

UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF IDAHO

PAM POE, et al.,

*Plaintiffs,*

v.

RAÚL LABRADOR, et al.,

*Defendants.*

Case No. 1:23-cv-269-BLW (hs)

**Plaintiffs' Notice Of Errata Regarding  
Declarations of Dr. Christine Brady and  
Dr. Kara Connelly [Dkts. 32-6, 32-7]**

PLEASE TAKE NOTICE that Plaintiffs respectfully submit this errata to correct the inadvertent omission of Exhibit A to the Declaration of Dr. Christine Brady (Dkt. 32-6) and Exhibit A to the Declaration of Dr. Kara Connelly (Dkt. 32-7) submitted in support of Plaintiff's Motion for a Preliminary Injunction. Plaintiffs respectfully submit the attached corrected versions of the Declarations of Dr. Brady and Dr. Connelly, which include the omitted exhibits. The omitted exhibits are the Declarants' Curricula Vitae. The Declarations have not been altered in any other manner.

Date: August 16, 2023

Respectfully submitted,

/s/ Alexia D. Korberg

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**CERTIFICATE OF SERVICE**

I hereby certify that a copy of the foregoing document was filed via the Court's electronic filing system on this 16<sup>th</sup> day of August 2023, to be served by operation of the electronic filing system on all ECF-registered counsel of record.

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**UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF IDAHO**

**PAM POE**, by and through her parents and next friends,  
Penny and Peter Poe; **PENNY POE**; **PETER POE**; **JANE  
DOE**, by and through her parents and next friends, Joan and  
John Doe; **JOAN DOE**; **JOHN DOE**,

*Plaintiffs,*

v.

**RAÚL LABRADOR**, in his official capacity as Attorney  
General of the State of Idaho; **JAN M. BENNETTS**, in her  
official capacity as County Prosecuting Attorney for Ada,  
Idaho; and the **INDIVIDUAL MEMBERS OF THE  
IDAHO CODE COMMISSION**, in their official capacities,

*Defendants.*

Case No. 1:23-cv-00269-CWD

**EXPERT DECLARATION OF CHRISTINE BRADY, PhD**

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*Attorneys for Plaintiffs*

I, Christine Brady, PhD, hereby declare and state as follows:

1. I am over 18 years of age and competent to testify.
2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. The opinions expressed herein are my own and do not necessarily express the views or opinions of my employer.
3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinions.
4. In preparing this declaration, I reviewed Idaho State Legislature House Bill 71 (hereafter “Ban”). My opinions contained in this declaration are based on my training as a psychologist; my clinical experience as a pediatric psychologist, including my experience treating youth and young adults up to age 23 with gender dysphoria; my knowledge of peer reviewed research relevant to the treatment of gender dysphoria; my knowledge of the clinical best practice guidelines set forth by professional organizations for the treatment of gender dysphoria including the World Professional Association for Transgender Health (“WPATH”) Standards of Care for the Health of Transgender and Gender Diverse People Version 8 (“SOC 8”), Endocrine Society’s the Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (“Endocrine Society Guideline”), and the American Psychological Association (“APA”) Guidelines for Psychological Practice With Transgender and Gender Nonconforming People.

#### **BACKGROUND AND QUALIFICATIONS**

5. I am a Clinical Assistant Professor in the Department of Pediatric Endocrinology and Diabetes, and (by courtesy) Psychiatry and Behavioral Sciences at Stanford University School of Medicine. I am the full-time psychologist at the Pediatric and Adolescent Gender

Clinic at Stanford Medicine Children's Health. I provide direct therapeutic service to patients (average of 350 families per year), clinical supervision/training to the psychology graduate program and psychiatry fellowship program, and lectures on gender affirming care to psychology students, residents, and fellows and psychiatry fellows. I also conduct research on cultural considerations related to Asian American Native Hawaii Pacific Islander (AANHPI) gender diverse youth.

6. I received my Bachelor of Science and Master of Arts in Psychology from James Madison University, Harrisonburg, VA. I completed my Ph.D. in Clinical Psychology at Ohio University, Athens, OH in 2014. I completed a year-long Pre-Doctoral Internship at the University of Washington/Seattle Children's Hospital as well as a year-long Post-Doctoral Fellowship at the University of Louisville/Norton Children's Hospital.

7. In 2015, I co-founded and was Co-Director of the Gender Clinic at Hennepin Healthcare in Minneapolis, MN. After a year in Minnesota, I became Co-Director of the Pediatric Gender Clinic at the University of Louisville and was there for three years before coming to Stanford, where I have been working for almost three years. In the eight years I have been working with individuals with gender dysphoria, I have treated over 1,000 youth and families. Currently, 100 percent of my clinical practice are transgender youth. In previous positions, I provided therapy to a wide range of presenting problems including ADHD, depression, anxiety, trauma, and coping with medical illness such as cancer. Thus, I have extensive experience and strong therapeutic skills in working with patients with gender dysphoria as well as other common diagnoses in adolescents and young adults.

