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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

LINDSAY HECOX, et al.,

Plaintiffs,

v.

BRADLEY LITTLE, et al.,

Defendants.

No. 1:20-cv-184-DCN

PLAINTIFFS LINDSAY HECOX'S AND JANE DOE'S REPLY TO OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION [Dkt. 41]

INTRODUCTION

H.B. 500 excludes women and girls who are transgender from school sports teams and burdens only women and girls to enforce that exclusion. As of July 1, 2020, Plaintiff Lindsay Hecox will be excluded from women's teams at Boise State University ("BSU") because she is transgender and cannot meet the statute's intentionally narrow requirements for proving a female "biological sex." Idaho Code §§ 33-6203(2), (3). And Plaintiff Jane Doe will be subject to a system of sex-based verification that applies only to girls and women.

This case is not, as Defendants ("the State") would have this Court believe, about the lawfulness of separate athletic teams for men and women. That separation preexisted H.B. 500 and is not challenged here. What is new about H.B. 500 is the complete exclusion of women and girls who are transgender from school sports in Idaho. Prior to H.B. 500, these athletes were allowed to participate on women's teams if they met stringent requirements for hormone suppression set forth by the Idaho High School Athletic Association ("IHSAA") for high school sports and the NCAA for collegiate sports, comparable to the Olympic standards for transgender inclusion. Even though those existing rules caused no issues, Idaho enacted H.B. 500 to become the first and only state to wholly ban transgender women and girls from athletics.

Under intermediate scrutiny, which applies here, it is the State's "demanding" burden under the Equal Protection Clause to provide an "exceedingly persuasive" justification for H.B. 500's differential treatment of both women who are transgender and women generally. *United States v. Virginia*, 518 U.S. 515, 533 (1996) ("*VMI*"); *see Bostock v. Clayton Cty., Ga.*, -- S. Ct. --, 2020 WL 3146686, at *7 ("[I]t is impossible to

discriminate against a person for being . . . transgender without discriminating against that individual based on sex."). The State has failed to show that it is likely to satisfy that standard. H.B. 500's definition of "biological sex" intentionally excludes the one factor that drives the differences between male and female athletic performance—circulating testosterone. In contrast, the preexisting Idaho and NCAA rules focused on that factor. The only reason H.B. 500 now omits that factor is to exclude transgender women and girls from qualifying as female.

In short, there is no state interest allegedly served by H.B. 500 that the preexisting rules did not already address—other than the invalid interest of excluding transgender women and girls. Because Plaintiffs are likely to succeed on the merits of their equal protection challenge, and because H.B. 500 will inflict immediate and irreparable injury on transgender women and girl athletes, as well as women and girl athletes more broadly, a preliminary injunction should issue.

ARGUMENT

I. Plaintiffs Have Standing to Challenge H.B. 500.

The State first claims, incorrectly, that Plaintiffs lack Article III standing to challenge H.B. 500. (Dkt. 41 at 8–10.) For the reasons set forth in Plaintiffs' Opposition to the State's Motion to Dismiss, incorporated here by reference, both Plaintiffs have shown actual injury and assert claims that are ripe. (Dkt. 55 at 6–16.) Lindsay plans to try out for the BSU women's cross-country team in the fall, but under H.B. 500, that team "shall not be open" to her. (*Id.* at 7–10, 14–16.) H.B. 500 also treats Lindsay, Jane, and all other women and girl student athletes differently, and less favorably, than similarly situated men and boys. (*Id.* at 10–11, 14–16.)

In addition to claiming lack of injury or ripeness, the State now also argues that any harms Plaintiffs face are not traceable to H.B. 500 as opposed to other laws or third-party actions. (Dkt. 41 at 9–10.) The State is wrong on both counts.

First, the State contends that Title IX, not H.B. 500, blocks women who are transgender, like Lindsay, from playing on women's sports teams. (Dkt. 41 at 4 n.2 & 9.) No court has ever so held.[1] Far from *requiring* exclusion of transgender women and girls, Title IX *forbids* it. The Supreme Court's reasoning in its recent Title VII decision requires this conclusion. *Bostock*, 2020 WL 3146686 (holding that Title VII prohibits discrimination on the basis of transgender status); *Emeldi v. Univ. of Oregon*, 698 F.3d 715, 724 (9th Cir. 2012) (interpreting Title IX in accordance with Title VII).

Second, the hypothetical scenarios the State conjures to argue that Lindsay may not make the BSU cross-country team regardless of H.B. 500 do not change the fact that H.B. 500 inflicts upon her an imminent redressable injury.[2] The "requisite

[1] The recent Connecticut enforcement action by the U.S. Department of Education, Office of Civil Rights ("OCR"), which the State cites as support for its argument (Dkt. 41 at 4–5, 9), explicitly states that "it is not a formal statement of OCR policy and should not be relied upon, cited, or construed as such." (*Id.* at ECF p.68.) In any event, the analysis in the OCR letter conflicts with and has been superseded by the Supreme Court's decision in *Bostock*.

[2] Contrary to the State's claim (Dkt. 41 at 9–10), Lindsay would be eligible to try out and compete for BSU fall sports under NCAA rules. (Dkt. 1 at ¶¶ 29, 31–32 ("Complaint"); Dkt. 22-6 at ¶¶ 14, 17 (Hecox Declaration explaining hormone treatment) ("Hecox Decl."); Dkt. 22-4 at ¶¶ 28–29 (Carroll Declaration explaining NCAA rules).) Lindsay is currently training for tryouts and has a real chance of making the team but for H.B. 500. (Hecox Decl at ¶¶ 23–27.) If precluded from tryouts or participation, Lindsay will irretrievably lose the limited amount of NCAA eligibility time she has. (*Id.* ¶ 38.)

'injury'" for standing purposes is the barrier to "compete," not the ability to obtain the ultimate benefit. *Ne. Fla. Chapter of Associated Gen. Contractors of Am. v. City of Jacksonville, Fla.*, 508 U.S. 656, 665 (1993) (quoting *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 281 n.14 (1978)). H.B. 500 prevents Lindsay from trying out for or competing on women's teams simply because, as a woman who is transgender, she cannot satisfy the statute's intentionally narrow conception of "biological sex." Idaho Code §§ 33-6203(2), (3).[3] This violates her rights and confers standing.

Jane's concrete and particularized injury is also directly traceable to H.B. 500. (Dkt. 41 at 19.) Under H.B. 500, Jane will be treated differently and worse than boys from the very first day of the athletic season, due to the different rules governing participation on girls' teams and the "biological sex" verification process that applies only to those who seek to join girls' teams. Idaho Code § 33-6203.[4] In contrast, H.B. 500 does not restrict who may participate on men's teams. *See id.* Such differential treatment constitutes an injury regardless whether Jane's sex is actually disputed. *Heckler v. Mathews*, 465 U.S. 728, 739–40 (1984) ("discrimination itself . . . can cause serious non-economic injuries") (internal citation omitted).[5]

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[3] The State is wrong to suggest that H.B. 500 allows Lindsay to try out for and participate in women's sports until her sex is challenged (Dkt. 41 at 10), given the statute's self-executing directive that women's teams "shall not be open" to her. Idaho Code § 33-6203(3).

[4] Lindsay is known to be transgender and thus categorically prohibited from participation.

[5] Although not necessary for standing, Jane has good reason to fear a challenge to her sex, given that she is high-performing and "people sometimes think of her as masculine." (Dkt. 1 at ¶¶ 46–47; *see* Dkt. 22-7 at ¶ 13 ("Jane Doe Decl."); Dkt. 22-8 at ¶¶ 3, 10–12 ("Jean Doe Decl.").)

The State asserts that if Jane's sex were disputed, then she could simply "refer" her school to her "IHSAA required Health Examination and Consent Form" to resolve the matter. (Dkt. 41 at 7, 19.) Such an approach—without a medical examination based on the statutory criteria for determining "biological sex"—would violate H.B. 500's requirement that "biological sex" be verified by reference to only three criteria, none of which the IHSAA form addresses. Idaho Code §§ 33-6203(2), (3); *see* Dkt. 55 at 5 n.5. Under the State's proposed interpretation, women and girls who are transgender—like Lindsay—could simply submit a doctor's statement accurately indicating that they are female without reference to the three criteria. This would contravene H.B. 500's terms and undermine its entire purpose: to exclude from women's teams those who cannot meet the statutory definition of a female "biological sex." Idaho Code §§ 33-6203(2), (3).

II. Plaintiffs Properly Assert Both Facial and As-Applied Challenges.

As in its Motion to Dismiss, the State argues that Plaintiffs have failed to properly assert a facial challenge to H.B. 500, allegedly precluding injunctive relief. This argument misconstrues both the law and Plaintiffs' claims.[6]

As explained in Plaintiffs' Opposition to the Motion to Dismiss, incorporated here by reference, Plaintiffs have properly asserted a facial challenge. (Dkt. 55 at 16–19.) The State claims that a statute may be challenged facially only if all of its applications are unconstitutional (Dkt. 41 at 11–12 (citing *United States v. Salerno*,

[6] As explained in Plaintiffs' Opposition to the Motion to Dismiss (Dkt. 55 at 17 n.10), Plaintiffs plead both as-applied and facial claims, but the State incorrectly assumes only a facial claim. The as-applied claim also supports injunctive relief.

481 U.S. 739 (1987))), but that is not the test. As the Supreme Court has explained, "[t]o the extent [it] ha[s] consistently articulated a clear standard for facial challenges, it is not the *Salerno* formulation, which has never been the decisive factor in any decision of th[e] Court." *City of Chicago v. Morales*, 527 U.S. 41, 51–52, 55 (1999) (plurality).[7] The "proper focus of the constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *City of Los Angeles, Cal. v. Patel*, 576 U.S. 409, 418 (2015).

Existing law and rules already prevented boys from playing on girls' teams in Idaho before H.B. 500's enactment. The law accordingly does nothing with regard to general sex separation in sports. *See* Idaho High School Activities Association's *Non-Discrimination Policy*, https://idhsaa.org/asset/RULE%2011.pdf (last visited Jun. 28, 2020) ("If a sport is offered for both boys and girls, girls must play on the girls team and boys must play on the boys team. . . . If a school sponsors only a single team in a sport . . . Girls are eligible to participate on boys teams. . . . Boys are not eligible to participate on girls teams."). Instead, H.B. 500 targets women and girls who are transgender (who are categorically excluded) and women and girls generally (who are subject to different rules and a testing regime not applicable to boys and men). The State cannot avoid a facial challenge by focusing on a different group—cisgender boys—whom H.B. 500 does not target and for whom the rules have not changed.[8]

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[7] Plaintiffs inadvertently omitted noting the *Morales* plurality opinion in their Opposition to the Motion to Dismiss. (Dkt. 40-1.)

[8] Proposed intervenors incorrectly claim that intersex individuals are the only individuals potentially harmed by H.B. 500 in "rare and speculative" situations

III. Plaintiffs are Likely to Succeed on the Merits of their Equal Protection Claim.

Plaintiffs are likely to succeed on the merits. H.B. 500 is subject to heightened equal protection scrutiny and the State has not—and cannot—meet its "demanding" burden of demonstrating an "exceedingly persuasive" justification for this discrimination. *VMI*, 518 U.S. at 533.[9]

A. H.B. 500 Must Be Tested Under Heightened Scrutiny.

The State concedes that H.B. 500 must be tested under heightened scrutiny, but for the wrong reason—that H.B. 500 excludes men from women's sports. (Dkt. 41 at 13 & n.8.) Plaintiffs do not challenge the preexisting sex separation in sport. Rather, Plaintiffs challenge what is new about H.B. 500: (1) its categorical exclusion of women and girls who are transgender (on the basis of their sex and transgender status); and (2) its different rules governing participation in women's sports, which burden women and girls through a sex verification system that applies only to their teams. Both of these claims trigger heightened scrutiny.

With respect to transgender exclusion, the State acknowledges that Circuit precedent (and a prior decision from this Court) "have held heightened scrutiny

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(Dkt. 46 at 18); H.B. 500 discriminates against (and is targeted at) transgender women and girl athletes, as well as all women and girl athletes. *See supra.*

[9] As Plaintiffs have explained (Dkt. 22-1 at 12), it is the State's burden to prove Plaintiffs' likely lack of success on the claim that H.B. 500 fails heightened scrutiny under Supreme Court precedent establishing that "the burdens at the preliminary injunction stage track the burdens at trial." *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 429 (2006). That the Ninth Circuit has implemented this reasoning in the First Amendment context (Dkt. 46 at 12 n.7) does not mean that it also does not apply in the equal protection context, where the government equally "bears the burden of proof on the ultimate question of [H.B. 500's] constitutionality." *Id.* (internal quotation marks and citation omitted).

applies if a law or policy treats transgender persons in a less favorable way than it treats all others." (Dkt. 41 at 13 n.8. (citing *Karnoski v. Trump*, 926 F.3d 1180 (9th Cir. 2019)).) Since the time of the State's brief, the Supreme Court has likewise made clear that anti-transgender discrimination is sex discrimination. *See Bostock*, 2020 WL 3146686 ("[I]t is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex"). Therefore, anti-transgender discrimination triggers heightened scrutiny under the Equal Protection analysis because it is sex discrimination.

