non-physical, psychological criteria—as Plaintiffs demand—would itself likely violate the Equal Protection clause (as the OCR has held that it violates Title IX), because such divisions would *lack* precisely those clear "biological" and "physiological" foundations which provide the legal justification for sex-separated sports.

The only other thing the Fairness in Women's Sports Act does is to establish a method of resolving disputes about eligibility to compete in girls' or women's leagues. *See* Idaho Code § 33-6203(3). Such disputes did not arise in an earlier generation; now they do. As the facts of the *Bauer* case illustrate, if a female category faces less strenuous physical standards or competition, today there is a possibility that a male will wish to compete subject to the female standards. As the recent experience in Connecticut illustrates, just one or two males who choose for any reason to compete in girls' or women's leagues can have a devastating effect on athletic opportunities and experiences for girls and women. (*Supra* pp. 4-6.) If the law is permitted to draw a line defined by sexual biology for purposes of athletics (and it is), then there must be a way to determine which side of that line an individual falls on, if that is disputed. The State in its

Memorandum has well explained how minimally intrusive the verification provision of the Fairness Act really is.

So long as we stay grounded in the realities of the "physiological differences between male and female individuals," *VMI*, 518 U.S. at 550 n.19, it is hardly necessary to explain why the Fairness Act does not *pari passu* bar females from competing in competitions designated for boys or men. The athletic performance capabilities of women are not merely "different" as compared to men: they are consistently lower across a wide range of sports and measures. Brown Decl. If a girl chooses to compete in a boys' team or league, she subjects no boy to inherently unfair competition, and is exceedingly unlikely to take honors that would otherwise have gone to a boy. Given the long history of *lesser* athletic opportunities available to girls and women, and the absence of any unfairness to males if females compete against them, it was reasonable and appropriate for the legislature to leave open to individuals, schools, and leagues to decide whether or when females may compete in athletics otherwise designated for boys or men.

C. Plaintiffs' Equal Protection challenges are based on word games, and are without merit.

Plaintiff Hecox's invocation of equal protection relies on a verbal game of "three card Monte," with words being substituted and shuffled so rapidly that one loses track of meaning. Plaintiffs seek to avail themselves of law they do not really invoke, and of categories they do not occupy.

Importantly, neither plaintiff claims that the time-honored division of athletics into separate male and female competitions violates equal protection. That would be a coherent challenge, if a misguided one. On the contrary, it appears that Plaintiff Hecox, at least, affirmatively *desires* the existence of separate "women's" sports, as a means by which to publicly declare and experience his "female gender identity." Pl. PI Mem. 10.

But this requires that Plaintiffs identify some other "class" supposedly discriminated against, and it is here that the sleight-of-hand occurs. The "victim category," according to Plaintiffs, is "Women . . . who are transgender." Pl. PI Mem. 13. But what this means, is "Women who are male," given that the very definition of "*trans*gender" means to have a gender identity the opposite of one's sex. Or to translate this even more completely into unambiguous English: "Individuals who assert a gender identity as a woman, but who are male."

The hand may be quicker than the eye, but if we subject the phrase "Women who are transgender" to slow scrutiny, we will see the moves.

- We see that Plaintiffs are attempting to create a novel class for Equal Protection purposes by rendering incoherent the words *man* and *woman*, *male* and *female*. But these words have been used since time immemorial, and in the Supreme Court and other precedents discussed above, *precisely* to signify exactly the binary differences of reproductive biology, and associated differences of physiology, with which the Fairness Act is concerned.
- We see that Plaintiffs are asking this Court to invert the meaning of words and thereby to declare unconstitutional the division of athletics into separate competitions for male and female that is both permitted and explained by the precedents discussed above.
- We see that Plaintiff Hecox is insisting—and asking this Court to rule as a matter of law—that his subjective and interior choice or experience of "gender identity" is in some sense more real than—and must override—the hard, objective facts of biological sex in our sexually dimorphic species.

- We see that Plaintiff Hecox seeks to highjack "women's athletics" to serve as a platform for personal expression, although that division *exists* to serve the different capabilities and needs founded on physiology, not for reasons of expression or therapy of *any* individual, male or female.
- And finally, we see that Plaintiff Hecox demands to participate in the lower-performance women's category even though Hecox does not possess the biological and physiological criteria that are the reason and justification for the very existence of that separate category.

But if we turn all the cards face up on the table, these moves do not work. Separation of athletics by sex is reasonable and serves the important governmental interest of providing equal athletic opportunities to girls and women *because* of the biological and related physiological differences between males and females. Idaho's Fairness in Women's Sports Act separates athletics by sex, *and on no other criteria*, so it cannot be guilty of "discriminating" based on any other criterion. All who are male must participate only in male sports, and no other questions are asked. And if an individual's eligibility to participate in girls' or women's athletics is challenged, then that individual must provide the verification called for by the Fairness Act, regardless of her or his sex, so there is no discrimination by sex at this point, either.

Instead, it is Plaintiffs who ask this Court to discriminate based on a novel class or division without justification. Plaintiffs do not seek (and indeed would repudiate) a ruling that *all* males may compete in women's divisions if they wish. Rather, Plaintiffs seek an order that only *some* males may compete in women's divisions: males who claim a female gender identity. That is, Plaintiffs ask this Court to order, as a matter of constitutional law, that some males are entitled to participate in female athletic competitions while other males are not, classifying and so

discriminating based on gender identity. But it cannot be correct that a sex-based "discrimination" in access to female athletic competition—justified by what the Supreme Court has recognized as "physical differences," "biological differences," and "physiological differences" (*supra* p. 9)—is unconstitutional, while discrimination based on gender identity—which by its definition has no relationship to biology or physiology—is not only permitted but constitutionally *required*.

For that matter, Plaintiffs cite no case in which equal protection has been held to *require* discrimination based on any criterion whatsoever. Yet that is what Plaintiffs ask this Court to order—discrimination based on gender identity. This type of radical inversion of the law is hardly a proper basis for a preliminary injunction.

III. Plaintiffs' extended discussions of disorders of sexual development are red herrings.

Plaintiffs devote many pages of expert declarations, and a considerable portion of their brief, to discussions of so-called "intersex conditions"—extremely rare "disorders of sexual development," or "DSDs"—in an effort to argue that categorization by sex is neither possible nor rational. But these extended meanderings are a meritless smokescreen designed to distract from the fatal flaws in Plaintiffs' facts and theories as explained in the State's opposition and above. The Court should spend no time on these detours for multiple reasons:

1. Neither Plaintiff claims to suffer from any DSD or "intersex condition," so they have no standing to raise concerns about how the Fairness Act might hypothetically be applied to other, unidentified individuals who do.

2. Plaintiffs make no record that it has *ever* occurred in Idaho that an individual who is genetically male but suffers from any DSD has wished to compete in girls' or women's athletics in Idaho. Hypothetical fringe cases do not provide a basis to strike down an otherwise valid law as violating Due Process. "[F]ew statutory classifications are entirely free from the

criticism that they sometimes produce inequitable results." *Lalli v. Lalli*, 439 U.S. 259, 273 (1978). The law need only be "substantially related" to an important government interest. *See Craig v. Boren*, 429 U.S. 190, 197 (1976); *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982). The Fairness in Women's Sports Act clears that hurdle with room to spare.

3. The Plaintiffs are implicitly inverting the standard that governs facial challenges to a law. They argue that the law should be enjoined because in some rare and speculative situations, it might produce an inequitable result. But on the contrary, in the facial challenge here, the law must be upheld if there are any circumstances in which its application is constitutional. *See Washington State Grange v. Washington State Republican Party*, 552 U.S. 442, 449 (2008); *see also United States v. Kaczynski*, 551 F.3d 1120, 1124 (9th Cir. 2009) ("A facial challenge to a statute is the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the statute would be valid.") (cleaned up). The Plaintiffs have it just wrong.

4. Given the many laws (by no means limited to Title IX) and many Supreme Court and lower court precedents that recognize that when it comes to reproductive biology, ours is a sexually dimorphic species, it is far too late in the day—and far beyond anything a lower court should consider in the context of a preliminary injunction motion—to brush biology and timeless human experience and legal precedent aside to conclude (as one misguided district court did) that "the terms 'biological male or female' should be avoided," *Grimm v. Gloucester County School Board*, 302 F. supp. 3d 730, 743 (E.D. Va. 2018), or that "male" and "female" are not real and legitimate categories for a legislature to address. The tragic fact that developmental and genetic disorders do in rare cases occur takes nothing away from the reality that we are a sexually dimorphic species, that we exist as male and female, that "a community made up of one sex is

different from a community composed of both," *VMI*, 518 U.S. at 533 (cleaned up), and that legislation must therefore sometimes take the biological reality of sex and sex-linked physical and physiological differences into account.

CONCLUSION

For the foregoing reasons, this Court should deny Plaintiffs' motion for a preliminary injunction.

Respectfully submitted this 9th day of June, 2020.

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CERTIFICATE OF SERVICE

I hereby certify that on June 9, 2020, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected in the Notice of Electronic Filing:

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EXHIBIT A

Declaration of Chelsea Mitchell in Opposition to Preliminary Injunction

UNITED STATES DISTRICT COURT
DISTRICT OF IDAHO

LINDSAY HECOX, and JANE DOE with her next friends JEAN DOE and JOHN DOE,

Plaintiffs,

v.

BRADLEY LITTLE, in his official capacity as Governor of the State of Idaho; SHERRI YBARRA, in her official capacity as the Superintendent of Public Instruction of the State of Idaho and as a member of the Idaho State Board of Education; THE INDIVIDUAL MEMBERS OF THE STATE BOARD OF EDUCATION, in their official capacities; BOISE STATE UNIVERSITY; MARLENE TROMP, in her official capacity as President of Boise State University; INDEPENDENT SCHOOL DISTRICT OF BOISE CITY #1; COBY DENNIS, in his official capacity as superintendent of the Independent School District of Boise City #1; THE INDIVIDUAL MEMBERS OF THE BOARD OF TRUSTEES OF THE INDEPENDENT SCHOOL DISTRICT OF BOISE CITY #1, in their official capacities; THE INDIVIDUAL MEMBERS OF THE IDAHO CODE COMMISSION, in their official capacities,

Defendants.

Case No. 1:20-cv-00184-DCN

DECLARATION OF CHELSEA MITCHELL IN OPPOSITION TO PRELIMINARY INJUNCTION

DECLARATION OF CHELSEA MITCHELL

I, Chelsea Mitchell, declare as follows:

1. I am a seventeen-year-old graduate of Canton High School in Canton, Connecticut.

2. I am an elite female athlete and competed in Connecticut Interscholastic Athletic Conference (CIAC) track and field events throughout all four years of high school.

3. A CIAC policy allows biological males who identify as girls to compete in the girls' category and on girls' athletic teams.

4. From the Spring 2017 outdoor track season through the Winter 2020 indoor track season[1]—six track seasons—I competed against biological males in my track and field athletic events due to the CIAC policy.

5. I understand that some individuals in this case state that they are not aware of any biological girls being harmed by the presence of transgender athletes competing in their league.

6. I personally have been harmed by competing against male athletes in my league. In total, I have lost four state championship titles, two All New England awards, medals, points, and publicity due to the CIAC policy that permits males to compete in girls' athletic events in Connecticut.