8. I am a licensed psychologist in the state of California.

9. I have been a member of WPATH since 2017.

10. Further information about my professional background and experience is outlined in my curriculum vitae, a true and accurate copy of which is attached as **Exhibit A** to this report.

11. 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.

### **EXPERT OPINIONS**

#### **A. Gender Identity**

12. A person's sex is typically assigned at birth based upon the external genitalia observed. A person's assigned or designated sex may or may not align with their gender identity. Transgender or gender diverse individuals have a gender identity that does not align with their assigned sex. Cisgender individuals have a gender identity that does align with their assigned sex.

13. Gender identity is a person's core, internal sense of gender, such as male or female. Every person has a gender identity.

14. Gender identity is not a choice. It is an essential part of one's identity and being. Moreover, gender identity is not something that can be voluntarily changed.

15. Efforts to try to change a person's gender identity through therapy have been shown to be ineffective and harmful. For example, in a survey of transgender adults, those who reported receiving talk therapy aimed at changing their gender identity to match their sex assigned at birth (sometimes referred to as conversion therapy) indicated a lack of effectiveness

of that treatment, higher psychological distress, and increased odds of suicide attempts.<sup>1</sup> The survey found that conversion efforts in children under the age of 10 correlated with a 4-fold increase in attempted suicides.<sup>2</sup> Major U.S. professional medical organizations have therefore published statements warning against the dangers of conversion therapy and their recommendations that it should not be used with transgender individuals (e.g., American Psychological Association, American Medical Association, and American Academy of Child and Adolescent Psychiatry).<sup>3</sup>

## **B. Diagnosing Gender Dysphoria**

16. Gender dysphoria is a clinical diagnosis given to an individual who is experiencing significant symptoms and impairment of function due to the incongruence between their assigned sex and their gender identity. Gender dysphoria (and past iterations of gender dysphoria) was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) in the 1980s (version 3). The diagnosis and its criteria have changed over time to reflect the most current research regarding the presentation of this diagnosis.

17. The current version of the DSM (DSM-5 published in 2013 and DSM-5-TR published in 2022) define gender dysphoria as a “marked difference between the individual’s

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<sup>1</sup> Jack L. Turban et al., *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, 77 JAMA PSYCHIATRY 68, 69 (2019).

<sup>2</sup> *Id.* at 68.

<sup>3</sup> AMERICAN PSYCHOLOGICAL ASSOCIATION, APA RESOLUTION ON GENDER IDENTITY CHANGE EFFORTS 1-2 (2021), <https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf>; AMERICAN MEDICAL ASSOCIATION & GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, SEXUAL ORIENTATION AND GENDER IDENTITY CHANGE EFFORTS (SO-CALLED “CONVERSION THERAPY”) 4 (2022), <https://www.ama-assn.org/system/files/conversion-therapy-issue-brief.pdf>; American Academy of Child & Adolescent Psychiatry, *Conversion Therapy Policy Statement* (Feb. 2018), [https://www.aacap.org/AACAP/Policy\\_Statements/2018/Conversion\\_Therapy.aspx](https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx).

expressed/experienced gender and the gender others would assign him or her.” Symptoms must be present for at least six months, be verbalized externally, and be causing significant impairment in various domains of functioning such as peer relationships, school, or home life. There are different diagnostic criteria for children than there are for adolescents and adults.

18. For pre-pubertal children, DSM-5 diagnostic criteria are as follows:

A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or insistence that one is the other gender (or some alternative gender different from one’s assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire, or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, game and activities.
7. A strong dislike of one’s sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender.

B. The condition is associated with clinically significant distress or impairment in social circles, school, or other important areas of functioning.

19. For adolescents and adults, DSM-5 diagnostic criteria are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

20. For adolescents and adults whose gender identity differs from their sex assigned at birth, it is very unlikely that they will later come to identify with their birth-assigned sex. In my experience with over 900 transgender adolescent patients who met the criteria for gender dysphoria, only 6 have later come to identify with their sex assigned at birth (4 had not engaged in medical interventions; 2 had received puberty delaying medications, stopped those medications, and their endogenous puberty resumed; none expressed regret around their gender exploration or care).