The State and the United States seek to avoid this clear precedent by arguing that H.B. 500 does not discriminate on the basis of transgender status because it does not expressly use the term "transgender." (Dkt. 41 at 13 n.8; Dkt. 53 at 13.) This argument ignores H.B. 500's intent, terms, and effect and is wrong as a matter of law. As the State's counsel previously conceded, H.B. 500 is "targeted toward transgender and intersex athletes." (A.G. Letter at 6.[10]) That is so because its criteria for determining "biological sex" are designed to exclude women and girls who are transgender and to reverse the prior rules that implemented general sex-separation in sports while permitting transgender women to compete. *See* Idaho Code § 33-6203(3). Incredibly, the United States' description of the statute's "key substantive provisions" (Dkt. 53 at 3–4) omits the statutory criteria for determining "biological

[10] *See*, Letter from Att'y Gen. Wadsen to Rep. Rubel (Feb. 25, 2020), https://www.idahostatesman.com/latest-news/article240619742.ece/BINARY/HB%20500%20Idaho%20AG%20response.pdf (last visited Jun. 28, 2020) ("A.G. Letter").

sex," which exists only to exclude transgender people.[11] H.B. 500's legislative findings further reinforce that the law is directed at excluding women and girls who are transgender. Those findings expressly refer to "a man [sic] who identifies as a woman and is taking cross-sex hormones." *Id.* § 33-6202(11). Likewise, in the legislative debate, the bill sponsors repeatedly described the goal of the statute as excluding women and girls who are transgender from women's sports. (Dkt. 22-1 at 13–14; Dkt. 22-3 at Exs. A–C.) The State's insistence on referring to women and girls who are transgender as "biological males"—in addition to being injurious and disrespectful—cannot mask H.B. 500's discriminatory design, operation, and effect. *See Bostock*, 2020 WL 3146686, at *9 ("[I]t's irrelevant what an employer might call its discriminatory practice, how others might label it, or what else might motivate it.").

The United States turns H.B. 500 further on its head by arguing that transgender people seek "special" treatment by challenging H.B. 500. (*E.g.*, Dkt. 53 at 9–10 (claiming that Plaintiffs seek "*a special exemption* for biological males if and only if they are transgender" (emphasis in original)).) This argument ignores that H.B. 500 was designed to, and does, exclude only transgender women and girls. Lindsay seeks what every cisgender student already has—an opportunity to participate as herself in sports with her peers.

[11] The United States' argument that *Karnoski* applied heightened scrutiny because the government required only transgender people, and not cisgender people, to serve in their "biological sex" (Dkt. 53 at 13) misses the point for the same reason. All cisgender people already serve in the military in what the United States would describe as their "biological sex," so the policy in *Karnoski* had no reason to refer to them—but the targeting of transgender individuals in the *Karnoski* policy and in H.B. 500 is the same.

Under the United States' flawed reasoning, there would never be actionable transgender discrimination, because it would always be permissible to insist that transgender people act contrary to their gender identity—that is, to demand they try to become, or act as if they were, cisgender. This is not the law. The Supreme Court recognized in *Bostock* that it was sex discrimination to fire someone for disclosing that she was transgender and planned to come to work as her authentic self.[12] Women and girls who are transgender do not have a mere "personal objection" to participating in men's sports as the United States claims. (Dkt. 53 at 12). Being forced to participate in sports on teams that contradict one's gender identity is equivalent to gender identity conversion efforts, which every major medical association has found to be dangerous and unethical. (Expert Declaration of Jack L. Turban, MD, MHS ("Turban Decl.") ¶¶ 24–28.)

H.B. 500 additionally triggers heightened scrutiny by singling out members of girls' and women's teams for sex verification. *See VMI*, 518 U.S. at 555 ("[A]ll gender-based classifications today warrant heightened scrutiny") (internal quotation marks and citation omitted). The State's only retort is the false claim that H.B. 500 does not treat "females differently as Plaintiffs suggest" because it "requires any athlete subject to dispute, whether male or female, to verify his or her sex." (Dkt. 41 at 13 n.8.) To the extent the State is arguing that those who play men's sports would also

[12] Arguing that H.B. 500 does not discriminate because transgender women could opt to play men's sports is analogous to rejected arguments, in support of same-sex marriage bans, that lesbians and gay men theoretically could marry someone of a different sex. *See, e.g., Latta v. Otter*, 771 F.3d 456, 467 (9th Cir. 2014).

be subject to sex verification, that is not true. The statute's only exclusion is from women's teams. *See* Idaho Code § 33-6203(2). To the extent the State is arguing that people of any sex who seek to play women's sports would be subject to sex verification, the State misses the point. The legislature deliberately created a different, more onerous set of rules for women's sports when compared to men's sports. Where spaces and activities for women are "different in kind . . . and unequal in tangible and intangible" ways from those for men, they are tested under heightened scrutiny. *VMI*, 518 U.S. at 547. The intentional sex classification triggers this level of review; the sex of the people affected is irrelevant except to the extent it reveals a sex-based motivation. *See e.g.*, *Pers. Adm'r of Massachusetts v. Feeney*, 442 U.S. 256, 273 (1979).[13]

B. H.B. 500 Is Not Substantially Related to Any Important Governmental Interest.

Rather than focus on the central question of whether H.B. 500's exclusion of women and girls who are transgender is substantially related to an important government interest, the State (and the United States) seeks to distract by defending the general separation of men's and women's athletics. Plaintiffs do not challenge that separation. Plaintiffs seek only to return to the status quo ante: the separation of teams for men and women, as well as a rule for inclusion of transgender athletes

[13] Proposed Intervenors apply an inconsistent standard of review throughout their brief, but ultimately appear to agree with the State that H.B. 500 must satisfy heightened scrutiny. (Dkt. 46 at 9-14.) To the extent their discussion of "physiological differences between men and women" is intended to dispute the application of heightened scrutiny (Dkt. 46 at 10-14), that is contrary to Supreme Court precedent, which applies heightened scrutiny to sex discrimination based on physiological or biological characteristics. *See Tuan Anh Nguyen v. INS*, 533 U.S. 53, 70, 73 (2001).

that required one year of testosterone suppression before women and girls who are transgender could participate on women's teams.

The State has failed to show how a sweeping ban excluding transgender women from women's athletics altogether is substantially—or even rationally—related to the asserted interest in "redressing past discrimination against women in athletics and promoting equality of athletic opportunity between the sexes." (Dkt. 41 at 14 (quoting *Clark by Clark v. Arizona Interscholastic Ass'n*, 695 F.2d 1126, 1131 (9th Cir. 1982)).) *Clark*—the State's central authority—pertained to sex separation in sport generally and is not determinative here, as the State's counsel has previously recognized: "[t]he issue of a transgender female wishing to participate on a team with other women requires considerations beyond those considered in *Clark* and presents issues that courts have not yet resolved." (A.G. Letter at 4.)

Now, relying almost exclusively on *Clark*, the State advances two faulty arguments, one legal and one factual. The flawed legal argument is that excluding women who are transgender from women's teams is the same as excluding cisgender men from women's teams. (Dkt. 41 at 14–15.) The flawed factual argument is that women who are transgender have average physiological advantages on the same scale as cisgender men.

1. Excluding Women Who Are Transgender from Women's Teams is Not the Same as Excluding Cisgender Men.

In *Clark*, the Ninth Circuit held that it was lawful to exclude men from women's volleyball teams because (1) women had historically been deprived of athletic opportunities in favor of men; (2) as a general matter, men had equal athletic

opportunities compared to women; and, (3) according to the stipulated facts, average physiological differences meant that "males would displace females to a substantial extent" if permitted to play on women's volleyball teams. *Clark*, 695 F.2d at 1131. None of these premises hold true for women and girls who are transgender.

First, women who are transgender have historically been discriminated against, not favored. Second, under H.B. 500, women and girls who are transgender will be unable to participate in any school sports,[14] unlike the men in *Clark*, who generally had equal athletic opportunities. Third, transgender women have not and could not "displace" cisgender women in athletics "to a substantial extent."[15] Elite international athletic organizations—including World Athletics and the Olympics—permit women who are transgender to compete in women's events after undergoing

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[14] (*See*, *e.g.*, Turban Decl. ¶¶ 24–28 (forcing a transgender woman to participate on a men's team would be tantamount to forcing her to be cisgender which is "associated with adverse mental health outcomes.").)

[15] The United States misreads *Clark by and through Clark v. Arizona Interscholastic Ass'n*, 886 F.2d 1191 (9th Cir. 1989) (*Clark II*), in suggesting (Dkt. 53 at 10) that participation by just one cisgender boy on the girls' volleyball team can be barred because it would "set back" the "goal of equal participation by females in interscholastic sports." *Id.* at 1193. That part of the decision responded to the boy's "mystifying" argument that the school association "ha[d] been wholly deficient in its efforts to overcome the effects of past discrimination against women." *Id.* It noted that the court could not see how the boy's "remedy [of allowing him to play on the girls' team] will help." *Id.* But the court remained focused on the risk that a ruling in the boy's favor would extend to other boys as well and so risk substantial displacement of girls in school sports. *See id.* (observing that the issue of "males . . . outnumber[ing] females by two to one" in school sports would "not be solved by opening the girls' volleyball team to Clark *and other boys*") (emphasis added); *id.* ("Clark does not dispute our conclusion in *Clark I* that 'due to physiological differences, males would displace females to a substantial extent if they were allowed to compete for positions on the volleyball team.'"). Notably, *Clark* is premised on a notion of sex separation where the only relevant groups are cisgender boys and cisgender girls, which is not the present context.

hormone therapy, reflecting the scientific consensus that such a rule (which mirrors the prior rule in Idaho) does not risk substantial displacement of women. (Supplemental Declaration of Joshua D. Safer, MD, FACP, FACE ("Safer Supp. Decl.") ¶ 10.) In fact, no woman who is transgender has ever even made a women's Olympic team. (*Id.*) Nor is there any evidence of displacement in Idaho under the prior policy permitting girls who are transgender to participate on girls' teams after hormone suppression. Indeed, the State has pointed to only one example of a transgender athlete ever defeating an Idaho cisgender woman in any competition—and that transgender athlete lives outside Idaho and would not be barred from participation under H.B. 500 even if she had not already graduated. One or a handful of transgender athletes doing well in sports is not the "substantial" "displace[ment]" feared in *Clark*.[16]

2. Women Who are Transgender and Have Suppressed Testosterone Do Not Have the Physiological Advantages of Cisgender Men.

The State's flawed factual argument is that women who are transgender and who have suppressed testosterone for a period of one year are physiologically the same as cisgender men and will thus displace athletic opportunities for cisgender women. (Dkt. 41 at 15–19.) For this argument, the State relies on a putative expert, Dr. Gregory Brown, who largely focuses on performance differences between

[16] Losing to a transgender woman has not deprived Proposed Intervenors of the opportunity to participate in Division I sports on athletic scholarships. (Dkt. 30-1 at 2.) Likewise, the transgender Connecticut runners noted by Proposed Intervenors were regularly defeated by cisgender women. (*See* Motion to Intervene, *Soule v. Connecticut Association of Schools, Inc.*, No. 3:20-cv-00201-RNC (D. Conn. Feb. 21, 2020), at 8.)

cisgender men and cisgender women (not at issue here), rather than transgender women and cisgender women. (Dkt. 41-1 ("Brown Decl.") at ¶¶ 12–112, 114–125; Dkt. 22-2 ("Safer Decl.") ¶¶ 11–15.) The only relevance of Dr. Brown's otherwise inapposite analysis is his repeated acknowledgement that circulating testosterone is the primary reason cisgender men on average outperform cisgender women in sports after puberty. (Brown Dec. ¶¶ 81, 86, 87, 105, 120.) That is why the IHSAA and NCAA used circulating testosterone as a basis for regulation in Idaho before H.B. 500 and why the Olympics and World Athletics rely on it as well. Yet H.B. 500 ignores circulating testosterone altogether. No study concludes that transgender women and girl athletes who have suppressed circulating testosterone for one year, as per the policies in place prior to H.B. 500, have a competitive advantage. (*See* Safer Supp. Decl. ¶ 11.)[17]

Although he confirms the relevance of the criterion used prior to H.B. 500, Dr. Brown offers no scientific evidence linking the *new* H.B. 500 criteria—reproductive anatomy, endogenous as opposed to circulating testosterone levels, or sex chromosomes—to athletic performance. He further fails to rebut the explanation of Plaintiffs' expert, Dr. Joshua Safer, that larger bones may actually be an athletic

[17] H.B. 500 even excludes transgender women and girls who began puberty-blocking hormonal treatment early enough to avoid experiencing any effects of elevated levels of circulating testosterone during puberty. Dr. Brown attempts to address this point by citing a few studies that show some differences in performance outcomes between pre-pubertal boys and girls, but as Dr. Safer explains, such studies "do not determine the cause for whatever is observed," which is more likely "explained by, among other things, greater encouragement of athleticism in boys and greater opportunities to play sports." (Safer Supp. Decl. ¶ 12.)

disadvantage for women who are transgender and on hormone suppression, because their muscle-to-bone ratio will be lower than that of cisgender women. (Safer Dec. ¶ 53–54.) Dr. Brown likewise fails to address Dr. Safer's point that any slight variations in the bodies of transgender women that could be relevant to athletic performance must be viewed in the context of the significant differences in size, strength, and natural ability that exist among cisgender women. (*Id.* ¶ 55–56.)