2016-2017 Freshman Year

7. I first competed against a male in girls' track and field as a fourteen-year-old freshman at the Spring 2017 outdoor CIAC State Open Championship.

8. On the way to this meet, I was instructed by my coach to respond "no comment" if asked about the issue of males competing in the female category.

9. In the 100m final at the 2017 outdoor State Open, I placed 7th overall. The top six receive a medal and qualify to advance to the New England Regional Championship: one of those top six spots was taken by male athlete Andraya Yearwood:

[1] The Spring 2020 outdoor season was cancelled due to the global COVID-19 pandemic.

Table 1: 2017 CIAC State Open Women's Outdoor Track 100m Results (June 5, 2017)[2]

Place	Grade	Sex	Name	Time	High School
1*	12	F	Caroline O'Neil	12.14s	Daniel Hand
2*	12	F	Kathryn Kelly	12.36s	Lauralton Hall
3*	9	M	Andraya Yearwood	12.41s	Cromwell
4*	11	F	Tia Marie Brown	12.44s	Windsor
5*	12	F	Kiara Smith	12.59s	Jonathan Law
6*	11	F	Kate Hall	12.62s	Stonington
7	9	F	Chelsea Mitchell	12.69s	Canton
8	12	F	Tiandra Robinson	FS	Weaver

* Qualified for the New England Championship.

2017-2018 Sophomore Year

10. During my sophomore year, I learned that Andraya Yearwood's school was reclassified to the Class S division for indoor track events (the school remained a Class M for outdoor track events)—which was the same class as my school.

11. This news was upsetting for me because I would now be racing against a male competitor at both the Class S championship and the State Open championship.

12. At the February 10, 2018, indoor Class S Championship in the 300m, I was knocked out of advancing to the State Open by just one spot—a spot was taken by Andraya.

13. On April 27, 2018, at the first invitational race of the Spring 2018 outdoor season, I was seeded in the 100m in a lane beside not just one, but two male athletes: Terry Miller and Andraya Yearwood.

14. I distinctly remember seeing Terry look over to Andraya and say: "You and me, one and two." At fifteen years old, I felt extremely intimidated to run against bigger, faster, and stronger male competitors.

[2] AthleticNet, https://www.athletic.net/TrackAndField/meet/306453/results/f/1/100m, last visited June 2, 2020.

15. But Terry was right. I should have won that 100m race; but instead, Terry and Andraya took first and second place, while I placed third.

16. Similarly, at the Spring 2018 outdoor State Open Championship, Terry won the women's 100m event by a wide margin, while Andraya finished second.

17. But for CIAC's policy, I would have won second place statewide:

Table 2: 2018 CIAC State Open Championship Women's Outdoor Track 100m Results (June 4, 2018)[3]

Place	Grade	Sex	Name	Time	High School
1*	10	M	Terry Miller	11.72s	Bulkeley
2*	10	M	Andraya Yearwood	12.29s	Cromwell
3*	11	F	Bridget Lalonde	12.36s	RHAM
4*	10	F	Chelsea Mitchell	12.39s	Canton
5*	11	F	Maya Mocarski	12.47s	Fairfield Ludlowe
6*	10	F	Selina Soule	12.67s	Glastonbury
7	12	F	Tia Marie Brown	12.71s	Windsor
8	11	F	Ayesha Nelson	12.80s	Hillhouse

* Qualified for the New England Championship.

18. Bridget Lalonde beat me by just three-hundredths of a second, but I was so relieved that she did. Emotionally, it was less of a loss to be denied runner-up status than to be denied a first place State Open Championship—a feat almost unheard of for a high school sophomore.

19. At the 2018 outdoor New England Regional Championship, I placed seventh in the 100m. Only the top six medal and receive the All New England award—one of those top six spots was taken by Terry.

20. Had I earned the title of All New England, I would have made Canton High School history as the first Canton female athlete to win this prestigious award.

[3] AthleticNet, https://www.athletic.net/TrackAndField/meet/334210/results/f/1/100m, last visited June 2, 2020.

2018-2019 Junior Year

21. In the fall of my junior year, I learned that male athlete Terry Miller transferred to Bloomfield, another Class S school.

22. I was devastated, fearing that with two males competing in my division, my chances of ever winning a state championship in sprints were now over.

23. I trained harder than ever, spending countless hours to shave mere fractions of seconds off of my times. I never missed a practice, squeezed in extra workouts where I could, and saw my race times consistently drop.

24. But it was not enough. And my fears of losing championship after championship were realized in the Winter and Spring 2019 seasons.

25. At the February 7, 2019, indoor Class S State Championship, Terry finished first in the 55m. I placed second. But for the CIAC's policy, I would have been named the Class S State Champion in the 55m.

26. The February 16, 2019, indoor State Open Championship saw similar results and a similar impact. Terry and Andraya finished first and second respectively in both the preliminary and final Women's 55m races, each time defeating the fastest girl by a wide margin. I placed third in the final.

27. But for CIAC's policy, I would have won the 2019 State Open Championship in the 55m dash:

Table 3: 2019 CIAC State Open Championship Women's Indoor Track 55m Preliminary Results (February 16, 2019)[4]

Place	Grade	Sex	Name	Time	High School
1*	11	M	Terry Miller	7.00s	Bloomfield
2*	11	M	Andraya Yearwood	7.07s	Cromwell
3*	12	F	Cori Richardson	7.24s	Windsor
4*	11	F	Chelsea Mitchell	7.27s	Canton
5*	12	F	Kate Shaffer	7.27s	Conard
6*	12	F	Ayesha Nelson	7.29s	Hillhouse
7*	12	F	Maya Mocarski	7.34s	Fairfield Ludlowe
8	11	F	Selina Soule	7.37s	Glastonbury
9	10	F	Kisha Francois	7.41s	East Haven

* Qualified for the women's 55m final.

Table 4: 2019 CIAC State Open Championship Women's Indoor Track 55m Final Results (February 16, 2019)[5]

Place	Grade	Sex	Name	Time	High School
1*	11	M	Terry Miller	6.95s	Bloomfield
2*	11	M	Andraya Yearwood	7.01s	Cromwell
3*	11	F	Chelsea Mitchell	7.23s	Canton
4*	12	F	Kate Shaffer	7.24s	Conard
5*	12	F	Ayesha Nelson	7.26s	Hillhouse
6*	12	F	Maya Mocarski	7.33s	Fairfield Ludlowe
7	12	F	Cori Richardson	7.39s	Windsor

* Qualified for the New England Championship.

28. Instead, I was not named State Open Champion in the 55m, I received a bronze medal instead of a gold medal, and I did not make Canton High School history as the first ever Canton female athlete to be named a State Open Champion.

29. However, after the 55m race, I returned to the finals of the long jump, which had no males competing. While listening to them announce Terry as the winner and new meet record holder in the 55m, I won the long jump event to solidify my place in the Canton record books as the first Canton indoor track athlete—male or female—to be named a State Open Champion.

[4] AthleticNet, https://www.athletic.net/TrackAndField/meet/352707/results/f/1/55m, last visited June 2, 2020.
[5] *Id*.

30. State Champions are recognized as All-State Athletes, an award listed on college applications, scholarship applications, and college recruiting profiles. State Champions are invited to the All-State Banquet, and get their name celebrated on a banner in their high school gym. I did not receive any of these awards for the 55m. But I was able to receive these awards for my long jump championship.

31. After the State Open Championship, I was repeatedly referred to in the press as the "third-place competitor, who is not transgender." I was the fastest biological girl in the 55m race at the State Open Championship, but the press did not mention my name—I felt invisible.

32. At the March 2, 2019, indoor New England Regional Championship, Terry took first and Andraya took third place in the 55m dash. I missed medaling and being named All New England Champion by just two spots—two spots that were taken by male competitors.

33. Following Terry Miller's sweep of the CIAC's Indoor Class S, State Open, and New England titles in the 55m dash and 300m, Terry was named "All-Courant girls indoor track and field athlete of the year" by the Hartford Courant newspaper. This felt like an injustice to my fellow female athletes.

34. In the Spring 2019 outdoor season, I competed against both Terry and Andraya in the Class S Championship. At this event, I ran the fastest biological female times in the 100m and 200m across all state class meets.

35. But because of the CIAC's policy, being the fastest biological girl just was not good enough to experience the thrill of victory. Instead, at the 2019 Class S Championship, Terry placed first in the 100m and 200m, while I placed second in both events. I won the long jump and received a state title. But because of the CIAC's policy, I took home only one state title instead of three.

36. The trend continued at the 2019 outdoor State Open Championship as Terry easily won the women's 200m race. But for CIAC's policy, Cori Richardson would have won the state championship, Alanna Smith would have finished runner-up, and Olivia D'Haiti would have advanced to the New England Championship:

Table 5: 2019 CIAC State Open Championship Women's Outdoor Track 200m Final Results (June 3, 2019)[6]

Place	Grade	Sex	Name	Time	High School
1*	11	M	Terry Miller	24.33s	Bloomfield
2*	12	F	Cori Richardson	24.75s	Windsor
3*	9	F	Alanna Smith	25.01s	Danbury
4*	11	F	Chelsea Mitchell	25.24s	Canton
5*	12	F	Nichele Smith	25.38s	East Hartford
6*	12	F	Bridget Lalonde	25.55s	RHAM
7	12	F	Olivia D'Haiti	25.63s	Kolbe-Cathedral

* Qualified for the New England Championship.

37. But I did receive one opportunity to compete on a more level playing field. At the Spring 2019 State Open Championship in the 100m, Terry, the top-seed in the race, false-started and was disqualified. This opened the door for me: I was able to relax, focus on my race, and win. I set a personal record of 11.67 seconds, made Canton High School history as the first sprinter to be a state open champion in any sprint event, medaled, received significant media publicity, and advanced to the New England Regional Championships.

38. I went on to win the New England Regional Championships in the 100m dash and was named All New-England. Here, too, I made Canton High School history as the first female to win a New England Championship.

[6] AthleticNet, https://www.athletic.net/TrackAndField/MeetResults.aspx?Meet=364088&show=all, last visited June 2, 2020.

39. Thereafter, I was awarded Track Athlete of the Year by the Connecticut High School Coaches Association, and the Hartford Courant named me 2019 All-Courant Girls Outdoor Track and Field Athlete of the Year and the Bo Kolinsky Female Athlete of the Year (across all sports).

40. My new personal record, State Open Champion and All New-England awards put me in a much better recruiting position for college scholarships—all because a false start that prevented a male from competing against me in the women's division leveled the playing field.

2019-2020 Senior Year

41. A similar scenario played out in the Winter 2020 season. At the indoor Class S Championship 55m race, Andraya Yearwood—the top seed in the race and the individual ranked number one in the state for the women's 55m dash—false-started and was disqualified. That false start opened the door for me to not only win the CIAC Class S Championship in the 55m dash, but also to advance to the 2020 Connecticut State Open Championship in the 55m event and win.

42. To my disappointment, the 2020 Spring outdoor season was cancelled in light of the global COVID-19 pandemic.

43. I just completed my senior year of high school and the final track season of my high school athletic career.

44. It feels defeating to know that records at my high school, CIAC, AthleticNet, MySportsResults, CT.Milesplit.com, and others do not reflect the four state titles and two All New England awards I should have earned. It is upsetting to know that the meet records of many great female athletes before me have also been wiped from the books.