21. There is some research on pre-pubertal children that has been described as showing high rates of “desistance” of transgender identity among pre-pubertal children.<sup>4</sup> Because that research included gender-non-conforming children who did not necessarily identify as a sex different than their birth-assigned sex, it can be misleading when used to talk about desistance of transgender identity. In other words, many of these youth did not identify as transgender, would not meet the criteria of gender dysphoria under the current DSM 5 standards, and would not be included in studies of transgender youth today. A more recent study of pre-pubertal transgender children who had socially transitioned (mean age of 8-years-old) reports 2.5% of participants identified with their designated sex at birth five years later (mean age of 13-years-old at follow-up).<sup>5</sup> Moreover, there is no evidence that transgender adolescents are likely to “desist” at high rates. One study found that only 3.5% of adolescents stopped taking puberty blockers because they no longer wished to have gender affirming treatment.<sup>6</sup>

22. Some patients with gender dysphoria may discontinue gender-affirming medical interventions for a variety of reasons, including having achieved their transition goals (e.g., voice deepening, facial hair growth), barriers to accessing care such as lack of insurance, or family or social pressure. Discontinuing care should not be interpreted to mean that the patient has “detransitioned” in the sense of coming to identify with one’s birth-assigned sex<sup>7</sup> and there are

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<sup>4</sup> See, e.g., Madeleine S.C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual Outcome of Gender-Dysphoric Children*, 47 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1413, 1413-23 (2008) (investigating which childhood measures of gender behavior related to “desistance”).

<sup>5</sup> Kristina R. Olson et. al., *Gender Identity 5 Years After Social Transition*, 150 PEDIATRICS 1, 3 (2022).

<sup>6</sup> Tessa Brik et al., *Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*, 49 ARCHIVES SEXUAL BEHAV. 2611, 2615 (2020).

<sup>7</sup> Jack L. Turban et al., *Factors Leading to “Detransition” Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis*, 8 LGBT HEALTH 273, 273-80 (2021).

no studies that have found that such an experience is common among those who receive gender affirming medical care.

### **C. The Treatment of Gender Dysphoria**

23. Being transgender or gender diverse alone is not pathological; a person's gender identity is not a medical condition or the target of treatment. DSM-5 states that treatments for the diagnosis of gender dysphoria should be focused on alleviating the distress/impairment of function stemming from the incongruence between the patient's gender identity and birth-assigned sex, not trying to change the patient's gender identity.

24. Gender dysphoria can be debilitating and cause significant impairment in function. It is well recognized that transgender adolescents and young adults are a vulnerable population at higher risk for depression/anxiety, suicidal ideation and suicide attempts. The Youth Risk and Behavior Survey (YRBS) is an ongoing study conducted by the Center for Disease Control that obtains data on variables relevant to adolescents in the United States. Data from states that ask about and can analyze variables related to gender identity found that adolescents who are gender diverse, when compared to cisgender peers, had higher rates of consideration of suicide (45% vs 10-20%) and attempted suicide (35% vs. less than 10%).<sup>8</sup>

25. Without treatment, adolescents and young adults with gender dysphoria can experience symptoms that make very basic tasks feel impossible such as showering, eating, attending school, or socializing. Clinically, many of my patients report not participating in class due to discomfort with their voice, avoiding the use of bathrooms throughout the school day,

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<sup>8</sup> Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts, 2017*, MORBIDITY & MORTALITY WKLY. REP., Jan. 25, 2019, at 67, 69.

avoiding physical activity due to body discomfort, as well as discomfort leaving the house in general. Delays in treatment can exacerbate symptoms, creating more impairment and psychological distress. A recent study of adults showed that longer wait times to establish care at a gender clinic resulted in low mood, worsening suicidal ideation and poorer quality of life.<sup>9</sup>

26. The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People are the most widely adopted clinical practice guidelines for the treatment of transgender and gender diverse individuals. The Standards of Care (SOC) were first published in 1979 and the most recent iteration (SOC 8) was published in 2022.<sup>10</sup> Per the methodology described by WPATH “SOC-8 is based on the best available science and expert professional consensus in transgender health. International professionals and stakeholders were selected to serve on the SOC-8 committee. Recommendation statements were developed based on data derived from independent systematic literature reviews, where available, background reviews and expert opinions.”<sup>11</sup> SOC 8 provides detailed guidance for evaluation of gender dysphoria and criteria for medical intervention, as well as procedures for hormone treatment and surgery when indicated.<sup>12</sup>

27. The Endocrine Society has also published a widely adopted clinical practice guideline for the treatment of gender dysphoria (Endocrine Society Guideline) to help guide

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<sup>9</sup> N. Henderson et al., *The Impact of Gender Identity Clinic Waiting Times on the Mental Health of Transitioning Individuals*, 65 EUR. PSYCHIATRY S851 (2022)

<sup>10</sup> E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT’L J. TRANSGENDER HEALTH S1 (2022).

<sup>11</sup> *Id.* at S3.