The State and the United States also both misconstrue a study cited in H.B. 500's legislative findings as supporting the notion that transgender women retain a physiological advantage after hormone suppression. The findings claim that "[t]he benefits that natural testosterone provides to male athletes is not diminished through the use of puberty blockers and cross-sex hormones." (Dkt. 53 at 6 n.2 (quoting Idaho Code § 33-6202(11)).) But the study cited in support of this proposition dealt with adults and did not address "puberty blockers" at all. Anna Wiik et al., *Muscle Strength, Size, and Composition Following 12 Months of Gender-affirming Treatment in Transgender Individuals*, J. CLIN. METAB., 105(3):e805-e813 (2020). Overall, it showed that transgender men increased strength and muscle mass with testosterone treatment while transgender women lost some strength and muscle mass with testosterone suppression (although not as much as expected, which could be partly due to the "learning effects" of repeating the test). (*Id.* ¶ 19.) As Dr. Safer explains, "[a]ll the Wiik[18] [Lundberg] study shows is that testosterone makes a

[18] The legislative findings and the citations in the State and United States briefs cite this study as Tommy Lundberg et al., *Muscle strength, size and composition following 12 months of gender-affirming treatment in transgender individuals: retained*

difference with regard to muscle. More testosterone is associated with more strength and more muscle mass." (*Id.*) The study authors themselves explain that because the subjects were not athletes, "'it is still uncertain how the findings would translate to transgender athletes . . . .'" (*Id.*) In contrast, the available research on transgender *athletes* indicates that testosterone suppression for a period of a year *does impair* pre-suppression performance—explaining why the Olympics, World Athletics, the NCAA, and IHSAA (prior to H.B. 500) regulate women's events based on circulating testosterone. (Safer Decl. ¶ 51.)[19]

In any event, one study showing that certain transgender women retained some muscle strength after a year of hormone suppression does not provide an "exceedingly persuasive" justification for H.B. 500's sweeping ban on the participation of all women and girls who are transgender from sport in Idaho. *VMI*, 518 U.S. at 533. Among other things, such a study does not evidence substantial "displacement" of cisgender women athletes. *Clark*, 695 F.2d at 1131. It certainly does not support the notion that a woman who is transgender who has undergone a year of hormone therapy has strength *equivalent* or even close to that of a cisgender man.

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advantage for the transwomen, Karolinksa Institutet (Sept. 26, 2019). The proper reference is Anna Wiik et al., *Muscle Strength, Size, and Composition Following 12 Months of Gender-affirming Treatment in Transgender Individuals*, J. CLIN. METAB., 105(3):e805-e813 (2020). (See Brown Decl. ¶ 20(o).)

[19] The State's attempt to discredit the rigor of the Harper study does not change the results. As Dr. Safer explains "This study, even with its limits, supports the conclusion that suppression of testosterone does diminish performance outcomes for women who are transgender. . . . Research with greater rigor must be done along the lines of the Harper study, but until that time there is no reason to conclude that the opposite of the Harper findings is true." (Safer Supp. Decl. ¶¶ 22–23.)

Ultimately, the lone study cited in the legislative findings is not enough for the State to carry its demanding burden. As the Supreme Court has made clear, the Equal Protection Clause applies to women "outside the average description" as well as those within it. *VMI*, 518 U.S. at 517.

Lacking any scientific study of transgender athletes to support its position, the State turns to an example of a single transgender woman runner, Cece Telfer, who showed slightly improved performance during one sports season after hormone therapy. (Dkt. 41 at 18.) From that example, the State improperly extrapolates that all transgender athletes must have a permanent advantage compared to cisgender women. (*Id.*) This is contrary to the reasoning of the State's own expert, who repeatedly emphasizes that circulating testosterone, not endogenous testosterone, is the most important determinant of sex-based physical advantage in sports. (Brown Dec. ¶¶ 81, 86–87, 105, 120.) The State also does not consider the possibility that Cece's improved performance could have been due to more and better training, or the mental health benefits of transition, which can relieve otherwise debilitating symptoms of gender dysphoria. (Dkt. 22-2 ("Adkins Decl.") ¶¶ 20, 23.) Athletes, including cisgender women, sometimes improve dramatically from one season to the next; if Cece had not suppressed her testosterone levels, it is entirely possible that her times would have improved far more than they actually did.

Plaintiffs do not demand a "perfect fit" (Dkt. 41 at 15) between H.B. 500 and the asserted government interest. Rather, as Plaintiffs have argued, H.B. 500 has no "exceedingly persuasive" justification. *VMI*, 518 U.S. at 533. At the end of the day,

the State cannot carry its heavy burden of showing that H.B. 500's departure from the preexisting regime (requiring hormone treatment for a year for women and girls who are transgender to participate in school sports) to the current categorical bar is substantially related to an important government interest.

IV. Plaintiffs Will Suffer Irreparable Harm Without an Injunction, and the Balance of Equities Favors an Injunction.

Unless H.B. 500 is enjoined, it will violate Lindsay and Jane's rights under the Equal Protection Clause. This alone constitutes irreparable injury sufficient to justify a preliminary injunction. *Hernandez v. Sessions*, 872 F.3d 976, 994 (9th Cir. 2017) (internal citations omitted). Likewise, when a party's constitutional rights are violated, the balance of equities and hardships favors injunctive relief. (Dkt. 22-1 at 28 (citing *Ariz. Dream Act Coalition v. Brewer,* 757 F.3d 1053, 1069 (9th Cir. 2014)).) The grave harms the Plaintiffs will suffer far outweigh the imaginary harms the State claims will be inflicted upon it or the public interest generally by enjoining H.B. 500.

In addition to violating her constitutional rights, H.B. 500 will deprive Lindsay of athletic opportunities, cause her emotional distress, and create shame and humiliation as she is singled out for exclusion and discriminatory treatment. (Dkt. 22-1 at 9, 27.) Jane will be treated worse than similarly situated boys and will suffer emotional distress from the prospect of unnecessary and invasive sex "verif[ication]" if someone disputes her sex. (Dkt. 22-1 at 26–27.) None of these prospective and irreparable harms have adequate remedies at law. *See Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Edu.,* 858 F.3d 1034, 1046 (7th

Cir. 2017); *Evancho v. Pine-Richland Sch. Dist.,* 237 F. Supp. 3d 267, 294 (W.D. Pa. 2017). They therefore justify an injunction. (Dkt. 22-1 at 27.)[20]

The State argues that Lindsay does not face irreparable harm because she could "tr[y] out for the BSU's men's cross-country or track teams." (Dkt. 41 at 20.) But that is not a viable option for Lindsay, who is not a man. Being forced to participate on a team contrary to one's gender identity is essentially a gender identity conversion effort—a practice deemed dangerous and unethical by every major medical association. (Turban Decl. ¶¶ 24–28.) Nor does the law require her to exercise such an option—just as it does not require gay men and women to marry a member of the opposite sex. Lindsay reports that transition has "drastically improved [her] body image," given her a sense of "peace," and allayed her gender dysphoria. (Hecox Decl. ¶¶ 15, 17.) Being treated as if she were a man would mean losing all that: "I would not compete on a men's team. I am not a man, and it would be embarrassing and painful to be forced onto a team for men—like constantly wearing a big sign that says 'this person is not a "real" woman.'" (Hecox Decl. ¶37.)[21] Data show that medical

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[20] The State oddly and incorrectly claims that "Plaintiffs focus solely on themselves" rather than the "interest of all female athletes" benefitting from H.B. 500. (Dkt. 41 at 19.) Plaintiffs, both female athletes, explain how H.B. 500 adversely impacts all women and girl athletes who are transgender (by excluding them) and all women and girl athletes generally (by subjecting them to different rules and a framework imposing "biological sex" testing on women and girls but not men and boys).

[21] Courts recognize the serious harms that occur from systematically misgendering transgender people. *Adams by and through Kasper v. Sch. Bd. of St. Johns Cty., Fla.*, 318 F. Supp. 3d 1293, 1312 (M.D. Fla. 2018) (finding that policy caused transgender boy anxiety and depression when he walked "past the boys' restroom on his way to a gender-neutral bathroom, knowing every other boy is permitted to use it but him"); *Evancho v. Pine-Richland Sch. Dist.,* 237 F. Supp. 3d 267, 294 (W.D. Pa. 2017) (granting preliminary injunction based in part on irreparable injury to transgender

treatment for gender dysphoria, including social transition, is the sole means to avoid the serious harms it causes if untreated. (Adkins Decl. ¶ 22.) The State's suggestion that Lindsay be treated as a man, or that the harm of being excluded from the women's team is somehow "self-inflicted" injury, contravenes both contemporary medical science and case law. *Whitaker,* 858 F.3d at 1045–46 (determining that the psychologist's account of transgender student's "psychological distress" justified injunctive relief, and that student's distress was not "self-inflicted"); *cf. Grimm v. Gloucester Cty. Sch. Bd.*, 400 F. Supp. 3d 444, 459 (E.D. Va. 2019) ("The Board's assertion that Mr. Grimm has suffered no harm as a result of its policy is strikingly unconvincing. Mr. Grimm broke down sobbing at school because there was no restroom he could access comfortably.").

Proposed Intervenors devote extensive briefing and testimony to unfounded and offensive arguments that Lindsay will not be harmed by H.B. 500 because she has not alleged a personal risk of suicide, and that transgender individuals are harmed by transitioning despite that it is the widely accepted standard of care for treating gender dysphoria. Proposed Intervenors have no legal support for their position that a plaintiff must allege she "will commit suicide" to experience irreparable injury, (Dkt. 46 at 6 (twisting Plaintiffs' citation of general suicide rates in the transgender community)), which is not the standard for irreparable harm. Proposed Intervenors' putative expert also falsely claims that there are "no studies

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students of not being permitted to use restrooms consistent with their gender identities, in part because this marginalization was "causing them genuine distress, anxiety, discomfort and humiliation").

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." (Dkt. 46 at 7.) In fact, multiple peer-reviewed studies confirm that social transition is *necessary* treatment for gender dysphoria. (Turban Decl. ¶ 11.) Dr. Levine's assertions about social transition are simply incorrect, and, among other things, misleadingly rely on a body of literature about pre-pubertal children. (*Id.* ¶ 9, 10.) Every major medical association supports affirming treatment for transgender individuals and all existing data show positive outcomes when transgender people of all ages are supported in their gender identity. (Turban Decl. ¶¶ 11, 20–23, 25; Adkins Supp. Decl. ¶¶ 11–12, 14.)

The State's further claim that "it is undisputed" that Jane "qualifies to play girls' sports" is irrelevant. Her injury arises from being treated differently than similarly situated boys, which includes the prospect of having to undergo invasive examination were her sex to be disputed. (Dkt. 41 at 20.) Also, much of the value she derives from sport is the opportunity to work hard toward a common goal with her teammates in an inclusive and welcoming environment. (Dkt. 1 ¶ 44; Dkt 22-5 ("Fry Decl.") ¶¶ 30, 32, 45, 49–50.) Excluding women and girls just because they are transgender or intersex would diminish those benefits for both Jane and the girls who are wholly barred from competing. (Dkt. 22-1 at 21; Fry Decl. ¶¶ 49, 50.)