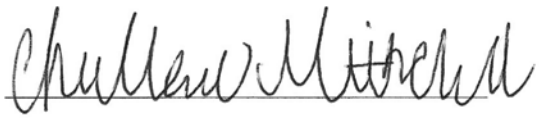
45. Competing against males makes me feel anxious and stressed. And stress has a direct, negative impact on my athletic performance.

46. I try to stay positive, to take support from family and friends, but it is hard when I know that I must compete against those who have a biological advantage because they were born male.

47. I hope that future female athletes will not have to endure the anxiety, stress, and performance losses that I have while competing under a policy that allows males to compete in the female category.

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

Executed this 2 day of June, 2020



Chelsea Mitchell

EXHIBIT B

Expert Affidavit of
Dr. Stephen B. Levine, M.D.

EXPERT AFFIDAVIT OF

DR. STEPHEN B. LEVINE, M.D.

June 4, 2020

TABLE OF CONTENTS

I. CREDENTIALS & SUMMARY

1. I am Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine, and maintain an active private clinical practice. I received my MD from Case Western Reserve University in 1967, and completed a psychiatric residency at the University Hospitals of Cleveland in 1973. I became an Assistant Professor of Psychiatry at Case Western in 1973, and became a Full Professor in 1985.

2. Since July 1973, my specialties have included psychological problems and conditions relating to individuals' sexuality and sexual relations, therapies for sexual problems, and the relationship between love, intimate relationships, and wider mental health. In 2005, I received the Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research. I am a Distinguished Life Fellow of the American Psychiatric Association.

3. I have served as a book and manuscript reviewer for numerous professional publications. I have been the Senior Editor of the first (2003), second (2010), and third (2016) editions of the *Handbook of Clinical Sexuality for Mental Health Professionals*. In addition to five previously solo-authored books for professionals, I have recently published *Psychotherapeutic Approaches to Sexual Problems* (2020). The book has a chapter titled "The Gender Revolution."

4. I first encountered a patient suffering what we would now call gender dysphoria in July 1973. In 1974, I founded the Case Western Reserve University Gender Identity Clinic, and have served as Co-Director of that clinic since that time. Across the years, our Clinic treated hundreds of patients who were experiencing a transgender identity. An occasional child was seen during this era. I was the primary psychiatric care-giver for several dozen of our patients and

supervisor of the work of other therapists. I was an early member of the Harry Benjamin International Gender Dysphoria Association (later known as WPATH) and served as the Chairman of the committee that developed the 5th version of its Standards of Care. In 1993 the Gender Identity Clinic was renamed, moved to a new location, and became independent of Case Western Reserve University. I continue to serve as Co-Director.

5. In 2006, Judge Mark Wolf of the Eastern District of Massachusetts asked me to serve as an independent, court-appointed expert in a litigation involving the treatment of a transgender inmate within the Massachusetts prison system. I have been retained by the Massachusetts Department of Corrections as a consultant on the treatment of transgender inmates since 2007.

6. In 2019, I was qualified as an expert and testified concerning the diagnosis, understanding, developmental paths and outcomes, and therapeutic treatment of transgenderism and gender dysphoria, particularly as it relates to children, in the matter of *In the Interest of J.A.D.Y. and J.U.D.Y.*, Case No. DF-15-09887-S, 255th Judicial District, Dallas County, TX (the "*Younger* litigation").

7. A fuller review of my professional experience, publications, and awards is provided in my curriculum vitae, a copy of which is attached hereto as Exhibit A.

8. I have reviewed the "Expert Declaration of Deanna Adkins, MD, in Support of Plaintiffs' Motion for Preliminary Injunction," dated April 27, 2020 ("Adkins"). In that declaration Dr. Adkins makes a variety of statements about gender dysphoria, therapies for gender dysphoria, and outcomes of therapies, which I believe to be inaccurate, or unsupported by scientific evidence. Dr. Adkins is a pediatric endocrinologist. I note with some concern that Dr. Adkins makes a number of sweeping and purportedly scientific assertions but cites almost no

peer-reviewed articles or studies that support her opinions, and I note also that Dr. Adkins herself has published only one peer-reviewed article relating to treatment of individuals suffering from gender dysphoria.

9. Based on her declaration, Dr. Adkins' practice is focused on children and adolescents; her CV and declaration do not suggest substantial experience in working with adults or older young adults who are living in a transgender identity, or who suffer from gender dysphoria. (This diagnosis requires distress). The wider lifecycle view that derives from experience with these adults (and familiarity with the literature concerning them) provides an important cautionary perspective. The psychiatrist or psychologist treating a trans child or adolescent, of course seeks to make the young patient happy, but the overriding consideration is the creation of a happy, highly functional, mentally healthy person for the next 50 to 70 years of life. I refer to treatment that keeps this goal in view as the "life course" perspective.

10. It is my opinion that a number of Dr. Adkins' assertions are inaccurate or unsupported, for reasons that I explain in this Declaration. I will provide citations to published, peer-reviewed articles that inform my judgments.

11. A summary of the key points that I explain in this statement is as follows:

a. Sex as defined by biology and reproductive function cannot be changed. While hormonal and surgical procedures may enable some individuals to "pass" as the opposite gender during some or all of their lives, such procedures carry with them physical, psychological, and social risks, and no procedures can enable an individual to perform the reproductive role of the opposite sex. (Section II.A.)

b. The diagnosis of "gender dysphoria" encompasses a diverse array of conditions, with widely differing pathways and characteristics depending on age of onset,

biological sex, mental health, intelligence, motivations for gender transition, socioeconomic status, country of origin, etc. Data from one population (e.g., adults) cannot be assumed to be applicable to others (e.g., children). (Section II.B.) Generalizations about the treatment children in one country (e.g., Holland) do not necessarily apply to another (e.g., United States).

c. Among psychiatrists and psychotherapists who practice in the area, there are currently widely varying views concerning both the causes of and appropriate therapeutic response to gender dysphoria in children. Existing studies do not provide a basis for a scientific conclusion as to which therapeutic response results in the best long-term outcomes for affected individuals. (Sections II.E, II.F.)

d. A majority of children (in several studies, a large majority) who are diagnosed with gender dysphoria "desist"—that is, their gender dysphoria does not persist—by puberty or adulthood. It is not currently known how to distinguish children who will persist from those who will not. (Section III.)

e. Some recent studies suggest that active affirmation of transgender identity in young children will substantially reduce the number of children "desisting" from transgender identity. This raises concern that this will increase the number of individuals who suffer the multiple long-term physical, mental, and social limitations that are strongly associated with living life as a transgender person. (Section III.)

f. Thus, social transition is itself an important intervention with profound implications for the long-term mental and physical health of the child. When a mental health professional evaluates a child or adolescent and then recommends social transition, presumably that professional is available to help with interpersonal, familial, and

psychological problems that may already exist and will likely arise after transition. However, many adolescents are medically transitioned without a thorough, long-lasting mental health assessment and psychological ongoing care, leaving themselves and their families on their own to deal with ongoing and subsequent problems. (Section III.)

g. The knowledge-base concerning the cause and treatment of gender dysphoria available today has low scientific quality. (Section IV.)

h. There are no studies that show that affirmation of transgender identity in young children reduces suicide or suicidal ideation, or improves long-term outcomes as compared to other therapeutic approaches. Meanwhile, multiple studies show that adult individuals living transgender lives suffer much higher rates of suicidal ideation, completed suicide, and negative physical and mental health conditions than does the general population before and after transition, hormones, and surgery. (Section IV.)

i. In light of what is known and not known about the impact of affirmation on the incidence of suicide, suicidal ideation, and other indicators of mental and physical health, it is scientifically baseless, and therefore unethical, to assert that a child or adolescent who express an interest in a transgender identity will kill him- or herself unless adults and peers affirm that child in a transgender identity. (Section IV.)

j. Putting a child or adolescent on a pathway towards life as a transgender person puts that individual at risk of a wide range of long-term or even life-long harms, including: sterilization (first chemical, then surgical) and associated regret and sense of loss; inability to experience orgasm (for trans women); physical health risks associated with exposure to elevated levels of cross-sex hormones; surgical complications and life-long after-care; alienation of family relationships; inability to form lasting romantic

relationships and attract a desirable mate; elevated mental health risks of depression, anxiety, and substance abuse. (Section V.)

II. BACKGROUND ON THE FIELD

A. The biological baseline of sex

12. Dr. Adkins refers to the sex of an individual as "given at birth" or "designated at birth." (Adkins 4, 5.) This phrasing is misleading. The sex of a human individual at its core structures the individual's biological reproductive capabilities—to produce ova and bear children as a mother, or to produce semen and beget children as a father. As physicians know, sex determination occurs at the instant of conception, depending on whether a sperm's X or Y chromosome fertilizes the egg. Medical technology can now be used to determine a fetus's sex before birth almost as easily as after birth. It is thus not correct to assert that doctors "designate" or "assign" the sex of a child at birth. Instead, they simply recognize the existing fact of that child's sex; barring rare disorders of sexual development, anyone can identify the sex of an infant by genital inspection. What the general public may not understand, however, is that every nucleated cell of an individual's body is chromosomally identifiably male or female—XY or XX.

13. The self-perceived gender of a child, in contrast, arises in part from how others label the infant: "I love you, son (daughter)." This designation occurs thousands of times in the first two years of life when a child begins to show awareness of the two possibilities. As acceptance of the designated gender corresponding to the child's sex is the outcome in >99% of children everywhere, anomalous gender identity formation begs for understanding. Is it biologically shaped? Is it biologically determined? Is it the product of how the child was privately regarded and treated? Does it stem from trauma-based rejection of maleness or

femaleness, and if so, flowing from what trauma? Does it derive from a tense, chaotic interpersonal parental relationship without physical or sexual abuse? Is it a symptom of another, as of yet unrevealed, emotional disturbance or neuropsychiatric condition (autism)? The answers to these relevant questions are not scientifically known.

14. Under the influence of hormones secreted by the testes or ovaries, numerous additional sex-specific differences between male and female bodies continuously develop post-natally, culminating in the dramatic maturation of the primary and secondary sex characteristics with puberty. These include differences in hormone levels, height, weight, bone mass, shape and development, musculature, body fat levels and distribution, and hair patterns, as well as physiological differences such as menstruation. These are genetically programmed biological consequences of sex, which also serve to influence the consolidation of gender identity during and after puberty.

15. Despite the increasing ability of hormones and various surgical procedures to reconfigure some male bodies to visually pass as female, or vice versa, the biology of the person remains as defined by his (XY) or her (XX) chromosomes, including cellular, anatomic, and physiologic characteristics and the particular disease vulnerabilities associated with that chromosomally-defined sex. For instance, the XX (genetically female) individual who takes testosterone to stimulate certain male secondary sex characteristics will nevertheless remain unable to produce sperm and father children. It is certainly true, as Dr. Adkins writes, that "[h]ormone therapy and social transition significantly change a person's physical appearance." (Adkins 9.) But in critical respects this change can only be "skin deep." Contrary to assertions and hopes that medicine and society can fulfill the aspiration of the trans individual to become "a

complete man" or "a complete woman," this is not biologically attainable.[1] It is possible for some adolescents and adults to pass unnoticed as the opposite gender that they aspire to be—but with limitations, costs, and risks, as I detail later. These risks include a continuing sense of inauthencity as a member of the opposite "sex."