<sup>12</sup> *Id.*

providers working with gender diverse adolescents and adults.<sup>13</sup> The SOC 8 and Endocrine Society Guideline have a high degree of overlap and consensus regarding best practices.

28. The American Psychological Association (APA) also released guidelines specific to the provision of mental health care to gender diverse individuals.<sup>14</sup> The APA defines gender affirming care to be “care that is respectful, aware, and supportive of the identities and life experiences of [transgender and gender non-conforming] people.”<sup>15</sup> Gender affirming care is creating a safe, therapeutic space where individuals can grow, evolve and understand themselves more completely, wherever their path may lead.

29. As stated above, these guidelines are widely accepted in the professional community. They have analyzed all available scientific research, and are widely referenced and endorsed by all major U.S. medical and mental health associations.

30. The SOC 8 and Endocrine Society Guideline described above emphasize the importance of mental health assessments and evaluations in the treatment of gender diverse adolescents. Beyond assessing eligibility criteria for medical interventions (puberty-delay, hormones, or surgery), which will be discussed below, mental health providers can facilitate exploration and deepen understanding of an individual’s gender, help manage anxiety/depression or other mental health diagnoses related to gender dysphoria, provide support related to social transition (e.g. dressing and using names and pronouns that accord with one’s gender identity), provide education to caregivers to increase support and positive communication, and enhance

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<sup>13</sup> Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (2017).

<sup>14</sup> American Psychological Association, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, AM. PSYCH. 832 (2015).

<sup>15</sup> *Id.* at 832-33.

coping skills to manage discrimination/minority stress. For some, non-medical interventions such as social transition, creating gender congruent expression, and getting social support of their identity is sufficient to manage gender dysphoria. For many others, medical intervention is clinically indicated.

31. Under the WPATH SOC 8 and the Endocrine Society Guideline, no medical interventions are recommended or indicated for the treatment of gender dysphoria prior to the onset of puberty (otherwise referred to as Tanner Stage 2). Prior to Tanner Stage 2, the recommended care is to help youth in their gender exploration, and provide support to youth and families as described above.

32. Once puberty begins, many adolescents with gender dysphoria will experience great distress related to the changes in their bodies that do not match their gender identity. For some of these youth, medical interventions may be deemed necessary. They may include puberty blockers (GnRH agonists) to pause puberty, hormone therapy in accordance with one's gender identity (e.g. testosterone for transgender boys and estrogen and anti-androgens for transgender girls), and sometimes surgery. Pausing puberty with blockers can help prevent the distress associated with physical changes inconsistent with an adolescent's gender identity and also provide the adolescent more time to understand their gender identity before considering less reversible treatments. Hormone therapy and surgery can alleviate the distress of gender dysphoria by helping align the adolescent's body with their gender identity.

33. The WPATH SOC and the Endocrine Society Guideline outline criteria for eligibility for medical interventions for adolescents with gender dysphoria including a) significant duration of gender incongruity, b) the diagnostic criteria for gender dysphoria are met, c) the adolescent has the emotional and cognitive capacity to provide informed consent

regarding the treatment they are seeking; d) any other mental health conditions do not interfere with diagnostic clarity or ability to consent and e) the patient and their family is fully informed of potential risks and fertility preservation options.

34. To determine if the eligibility criteria are met and if medical interventions are appropriate for an adolescent patient, the SOC 8 and Endocrine Society Guideline recommend a comprehensive psychosocial assessment. Assessment procedures can vary based on the practice setting, discipline of the provider conducting the assessment, presence of neurodiversity, or other individual patient considerations/needs.

35. During the assessment, a thorough history and diagnosis of gender dysphoria (evolution of identity, onset of symptoms, types of symptoms experienced, disclosure of identity, impairment experienced) is obtained. It is important to understand fully how identity has developed over time and how their gender dysphoria manifests. Some patients who are evaluated do not meet the criteria for gender dysphoria (either due to symptom length or lack of symptoms), in which case a treatment plan may include non-medical support and intervention to address symptoms/distress.

36. Evaluation of co-occurring mental health disorders is also obtained. If other conditions are present, it is important to understand how/if other diagnoses are related to gender dysphoria and ensure that other mental health needs are getting adequate support and are addressed. Further assessment or testing may be needed to fully understand more complex presentations (e.g., challenging psychopathology, co-occurring neurodiversity) prior to initiating medical intervention. The presence of co-occurring disorders does not preclude eligibility for medical intervention. Gender dysphoria can contribute to symptoms of depression, anxiety, eating disorder, etc., thus we often cannot expect symptoms to improve or be in remission until

the gender dysphoria is treated. Any co-occurring mental health issue should be managed enough so that it is not interfering in the diagnostic picture or impairing one's judgment or ability to make informed decisions. In some cases, further testing or therapy may be needed to address this criterion prior to recommending medical intervention.