In contrast to the grave harms that Plaintiffs face without injunctive relief, the State will suffer no harm. An injunction would simply preserve the status quo ante. The preexisting policies from the NCAA and IHSAA for the inclusion of transgender

athletes would apply. (Dkt. 22-1 at 28.) To the contrary, if the law remains in effect, the State's economy will suffer severe, negative economic consequences.[22]

That some cisgender women strongly dislike the idea of possibly competing against Lindsay, (Dkt. 46 at 4–5), is not a legally cognizable harm, as this Circuit does not recognize the desire to exclude transgender people from single-sex environments as a legally protected interest. *Parents for Privacy v. Barr,* 949 F.3d 1210, 1228 (9th Cir. 2020). But even if competing with women who are transgender were legally relevant (Dkt. 46 at 4), it would have to be put in context and weighed against the Plaintiffs' harms. Proposed Intervenors could continue to run on their teams, while Lindsay would be shut out of sports altogether, simply because she is transgender. *Cf. Doe by and through Doe v. Boyertown*, 897 F.3d 518, 530 (3d Cir. 2018) ("Nothing in the record suggests that cisgender students who voluntarily elect to use single-user facilities to avoid transgender students face the same extraordinary consequences as transgender students would if they were forced to use them"). And "it is always in the public interest to prevent the violation of a party's constitutional rights." *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (citation omitted).

CONCLUSION

For the foregoing reasons, and the reasons set forth in Plaintiffs' opening submission, the Court should grant Plaintiffs' Motion for Preliminary Injunction.

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[22] Kristin Muchow et al., *Idaho's anti-transgender bills will have a deep economic impact on tourism and business* (June 29, 2020, 4:00 AM), https://www.idahostatesman.com/opinion/readers-opinion/article243819502.html?fbclid=IwAR2jFuByjLAziZM7bu1JqNq_guJhuUdtx0OxbtNeu_El60QRcJt1gp-XlBI.

Dated: June 29, 2020

/s/ Richard Eppink

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

LINDSAY HECOX, et al.,

Plaintiffs,

v.

BRADLEY LITTLE, et al.,

Defendants.

No. 1:20-cv-184-CWD

SUPPLEMENTAL DECLARATION OF DEANNA ADKINS, MD, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Deanna Adkins, MD, declare as follows:

1. I have personal knowledge of the matters stated in this declaration.

2. As set forth in greater detail in my previously submitted declaration dated April 24, 2020, my background and credentials include the following: I served as the Fellowship Program Director of Pediatric Endocrinology at Duke University School of Medicine for fourteen years and am currently the Director of the Duke Center for Child and Adolescent Gender Care; I have treated approximately 500 transgender and intersex young people in my career. My CV is attached to my previously submitted declaration.

3. I reviewed the declaration of Stephen Levine, MD, dated June 4, 2020. Here, I respond to the central points raised in Dr. Levine's declaration. I do not specifically address each study or article cited by Dr. Levine, but instead explain the overall problems with some of the conclusions that he draws and provide data showing why such conclusions are in error. I reserve the right to supplement my opinions concerning Dr. Levine's opinions if necessary as the case proceeds.

"BIOLOGICAL SEX"

4. In his discussion of "the biological baseline of sex," Dr. Levine provides no citations—with the exception of one citation to his own work—and oversimplifies the biological components of sex.

5. As I explained in paragraphs 42 through 44 of my previous declaration, sex-related characteristics include external genitalia, internal reproductive organs,

gender identity, chromosomes, and secondary sex characteristics. All of these characteristics have biological bases.

6. Dr. Levine claims that "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." (Levine Decl. ¶ 12.) But this is not how we define or think about sex as a matter of science of medicine. For example, many individuals are unable to produce ova or semen, but have other sex characteristics. I have been involved in designating sex for over one hundred infants and the medical standards look at multiple factors, among which reproductive capacity is just one, to determine sex assignments at birth.[1] If we designate sex incorrectly at birth, protocol is to update it once the person is old enough to articulate their gender identity and re-assign consistent with gender identity.

7. It also is not correct that in medicine we only look at whether an individual has 46-XX or 46-XY chromosomes to understand the biological components of sex. (Levine Decl. ¶12.) As the Endocrine Society guidelines explain, the terms "[b]iological sex, biological male or female . . . are imprecise and should be avoided."[2] Generally speaking, "[t]hese terms refer to physical aspects of maleness

[1] Cools, M., Nordenström, A., Robeva, R. et al., Caring for individuals with a difference of sex development (DSD): a Consensus Statement. *Nat Rev Endocrinol* 14, 415–429 (2018).

[2] Hembree, Wiley C., et al., Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *J Clin Endocrinol Metab*, Vol. 102, Issue 11, 1 November 2017, 3869–3903.; Berenbaum S., et al., Effects on gender identity of prenatal androgens and genital appearance:

and femaleness [but] these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia)."[3]

TREATMENT PROTOCOLS FOR TRANSGENDER YOUTH

8. I am currently a provider to approximately 350 transgender youth. Each patient is treated individually by a multi-disciplinary team.

9. Though Dr. Levine claims that the treatment protocols for transgender youth and adolescents recommended by the World Professional Association for Transgender Health ("WPATH"), the Endocrine Society, and the American Academy of Pediatrics ("AAP") are not in the best interests of such patients, that is contrary to an overwhelming body of contemporary research that says the opposite as well as to the teachings of clinical practice, including mine.

Evidence from girls with congenital adrenal hyperplasia. *J Clin Endocrinol Metab* 2003;88(3):1102-6; Dittmann R, et al., Congenital adrenal hyperplasia. I: Gender-related behavior and attitudes in female patients and sisters. *Psychoneuroendocrinology* 1990;15(5-6):401-20; Cohen-Kettenis P. Gender change in 46,XY persons with 5alpha-reductase-2 deficiency and 17beta-hydroxysteroid dehydrogenase-3 deficiency. *Arch Sex Behav* 2005;34(4):399-410; Reiner W, Gearhart J. Discordant sexual identity in some genetic males with cloacal exstrophy assigned to female sex at birth. *N Engl J Med* 2004;350(4):333-41.

[3] Wylie et al. (2017); Meyer-Bahlburg H. Gender identity outcome in female-raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Arch Sex Behav* 2005;34(4):423-38; Reiner W. Assignment of sex in neonates with ambiguous genitalia. *Curr Opin Pediatri* 1999;11(4):363-5; Byne W, Sekaer C. *The question of psychosexual neutrality at birth*. In Legato M, ed. Principles of Gender Specific Medicine. San Diego: Academic Press, 2004:155-66. Coates S, Wolfe S. Assessment of gender and sex in children in Noshpitz J, ed. Handbook of Child and Adolescent Psychiatry: Clinical Assessment/Intervention. New York: John Wiley and Sons; 2004:242-52; Cohen-Bendahan C, van de Beek C, Berenbaum S. Prenatal sex hormone effects on child and adult sex-typed behavior: methods and findings. *Neurosci Biobehav Rev* 2005;29(2):353-84.

10. WPATH is the leading association of medical and mental health professionals in the treatment of transgender individuals. The AAP is an association representing more than 67,000 pediatricians. The Endocrine Society is an organization representing more than 18,000 endocrinologists. WPATH and the Endocrine Society have published widely accepted standards of care for treating gender dysphoria, which are based on considerable scientific and medical research, and which have been endorsed by the AAP.

11. Dr. Levine critiques WPATH because it is "a voluntary membership organization" and "attendance at its biennial meetings has been open to trans individuals who are not licensed professionals." (Levine ¶ 54.) This critique is misplaced, as an organization can be both an advocacy and a scientific organization, as is WPATH. This is not a new phenomenon in medicine. The American Diabetes Association, for example, is a professional association that both advocates for patients with diabetes and is a scientific organization. Rigorous papers are presented at the WPATH meetings and well-funded scientific research is reported on.

12. Dr. Levine's critique also ignores the November 2017 Endocrine Society Guidelines on the treatment of gender-incongruent persons. This more recent treatment protocol mirrors the WPATH Standards of Care and recommends pubertal suppression and gender-affirming hormone therapy for adolescents and young adults who meet the clinical standards.[4] The guidelines were developed

[4] Wylie et al. (2017).

through rigorous scientific processes in which "followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines."[5] The guidelines affirm that patients with gender dysphoria often must be treated with "a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender."[6]

13. Dr. Levine critiques WPATH and its members claiming, "most current members of WPATH have little ongoing experience with the mentally ill." (Levine Decl. ¶ 60.) In my clinic, as is recommended by the Endocrine Guidelines, every patient is treated by a multi-disciplinary team that includes a social worker, psychological, psychiatrist, and an endocrinologist. The providers are all well-trained faculty and clinicians at Duke with years of experience diagnosing and treating mental health conditions.

14. Dr. Levine's only support for his critique of the AAP's position on affirming gender identity in youth is an article by James Cantor in the Journal of Sex & Marital Therapy. Cantor's article is his opinion and critique but relies on outdated evidence and misinformation about the benefits of gender affirming

[5] *Id.*
[6] *Id.*

treatment for children and adolescents.[7] In any event, a lone critique of the medical standards that govern the profession is not a legitimate basis to attack well-researched, widely accepted medical protocols. By contrast, these protocols are being followed by thousands of medical providers to achieve life-saving ends for our patients.

15. Dr. Levine claims that "the use of puberty blockers for transgender children, [is] a recent phenomenon." (Levine Decl. ¶ 83.) However, puberty blockers began to be used in transgender patients in 2004, which is not considered recent in medicine. We also have over thirty years of data on the impact of puberty blockers on children who undergo precocious puberty[8] that we can apply to the transgender population. There is no evidence of short or long-term negative effects on patients who receive puberty blockers from the more than thirty years of data that we have. And for transgender youth (as compared to those treated for precocious puberty), the treatment is used for a much shorter period of time, in order to pause puberty before either initiating puberty with cross-sex hormones or resuming endogenous puberty. This medication is also used in adolescents and adults undergoing

[7] Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. Pediatrics, 137(3). Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. Journal of the American Academy of Child & Adolescent Psychiatry, 56(2), 116-123.

[8] Children with precocious puberty develop signs of puberty before the typically expected time. In some this can happen as early as 12 months of age and puberty blockers are used to pause puberty until the appropriate time.

chemotherapy to preserve fertility and in patients with hormone sensitive cancers, like breast and prostate cancer.

16. Though Dr. Levine warns about delaying puberty, pubertal suppression in transgender youth does not delay puberty beyond the typical range. (Levine Decl. ¶ 92.) Pubertal development has a very wide variation among individuals. Puberty in individuals assigned male at birth typically begins anywhere from age nine to age fourteen, and sometimes does not complete until a person's early twenties. For those individuals assigned female at birth, puberty typically ranges from age eight to age seventeen.[9] Protocols used for transgender youth would tend to put them in the latter third of typical puberty but nothing outside of the typical range.[10] As such there is no reason to assume, and no data to support, Dr. Levine's assumption that slightly delaying puberty will have negative short- or long-term consequences. This is particularly true given the life-saving results early treatment has for transgender youth.[11]

17. Dr. Levine incorrectly suggests that lifelong hormone treatment is, as a blanket matter, bad for one's health. (Levine Decl. ¶¶ 92–93.) There is nothing inherently harmful about undergoing hormone treatment to sustain one's health. Many transgender people have been on hormone therapy for decades, and we are

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[9] Wyshak, Grace, PhD and Frisch, Rose E., Evidence for a Secular Trend in Age of Menarche, April 29, 1982, N Engl J Med 1982; 306:1033-1035.
[10] Wylie et al. (2017); Euling SY, Herman-Giddens ME, Lee PA, et al. Examination of U.S. puberty-timing data from 1940 to 1994 for secular trends: panel Findings. *Pediatrics*. 2008;1221: S172–S191.
[11] Turban JL, King D, Carswell JM, et al. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. 2020;145(2):e20191725.

not seeing proof of negative health outcomes as a result. Likewise, many non-transgender individuals must undergo hormone treatment for the majority of their lives, and it is well-managed. This includes patients with Turner syndrome, Klinefelter syndrome, premature ovarian failure, and cancer. Moreover, not all individuals who initiate gender-affirming hormone therapy continue such therapy for the entirety of their lives. Transgender women who have testicles surgically removed, for example, no longer take testosterone suppressors after the procedure. Some transgender individuals also may limit or change the dose of hormone therapy that is needed at different stages of life, not unlike cisgender women undergoing menopause and experiencing changing hormones.