B. Definition and diagnosis of gender dysphoria

16. Specialists have used a variety of terms over time, with somewhat shifting definitions, to identify and speak about a distressing incongruence between an individual's sex as determined by their chromosomes and their thousands of genes, and the gender with which they eventually subjectively identify or to which they aspire. Today's American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5") employs the term Gender Dysphoria and defines it with separate sets of criteria for adolescents and adults on the one hand, and children on the other.

17. There are at least five distinct pathways to gender dysphoria: early childhood onset; onset near or after puberty with no prior cross gender patterns; onset after defining oneself as gay for several or more years and participating in a homosexual life style; adult onset after years of heterosexual transvestism; and onset in later adulthood with few or no prior indications of cross-gender tendencies or identity. The early childhood onset pathway and the more recently observed onset around puberty pathway are relevant to this matter.

18. Gender dysphoria has very different characteristics depending on age and sex at onset. Young children who are living a transgender identity commonly suffer materially fewer

[1] S. Levine (2018), *Informed Consent for Transgendered Patients*, J. OF SEX & MARITAL THERAPY, at 6, DOI: 10.1080/0092623X.2018.1518885 ("*Informed Consent*"); S. Levine (2016), *Reflections on the Legal Battles Over Prisoners with Gender Dysphoria*, J. AM. ACAD. PSYCHIATRY LAW 44, 236 at 238 ("*Reflections*").

symptoms of concurrent mental distress than do older patients.[2] The developmental and mental health patterns for each of these groups are sufficiently different that data developed in connection with one of these populations cannot be assumed to be applicable to another.

19. The criteria used in DSM-5 to identify Gender Dysphoria include a number of signs of discomfort with one's natal sex and vary somewhat depending on the age of the patient, but in all cases require "clinically significant distress or impairment in . . . important areas of functioning" such as social, school, or occupational settings.

20. When these criteria in children (or adolescents, or adults) are not met, two other diagnoses may be given. These are: Other Specified Gender Dysphoria and Unspecified Gender Dysphoria. Specialists sometimes refer to children who do not meet criteria as being "subthreshold."

21. Children who conclude that they are transgender are often unaware of a vast array of adaptive possibilities for how to live life as a man or a woman—possibilities that become increasingly apparent over time to both males and females. A boy or a girl who claims or expresses interest in pursuing a transgender identity often does so based on stereotypical notions of femaleness and maleness that reflect constrictive notions of what men and women can be.[3] A young child's—or even an adolescent's—understanding of this topic is quite limited. Nor can they grasp what it may mean for their future to be sterile. These children and adolescents consider themselves to be relatively unique; they do not realize that discomfort with the body

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[2] K. Zucker (2018), *The Myth of Persistence: Response to "A Critical Commentary on Follow-Up Studies & 'Desistance' Theories about Transgender & Gender Non-Conforming Children" by Temple Newhook et al.*, INT'L J. OF TRANSGENDERISM at 10, DOI: 10.1080/15532739.2018.1468293 ("*Myth of Persistence*").

[3] S. Levine (2017), *Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria*, J. OF SEX & MARITAL THERAPY at 7, DOI: 10.1080/0092623X.2017.1309482 ("*Ethical Concerns*").

and perceived social role is neither rare nor new to civilization. What is new is that such discomfort is thought to indicate that they must be a trans person.

C. Impact of gender dysphoria on minority and vulnerable groups

22. In considering the appropriate response to gender dysphoria, it is important to know that certain groups of children and adolescents have an increased prevalence and incidence of trans identities. These include: children of color,[4] children with mental developmental disabilities,[5] including children on the autistic spectrum (at a rate more than 7x the general population),[6] children residing in foster care homes, adopted children (at a rate more than 3x the general population),[7] children with a prior history of psychiatric illness,[8] and more recently adolescent girls (in a large recent study, at a rate more than 2x that of boys). (G. Rider at 4.)

[4] G. Rider et al. (2018), *Health and Care Utilization of Transgender/Gender Non-Conforming Youth: A Population Based Study*, PEDIATRICS at 4, DOI: 10.1542/peds.2017-1683. (In a large sample, non-white youth made up 41% of the set who claimed a transgender or gender-nonconforming identity, but only 29% of the set who had a gender identity consistent with their sex.)

[5] D. Shumer & A. Tishelman (2015), *The Role of Assent in the Treatment of Transgender Adolescents*, INT. J. TRANSGENDERISM at 1, DOI: 10.1080/15532739.2015.1075929.

[6] D. Shumer et al. (2016), *Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic*, LGBT HEALTH, 3(5) 387 at 387.

[7] D. Shumer et al. (2017), *Overrepresentation of Adopted Adolescents at a Hospital-Based Gender Dysphoria Clinic*, TRANSGENDER HEALTH Vol. 2(1) 76 at 77.

[8] L. Edwards-Leeper et al. (2017), *Psychological Profile of the First Sample of Transgender Youth Presenting for Medical Intervention in a U.S. Pediatric Gender Center,* PSYCHOLOGY OF SEXUAL ORIENTATION AND GENDER DIVERSITY, 4(3) 374 at 375 ("*Psychological Profile*"); R. Kaltiala-Heino et al. (2015), *Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development*, CHILD & ADOLESCENT PSYCHIATRY & MENTAL HEALTH 9(9) 1 at 5. (In 2015 Finland gender identity service statistics, 75% of adolescents assessed "had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria."); L. Littman (2018), *Parent Reports of Adolescents & Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, PLoS ONE 13(8): e0202330 at 13 (Parental survey concerning adolescents exhibiting Rapid Onset Gender Dysphoria reported that 62.5% of gender dysphoric adolescents had "a psychiatric disorder or neurodevelopmental disability preceding the onset of gender dysphoria."

23. The social transitioning, hormonal, and surgical paths often recommended and facilitated by gender clinics may lead to life-long sterilization by the time the patient reaches young adulthood. They may add a future source of despair in an already vulnerable person. Caution, and time to reflect as one matures, are prudent.

D. Three competing conceptual models of gender dysphoria and transgender identity

24. Discussions about appropriate responses by mental health professionals ("MHPs") to actual or sub-threshold gender dysphoria are complicated by the fact that various speakers and advocates (or a single speaker at different times) view transgenderism through at least three very different paradigms, often without being aware of, or at least without acknowledging, the distinctions.

25. Gender dysphoria is **conceptualized and described by some professionals and laypersons as though it were a serious, physical medical illness that causes suffering**, comparable, for example, to prostate cancer, a disease that is curable before it spreads. Within this paradigm, whatever is causing distress associated with gender dysphoria—whether secondary sex characteristics such as facial hair, nose and jaw shape, presence or absence of breasts, or the primary anatomical sex organs of testes, ovaries, penis, or vagina—should be removed to alleviate the illness. The promise of these interventions is the cure of the gender dysphoria.

26. Dr. Adkins appears to endorse this perspective, asserting that gender dysphoria is a “medical condition.” (Adkins 5.) It should be noted, however, that gender dysphoria is a psychiatric, not a medical, diagnosis. Since its inception in DSM-III in 1983, it has always been specified in the psychiatric DSM manuals and is not specified in medical diagnostic manuals. Notably, gender dysphoria is the only psychiatric condition to be treated by surgery, even though

no endocrine or surgical intervention package corrects any identified biological abnormality. (Levine, *Reflections,* at 240.)

27. Gender dysphoria is alternatively **conceptualized in developmental terms**, as an adaptation to a psychological problem that was first manifested as a failure to establish a comfortable conventional sense of self in early childhood. This paradigm starts from the premise that all human lives are influenced by past processes and events. Trans lives are not exceptions to this axiom. (Levine, *Reflections*, at 238.) MHPs who think of gender dysphoria through this paradigm may work both to identify and address causes of the basic problem of the deeply uncomfortable self, and also to ameliorate suffering when the underlying problem cannot be solved. They work with the patient and (ideally) family to inquire what forces may have led to the trans person repudiating the gender associated with his sex. The developmental paradigm is mindful of temperamental, parental bonding, psychological, sexual, and physical trauma influences, and the fact that young children work out their psychological issues through fantasy and play.

28. In addition, the developmental paradigm recognizes that, with the important exception of genetic sex, essentially all aspects of an individual's identity evolve—often markedly—across the individual's lifetime. This includes gender. Some advocates assert that a transgender identity is biologically caused, fixed from early life, and eternally present in an unchanging manner. Taking this line, Dr. Adkins asserts that gender identity is "fixed." (Adkins 5.) This assertion, however, is not supported by science.[9] Although numerous studies have been undertaken to attempt to demonstrate a distinctive physical brain structure associated with transgender identity, as of yet there is no evidence that these patients have any defining

[9] Even the advocacy organization The Human Rights Campaign asserts that a person can have "a fluid or unfixed gender identity." https://www.hrc.org/resources/glossary-of-terms.

abnormality in brain structure that precedes the onset of gender dysphoria. The belief that gender dysphoria is the consequence of brain structure is challenged by the sudden increase in incidence of child and adolescent gender dysphoria over the last twenty years in North America and Europe. Meanwhile, multiple studies have documented rapid shifts in gender ratios of patients presenting for care with gender-related issues, pointing to cultural influences,[10] while a recent study documented "clustering" of new presentations in specific schools and among specific friend groups, pointing to social influences (Littman). Both of these findings strongly suggest cultural factors. From the beginning of epidemiological research into this arena, there have always been some countries, Poland and Australia, for example, where the sex ratios were reversed as compared to North America and Europe, again demonstrating a powerful effect of cultural influences.

29. Further, as I detail later below, many studies and clinical observations confirm that gender identity can and does change or evolve over time for many individuals. And recent studies and anecdotal reports provide strong if preliminary evidence that therapeutic choices can have a powerful effect on whether and how gender identity does change, or gender dysphoria desists.

30. In recent years, for adolescent patients, intense involvement with online transgender communities or "friends" is the rule rather than the exception, and the MHP will also be alert to this as a potentially significant influence on the identity development of the patient.

31. The third paradigm through which gender dysphoria is alternatively conceptualized is from **a sexual minority rights perspective**. Under this paradigm, any response

[10] Levine, *Ethical Concerns*, at 8 (*citing* M. Aitken, T. D. Steensma, et al. (2015), *Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria*, J. OF SEXUAL MEDICINE 12(3) 756 at 756-63).

other than medical and societal affirmation and implementation of a patient's claim to "be" the opposite gender is a violation of the individual's civil right to self-expression. Any effort to ask "why" questions about the patient's condition, or to address underlying causes, is viewed as a violation of autonomy and civil rights. In the last few years, this paradigm has been successful in influencing public policy and the education of pediatricians, endocrinologists, and many mental health professionals. Obviously, however, this is not a medical or psychiatric perspective.

E. Four competing models of therapy

32. Because of the complexity of the human psyche and the difficulty of running controlled experiments in this area, substantial disagreements among professionals about the causes of psychological disorders, and about the appropriate therapeutic responses, are not unusual. When we add to this the very different paradigms for understanding transgender phenomena discussed above, it is not surprising that such disagreements also exist with regard to appropriate therapies for patients experiencing gender-related distress. I summarize below the leading approaches, and offer certain observations and opinions concerning them.