37. The assessment should also include an evaluation of an adolescent's ability to understand the potential risks, benefits, and long-term consequences of treatment. Treatment options should be discussed thoroughly, including changes (both reversible and permanent), timeline for when changes occur, realistic expectations of physical changes, medical risks and side effects, and potential implications for fertility and fertility preservation options. As with all medicine, information should be presented in a developmentally appropriate manner to both the adolescent and caregivers. Information should be presented using the current evidence available. Once an adolescent has been provided all the information necessary to make an informed choice, if they want to proceed with the treatment, they must provide assent and their parent or guardian must provide consent.

#### **D. Efficacy of Medical Treatment for Gender Dysphoria**

38. In the years that I have been seeing patients with gender dysphoria, I have clinically seen the life-changing—and sometimes life-saving—benefits of gender-affirming medical interventions. Not only do I see improvements in depression, anxiety, and suicidal ideation, but I have seen significant improvements in overall daily functioning in adolescents after receiving gender-affirming medical care. Adolescents who were previously too anxious to attend school in person are now going to school and thriving academically. They are now able to make friends, date, and work, and do so with confidence. Caregivers have often commented on

the weight that has been lifted from their child or how happy they are to see their child thriving again.

39. Research conducted in this area echoes what I have seen clinically. A substantial body of evidence shows the efficacy of gender affirming medical care. Studies have demonstrated improvements in mental health following gender-affirming medical interventions.<sup>16</sup> Many of these studies demonstrate improvement in depression and anxiety symptoms, quality of life indicators, as well as reductions in suicidal ideation and attempts.

40. Moreover, as I have seen in my experience as a clinician the use of hormone blockers and cross-sex hormone therapy during adolescence can prevent the need for future medical treatments (such as surgeries to remove or alter secondary sex characteristics) and allow for more favorable future outcomes. This, in turn, reduces the gender dysphoria associated with one's body failing to align with one's gender identity.

41. There are no scientific studies demonstrating that non-medical treatments alone (such as therapy only) are effective in the treatment of gender dysphoria.

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<sup>16</sup> See e.g., Diane Chen et al., *Psychological Functioning in Transgender Youth After 2 Years of Hormones*, 388 NEW ENG. J. MED. 240, 245-247 (2023) (demonstrating increased mental health benefits from gender affirming care for transgender people); Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. ADOLESCENT HEALTH 643, 647-48 (2022) (same); Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 PEDIATRICS 1, 3 (2020) (same); Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, 8 J. SEXUAL MED. 2276, 2281-90 (2011) (same); Rosalia Costa et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12 J. SEXUAL MED. 2206, 2212-13 (2015) (same); Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 PEDIATRICS 696, 701-03 (2014) (same).

### **E. Harm to Transgender Youth if Care is Restricted**

42. Withholding or discontinuing widely accepted, effective medical care from adolescents with gender dysphoria will cause serious harm. Having seen the significant distress and limitations on function experienced by adolescent patients with gender dysphoria, and the transformative effects of gender affirming medical treatments, the thought of withholding this care from those who need it is deeply concerning. Doing so will predictably result in adolescents unnecessarily suffering distress, withdrawing from life activities and, for some, hurting themselves. It will deny many adolescents with gender dysphoria the opportunity to be healthy and thrive. In a large survey of transgender adolescents and young adults, those who had access to medical interventions reported lower depression and suicidal ideation compared to adolescents and young adults who sought medical interventions but were not receiving them.<sup>17</sup> Restricting access will increase depression and suicidal ideation within an already vulnerable population.

43. For youth entering puberty, access to puberty blockers prior to the onset of irreversible secondary sex characteristics (e.g., deep voice, chest development) bypasses much of the dysphoria, distress and psychological harm that going through misaligned puberty can cause, as well as prevent more invasive and costly procedures in adolescence and adulthood such as surgery.

44. Clinically, I have had cases where patients are not able to receive gender affirming medical care for various reasons and are forced to wait until they turn 18. While waiting, there is often increased psychological distress impairing their daily life and functioning. For example, individuals may become so dysphoric with their bodies that they are not able to

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<sup>17</sup> Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. ADOLESCENT HEALTH 643, 647-48 (2022).

leave the house to attend school, participate in extra-curricular activities, or continue working or obtain employment. Those who are forced to wait can decompensate. I have had several cases where depression related to gender dysphoria increased to such a degree that inpatient hospitalization was needed for stabilization following significant self-harm, suicidal ideation or a suicide attempt. In some cases, adolescent patients become desperate and have explored or obtained hormones online or from other countries. Doing so without appropriate dosing and monitoring places them at risk for physical harm.