18. It also is not true, as Dr. Levine suggests, that gender-affirming surgical treatment that involves the removal of internal reproductive organs is "inevitably sterilizing." (Levine ¶ 90.) Many people undergo fertility preservation before any treatment that would compromise fertility. Many more transgender people may be treated with gender affirming surgery that has no impact on fertility such as chest reconstruction, breast augmentation, and facial feminization, which are among the more common surgical treatments for transgender patients. Though Dr. Levine warns of risks of infertility related to gender-affirming hormone therapy, this too is speculative and not borne out by data. Many transgender individuals conceive children after undergoing hormone therapy.[12] More generally, many

[12] Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol.* 2014;124(6):1120-1127; Maxwell S, Noyes N, Keefe D, Berkeley AS, Goldman KN.

medical interventions that are necessary to preserve a person's health and well-being can impact an individual's fertility, but we proceed with the treatment after informed consent.

19. Given the extreme dysphoria that many transgender individuals experience with respect to their genitals, it is not true, as Dr. Levine suggests, that data concerning loss of genital sensation and orgasm in non-transgender individuals can be applied to transgender individuals. (Levine Decl. ¶ 91.) Distress of genital change and sensation loss for someone who has a positive association with their genital characteristics does not translate to the experience of someone who might experience disgust and extreme distress at the sight of their genitals. It is simply not reasonable to compare cisgender experiences to transgender experience in the context of genital sensation.

20. Though Dr. Levine attacks the widely accepted treatment protocols for transgender patients, recent studies affirm just how critical such treatment is for the long-term health of pediatric patients with gender dysphoria. In a 2020 study published in *Pediatrics*, the official journal of the American Academy of Pediatrics, researchers concluded that "Treatment with pubertal suppression among those who wanted it was associated with lower odds of lifetime suicidal ideation when compared with those who wanted pubertal suppression but did not receive it.

Pregnancy Outcomes After Fertility Preservation in Transgender Men. *Obstet Gynecol*. 2017;129(6):1031-1034; Neblett MF 2nd, Hipp HS. Fertility Considerations in Transgender Persons. *Endocrinol Metab Clin North Am*. 2019;48(2):391-402.

Suicidality is of particular concern for this population because the estimated lifetime prevalence of suicide attempts among transgender people is as high as 40%."[13] More recent studies than those cited by Dr. Levine also show significantly improved outcomes for patients who undergo gender-affirming surgery when such surgery is medically indicated.[14]

21. Ultimately, it appears from Dr. Levine's declaration that his central point is that it is not healthy to be transgender and that government policies and medical practice should consider efforts to make people not transgender (i.e., encourage people to live in accordance with their assigned sex at birth rather than their gender identity). This approach to treating transgender people is known to be extremely harmful and is considered unethical by every major medical association.[15]

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[13] Turban JL, King D, Carswell JM, et al. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. 2020;145(2):e20191725.
[14] Bränström, R., & Pachankis, J. E. (2019). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study. American Journal of Psychiatry; Wiepjes, C. M., et al. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, 15(4), 582-590.
[15] American Academy of Child & Adolescent Psychiatry. Conversion Therapy. 2018. https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx; American Medical Association. Health care needs of lesbian, gay, bisexual and transgender populations. H-160.991. 2017. https://policysearch.ama-assn.org/policyfinder/detail/H-160.991%20?uri=%2FAMADoc%2FHOD.xml-0-805.xml; Rafferty, J., & Committee on Psychosocial Aspects of Child and Family Health. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*, 142(4).

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

Executed on: 6/28/2020

Deanna Adkins, MD

EXHIBIT C

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

LINDSAY HECOX, et al.,

Plaintiffs,

v.

BRADLEY LITTLE, et al.,

Defendants.

No. 1:20-cv-184-CWD

SUPPLEMENTAL DECLARATION OF JOSHUA D. SAFER, MD, FACP, FACE, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Joshua D. Safer, MD, FACP, FACE, declare as follows:

1. I have personal knowledge of the matters stated in this declaration.

2. As set forth in greater detail in my previously submitted declaration dated April 24, 2020, my background and credentials include the following: I am a Staff Physician in the Endocrinology Division of the Department of Medicine at the Mount Sinai Hospital and Mount Sinai Beth Israel Medical Center in New York, NY. I serve as Executive Director of the Center for Transgender Medicine and Surgery at Mount Sinai. I have served as a Transgender Medicine Guidelines Drafting Group Member for the International Olympic Committee ("IOC") since 2017. I have also served since 2019 as a drafting group member of the transgender medical guidelines of World Athletics, formerly known as the International Amateur Athletic Federation ("IAAF"). My CV is attached to my previously submitted declaration.

3. I reviewed the declaration of Gregory A. Brown, Ph.D. ("Brown Decl.") dated June 3, 2020, and am responding to certain statements therein. Here, I respond to the central points raised in Dr. Brown's declaration. I do not specifically address each study or article cited by Dr. Brown, but instead explain the overall problems with the conclusions that he draws and provide data showing why such conclusions are in error. I reserve the right to supplement my opinions concerning Dr. Brown's opinions if necessary as the case proceeds.

4. In his declaration, Dr. Brown makes three general arguments: "a. At the level of elite, college, high school, and recreational competition, men or boys have an advantage over comparably aged women or girls, in almost all athletic contests; b.

Biological male physiology and anatomy is the basis for the performance advantage that men or boys have over women or girls, in almost all athletic contests; and c. Administration of androgen inhibitors and cross-sex hormones to men, or adolescent boys, after male puberty, and administration of testosterone to women or adolescent girls, after female puberty, does not eliminate the performance advantage of men or adolescent boys over women or adolescent girls in almost all athletic contests." (Brown Decl. ¶ 11.)

5. With respect to point (a), it is my opinion that on average, beginning during puberty, cisgender men and boys have better performance outcomes in most athletic competition as compared to cisgender women and girls. However, this is not a controversial statement and is beside the point here, as it does not concern the alleged performance advantages of transgender athletes (as opposed to men versus women generally).

6. As to Dr. Brown's point (b), he states that "[b]iological male physiology and anatomy is the basis for the performance advantage." (Brown Decl. ¶ 11.)

7. This point is not supported by the studies that Dr. Brown cites. Rather, these studies explain that the advantage observed among cisgender boys and men is due to circulating testosterone levels that typically diverge significantly between cisgender males and females at puberty. Dr. Brown only speculates that any advantage is not due to testosterone alone but other physiological factors that he describes as "male physiology and anatomy." This claim is not supported by the studies that exist and that we both cite. For example, Dr. Brown cites Handelsman

et al, which states that ". . . evidence makes it highly likely that the sex difference ***in circulating testosterone*** of adults explains most, if not all, of the sex differences in sporting performance." (Brown Decl. ¶ 81 (emphasis added).)

8. In paragraphs 63 and 64, Dr. Brown cites to additional studies that look at differences between adult cisgender men and adult cisgender women. These studies make no claims about inherent differences in athleticism that are independent of levels of circulating testosterone. (Brown Decl. ¶¶ 63–64.) The Gershoni et al. study compares genes from adult cisgender men and adult cisgender women. (Brown Decl. ¶ 63.) However, hormone levels might explain the differences observed. Notably, the largest number of genes observed to be different are related to breast tissue, which is a type of tissue that can be changed with hormone therapy. The Haizlip et al. study (Brown Decl. ¶ 64) reviews 56 articles relating to sex-based differences in skeletal muscle. This study draws no conclusions about the impact of hormone suppression or circulating testosterone on the differences the authors observe, underscored by the authors' concluding observations that future "studies should be aimed at determining the role of hormonal interventions in males and females given their clinical relevance" and that "[t]his review summarizes key findings in skeletal muscle physiology in the hopes of bringing to the forefront areas of future research . . . ."[1]

9. In addition, none of the studies cited by Dr. Brown about comparative foot and toe size of cisgender men and cisgender women look at the impact of

[1] K. M. Haizlip, et al., Sex-based differences in skeletal muscle kinetics and fiber-type composition, 30 *PHYSIOLOGY (BETHESDA)*, 39 (2015).

circulating testosterone on those differences. In fact, several of the articles (cited in Brown ¶ 72) simply look at intra-sex differences among male athletes with no data about any differences between cisgender men and cisgender women.

10. The proven impact of circulating testosterone on the body is the reason why the Olympics, World Athletics, and the National Collegiate Athletic Association ("NCAA") focus on testosterone suppression for transgender and intersex inclusion in women's sports. Though Dr. Brown calls these standards into question, claiming that they still allow for levels of circulating testosterone above what is typical for cisgender women, he fails to note that (a) some cisgender women have testosterone levels of up to approximately 5 nmol/L;[2] and (b) these are the best practices that have been in place for years with absolutely no evidence of any dominance among transgender women at the elite level—in fact no trans woman has ever even qualified for the Olympics.

11. The majority of the studies that Dr. Brown cites and almost the entirety of his declaration have nothing to do with transgender women who have suppressed testosterone. For example, the data about the general differences between male and female athletes cited in paragraphs 12-112 and 114-125 includes no reference to or information about transgender athletes. That is also true of the first ***fourteen*** studies (those identified from letters (a) through (l) in paragraph 20) that Dr. Brown

[2] Approximately 6% to 10% of women have a condition called polycystic ovary syndrome (PCOS), which can raise women's testosterone levels up to 4.8 nmol/L. *See* Handelsman DJ, et al. Circulating testosterone as the hormonal basis of sex differences in athletic performance. Endocrine Reviews 2018; 39:803-29 (pp. 806-807).

references. These studies have no bearing on transgender athletes who have suppressed testosterone—i.e., the impact of hormone therapy on physiological characteristics relative to undergoing endogenous puberty.

12. Though Dr. Brown states that "a number of studies indicate that males' athletic advantages over females begin before puberty, and may be apparent as early as six years of age," the cited studies are epidemiological studies from which cause cannot be assessed. (Brown Decl. 23.) The studies merely observe phenomena across a population sample but do not determine the cause for whatever is observed. Here, for example, the role played by cultural factors is not addressed in these studies. Thus, differences could be explained by, among other things, greater encouragement of athleticism in boys and greater opportunities to play sports. (Brown Decl. ¶ 23.)

13. Moreover, the more detailed studies that Dr. Brown cites state that before puberty there are not noticeable performance difference between boys and girls. For example, Dr. Brown cites Louis J. G. Gooren & Mathijs C. M. Bunck, Transsexuals & Competitive Sports, 151 European J. of Endocrinology 425 (2004) in paragraph 114 of his declaration stating: "[b]efore puberty, boys and girls do not differ in height, muscle and bone mass. Recent information shows convincingly that actual levels of circulating testosterone determine largely muscle mass and strength." (Brown Decl. ¶ 114.) Likewise, Dr. Brown references Tonnessen et al., which states that "[m]ale and female athletes perform almost equally in running and jumping events up to the age of 12." (Brown Decl. ¶ 49.) Similar conclusions can be found in

almost every study he cites. There is simply no basis for the assertion that pre-pubertal children have physical sex-based performance differences.

14. With respect to point (c), Dr. Brown and I both agree that levels of circulating testosterone are the definitive factor impacting sex-based performance differences between cisgender males and females beginning in puberty.

15. I disagree with and the science does not support Dr. Brown's assertion that "[a]dministration of androgen inhibitors and cross-sex hormones to men, or adolescent boys, after male puberty . . . does not eliminate the performance advantage of men or adolescent boys over women or adolescent girls in almost all athletic contests." (Brown Decl. ¶ 11.)

16. Though Dr. Brown argues that testosterone suppression is not sufficient to reduce any performance disparities between transgender women and girls and cisgender women and girls, his assumptions are not borne out by data.

17. Dr. Brown states that "[i]t is obvious that some effects of male puberty that confer advantages for athletic performance—in particular bone size and configuration—cannot be reversed once they have occurred." (Brown Decl. ¶ 128.) This is misleading. First, decreased muscle will have some impact on corresponding bone. That means that bone grows when corresponding muscle grows and bone shrinks when corresponding muscle shrinks (Hart NH et al. J Musculoskelet Neuronal Interact 2017; 17:114-139.) Second, carrying larger bones without typical male range levels of circulating testosterone does not necessarily confer an athletic

advantage. As I explained in my previous declaration, it could potentially slow a runner down or change an athlete's weight class.

18. The Knox study that Dr. Brown discusses in paragraphs 138 through 144 does not accurately assess the impact of sustained hormone therapy on transgender women. The study documented the effects of administering hormone therapy to cisgender males for a period of 20 weeks. By contrast, transgender women who are on consistent treatment and eligible to participate on women's teams under prevailing NCAA or Olympic inclusion policies would be suppressing their levels for at least one full year.