(1) The "watchful waiting" therapy model

33. I review below the uniform finding of follow-up studies that the large majority of children who present with gender dysphoria will desist from desiring a transgender identity by adulthood if left untreated. (See infra ¶ 60.)

34. When a pre-adolescent child presents with gender dysphoria, a "watchful waiting" approach seeks to allow for the fluid nature of gender identity in children to naturally evolve—that is, take its course from forces within and surrounding the child. Watchful waiting has two versions:

a. Treating any other psychological co-morbidities—that is, other mental illnesses as defined by DSM-5—that the child may exhibit (separation anxiety,

bedwetting, attention deficit disorder, obsessive-compulsive disorder) without a focus on gender (model #1); and

b. No treatment at all for anything but a regular follow-up appointment. This might be labeled a "hands off" approach (model #2).

(2) The psychotherapy model: Alleviate distress by identifying and addressing causes (model #3)

35. One of the foundational principles of psychotherapy has long been to work with a patient to identify the causes of observed psychological distress and then to address those causes as a means of alleviating the distress. The National Institute of Mental Health has promulgated the idea that 75% of adult psychopathology has its origins in childhood experience.

36. Many experienced practitioners in the field of gender dysphoria, including myself, have believed that it makes sense to employ these long-standing tools of psychotherapy for patients suffering gender dysphoria, asking the question as to what factors in the patient's life are the determinants of the patient's repudiation of his or her natal sex. (Levine, *Ethical Concerns*, at 8.) I and others have reported success in alleviating distress in this way for at least some patients, whether or not the patient's sense of discomfort or incongruence with his or her natal sex entirely disappeared. Relieving accompanying psychological co-morbidities leaves the patient freer to consider the pros and cons of transition as he or she matures.

37. Among other things, the psychotherapist who is applying traditional methods of psychotherapy may help—for example—the male patient appreciate the wide range of masculine emotional and behavioral patterns as he grows older. He may discuss with his patient, for example, that one does not have to become a "woman" in order to be kind, compassionate,

caring, noncompetitive, and devoted to others' feelings and needs.[11] Many biologically male trans individuals, from childhood to older ages, speak of their perceptions of femaleness as enabling them to discuss their feelings openly, whereas they perceive boys and men to be constrained from emotional expression within the family and larger culture. Men, of course, can be emotionally expressive, just as they can wear pink. Converse examples can be given for girls and women. These types of ideas regularly arise during psychotherapies.

38. As I note above, many gender-nonconforming children and adolescents in recent years derive from minority and vulnerable groups who have reasons to feel isolated and have an uncomfortable sense of self. A trans identity may be a hopeful attempt to redefine the self in a manner that increases their comfort and decreases their anxiety. The clinician who uses traditional methods of psychotherapy may not focus on their gender identity, but instead work to help them to address the actual sources of their discomfort. Success in this effort may remove or reduce the desire for a redefined identity. This often involves a focus on disruptions in their attachment to parents in vulnerable children, for instance, those in the foster care system.

39. Because "watchful waiting" can include treatment of accompanying psychological co-morbidities, and the psychotherapist who hopes to relieve gender dysphoria may focus on potentially causal sources of psychological distress rather than on the gender dysphoria itself, there is no sharp line between "watchful waiting" and the psychotherapy model in the case of prepubescent children.

40. To my knowledge, there is no evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescents, and men, or return to female identification for genetically female girls, adolescents, and women.

[11] S. Levine (2017), *Transitioning Back to Maleness*, ARCH. OF SEXUAL BEHAVIOR at 7, DOI: 10.1007/s10508-017-1136-9) ("*Transitioning*").

On the other hand, anecdotal evidence of such outcomes does exist; I and other clinicians have witnessed reinvestment in the patient's biological sex in some individual patients who are undergoing psychotherapy. The Internet contains many such reports, and I have published a paper on a patient who sought my therapeutic assistance to reclaim his male gender identity after 30 years living as a woman and is in fact living as a man today. (Levine, *Transitioning*, at 1.) I have seen children desist even before puberty in response to thoughtful parental interactions and a few meetings of the child with a therapist.

(3) The affirmation therapy model (model #4)

41. While it is widely agreed that the therapist should not directly challenge a claimed transgender identity in a child, some advocates and practitioners go much further, and promote and recommend that any expression of transgender identity should be immediately accepted as decisive, and thoroughly affirmed by means of consistent use of clothing, toys, pronouns, etc., associated with transgender identity. As I understand it, this is asserted as a reason why male students who assert a female gender identity must be permitted to compete in girls' or women's athletic events. These advocates treat any question about the causes of the child's transgender identification as inappropriate, and assume that observed psychological co-morbidities in the children or their families are unrelated or will get better with transition, and need not be addressed by the MHP who is providing supportive guidance concerning the child's gender identity.

42. Some advocates, indeed, assert that unquestioning affirmation of any claim of transgender identity in children is essential, and that the child will otherwise face a high risk of suicide or severe psychological damage. Dr. Adkins appears to follow this line, asserting that "My clinical experience . . . has been that [patients] suffer and experience worse health outcomes" when they are not permitted to enter all spaces and participate in all activities in a

manner "consistent with gender identity." (Adkins 11.) I address claims about suicide and health outcomes in Sections IV and V below.

43. Dr. Adkins asserts that fully supported social transition is the "only treatment for prepubertal children." (Adkins 7.) As my discussion above indicates, this is not correct. On the contrary, one respected academic in the field has recently written that "almost all clinics and professional associations in the world" do not use "gender affirmation" for prepubescent children and instead "delay any transitions after the onset of puberty."[12]

44. It is notable that even the Standards of Care published by WPATH, an organization which in general leans strongly towards affirmation in the case of adults, do not specify affirmation of transgender identity as the indicated therapeutic response for young children. Instead, the WPATH Standards of Care recognize that social transition in early childhood "is a controversial issue, and divergent views are held by health professionals"; state that "[t]he current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood"; and acknowledge that "previously described relatively low persistence rates of childhood gender dysphoria" are "relevant" to the wisdom of social transition in childhood. (WPATH SOC p. 17.)

45. Dr. Adkins cites a statement published by the American Academy of Pediatrics (Rafferty 2019) as asserting that "gender transition" "is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria." (Adkins 7.) Dr. Adkins neglects to mention that a detailed and peer-reviewed review of that AAP statement by prominent researcher James Cantor concluded that "In its policy

[12] J. Cantor (2019), *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. OF SEX & MARITAL THERAPY at 1, DOI: 10.1080.0092623X.2019.1698481.

statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all," and described Rafferty 2019 as "a systematic exclusion and misrepresentation of entire literatures." Based on my professional expertise and my review of the literature, I agree with Dr. Cantor's evaluation of Rafferty 2019.

46. In fact, the DSM-5 added—for both children and adolescents—a requirement that a sense of incongruence between biological and felt gender must last at least six months as a precondition for a diagnosis of gender dysphoria, precisely because of the risk of "transitory" symptoms and "hasty" diagnosis that might lead to "inappropriate" treatments.[13]

47. I do not know what proportion of practitioners are using which model. However, in my opinion, in the case of young children, prompt and thorough affirmation of a transgender identity disregards the principles of child development and family dynamics and is not supported by science. Rather, the MHP must focus attention on the child's underlying internal and familial issues. Ongoing relationships between the MHP and the parents, and the MHP and the child, are vital to help the parents, child, other family members, and the MHP to understand over time the issues that need to be dealt with over time by each of them.

48. Likewise, since the child's sense of gender develops in interaction with his parents and their own gender roles and relationships, the responsible MHP will almost certainly need to delve into family and marital dynamics.

F. Patients Differ Widely and Must Be Considered Individually.

49. In my opinion, it is not possible to make a single, categorical statement about the proper treatment of children or adolescents presenting with gender dysphoria or other gender-

[13] K. Zucker (2015), *The DSM-5 Diagnostic Criteria for Gender Dysphoria*, in C. Trombetta et al. (eds.), MANAGEMENT OF GENDER DYSPHORIA: A MULTIDISCIPLINARY APPROACH, DOI 10.1007/978-88-470-5696-1_4 (Springer-Verlag Italia 2015).

related issues. There is no single pathway of development and outcomes governing transgender identity, nor one that predominates over the large majority of cases. Instead, as individuals grow up and age, depending on their differing psychological, social, familial, and life experiences, their outcomes differ widely.

50. As to causes in children and adolescents, details about the onset of gender dysphoria may be found in an understanding of family relationship dynamics. In particular, the relationship between the parents and each of the parents and the child, and each of the siblings and the child, should be well known by the MHP. Further, a disturbingly large proportion of children and adolescents who seek professional care in connection with gender issues have a wider history of psychiatric co-morbidities. (*See supra* n. 9.) A 2017 study from the Boston Children's Hospital Gender Management Service program reported that: "Consistent with the data reported from other sites, this investigation documented that 43.3% of patients presenting for services had significant psychiatric history, with 37.1% having been prescribed psychotropic medications, 20.6% with a history of self-injurious behavior, 9.3% with a prior psychiatric hospitalization, and 9.3% with a history of suicide attempts." (L. Edwards-Leeper, *Psychological Profile*, at 375.) It seems likely that an even higher proportion will have had prior undiagnosed psychiatric conditions.

51. In the case of adolescents, as I have noted above, there is evidence that peer social influences through "friend groups" (Littman) or through the internet can increase the incidence of gender dysphoria or claims of transgender identity, so the responsible MHP will want to probe these potential influences to better understand what is truly deeply tied to the psychology of this particular individual, and what may instead be "tried on" by the youth as part of the adolescent process of self-exploration and self-definition.

G. Understanding the WPATH and its "Standards of Care"

52. Dr. Adkins notes that she is a member of the World Professional Association for Transgender Health (WPATH), invokes Standards of Care that that organization publishes, and asserts that the WPATH Standards of Care are "widely accepted." (Adkins 3, 6.) Accordingly, I provide some context concerning that private organization and its Standards of Care.

53. I was a member of the Harry Benjamin International Gender Dysphoria Association from 1974 until 2001. From 1997 through 1998, I served as the Chairman of the eight-person International Standards of Care Committee that issued the fifth version of the Standards of Care. I resigned my membership in 2002 due to my regretful conclusion that the organization and its recommendations had become dominated by politics and ideology, rather than by scientific process, as it was years earlier. In approximately 2007, the Henry Benjamin International Gender Dysphoria Association changed its name to the World Professional Association for Transgender Health.

54. WPATH is a voluntary membership organization. Since at least 2002, attendance at its biennial meetings has been open to trans individuals who are not licensed professionals. While this ensures taking patients' needs into consideration, it limits the ability for honest and scientific debate, and means that WPATH can no longer be considered a purely professional organization.

55. WPATH takes a decided view on issues as to which there is a wide range of opinion among professionals. WPATH explicitly views itself as not merely a scientific organization, but also as an advocacy organization. (Levine, *Reflections,* at 240.) WPATH is supportive to those who want sex reassignment surgery ("SRS"). Skepticism as to the benefits of SRS to patients, and strong alternate views, are not well tolerated in discussions within the organization or their educational outreach programs. Such views have been known to be shouted

down and effectively silenced by the large numbers of nonprofessional adults who attend the organization's biennial meetings.