45. Our clinic has recently had around ten families come to us from other states where bans on gender-affirming medical care for minors have been enacted. With some families, they come to us every 3-6 months for follow-up. This places significant financial strain on families as well as disrupts daily life every 3-6 months. Some families have made the difficult decision to move to California, leaving a state that they loved and leaving their support systems behind in order to care for their child.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: 7/19/2023

  
\_\_\_\_\_  
Christine Brady, PhD

# Exhibit A

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Curriculum Vitae  
**Christine Erin Lam Brady, PhD**  
[bradyce@stanford.edu](mailto:bradyce@stanford.edu)  
California License # PSY31431  
Updated 01/19/2023

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## A. IDENTIFYING DATA

<b>Name</b>	<b>Christine Erin Lam Brady, PhD</b>
<b>Current Position</b>	<b>Clinical Assistant Professor</b>
	<b>Psychologist Gender Clinic</b>
<b>Current Affiliation</b>	<b>Stanford University</b>

## II. EDUCATIONAL BACKGROUND

### Colleges and Universities Attended

- 2009 - 2014 Ph.D.  
Child Clinical Psychology, Ohio University, Athens, OH  
Dissertation: *Adolescent Social Functioning: Theory, Measure Development and Preliminary Validation.*  
Advisor: Dr. Steven W. Evans
- 2007- 2009 M.A.  
Psychological Sciences, Clinical, James Madison University, Harrisonburg, VA  
Thesis: *Psychometric properties of the Alabama Parenting Questionnaire Using an Adolescent Sample*
- 2001- 2005 B.S.  
Psychology, minor in English, James Madison University, Harrisonburg, VA  
Previously attended Mary Washington College August 2001-May 2002

### Residency and Fellowship Training

- 2014 – 2015 Post-Doctoral Fellowship Pediatric Psychology, Consultation Liaison  
University of Louisville, Norton Children’s Hospital
- 2013 – 2014 Pre-Doctoral Internship, Child Track  
University of Washington School of Medicine, Seattle Children’s Hospital

### Board Certifications

- 2019 - present California Board of Psychology – Licensed Psychologist (# 31431)  
Previously licensed in Minnesota and Kentucky (expired)

### III. EMPLOYMENT

#### Academic Appointments:

- 2020 – present Clinical Assistant Professor, Stanford University, Palo Alto, CA  
Psychologist, Pediatric and Adolescent Gender Clinic
- 2016 – 2019 Assistant Professor, University of Louisville School of Medicine, Louisville, KY  
Pediatric Psychologist, Bingham Clinic  
Director Pediatric Consultation Liaison Service, Norton Children’s Hospital  
Co-Director, Pediatric Gender Clinic

#### Other Appointments:

- 2019 – 2020 Gender Specialist, Gender Case Manager, and Child Psychologist  
Kaiser Permanente Santa Clara, CA
- 2015 – 2016 Senior Clinical Pediatric Psychologist  
Hennepin County Medical Center, Minneapolis, MN

### IV. HONORS AND AWARDS

- 2020 1<sup>st</sup> Place Poster Award Diversity Special Interest Group APA Division 54  
2017 Building Block Award for Psychology, Excellence in Teaching

### V. BIBLIOGRAPHY

#### Peer-Reviewed Original Research (6 total)

1. Carter, B., Kronenberger, W., Cruce, S., Mizell, D., Threlkeld, B., **Brady, C. E.\***, & Jones, L. (2015). Factors associated with dropout versus completion of a manualized treatment for pediatric chronic pain. *Clinical Practice in Pediatric Psychology*, 3, 327-339.
2. Zoromski, A. K., Owens, J. S., Evans, S. W., **Brady, C. E.\***. (2015). Identifying ADHD symptoms that best predict disorder-related impairment in early, middle, and late childhood. *Journal of Abnormal Child Psychology*, 43, 1243-1255.
3. Evans, S.W., **Brady, C.E.\***, Harrison, J.R., Bunford, N., State, T., Kern, L., & Andrews, C. (2013). Measuring ADHD Symptoms and Impairment Based on High School Teachers’ Ratings. *Journal of Clinical Child and Adolescent Psychology*, 42, 197-207.

4. Evans, S.W., Koch, R., **Brady, C.E.\***, Meszaros, P., & Sadler, J.M. (2013). Community and school mental health professionals' knowledge and use of evidence based substance use prevention programs. *Administration and Policy in Mental Health and Mental Health Service Research*, 40, 319-330.
5. **Brady, C.E.**, Evans, S.W., Berlin, K.S., Bunford, N., & Kern, L. (2012). Evaluating School Impairment with Adolescents: A Psychometric Evaluation of the Classroom Performance Survey. *School Psychology Review*. 41, 429-446.
6. Evans, S. W., Schultz, B., White, C. L., **Brady, C. E.\***, Sibley, M. H., & Van Eck, K. (2009). A school-based organization intervention for young adolescents with ADHD: Patterns of responding. *School Mental Health*, 1, 78-88.