19. The Wiik study that Dr. Brown cites does not study athletes at all. As the authors report, because the subjects were not athletes, findings might be attributable in part to the subjects improving over time as they got better at the items tested. For example, for knee flexion, the authors state " . . . measurements in the TW [transgender women] most likely arose from the learning effects from repeating the test . . ." All the Wiik study shows is that testosterone makes a difference with regard to muscle. More testosterone is associated with more strength and more muscle mass. Also, the Wiik study is only "provocative," meaning the findings are not conclusive but should be studied in the future. The authors themselves state, "[i]t is also important to recognize that we only assessed proxies for athletic performance, such as muscle mass and strength. Future studies are needed to examine a more comprehensive battery of performance outcomes in transgender athletes" and " . . . it is still uncertain how the findings would translate to transgender athletes . . . "

20. The Scharff study that Dr. Brown cites (his final cited study dealing with transgender individuals) also does not support the conclusion he draws. Transgender women had a decrease in grip strength and transgender men had an increase in grip strength while on their respective hormone regimens. (Brown Decl. ¶ 151.) Dr. Brown suggests that the decrease in grip strength observed among transgender women still left them with more strength than would be expected for most cisgender women. However, the study was only intended to demonstrate the direction of change, not its absolute amount. The absolute degree of change in a larger population of transgender women along with the net impact on specific athletic activities remains conjecture, subject to future study.

21. My opinions about the impact of hormone therapy, including testosterone suppression and estrogen, on transgender people are not from the Harper study as the Defendants suggest. They are, by contrast, drawn from my more than 15 years of treating transgender patients with hormone therapy, my training as an endocrinologist, my review of the literature concerning the impact of circulating testosterone on athletic performance, and my experience as an expert in establishing policies for the inclusion of transgender athletes in the Olympics and World Athletics.

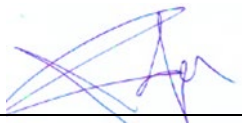
22. The Harper study, although modest with a sample of eight individuals, is the only study of transgender female athletes treated for a sustained period of time with (1) evaluation of athletic performance prior to gender affirming treatment relative to cisgender men followed by (2) evaluation of athletic performance after gender affirming treatment relative to cisgender women. This study, even with its

limits, supports the conclusion that suppression of testosterone *does* diminish performance outcomes for women who are transgender.

23. Research with greater rigor must be done along the lines of the Harper study, but until that time there is no reason to conclude that the opposite of the Harper findings is true.

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

Executed on: June 25, 2020



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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

LINDSAY HECOX, et al.,

Plaintiffs,

v.

BRADLEY LITTLE, et al.,

Defendants.

No. 1:20-cv-184-CWD

EXPERT DECLARATION OF JACK L. TURBAN, MD, MHS, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Jack L. Turban, MD, MHS, have been retained by counsel for Plaintiffs Lindsay Hecox and Jane Doe, with her next friends, Jean Doe and John Doe, as an expert in connection with the above-captioned litigation.

1. The purpose of this declaration is to respond to certain opinions set forth by Dr. Stephen Levine in opposition to Plaintiffs' Motion for Preliminary Injunction. Here, I respond to the central points raised in Dr. Levine's declaration ("Levin Decl."). I do not specifically address each study or article cited by Dr. Levine, but instead explain the overall problems with the conclusions that he draws and provide data showing why such conclusions are in error. I reserve the right to supplement my opinions concerning Dr. Levine's opinions if necessary as the case proceeds.

2. I have actual knowledge of the matters stated in this declaration. In preparing this declaration, I reviewed the materials listed in the attached Bibliography (Exhibit B), as well as the Expert Report of Dr. Stephen Levine. I may rely on those documents as additional support for my opinions. I have also relied on my years of research and other experience, as set out in my curriculum vitae (Exhibit A), and on the materials listed therein. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

BACKGROUND AND QUALIFICATIONS

3. I am currently a clinical fellow in psychiatry at Harvard Medical School, where I research the mental health of transgender youth. Beginning on July 1, 2020, I will be a Fellow in Child and Adolescent Psychiatry at Stanford University.

4. I received my undergraduate degree in neuroscience from Harvard College. I received both my MD and Masters of Health Science degree from Yale University School of Medicine. I am writing in my capacity as a mental health researcher.

5. My research focuses on the mental health of transgender youth. While at Yale, I was awarded the Ferris Prize for my thesis entitled "Evolving Treatment Paradigms for Transgender Youth." In 2017, I received the United States Preventative Health Services Award for Excellence in Public Health based on my work related to the mental health of transgender youth. I have lectured on the mental health of transgender youth at Yale School of Medicine and Massachusetts General Hospital (a teaching hospital of Harvard Medical School).

6. I have served as a manuscript reviewer for numerous professional publications including *The Journal of The American Medical Association*, *The Journal of The American Academy of Child & Adolescent Psychiatry*, *Pediatrics*, *The Journal of Adolescent Health*, and *The American Journal of Public Health*. I have served as lead author for textbook chapters on the mental health of transgender youth, including for *Lewis's Child & Adolescent Psychiatry: A Comprehensive Textbook* and the textbook of The International Academy for Child & Adolescent

Psychiatry and Allied Professionals. I am co-editor of the textbook, *Pediatric Gender Identity: Gender-affirming Care for Transgender and Gender Diverse Youth.*

7. I have published extensively on the topic of transgender youth, including five articles in peer-reviewed journals in the past two years alone.

8. I have never testified as an expert at trial or in deposition. I am being compensated at an hourly rate of $250 per hour for preparation of expert declarations and reports, and $400 per hour for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

SUMMARY OF OPINIONS

9. Dr. Levine is an adult psychiatrist who appears to have limited understanding of the research involving the mental health of children and adolescents who are transgender. He applies outdated research about pre-pubertal children presenting to gender clinics to make broad arguments about the treatment of transgender patients of all ages. His sweeping claims about alleged harms of affirming treatment for transgender youth are contradicted by all recent data, which show precisely the opposite of what he argues: youth and young adults who are affirmed in their gender identity and who have access to social transition and appropriate medical treatment, including puberty blockers and gender affirming hormones, have favorable mental health outcomes.

10. In this declaration, I cite relevant literature to support my opinions that: (1) existing evidence supports transition for transgender youth; (2) the "desistence"

literature that Dr. Levine cites does not apply once a young person reaches the earliest stages of puberty; (3) the "watchful waiting" approach that Dr. Levine describes is only relevant to pre-pubertal children and is not generally practiced in the United States; (4) "regret" is not common among youth who receive gender affirming treatment and all existing evidence regarding gender-affirming care for transgender youth has shown positive mental health outcomes; and (5) efforts to force transgender people to be cisgender are dangerous and unethical.

EXISTING EVIDENCE SUPPORTS SOCIAL TRANSITION FOR TRANSGENDER YOUTH

11. Though the premise of Dr. Levine's declaration is that social transition for transgender youth is harmful to youth who undergo it, existing evidence shows the opposite. For example, Dr. Levine neglects to cite the recent work of Dr. Kristina Olson at The University of Washington, which found that transgender youth who socially transition have levels of depression no different from cisgender controls and only marginally elevated levels of anxiety (in the pre-clinical range).[1] As Olson's team explains in their 2017 manuscript (Durwood et al.), "our findings of normative levels of depression, slightly higher rates of anxiety [pre-clinical], and high self-worth in socially transitioned transgender children stand in marked contrast with previous

[1] Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics*, *137*(3). Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(2), 116-123.

work with gender non-conforming children who had not socially transitioned."[2] In other words, the research shows that youth who are treated consistent with their gender identity and allowed to socially transition have better mental health than cohorts of youth who were not allowed to socially transition. In contrast, if a transgender child's gender identity is not supported, and professionals attempt to make them cisgender, they have a higher likelihood of attempting suicide.[3] Among transgender people who were exposed to efforts to make them cisgender during childhood, 90% had considered suicide.[4] The dangers of efforts to force transgender people to be cisgender are further described below.

12. Dr. Levine also implies that allowing a child to socially transition makes them identify more strongly as transgender and thus more likely to "persist" in their transgender identity. (Levine Decl. ¶ 64.) A study recently published by Dr. Olson's group, which Dr. Levine also failed to cite, has found this not to be true.[5] The study authors found that gender identification did not meaningfully differ before and after social transition.

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[2] Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(2), 116-123.

[3] Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, *77*(1), 68-76.

[4] *Id*.

[5] Rae, J. R., Gülgöz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science*, *30*(5), 669-681.

13. In addition, no evidence establishes a "social contagion" theory of gender transition mentioned by Dr. Levine. He claims that "[i]n the case of adolescents . . . 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." (Levine Decl. ¶ 51.) The Littman study he cites was an anonymous online survey of the parents of transgender youth, recruited from websites where this notion of "social contagion" leading to transgender identity is popular. The anonymous survey participants were asked what they thought was the etiology of their children's transgender identity. Some of these parents believed that their children became transgender as a result of watching transgender-related content on websites like YouTube and having LGBTQ friends. The obvious alternative interpretation is that these youth sought out transgender-related media and LGBTQ friends because they wanted to find other people who understood their experiences and could offer support. If the study had surveyed the children in addition to their parents, they may have been able to establish if this were the case. Unfortunately, the Littman study is based on an anonymous survey of parents only. No conclusions can be drawn from the Littman study other than the fact that some anonymous people recruited from the Internet theorize that transgender identity is due to social contagion. This theorizing from people online does not establish a true phenomenon. No study to date has found a psychosocial determinant of gender

identity. Preliminary biological studies have estimated that gender identity is as much as 70% heritable.[6]

14. In addition, there is no established medical phenomenon of "rapid onset gender dysphoria" as Dr. Levine claims. (Levine Decl. ¶ 63.) This term entered the literature through this same article from Dr. Lisa Littman. A correction was published on this article, which noted, "Rapid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis at this time. This report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon."[7] The correction goes on to say "the term should not be used in any way to imply that it explains the experiences of all gender dysphoric youth . . . "

"DESISTENCE LITERATURE" DOES NOT APPLY ONCE YOUTH REACH THE EARLIEST STAGES OF PUBERTY

15. Dr. Levine references a body of literature commonly referred to as the "desistence literature." (Levine Decl. ¶ 61.) He incorrectly states that this literature found that "the large majority of children who present with gender dysphoria will desist from desiring a transgender identity." (Levine Decl. ¶ 33.) The studies cited by Dr. Levine did not use the current DSM-5 gender dysphoria diagnosis. Rather, most of these studies used the DSM-IV construct of "gender identity disorder." One could meet criteria for the DSM-IV diagnosis of gender identity disorder without identifying

[6] Turban, J. L., & Ehrensaft, D. (2018). Research Review: Gender identity in youth: treatment paradigms and controversies. *Journal of Child Psychology and Psychiatry*, *59*(12), 1228-1243.
[7] Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PloS One*, *14*(3), e0214157.

as transgender because the diagnostic criteria did not require identification with a gender other than the one assigned to the person at birth. This problem with the diagnosis was remedied with the new DSM-5 diagnosis of "gender dysphoria in children," which requires a child to have "a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)." Furthermore, a large proportion of children in these studies did not even meet criteria for DSM-IV's "gender identity disorder" diagnosis. Because these children did not necessarily identify as transgender to begin with, it is not surprising that they did not identify as transgender at follow-up.

16. Perhaps more importantly, these studies all examined *pre-pubertal* children. There is broad consensus that once youth reach the earliest stages of puberty (i.e. Tanner 2) and identify as transgender, "desistence" is rare.[8] The notion of "desistence" therefore is not generally applied to transgender people once they reach Tanner 2 (the earliest stage of puberty). Even the researchers who published the dataset about desistance that Dr. Levine cites are clear that once a child reaches puberty, it is not medically appropriate to withhold affirming treatment. When discussing individuals in high school and college who have transitioned, this data is completely irrelevant.

[8] Turban JL, DeVries ALC, Zucker K. Gender Incongruence & Gender Dysphoria. In Martin A, Bloch MH, Volkmar FR (Editors): *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook*, Fifth Edition. Philadelphia: Wolters Kluwer 2018.

THE "WATCHFUL WAITING" APPROACH REFERS TO THE TREATMENT OF PREPUBERTAL YOUTH ONLY

17. Dr. Levine references the "watchful waiting" approach to the treatment of transgender youth. (Levine Decl. ¶¶ 33–34.) This approach was developed by the VUMC Center for Expertise in Gender Dysphoria in Amsterdam and only applies to the treatment of prepubertal youth.