56. The Standards of Care ("SOC") is the product of an enormous effort to be balanced, but it is not a politically neutral document. WPATH aspires to be both a scientific organization and an advocacy group for the transgendered. These aspirations sometimes conflict. The limitations of the Standards of Care, however, are not primarily political. They are caused by the lack of rigorous research in the field, which allows room for passionate convictions on how to care for the transgendered.

57. In recent years, WPATH has fully adopted some mix of the medical and civil rights paradigms. It has downgraded the role of counseling or psychotherapy as a requirement for these life-changing processes. WPATH no longer considers preoperative psychotherapy to be a requirement. It is important to WPATH that the person has gender dysphoria; the pathway to the development of this state is not. (Levine, *Reflections*, at 240.) The trans person is assumed to have thoughtfully considered his or her options before seeking hormones, for instance.

58. Most psychiatrists and psychologists who treat patients suffering sufficiently severe distress from gender dysphoria to seek inpatient psychiatric care are not members of WPATH. Many psychiatrists, psychologists, and pediatricians who treat some patients suffering gender dysphoria on an outpatient basis are not members of WPATH. WPATH represents a self-selected subset of the profession along with its many non-professional members; it does not capture the clinical experiences of others. WPATH claims to speak for the medical profession; however, it does not welcome skepticism and therefore, deviates from the philosophical core of medical science.

59. For example, in 2010 the WPATH Board of Directors issued a statement advocating that incongruence between sex and felt gender identity should cease to be identified in the DSM as a pathology.[14] This position was debated but not adopted by the (much larger) American Psychiatric Association, which maintained the definitions and diagnoses of gender dysphoria as a pathology in the DSM-5 manual issued in 2013.

60. In my experience most current members of WPATH have little ongoing experience with the mentally ill, and many trans care facilities are staffed by MHPs who are not deeply experienced with recognizing and treating frequently associated psychiatric co-morbidities. Because the 7th version of the WPATH SOC deleted the requirement for therapy, trans care facilities that consider these Standards sufficient are permitting patients to be counseled to transition by means of social presentation, hormones, and surgery by individuals with masters rather than medical degrees. As a result of the downgrading of the role of the psychiatric assessment of patients, new "gender affirming" clinics have arisen in many urban settings that quickly (sometimes within an hour's time) recommend transition. Concerned parents who came wanting to know what is going on in their children are overwhelmed, and feel disoriented, fearful for the health and safety of their children, and dependent on the professional. In has been nine years since the Standards of Care were last revised. Much has changed in that interval. It is my understanding that the complex committee process that will generate an 8th version is underway.

[14] WPATH *De-Psychopathologisation Statement* (May 26, 2010), available at wpath.org/policies (last accessed January 21, 2020).

III. GENDER IDENTITY, GENDER DYSPHORIA, AND THERAPIES FOR GENDER DYSPHORIA IN YOUNGER CHILDREN

61. A distinctive and critical characteristic of juvenile gender dysphoria is that multiple studies from separate groups and at different times have reported that in the large majority of patients, absent a substantial intervention such as social transition and/or hormone therapy, it does *not* persist through puberty. A recent article reviewed all existing follow-up studies that the author could identify of children diagnosed with gender dysphoria (11 studies), and reported that "every follow-up study of GD children, without exception, found the same thing: By puberty, the majority of GD children ceased to want to transition." (Cantor at 1.) Another author reviewed the existing studies and reported that in "prepubertal boys with gender discordance . . . the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance."[15] A third summarized the existing data as showing that "Symptoms of GID at prepubertal ages decrease or disappear in a considerable percentage of children (estimates range from 80-95%)."[16]

62. It is not yet known how to distinguish those children who will desist from that small minority whose trans identity will persist. (Levine, *Ethical Concerns*, at 9.)[17]

63. Desistance within a relatively short period may also be a common outcome for post-pubertal youths who exhibit recently described "rapid onset gender disorder." I observe an increasingly vocal online community of young women who have reclaimed a female identity

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[15] S. Adelson & American Academy of Child & Adolescent Psychiatry (2012), *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 51(9) 957 at 963 ("*Practice Parameter*").

[16] P. T. Cohen-Kettenis, H. A. Delemarre-van de Waal et al. (2008), *The Treatment of Adolescent Transsexuals: Changing Insights*, J. SEXUAL MEDICINE 5(8) 1892 at 1895.

[17] It is also apparent in the adolescent phenomenon of rapid onset of gender dysphoria following a gender normative childhood that childhood gender identity is not inherently stable in either direction.

after claiming a male gender identity at some point during their teen years. However, data on outcomes for this age group with and without therapeutic interventions is not yet available to my knowledge.

64. In contrast, there is now data that suggests that a therapy that encourages social transition before or during puberty—which would include participation on athletic teams designated for the opposite sex—dramatically changes outcomes. A prominent group of authors has written that "The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood."[18] Similarly, a comparison of recent and older studies suggests that when an "affirming" methodology is used with children, a substantial proportion of children who would otherwise have desisted by adolescence—that is, achieved comfort identifying with their natal sex—instead persist in a transgender identity. (Zucker, *Myth of Persistence*, at 7.)[19]

65. Indeed, a review of multiple studies of children treated for gender dysphoria across the last three decades found that early social transition to living as the opposite sex severely reduces the likelihood that the child will revert to identifying with the child's natal sex, at least in the case of boys. That is, while, as I review above, studies conducted before the widespread use of social transition for young children reported desistance rates in the range of 80-98%, a more recent study reported that fewer than 20% of boys who engaged in a partial or complete social transition before puberty had desisted when surveyed at age 15 or older. (Zucker,

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[18] C. Guss et al. (2015), *Transgender and Gender Nonconforming Adolescent Care: Psychosocial and Medical Considerations*, CURR. OPIN. PEDIATR. 26(4) 421 at 421 ("TGN Adolescent Care").

[19] One study found that social transition by the child was found to be strongly correlated with persistence for natal boys, but not for girls. (Zucker, *Myth of Persistence*, at 5 (citing T.D. Steensma, J.K. McGuire et al. (2013), *Factors Associated with Desistance & Persistence of Childhood Gender Dysphoria: A Qualitative Follow-up Study*, J. OF THE AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 52, 582.).)

Myth of Persistence, at 7; Steensma (2013).)[20] Some vocal practitioners of prompt affirmation and social transition even claim that essentially *no* children who come to their clinics exhibiting gender dysphoria or cross-gender identification desist in that identification and return to a gender identity consistent with their biological sex.[21] This is a very large change as compared to the desistance rates documented apart from social transition. Some researchers who generally advocate prompt affirmation and social transition also acknowledge a causal connection between social transition and this change in outcomes.[22]

66. Accordingly, I agree with a noted researcher in the field who has written that social transition in children must be considered "a form of psychosocial treatment." (Zucker, *Debate*, at 1.)

67. Dr. Adkins speaks of the use of puberty blockers as though this major hormonal disruption of some of the most basic aspects of ordinary human development were a small thing, and entirely benign. (Adkins 8.) It should be understood that puberty blockers are usually administered to early-stage adolescents as part of a path that includes social transition. I address later medical, social, and mental health risks associated with the use of puberty blockers. Here, I note that the data reviewed above strongly suggests that the administration of puberty blockers,

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[20] Only 2 (3.6%) of 56 of the male desisters observed by Steensma et al. had made a complete or partial transition prior to puberty, and of the twelve males who made a complete or partial transition prior to puberty, only two had desisted when surveyed at age 15 or older. Steensma (2013) at 584.

[21] *See, e.g.,* B. Ehrensaft (2015), *Listening and Learning from Gender-Nonconforming Children*, THE PSYCHOANALYTIC STUDY OF THE CHILD 68(1) 28 at 34: "In my own clinical practice . . . of those children who are carefully assessed as transgender and who are allowed to transition to their affirmed gender, we have no documentation of a child who has 'desisted' and asked to return to his or her assigned gender."

[22] *See* Guss, *TGN Adolescent Care*, at 2. "The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood." "Youth with persistent TNG [transgender, nonbinary, or gender-nonconforming] identity into adulthood . . . are more likely to have experienced social transition, such as using a different name . . . which is stereotypically associated with another gender at some point during childhood."

too, must be considered to be a component of a "psychosocial treatment" with complex implications, and an experimental treatment at that.

68. So far as I am aware, no study yet reveals whether the life-course mental and physical health outcomes for this relatively new class of "persisters" are more similar to those of the general non-transgender population, or to the notably worse outcomes exhibited by the transgender population generally.

69. However, I agree with Zucker who has written, "…we cannot rule out the possibility that early successful treatment of childhood GID [Gender Identity Disorder] will diminish the role of a continuation of GID into adulthood. If so, successful treatment would also reduce the need for the long and difficult process of sex reassignment which includes hormonal and surgical procedures with substantial medical risks and complications."[23] By the same token, a therapeutic methodology for children that *increases* the likelihood that the child will continue to identify as the opposite gender into adulthood will *increase* the need for the long and potentially problematic processes of hormonal and genital and cosmetic surgical procedures.

70. Not surprisingly, given these facts, encouraging social transition in children remains controversial. Supporters of such transition acknowledge that "Controversies among providers in the mental health and medical fields are abundant. . . . These include differing assumptions regarding . . . the age at which children . . . should be encouraged or permitted to

[23] Zucker, *Myth of Persistence*, at 8 (citing H. Meyer-Bahlburg (2002), *Gender Identity Disorder in Young Boys: A Parent- & Peer-Based Treatment Protocol*, CLINICAL CHILD PSYCHOLOGY & PSYCHIATRY 7, 360 at 362.).

socially transition . . . . These are complex and providers in the field continue to be at odds in their efforts to work in the best interests of the youth they serve."[24]

71. In sum, therapy for young children that encourages transition (including use of names, clothing and restrooms, and participating on athletic teams, associated with the opposite sex) cannot be considered to be neutral, but instead is an experimental procedure that has a high likelihood of changing the life path of the child, with highly unpredictable effects on mental and physical health, suicidality, and life expectancy. Claims that a civil right is at stake do not change the fact that what is proposed is a social and medical experiment. (Levine, *Reflections,* at 241.) Ethically, then, it should be undertaken only subject to standards, protocols, and reviews appropriate to such experimentation.

IV. THE AVAILABLE DATA DOES NOT SUPPORT THE CONTENTION THAT "AFFIRMATION" OF TRANSGENDER IDENTITY REDUCES SUICIDE OR RESULTS IN BETTER PHYSICAL OR MENTAL HEALTH OUTCOMES GENERALLY.

72. I am aware that organizations including The Academy of Pediatrics and Parents, Families and Friends of Lesbians and Gays (PFLAG) have published statements that suggest that all children who express a desire for a transgender identity should be promptly supported in that claimed identity. This position appears to rest on the belief—which is widely promulgated by certain advocacy organizations—that science has already established that prompt "affirmance" is best for all patients, including all children, who present indicia of transgender identity. As I discuss later below, this belief is scientifically incorrect, and ignores both what is known and what is unknown.