#### **Invited Commentaries (1 total)**

1. Turban, J., **Brady, C. E.**, & Olson-Kennedy, J. (2022). Understanding and supporting patients with dynamic desires for gender-affirming medical interventions. *Journal of the American Medical Association Network Open*. doi:10.1001/jamanetworkopen.2022.24722

#### **Book Chapters (4 total)**

1. Carter, B., Tsang, K., & **Brady, C. E.** (2020). Models of Consultation-Liaison. In B. Carter and K. Kullgren (Eds.), *Clinician Handbook of Pediatric Psychological Consultation in Medical Settings*, 11-24.
2. **Brady, C. E.** & Ernst, M. M. (2020). Gender identity: Disorders/differences of sex development/intersex and transgender concerns. In B. Carter and K. Kullgren (Eds.), *Clinician Handbook of Pediatric Psychological Consultation in Medical Settings*, 439-450.
3. Carter, B., Kronenberger, W., Scott, E., Kullgren, K., Piazza-Waggoner, C., & **Brady, C. E.** (2017). Inpatient pediatric consultation-liaison. In M. Roberts and R. Steele (Eds.), *Handbook of pediatric psychology (5<sup>th</sup> Ed.)*, 105-118.
4. Evans, S.W., Sadler, J.M., & **Brady, C.E.** (2009). *Treating Children and Adolescents with ADHD in the Schools*. In A. Roberts (Ed.), *Social Workers Desk Reference 2<sup>nd</sup> Edition*. New York, NY: Oxford University Press.

#### **Books (1 total)**

1. Carter, B., Kronenberger, W., Scott, E., & **Brady, C. E.** (2020). *Children's Health and Illness Recovery Program: Clinician's Handbook*. Oxford, England: Oxford University Press, Programs that Work Series.

#### **Abstracts (39 total)**

1. Aye, T., **Brady, C. E.**, & Orr, A. (July 2022). Multidisciplinary Lessons Learned from the Care of Transgender and Gender Expansive AAPI Youth and Adolescents. Symposium presented at Gender Spectrum 2022 Professional Symposium (virtual conference).
2. Aye, T., **Brady, C. E.**, & Orr, A. (Nov 2021). Multidisciplinary Lessons Learned from the Care of Transgender and Gender Expansive AAPI Youth and Adolescents. Mini Symposium presented at the US Professional Association for Transgender Health (virtual conference).
3. **Brady, C.E.**, & Aye, T. (July 2021). Supporting Gender Diverse Youth with Medical Conditions. Workshop presented at the Gender Spectrum Professional Symposium (virtual conference).
4. Bazier, A., Anastasiadis, W., Gilbert, E., **Brady, C.**, Schwartzkopf, K., & Naramore, S. (April 2021). Optimizing Equity of Healthcare for Transgender Youth within a Pediatric Gastroenterology Subspecialty Clinic. Poster presented at the 51<sup>st</sup> annual Society of Pediatric Psychology Conference (virtual conference).
5. **Brady, C. E.**, Gilbert, E., & Kellison, J. (April, 2019). *Health Disparities in Pediatric Populations: Recommendations for Sensitive and Inclusive Care*. Professional development workshop given at the 50<sup>th</sup> annual Society for Pediatric Psychology Annual in New Orleans, LA.
6. Carter, B. D. & **Brady, C. E.** (July, 2015). *Innovations in the Treatment of Children and Adolescents with Chronic Pain and Medically Unexplained Conditions*. Talk given at the annual meeting of the Indiana Psychological Association, Evansville, IN.
7. **Brady, C. E.**, Evans, S. W., Bunford, N., & Weist, M. (February, 2013). *Measuring school impairment in secondary schools*. Paper presentation given at the annual meeting of the National Association of School Psychologists, Seattle, WA.
8. Zoromski, A. K., Evans, S. W., Owens, J. S., & **Brady, C. E.** (February 2013). *Relationship between ADHD symptoms and impairment across three age ranges*. Paper presented at the National Association of School Psychologists 2013 Annual Convention, Seattle, Washington.
9. Zoromski, A. K., **Brady, C. E.**, & Evans, S. W. (November, 2012). Poster presented at the 46<sup>th</sup> annual meeting of the Association for Behavioral and Cognitive Therapies, National Harbor, MD.
10. Evans, S. W., **Brady, C. E.**, Harrison, J.R., Bunford, N., State, T., & Kern, L. (November, 2011). *Measuring ADHD symptoms and impairment in adolescence*. Paper presented at the 45th annual meeting of the Association for Behavioral and Cognitive Therapies, Toronto, Canada.