18. "Watchful waiting" refers to advising parents to wait until the earliest stages of puberty before facilitating a social transition for their child. The VUMC clinic does not advocate for "watchful waiting" once transgender adolescents reach the earliest stages of puberty (i.e. Tanner 2). At that developmental stage, they recommend affirmation of the adolescent's gender identity. In fact, the VUMC clinic was the first clinic in the world to utilize pubertal suppression and gender-affirming hormones for transgender youth and has published on the positive outcomes for youth who receive these medical interventions.[9]

19. Most practitioners in the U.S. do not follow the "watchful waiting" approach for prepubertal youth, as there is concern that forcing a child to wait until the beginning of puberty to facilitate social transition may promote stigma and damage relationships between the child and their parents and clinicians, which could subsequently lead to adverse mental health outcomes.[10] In any event, "watchful

[9] De Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, *134*(4), 696-704.

[10] Turban, J. L., & Ehrensaft, D. (2018). Research Review: Gender identity in youth: treatment paradigms and controversies. *Journal of Child Psychology and Psychiatry*, *59*(12), 1228-1243.

waiting" is not considered an ethical model of treatment for a young person once puberty has begun in the U.S. or elsewhere.

ALL EXISTING EVIDENCE SHOWS THAT, AMONG TRANSGENDER YOUTH WHO RECEIVE GENDER-AFFIRMING MEDICAL INTERVENTIONS, MENTAL HEALTH OUTCOMES ARE FAVORABLE AND REGRET IS RARE

20. In the largest longitudinal study of transgender adolescents to date, 98.1% of those who started pubertal suppression continued on to receive gender-affirming medical care.[11] This same study found extremely low rates of surgical regret among transgender adults: 99.4% of transgender women and 99.7% of transgender men did not have identified surgical regret.

21. All existing data examining the mental health outcomes of transgender adolescents who received pubertal suppression indicate positive mental health outcomes. In a study of 55 transgender people from the Netherlands—the only study following young transgender people through receiving pubertal suppression, gender-affirming hormones, and gender-affirming surgeries—none regretted treatment.[12] Over the course of treatment, their mental health and global functioning scores improved. By the end of the treatment protocol, these properly treated transgender young adults had global functioning scores on par with the general population of the

[11] Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., ... & Gooren, L. J. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, *15*(4), 582-590.

[12] De Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, *134*(4), 696-704.

Netherlands. This is a remarkable finding, given the high rates of anxiety, depression, and suicidality generally seen among transgender people, most of whom are unable to access this type of care. A recent study from our group found that among transgender people who expressed a desire for pubertal suppression, those who accessed it had a 70% lower odds of considering suicide in their lifetime.[13] In another study by Costa et al., transgender youth who received pubertal suppression in addition to psychological support had better global functioning scores than those who received psychological support alone.[14] In other words, Dr. Levine's suggestion that "[w]hat is known [about the impact of treatment] . . . is not encouraging" is not accurate. (Levine Decl. ¶ 77.) The data that we do have is all encouraging regarding the mental health benefits of gender-affirming medical interventions for transgender youth.

22. Dr. Levine cites a study by Dhejne et al. that examined long-term follow-up of transgender individuals who received gender-affirming surgeries. He states that, "the Swedish follow-up study found a suicide rate in the post-SRS [Sex Reassignment Surgery] population 19.1 times greater than that of controls . . . " (Levine Decl. ¶ 78.) Dr. Levine's extrapolation from this data set is flawed. First, the control group Dr. Levine references consists of cisgender people. This is not an

[13] Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, *145*(2).
[14] Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *The journal of sexual medicine*, *12*(11), 2206-2214.

appropriate control group. Transgender people face a range of stressors that affect their mental health, most prominently societal rejection based on being transgender. Though gender-affirming surgery improves mental health, it cannot eliminate societal discrimination for many people, and thus even after surgery, many transgender people still suffer elevated rates of mental health problems compared to cisgender people. This reality of mental health challenges even with gender-affirming care is not a valid argument against the provision of gender-affirming care. The very study Dr. Levine cites explains this point: "no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism [sic]. In other words, the results should not be interpreted such as sex reassignment *per se* increases morbidity and mortality. Things might have been even worse without sex reassignment. As an analogy, similar studies have found increased somatic morbidity, suicide rate, and overall mortality for patients treated for bipolar disorder and schizophrenia. This is important information, but it does not follow that mood stabilizing treatment or antipsychotic treatment is the culprit."[15] Second, the study was published in 2011, and it followed individuals who had surgery when the surgical techniques were not as advanced and discrimination in society was far worse.

23. A more recent study of Swedish population registry data once again found (unsurprisingly, given the stressors faced) evidence that transgender people suffer from mental health needs at higher rates than cisgender people; however, this

[15] 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, 7.

study also found a reduction in mental health treatment needs among transgender people following gender-affirming surgery.[16] The authors of this more recent study conclude: "The longitudinal association found in the present study between gender-affirming surgery and reduced mental health treatment utilization, combined with the physical and mental health risks of surgery denial, supports policies that provide gender affirming surgeries to transgender individuals who seek such treatments."[17]

EFFORTS TO FORCE TRANSGENDER PEOPLE TO BE CISGENDER ARE DANGEROUS AND UNETHICAL

24. Dr. Levine advocates for psychotherapeutic attempts to change a young person's gender identity from transgender to cisgender. He offers a litany of speculative and unsupported harms of "being transgender" and concludes that "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," suggesting that there should be a therapeutic goal of preventing someone from being transgender.[18] (Levine Decl. ¶ 109.) Often, this approach is colloquially referred to as "gender identity conversion therapy." Given that it is not considered an

[16] Bränström, R., & Pachankis, J. E. (2019). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study. *American Journal of Psychiatry*.
[17] *Id.*
[18] As just one example of this, Dr. Levine cites only himself in non-peer reviewed articles in support of the idea that transgender individuals are "strongly narcissistic" and have difficulty forming romantic attachments. (Levine ¶ 98.) I am not familiar with any data that demonstrate increased rates of narcissism among transgender individuals. Likewise, Dr. Levine suggests that transgender individuals only form attachments to other transgender individuals, again without any data to support this supposition, which I have never seen borne out in any data. (Levine ¶ 96.)

appropriate therapeutic modality, it is often referred to in the academic literature as "gender identity conversion efforts."

25. All relevant major medical organizations have issued clear statements that gender identity conversion efforts should not be practiced, including The American Medical Association,[19] The American Academy of Pediatrics,[20] and The American Academy of Child & Adolescent Psychiatry.[21]

26. In a recent paper from our team at Harvard Medical School, published in *JAMA Psychiatry*, we found that, after adjusting for a range of potentially confounding variables, exposure to gender identity conversion efforts was associated with greater odds of attempting suicide.[22] The increased odds of attempting suicide were even greater for transgender people who were exposed to gender identity conversion efforts during childhood.

27. Dr. Levine is correct in pointing out that our study in *JAMA Psychiatry* was cross-sectional. In the realm of scientific evidence, this level of evidence is less

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[19] American Medical Association. Health care needs of lesbian, gay, bisexual and transgender populations. H-160.991. 2017. https://policysearch.ama-assn.org/policyfinder/detail/H-160.991%20?uri=%2FAMADoc%2FHOD.xml-0-805.xml. Accessed June 21, 2020.

[20] Rafferty, J., & Committee on Psychosocial Aspects of Child and Family Health. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*, *142*(4).

[21] The American Academy of Child & Adolescent Psychiatry. Conversion Therapy. 2018. https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx Accessed June 21, 2020.

[22] Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, *77*(1), 68-76.

conclusive than a randomized controlled trial. However, given that gender identity conversion efforts have been labeled unethical by the major medical organizations cited above, it is not possible to conduct a randomized controlled trial of gender identity conversion efforts. No institutional review board would allow such a study to proceed. Because such a study design is not ethically permissible or feasible, we must rely on the evidence we currently have. All existing evidence suggests that trying to force a transgender person to be cisgender is harmful to those exposed to this intervention.[23] There is no evidence of any benefit from such interventions.

28. Rejection of a young transgender person's gender identity is one of the strongest predictors for adverse mental health outcomes. Family rejection of a young transgender person's gender identity is associated with mental health problems for these youth.[24] Non-acceptance by peers is another major risk factor for mental health problems.[25] Inability to obtain gender congruent government identification has been shown to be associated with adverse mental health outcomes.[26] Given that all data

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[23] Not all transgender people will desire medical or surgical interventions. However, for these individuals, it would still be unsafe and unethical to try to force them to live as their sex assigned at birth. Doing so would be a clear violation of the policy statements set forth by these major professional organizations.

[24] Travers, R., Bauer, G., & Pyne, J. (2012). Impacts of strong parental support for trans youth: A report prepared for Children's Aid Society of Toronto and Delisle Youth Services. Trans Pulse.

[25] de Vries, A. L., Steensma, T. D., Cohen-Kettenis, P. T., VanderLaan, D. P., & Zucker, K. J. (2016). Poor peer relations predict parent-and self-reported behavioral and emotional problems of adolescents with gender dysphoria: a cross-national, cross-clinic comparative analysis. *European Child & Adolescent Psychiatry*, *25*(6), 579-588.

[26] Scheim, A. I., Perez-Brumer, A. G., & Bauer, G. R. (2020). Gender-concordant identity documents and mental health among transgender adults in the USA: a cross-sectional study. *The Lancet Public Health*, 5(4), e196-e203.

point to the conclusion that non-acceptance of a person's gender identity leads to poor mental health outcomes, it is likely that rejection of a transgender person's gender identity by forcing them to play on a sports team that does not match their gender identity would damage their mental health. Doing so would also be, in essence, forcing them to express themselves as cisgender, and as described above, forcing a transgender person to be cisgender is associated with adverse mental health outcomes.

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

Executed on: June 26, 2020

Jack L. Turban

JACK L. TURBAN, MD, MHS

EXHIBIT A

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EDUCATION

Yale School of Medicine New Haven, CT 2012-2017
Doctor of Medicine & Master of Health Science with honors. Clinical rotations included inpatient pediatrics, inpatient child psychiatry, inpatient adolescent psychiatry, residential adolescent psychiatry, psychiatric consult liaison service, clinical neuromodulation, neurology clinics, and neurosurgery. Completed award-winning masters' thesis as a Howard Hughes Medical Institute (HHMI) medical research fellow on evolving treatment paradigms for transgender youth. Clerkship Grades: All Honors

Harvard University Cambridge, MA 2007-2011
B.A. Neurobiology magna cum laude. Coursework included clinical neuroscience, systems neurobiology, visual neuroscience, positive psychology, neurobiology of behavior, CNS regenerative techniques, neuroanatomy, vertebrate surgery, and extensive coursework in dramatic theory and practice. International study included Spanish language (Alicante, Spain), stem cell biology (Shanghai, China), and studying how visual art may be used as a window into the mechanisms of neural processing (Trento, Italy). Honors thesis completed at The Massachusetts Eye & Ear Infirmary studying inner-ear development and regeneration. GPA: 3.8/4.0

WORK EXPERIENCE

Stanford Healthcare Palo Alto, CA 2020-2022
Fellow in Child & Adolescent Psychiatry. Fellow in child and adolescent psychiatry. Research focuses on pediatric gender identity and LGBTQ health.

Harvard Medical School Boston, MA 2017-2020
Clinical Fellow in Psychiatry. Resident physician in the MGH/McLean integrated adult, child, and adolescent psychiatry program. Research focuses on pediatric gender identity and LGBT mental health.

Clarion Healthcare Consulting, LLC Boston, MA 2011-2012
Associate Consultant. Worked as a strategy and management consultant for top ten pharmaceutical companies and emerging biotech. Areas of focus included neuroscience business development, life cycle management, and innovation in new product commercialization.

Harvard Summer School in Mind/Brain Sciences Trento, Italy 2011-2012
Resident Director. Directed a study abroad program for Harvard undergraduate and Italian graduate students, introducing them to the basic principles of neuroscience and cognitive psychology.

RESEARCH EXPERIENCE

The Fenway Institute Boston, MA 2017-Present
LGBT Mental Health Research. Currently using data from the National Transgender Discrimination Survey to determine the adult mental health correlates of recalled childhood experiences including exposure to conversion therapy and access to gender-affirming hormonal interventions.

McLean Institute for Technology in Psychiatry Belmont, MA 2017-Present
LGBT Mental Health Research. Conducting cross-sectional studies that examine the associations between geosocial "hook-up apps," internalizing psychopathology, and compulsive sexual behavior. Utilizing the TestMyBrain platform.

Yale Program for Research on Impulsivity & Impulse Control Disorders New Haven, CT 2016-Present
Clinical Research. Conducted a study on US military veterans who had recently returned from deployment, studying rates and comorbidities of those veterans who exhibit compulsive sexual behavior facilitated by social media. Currently studying psychiatric morbidities among veterans who send sexually explicit self-images over social media.