[24] A. Tishelman et al. (2015), *Serving Transgender Youth: Challenges, Dilemmas and Clinical Examples*, PROF. PSYCHOL. RES. PR. at 11, DOI: 10.1037/a0037490 ("*Serving TG Youth*").

73. The knowledge-base concerning the causes and treatment of gender dysphoria has low scientific quality.

74. In evaluating claims of scientific or medical knowledge, it is important to understand that it is axiomatic in science that no knowledge is absolute, and to recognize the widely-accepted hierarchy of reliability when it comes to "knowledge" about medical or psychiatric phenomena and treatments. Unfortunately, in this field opinion is too often confused with knowledge, rather than clearly locating what exactly is scientifically known. In order of increasing confidence, such "knowledge" may be based upon data comprising:

a. Expert opinion—it is perhaps surprising to educated laypersons that expert opinion standing alone is the lowest form of knowledge, the least likely to be proven correct in the future, and therefore does not garner as much respect from professionals as what follows;

b. A single case or series of cases (what could be called anecdotal evidence) (Levine, *Reflections*, at 239.);

c. A series of cases with a control group;

d. A cohort study;

e. A randomized double-blind clinical trial;

f. A review of multiple trials;

g. A meta-analysis of multiple trials that maximizes the number of patients treated despite their methodological differences to detect trends from larger data sets.

75. Prominent voices in the field have emphasized the severe lack of scientific knowledge in this field. The American Academy of Child and Adolescent Psychiatry has recognized that "Different clinical approaches have been advocated for childhood gender

discordance. . . . There have been no randomized controlled trials of any treatment. . . . [T]he proposed benefits of treatment to eliminate gender discordance … must be carefully weighed against … possible deleterious effects." (Adelson et al., *Practice Parameter*, at 968–69.) Similarly, the American Psychological Association has stated, "because no approach to working with [transgender and gender nonconforming] children has been adequately, empirically validated, consensus does not exist regarding best practice with pre-pubertal children."[25]

76. Critically, "there are no randomized control trials with regard to treatment of children with gender dysphoria." (Zucker, *Myth of Persistence*, at 8.) On numerous critical questions relating to cause, developmental path if untreated, and the effect of alternative treatments, the knowledge-base remains primarily at the level of the practitioner's exposure to individual cases, or multiple individual cases. As a result, claims to certainty are not justifiable. (Levine, *Reflections*, at 239.)

77. Extending beyond treatment of children, a review of 28 studies of outcomes from hormonal therapy in connection with sex reassignment reported that these studies provided only "very low quality evidence" for a variety of reasons.[26] Large gaps exist in the medical community's knowledge regarding the long-term effects of SRS and other gender identity disorder treatments in relation to their positive or negative correlation to suicidal ideation, attempts, and completion. What is known, however, is not encouraging.

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[25] American Psychological Association, *Guidelines for Psychological Practice with Transgender & Gender Nonconforming People* (2015), AM. PSYCHOLOGIST 70(9) 832 at 842.

[26] H. Murad et al., *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes*. CLINICAL ENDOCRINOLOGY 2010; 72(2): 214-231. *See also* R. D'Angelo, *Psychiatry's ethical involvement in gender-affirming care*, AUSTRALASIAN PSYCHIATRY 2018, Vol 26(5) 460-463, noting the large number of non-responders in follow-up outcome studies, and observing that "it is generally not known whether they are alive or dead," and that "it is . . . pure speculation to assume that none committed suicide."

78. With respect to suicide, individuals with gender dysphoria are well known to commit suicide or otherwise suffer increased mortality before and after not only social transition, but also before and after SRS. (Levine, *Reflections,* at 242.) For example, in the United States, the death rates of trans veterans are comparable to those with schizophrenia and bipolar diagnoses—20 years earlier than expected. These crude death rates include significantly elevated suicide rates. (Levine, *Ethical Concerns,* at 10.) Similarly, researchers in Sweden and Denmark have reported on almost all individuals who underwent sex-reassignment surgery over a 30-year period.[27] The Swedish follow-up study found a suicide rate in the post-SRS population 19.1 times greater than that of the controls; both studies demonstrated elevated mortality rates from medical and psychiatric conditions. (Levine, *Ethical Concerns*, at 10.)

79. Advocates of immediate and unquestioning affirmation of social transition in children who indicate a desire for a transgender identity sometimes assert that any other course will result in a high risk of suicide in the affected children and young people. Dr. Adkins asserts that "Attempted suicide rates in the transgender community are over 40%," and that "[t]he only treatment to avoid this serious harm is to . . . affirm gender identity." (Adkins 6.) Contrary to these assertions, no studies show that affirmation of children (or anyone else) reduces suicide, prevents suicidal ideation, or improves long-term outcomes, as compared to either a "watchful waiting" or a psychotherapeutic model of response, as I have described above.[28] In considering

[27] C. Dhejne et al. (2011), *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden,* PLOS ONE 6(2) e16885 ("*Long Term*"); R. K. Simonsen et al. (2016), *Long-Term Follow-Up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity & Mortality*, NORDIC J. OF PSYCHIATRY 70(4).

[28] A recent article, J. Turban et al. (2020), *Puberty Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS 145(2), DOI: 10.1542/peds.2019-1725, has been described in press reports as demonstrating that administration of puberty suppressing hormones to transgender adolescents reduces suicide or suicidal ideation. The paper itself does not make that claim, nor permit that conclusion.

"suicide," mental health professionals distinguish between suicidal thoughts (ideation), suicide gestures, suicide attempts with a lethal potential, and completed suicide. Dr. Atkins may be referring to numerous studies that have found suicidal ideation to have been present at some time in life in ~40-50%. This figure is approximately twice that in gay and lesbian communities. In the heteronormative communities it is approximately 4%. Mental health professionals distinguish clearly between gestures and potentially lethal attempts, which often result in hospitalization.

80. I will also note that any discussion of suicide when considering younger children involves very long-range and very uncertain prediction. Suicide in pre-pubescent children is rare and the existing studies of gender identity issues in pre-pubescent children do not report significant incidents of suicide. The estimated suicide rate of trans adolescents is the same as teenagers who are in treatment for serious mental illness. What trans teenagers do demonstrate is more suicidal ideation and attempts (however serious) than other teenagers.[29] Their completed suicide rates are not known.

81. In sum, claims that affirmation will reduce the risk of suicide for children are not based on science. Such claims overlook the lack of even short-term supporting data as well as the lack of studies of long-term outcomes resulting from the affirmation or lack of affirmation of transgender identity in children. They also overlook the other tools that the profession does have for addressing depression and suicidal thoughts in a patient once that risk is identified. (Levine, *Reflections*, at 242.)

[29] A. Perez-Brumer, J. K. Day et al. (2017), *Prevalence & Correlates of Suicidal Ideation Among Transgender Youth in Cal.: Findings from a Representative, Population-Based Sample of High Sch. Students*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 56(9), 739 at 739.

82. A number of data sets have also indicated significant concerns about wider indicators of physical and mental health, including ongoing functional limitations;[30] substance abuse, depression, and psychiatric hospitalizations;[31] and increased cardiovascular disease, cancer, asthma, and COPD.[32] Worldwide estimates of HIV infection among transgendered individuals are up to 17-fold higher than the cisgender population. (Levine, *Informed Consent*, at 6.)

83. Meanwhile, no studies show that affirmation of pre-pubescent children or adolescents leads to more positive outcomes (mental, physical, social, or romantic) by, e.g., age 25 or older than does "watchful waiting" or ordinary therapy. Because affirmation and social transition for children and adolescents, and the use of puberty blockers for transgender children, are a recent phenomenon, it could hardly be otherwise.

84. Given what is known and what is not known about the incidence and causes of suicide attempts and suicide in children and adolescents who suffer from gender dysphoria, and what is known about the incidence of suicide attempts and suicide in individuals who have transitioned to live in a transgender identity, it is in my view unethical for a mental health professional to tell a young patient, or the parents of a young patient, that social transition, puberty blockers, or use of cross-sex hormones will reduce the likelihood that the young person will commit suicide.

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[30] G. Zeluf, C. Dhejne et al. (2016), *Health, Disability and Quality of Life Among Trans People in Sweden—A Web-Based Survey*, BMC PUBLIC HEALTH 16(903), DOI: 10.1186/s12889-016-3560-5.

[31] C. Dhejne, R. Van Vlerken et al. (2016), *Mental Health & Gender Dysphoria: A Review of the Literature*, INT'L REV. OF PSYCHIATRY 28(1) 44.

[32] C. Dragon, P. Guerino, et al. (2017), *Transgender Medicare Beneficiaries & Chronic Conditions: Exploring Fee-for-Service Claims Data*, LGBT HEALTH 4(6) 404, DOI: 10.1089/lgbt.2016.0208.

85. Instead, transition of any sort must be justified, if at all, as a life-enhancing measure, not a lifesaving measure. (Levine, *Reflections,* at 242.) In my opinion, this is an important fact that patients, parents, and even many MHPs fail to understand.

V. KNOWN, LIKELY, OR POSSIBLE DOWNSIDE RISKS ATTENDANT ON MOVING QUICKLY TO "AFFIRM" TRANSGENDER IDENTITY IN CHILDREN.

86. As I have detailed above, enabling and affirming social transition in a prepubescent child appears to be highly likely to increase the odds that the child will in time pursue pubertal suppression and persist in a transgender identity into adulthood. This means that the MHP, patient, and in the case of minors, parents must consider long-term as well as short-term implications of life as a transgender individual when deciding whether to permit or encourage a child to socially transition.

87. Dr. Adkins asserts without citation to peer-reviewed literature that social transition and hormone therapy are "safe, effective and essential" for young people. (Adkins 6, 10.) A great deal of data point in the opposite direction. The multiple studies from different nations that have documented the increased vulnerability of the adult transgender population to substance abuse, mood and anxiety disorders, suicidal ideation, and other health problems warn us that assisting the child or adolescent down the road to becoming a transgender adult is a very serious decision, and stand as a reminder that a casual assumption that transition will improve the young person's life is not justified based on numerous scientific snapshots of cohorts of trans adults and teenagers.

88. The possibility that steps along this pathway, while lessening the pain of gender dysphoria, could lead to additional sources of crippling emotional and psychological pain, are

too often not considered by advocates of social transition and not considered at all by the trans child. (Levine, *Reflections*, at 243.)

89. I detail below several classes of predictable, likely, or possible harms to the patient associated with transitioning to live as a transgender individual.

A. Physical risks associated with transition

90. Sterilization. Dr. Adkins rightly notes that many patients who begin down the path defined by puberty blockers and social transition end up feeling the need to undergo "surgical treatment" "to alleviate gender dysphoria." (Adkins 10.) As I have noted above, there is not good scientific evidence that SRS results in better long-term mental health outcomes. What is certain, however, is that SRS that removes testes, ovaries, or the uterus is inevitably sterilizing. While by no means all transgender adults elect SRS, many patients do ultimately feel compelled to take this serious step in their effort to live fully as the opposite sex. More immediately, practitioners recognize that the administration of cross-sex hormones, which is often viewed as a less "radical" measure, and is now increasingly done to minors, creates at least a risk of irreversible sterility.[33] As a result, even when treating a child, the MHP, patient, and parents must consider loss of reproductive capacity—sterilization—to be one of the major risks of starting down the road. The risk that supporting social transition may put the child on a pathway that leads to intentional or unintentional permanent sterilization is particularly concerning given the disproportionate representation of minority and other vulnerable groups among children reporting a transgender or gender-nonconforming identity. (*See supra* ¶ 21.)