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Yale Child Study Center New Haven, CT 2015-2017
Medical Education Research. Conducted a study to evaluate pediatric attending and medical student knowledge regarding transgender pediatric patient care. Additionally studied participants' personal ethical views regarding pubertal blockade and cross-sex hormone therapy for adolescent patients.

Eaton-Peabody Laboratory Cambridge, MA 2009-2011
Basic Research. Worked at the Massachusetts Eye and Ear Infirmary laboratory, studying stem cells of the inner ear and working toward cochlear hair cell regeneration.

Novartis Pharmaceuticals Shanghai, China 2009-2009
Intern. Worked as a biological research intern, studying the role of Math-1 in inner-ear development and regeneration.

LEADERSHIP

MGH Psychiatry Gender Lab Meetings 2019-Present
Founder. Established monthly lab meetings for those in the MGH psychiatry department to discuss ongoing research regarding transgender mental health.

Yale School of Medicine Cultural Competence Committee New Haven, CT 2012-2017
Chair. Worked with individual course directors to develop course material on cultural competence. Authored case studies on handling pediatric patient sexuality (Professional Responsibility Course), authored a pre-clinical lecture on LGBT healthcare (Ob/Gyn Module), and lectured on transgender pediatric patient care (Pediatrics Clinical Clerkship).

Dean's Advisory Committee on LGBTQ Affairs (Yale School of Medicine) New Haven, CT 2016-2017
Member. Served on the advisory committee to the Dean of Yale School of Medicine, advising on issues related to LGBTQ affairs.

Yale HIV Dermatology Roundtable New Haven, CT 2014-2017
Founder. Eighty percent of patients suffering from HIV face a dermatologic manifestation of their disease. Struck by these patients' experience of stigma, I organized a bi-monthly interdisciplinary roundtable to improve research, education, and clinical care in HIV dermatology. Interventions have included primary care provider training on the treatment of genital warts and improved referral systems for cutaneous malignancies.

Yale Gay & Lesbian Medical Association New Haven, CT 2013-2017
President. Led a group of medical students focused on supporting careers in medicine for LGBT individuals. Organized mixers with LGBT organizations from other graduate schools and with LGBT faculty. Coordinated trips to GLMA national conferences. Worked with the medical school administration to create an LGBT faculty advisor position.

VOLUNTEER WORK & ADVOCACY

American Academy of Child & Adolescent Psychiatry "Break the Cycle" 2017-2017
Event Coordinator. Worked with Dr. Andres Martin to coordinate a fundraising indoor cycling event for the AACAP *Break The Cycle* fundraising campaign to fight children's mental illness.

Yale Hunger & Homelessness Auction New Haven, CT 2012-2014
Logistics Co-Chair. Organized a group of ten students to coordinate entertainment, donations, and event logistics for the Yale annual charity auction. All proceeds for the auction go to support local charities.

Yale School of Medicine Admissions Committee New Haven, CT 2015-2017
Interviewer. Served as a full voting member of the admissions committee. Responsibilities include student interviewing, recruitment, and organizing LGBT-focused activities for admitted students.

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Harvard College Admissions New Haven, CT 2012-Present
Interviewer. Interviewing students from the Boston area for admission to Harvard College.

SELECTED PUBLICATIONS

Turban, J. L., Passell E, Scheer L, Germine L. Use of Geosocial Networking Applications Is Associated With Compulsive Sexual Behavior Disorder in an Online Sample. *The Journal of Sexual Medicine*. [ePub ahead of print]

Turban, J. L., Keuroghlian, A. S., & Mayer, K. H. Sexual Health in the SARS-CoV-2 Era. *Annals of Internal Medicine*. [ePub ahead of print]

Suozzi, K., **Turban, J.**, & Girardi, M. (2020). Focus: Skin: Cutaneous Photoprotection: A Review of the Current Status and Evolving Strategies. *The Yale Journal of Biology and Medicine*, *93*(1), 55.

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Turban, J. L., Carswell, J., & Keuroghlian, A. S. (2018). Understanding pediatric patients who discontinue gender-affirming hormonal interventions. *JAMA Pediatrics*, *172*(10), 903-904.

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Turban, J. L., & van Schalkwyk, G. I. (2018). "Gender dysphoria" and autism spectrum disorder: Is the link real?. *Journal of the American Academy of Child & Adolescent Psychiatry*, *57*(1), 8-9.

Turban, J. L., Winer, J., Boulware, S., VanDeusen, T., & Encandela, J. (2018). Knowledge and attitudes toward transgender health. *The clinical teacher*, *15*(3), 203-207.

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Turban, J. L., Genel, M. (2017) Evolving Treatment Paradigms for Transgender Patients. *Connecticut Medicine*, 81(8), 483-486.

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Turban, J. L., Martin A. (2017) Book Forum: Becoming Nicole. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(1): 91-92.

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PRESENTATIONS & ABSTRACTS

Turban JL, McFarland C, Walters O, Rosenblatt S. An Overview of Best Outpatient Practice in the Care of Transgender Individual. Oral Presentation, Annual Meeting of the American Psychiatric Association, Philadelphia, 2020. [Accepted, but cancelled due to COVID19]

Turban JL, Lakshmin P, Gold J, Khandai C. #PsychiatryMatters: Combating Mental Health Misinformation Through Social Media and Popular Press. Oral Presentation, Annual Meeting of the American Psychiatric Association, Philadelphia, 2020. [Accepted, but cancelled due to COVID19]

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Turban JL, The Pen and the Psychiatrist: Outreach and Education Through the Written Word. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban, JL, For Better and For Worse: Gender and Sexuality Online, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban, JL, Gender Diverse Young Adults: Narratives and Clinical Considerations, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban, JL, Transgender Youth: Controversies and Research Updates, Oral Presentation, Annual Meeting of the American Psychiatric Association, San Francisco, 2019.

Turban, JL, Beckwith N, Reisner S, Keuroghlian A. Exposure to Conversion Therapy for Gender Identity Is Associated with Poor Adult Mental Health Outcomes among Transgender People in the U.S. Poster Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Seattle, 2018.

Shirk SD, **Turban JL**, Potenza M, Hoff R, Kraus S. Sexting among military veterans: Prevalence and correlates with psychopathology, suicidal ideation, impulsivity, hypersexuality, and sexually transmitted infections. Oral Presentation, International Conference on Behavioral Addictions, Cologne, Germany, 2018.

Turban JL, Gender Identity and Autism Spectrum Disorder. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Washington D.C., 2017.

Turban JL, Tackling Gender Dysphoria in Youth with Autism Spectrum Disorder from the Bible Belt to New York City. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent psychiatry, Washington D.C., 2017.

Turban JL, Affirmative Protocols for Transgender Youth. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Washington D.C., 2017.

Turban JL, Evolving Management of Transgender Youth. Oral Presentation, Klingenstein Third Generation Foundation Conference, St Louis, 2017.

Turban, JL, Potenza M, Hoff R, Martino S, Kraus S. Clinical characteristics associated with digital hookups, psychopathology, and clinical hypersexuality among US military veterans. Oral Presentation, International Conference on Behavioral Addictions, Haifa, Israel, 2017.

Lewis J, Monaco P, **Turban JL**, Girardi M. UV-induced mutant p53 ketatinocyte clonal expansion dependence on IL-22 and RORγT. Poster, Society of Investigative Dermatology, Portland, 2017.

Turban JL, Winer J, Encandela J, Boulware S, VanDeusen T. Medical Student Knowledge of and Attitudes toward Transgender Pediatric Patient Care. Abstract, Gay & Lesbian Medical Association, St Louis, 2016.

Turban JL, Lu A, Damisah E, Eid T, Chiang V. Metabolomics to Differentiate Radiation Necrosis from Recurrent Tumor following Gamma Knife Stereotactic Radiosurgery for Brain Metastases. Oral Presentation, 14th Annual Leksell Gamma Knife Conference, New York City, 2014.

Turban JL, Lewis J, Girardi M. UVB-induced HMGB1 and extracellular ATP increase Langerhans cell production of IL-23 implicated in ILC3 activation. Poster, Society of Investigative Dermatology, Scottsdale, 2016.

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Turban JL, Lewis J, Girardi M. Characterization of cytokine pathways associated with Langerhans cell facilitation of UVB-induced epidermal carcinogenesis. Poster, American Society of Clinical Investigation, Chicago, 2016.

Lewis J, **Turban JL**, Girardi M, Michael Girardi. Langerhans cells and UV-radiation drive local IL22+ ILC3 in association with enhanced cutaneous carcinogenesis. Poster, Society of Investigative Dermatology, Scottsdale, 2016.

Sewanan L, Zheng D, Wang P, Guo X, Di Bartolo I, Marukian N, **Turban JL**, Rojas-Velazques D, Reisman A. Reflective Writing Workshops Led By Near Peers During Third-Year Clerkships: A Safe Space for Solidarity, Conversation, and Finding Meaning in Medicine. Poster & Workshop, Society of General Internal Medicine, New Haven and Hollywood, 2016.

EDUCATIONAL PRESENTATIONS

Gender-affirming Care for Transgender Elders. McLean Geriatric Psychiatry Seminar Series, 2019
Writing about Gender & Sexuality (Guest Lecture), Course: Sexual Outcasts & Uncommon Desires, Emerson College, 2019
Gender-affirming Care for Transgender and Gender Diverse Patients on Inpatient Psychiatric Units, MGH Inpatient Psychiatry Seminar Series, 2019
Transgender & Gender Non-conforming Youth, MGH/McLean Adult Residency program, 2018
Writing about Gender Identity for the Lay Audience (Guest Lecture), Course: Kids These Days, Emerson Journalism Program, 2017
International Approaches to the Treatment of Gender Incongruence, VU Medical Center, Amsterdam, 2017
Time to Talk About It: Physician Depression and Suicide, Yale Clerkship Didactics, 2017
Medical Management of Adolescent Gender Dysphoria. Yale Pediatrics Clerkship, 2015-2016
Medical Management of Children and Adolescents with Gender Dysphoria, Yale Pediatrics Residency Didactics, 2016
Reflective Writing Workshop Leader. Yale Surgery Clerkship, 2015-2016
Langerhans Cell Facilitation of Photocarcinogenesis. Yale Department of Dermatology Research Forum, 2016
Panel: Treating Transgender & Gender Non-conforming Patients in the Emergency Setting. Yale Emergency Medicine Clerkship, 2016
Panel: Challenges to the Learning Climate: Difficult Patients, Harassment, and Mistreatment. Yale Pre-Clinical Orientation, 2016
Panel: Personal Behavior and Professionalism, Introduction to the Profession, 2016

AWARDS & HONORS

American Academy of Child & Adolescent Psychiatry Pilot Research Award, $15,000 (2019-2020)
American Psychiatric Association Child & Adolescent Psychiatry Fellowship (2019-2021)
Ted Stern Scholarship and Travel Award (2019)
Ted Stern Scholarship and Travel Award (2018)
Medaris Grant (2018)
United States Preventative Health Services Award for Excellence in Public Health (2017)
NBC Pride 30 Innovator (2017)
Ferris Thesis Prize, Yale School of Medicine (2017)
Parker Prize, Yale School of Medicine (2017)
Howard Hughes Medical Institute Medical Research Fellowship (2015-2016)
American Academy of Child and Adolescent Psychiatry Life Members Mentorship Grant (2016)
Student Scholarship, Gender Conference East (2016)
Farr Award for Excellence in Research (2016)
Yale Office of International Medical Education Grant, Buenos Aires, Argentina (2016)
Yale Office of International Medical Education Grant, VU Medical Center, The Netherlands (2016)
Yale Summer Research Grant (2012)

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AIG International Scholar, Harvard College (2007-2011)
Harvard International Study Grant, Alicante, Spain (2008)
David Rockefeller International Study Grant, Shanghai, China (2009)

PROFESSIONAL MEMBERSHIPS

American Medical Association, Member
American Psychiatric Association, Member
American Psychiatry Association, Council on Communications
American Academy of Child & Adolescent Psychiatry, Member
American Academy of Child & Adolescent Psychiatry, Media Committee
Journal of the American Medical Association, Peer Reviewer
Journal of the American Academy of Child & Adolescent Psychiatry, Peer Reviewer
Pediatrics, Peer Reviewer
Journal of Adolescent Health, Peer Reviewer
Academic Psychiatry, Peer Reviewer
Journal of Autism and Developmental Disorders, Peer Reviewer
Journal of Child Psychology and Psychiatry, Peer Reviewer
American Journal of Public Health, Peer Reviewer
Journal of Clinical Medicine, Peer Reviewer
Brain Sciences, Peer Reviewer
Journal of Homosexuality, Peer Reviewer
American Journal of Geriatric Psychiatry, Peer Reviewer

EXHIBIT B

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