[33] *See* C. Guss et al., *TGN Adolescent Care* at 4 ("a side effect [of cross-sex hormones] may be infertility") and 5 ("cross-sex hormones . . . may have irreversible effects"); Tishelman et al., *Serving TG Youth* at 8 (Cross-sex hormones are "irreversible interventions" with "significant ramifications for fertility").

91. Loss of sexual response. Puberty blockers prevent maturation of the sexual organs and response. Some, and perhaps many, transgender individuals who transitioned as children and thus did not go through puberty consistent with their sex face significantly diminished sexual response as they enter adulthood and are unable ever to experience orgasm. Dr. Adkins acknowledges that those "who undergo hormone treatment before the end of puberty may experience some permanent changes that a person who transitions later in life would not" (Adkins 10), and this may be one of the irreversible effects to which she refers. She may also be referring to the social, psychological, and interpersonal impact of not being in puberty for 4-5 years while one's peers are challenged by the normative processes of maturing bodies and minds. To my knowledge, data quantifying these impacts has not been published. In the case of males, the cross-sex administration of estrogen limits penile genital function. Much has been written about the negative psychological and relational consequences of anorgasmia among non-transgender individuals that is ultimately applicable to the transgendered. (Levine, *Informed Consent*, at 6.)

92. Other effects of hormone administration. While it is commonly said that the effects of puberty blockers are reversible after cessation (Dr. Adkins describes the effect of puberty blockers as just a "pause" (Adkins 8)), in fact controlled studies have not been done of how completely this is true. A more prudent assessment is that medicine does not know what the long-term health effects on bone, brain, and other organs are of a "pause" between ages 11-16, and psychology likewise does not know the long-term effects on coping skills, interpersonal comfort, and intimate relationships of this "pause" while one's peers are undergoing their maturational gains in these vital arenas of future mental health. However, it is well known that many effects of cross-sex hormones cannot be reversed should the patient later regret his

transition. After puberty, the individual who wishes to live as the opposite sex will in most cases have to take cross-sex hormones for most of life.

93. The long-term health risks of this major alteration of hormonal levels have not yet been quantified in terms of exact risk.[34] However, a recent study found greatly elevated levels of strokes and other acute cardiovascular events among male-to-female transgender individuals taking estrogen. Those authors concluded, "it is critical to keep in mind that the risk for these cardiovascular events in this population must be weighed against the benefits of hormone treatment."[35] Another group of authors similarly noted that administration of cross-sex hormones creates "an additional risk of thromboembolic events"—which is to say blood clots (Guss et al., *TGN Adolescent Care* at 5), which are associated with strokes, heart attacks, and lung and liver failure. Clinicians must distinguish the apparent short-term safety of hormones from likely or possible long-term consequences, and help the patient or parents understand these implications as well. The young patient may feel, "I don't care if I die young, just as long I get to live as a woman." The mature adult may take a different view.

94. Health risks inherent in complex surgery. Complications of surgery exist for each procedure,[36] and complications in surgery affecting the reproductive organs and urinary tract can have significant anatomical and functional complications for the patient's quality of life.

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[34] *See* Tishelman et al., *Serving TG Youth* at 6-7 (Long-term effect of cross-sex hormones "is an area where we currently have little research to guide us.").

[35] D. Getahun et al. (2018), *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, ANNALS OF INTERNAL MEDICINE at 8, DOI:10.7326/M17-2785.

[36] Levine, *Informed Consent*, at 5 (citing T. van de Grift, G. Pigot et al. (2017), *A Longitudinal Study of Motivations Before & Psychosexual Outcomes After Genital Gender-Confirming Surgery in Transmen*, J. SEXUAL MEDICINE 14(12) 1621.).

95. Disease and mortality generally. The MHP, the patient, and in the case of a child, the parent must also be aware of the wide sweep of strongly negative health outcomes among transgender individuals, as I have detailed above.

B. Social risks associated with transition

96. Family and friendship relationships. Gender transition routinely leads to isolation from at least a significant portion of one's family in adulthood. In the case of a juvenile transition, this will be less dramatic while the child is young, but commonly increases over time as siblings who marry and have children of their own do not wish the transgender individual to be in contact with those children. By adulthood, the friendships of transgender individuals tend to be confined to other transgender individuals (often "virtual" friends known only online) and the generally limited set of others who are comfortable interacting with transgender individuals. (Levine, *Ethical Concerns*, at 5.)

97. Long term psychological and social impact of sterility. The life-long negative emotional impact of infertility on both men and women has been well studied. While this impact has not been studied specifically within the transgender population, the opportunity to be a parent is likely a human, emotional need, and so should be considered an important risk factor when considering gender transition for any patient. However, it is particularly difficult for parents of a young child to seriously contemplate that child's potential as a future parent and grandparent. This makes it all the more critical that the MHP spend substantial and repeated time with parents to help them see the implications of what they are considering.

98. Sexual-romantic risks associated with transition. After adolescence, transgender individuals find the pool of individuals willing to develop a romantic and intimate relationship with them to be greatly diminished. When a trans person who passes well reveals his or her natal sex, many potential cisgender mates lose interest. When a trans person does not pass well, he

discovers that the pool of those interested consists largely of individuals looking for exotic sexual experiences rather than genuinely loving relationships. (Levine, *Ethical Concerns*, at 5, 13.) Nor is the problem all on the other side; transgender individuals commonly become strongly narcissistic, unable to give the level of attention to the needs of another that is necessary to sustain a loving relationship.[37]

99. Social risks associated with delayed puberty. The social and psychological impacts of remaining puerile for, e.g., three-to- five years while one's peers are undergoing pubertal transformations, and of undergoing puberty at a substantially older age, have not been systematically studied, although clinical mental health professionals often hear of distress and social awkwardness in those who naturally have a delayed onset of puberty. In my opinion, individuals in whom puberty is delayed multiple years are likely to suffer at least subtle negative psychosocial and self-confidence effects as they stand on the sidelines while their peers are developing the social relationships (and attendant painful social learning experiences) that come with adolescence. (Levine, *Informed Consent*, at 9.)

C. Mental health costs or risks

100. One would expect the negative physical and social impacts reviewed above to adversely affect the mental health of individuals who have transitioned. In addition, adult transitioned individuals find that living as the other (or, in a manner that is consistent with the stereotypes of the other as the individual perceives them) is a continual challenge and stressor, and many find that they continue to struggle with a sense of inauthenticity in their transgender identity. (Levine, *Informed Consent*, at 9.)

[37] S. Levine, *Barriers to Loving: A Clinician's Perspective*, at 40 (Routledge, New York 2013).

101. In addition, individuals often pin excessive hope in transition, believing that transition will solve what are in fact ordinary social stresses associated with maturation, or mental health co-morbidities. Thus, transition can result in deflection from mastering personal challenges at the appropriate time or addressing conditions that require treatment.

102. Whatever the reason, transgender individuals including transgender youth certainly experience greatly increased rates of mental health problems. I have detailed this above with respect to adults living under a transgender identity. Indeed, Swedish researchers in a long-term study (up to 30 years since SRS, with a median time since SRS of > 10 years) concluded that individuals who have SRS should have postoperative lifelong psychiatric care. (Dhejne, *Long Term*, at 6-7.) With respect to youths a cohort study found that transgender youth had an elevated risk of depression (50.6% vs. 20.6%) and anxiety (26.7% vs. 10.0%); a higher risk of suicidal ideation (31.1% vs. 11.1%), suicide attempts (17.2% vs. 6.1%), and self-harm without lethal intent (16.7% vs. 4.4%) relative to the matched controls; and a significantly greater proportion of transgender youth accessed inpatient mental health care (22.8% vs. 11.1%) and outpatient mental health care (45.6% vs. 16.1%) services.[38]

103. Dr. Adkins asserts that when the "transition, affirmation, and hormones" therapy that she advocates is followed, "gender dysphoria is easily managed." (Adkins 6.) I am not aware of any long-term studies that justify this assertion, and as I have explained above, the responsible MHP cannot focus narrowly on the short-term happiness of the patient, but must instead consider the happiness and health of the patient from a "life course" perspective. The many studies that I have cited here warn us that as we look ahead to the patient's life as a young adult and adult, the

[38] S. Reisner et al. (2015), *Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study*, J. OF ADOLESCENT HEALTH 56(3) at 6, DOI:10.1016/j.jadohealth.2014.10.264; *see also supra* ¶ 21.

prognosis for the physical health, mental health, and social well-being of the child or adolescent who transitions to live in a transgender identity is not good. Gender dysphoria is not "easily managed" except when it naturally desists. A recent study in the American Journal of Psychiatry reported the high mental health utilization patterns of adults for ten years after surgery for approximately 35% of patients.[39] This is not "easy" management.

D. Regret following transition is not an infrequent phenomenon.

104. The large numbers of children and young adults who have desisted as documented in both group and case studies each represent "regret" over the initial choice in some sense.

105. The phenomenon of desistance or regret experienced *later* than adolescence or young adulthood, or among older transgender individuals, has to my knowledge not been quantified or well-studied. However, it is a real phenomenon. I myself have worked with multiple individuals who have abandoned trans female identity after living in that identity for years, and who would describe their experiences as "regret."

106. I have seen several Massachusetts inmates and trans individuals in the community abandon their [trans] female identity after several years. (Levine, *Reflections*, at 239.) In the gender clinic which I founded in 1974 and to this day, in a different location, continue to co-direct, we have seen many instances of individuals who claimed a transgender identity for a time, but ultimately changed their minds and reclaimed the gender identity congruent with their sex.

[39] Branstrom & Pachankis, (2019), *Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries*, AM. J. OF PSYCHIATRY. 4:Appiajp201919010080. Doi: 10.1176/Appi.Ajp.2019.19010080.

107. More dramatically, a surgical group prominently active in the SRS field has published a report on a series of seven male-to-female patients requesting surgery to transform their surgically constructed female genitalia back to their original male form.[40]

108. I noted above an increasingly visible online community of young women who have desisted after claiming a male gender identity at some point during their teen years. (*See supra* ¶ 62.) Given the rapid increase in the number of girls presenting to gender clinics within the last few years, the phenomena of regret and desistance by young women deserves careful attention and study by MHPs.

109. Thus, one cannot assert with any degree of certainty that once a transgendered person, always a transgendered person, whether referring to a child, adolescent, or adult, male or female.

I, Dr. Stephen B. Levine, swear that the statements in this affidavit are true and accurate to the best of my knowledge, and represent my professional opinions. Because of restrictions and health concerns relating to COVID-19, I am not readily able to subscribe this affidavit in the presence of a notary, but I am willing to do so if desired when it becomes practical to do so.

Dated: June 4, 2020.

Stephen B. Levine

[40] Djordjevic et al. (2016), *Reversal Surgery in Regretful Male-to-Female Transsexuals After Sex Reassignment Surgery*, J. Sex Med. 13(6) 1000, DOI: 10.1016/j.jsxm.2016.02.173.