11. Zoromski, A. K., **Brady, C. E.**, & Evans, S.W. (November, 2011). *ADHD Symptoms in Adolescence: Which are most predictive of impairment?* Poster presented at the 45<sup>th</sup> annual meeting of the Association for Behavioral and Cognitive Therapies, Toronto, Canada.
12. Sadler, J.M., **Brady, C. E.**, & Evans, S. W. (September, 2011). *Interpersonal Skills Group: A social functioning intervention for adolescents with ADHD.* Talk presented at the annual meeting of the Center for School Mental Health, Charleston, SC.
13. Davis, H. I., **Brady, C. E.**, & Evans, S. W. (August 2011). *Rates of Assignment Completion in High School Students Meeting Symptom Criteria for a Disruptive Behavior Disorder.* Poster presented at the 119<sup>th</sup> American Psychological Association Conference, Washington, D.C.
14. **Brady, C. E.** & Evans, S. W. (February, 2011). Measuring parenting practices: Implications for school mental health. In J. S. Owens (Chair), *Impact of family factors on school-based assessment and treatment.* Symposium presented at the annual meeting of the National Association of School Psychologists, San Francisco, CA.
15. Evans, S. W., Schultz, B. K., Sadler, J. M., **Brady, C. E.**, & Demars, C. (November, 2010). *Psychosocial and educational school based interventions for high school students with ADHD.* In S. W. Evans (Chair), *Providing evidence-based interventions in secondary schools.* Symposium presented at the 44<sup>th</sup> annual meeting of the Association for Behavioral and Cognitive Therapies, San Francisco, CA.
16. Zoromski, A. K., Sadler, J. M., **Brady, C. E.**, Schultz, B. K., & Evans, S. W. (November, 2010). *An organization intervention for high school students with Attention Deficit Hyperactivity Disorder.* Poster presented at the 44<sup>th</sup> annual meeting of the Association for Behavioral and Cognitive Therapies, San Francisco, CA.
17. Evans, S. W., Owens, J. S., Sadler, J. M., **Brady, C. E.**, Storer, J., Zoromski, A. (October, 2010). *Evidence-based Interventions for Helping Children & Adolescents with ADHD.* Intensive Training Session presented at the 15<sup>th</sup> annual conference on Advancing School Mental Health, Albuquerque, NM.
18. **Brady, C. E.**, Sadler, J. M., Zoromski, A. K., & Evans, S.W. (October, 2010). *Youth with ADHD and Sports Participation: A Preliminary Investigation.* Poster presented at the 15<sup>th</sup> annual conference on Advancing School Mental Health, Albuquerque, NM.
19. Evans, S. W., Cloth, A., **Brady, C. E.**, & Sadler, J. M. (August, 2010). *Overcoming Obstacles to Implementing Evidence Based Mental Health Practices in Secondary Schools.* In C. Paternite (Chair), *Development of Effective Interventions for Adolescents with ED.* Symposium presented at the 118<sup>th</sup> annual conference of the American Psychological Association, San Diego, CA.

20. Evans, S. W., **Brady, C. E.**, Kern, L., Andrews, C. & CARS Research Team. (June 2010). Measurement development and inclusion criteria: Developing meaningful standards. In J. Buckley (Chair), *It's Time to Stem the Tide of Failure: Building Interventions to Support High School Students with Emotional and Behavioral Disorders*. Symposium presented at 5<sup>th</sup> Annual IES Research Conference, Washington D.C.
21. Evans, S. W., **Brady, C. E.**, Sadler, J. & Schultz, B. (November, 2009). The relationship between improvement in symptoms and functioning for young adolescents with ADHD. In J.S. Owens (Chair), *Symptoms and Beyond: The Importance of Assessing Treatment-Related Changes in Functioning in Youth and Parents with ADHD*. Symposium presented at the 43<sup>rd</sup> annual meeting of the Association for Behavioral and Cognitive Therapies, New York, New York.
22. Koch, R. J., Meszaros, P. S., Evans, S. W., Meyer, B. L., **Brady, C. E.**, Duncan Lane, C. L, Mays, S.A., & Sadler, J. M. (November 2009). *An evidence-based substance abuse preventive intervention for youth with psychiatric disorders: Initial results*. Presentation given at the American Public Health Association Meeting and Expo, Philadelphia, PA.
23. **Brady, C. E.**, Sadler, J., Sibley, M., Zoromski, A., & Evans, S. (November 2009). *Peer characteristics preferred by youth with and without ADHD*. Poster presented at the 43<sup>rd</sup> annual meeting of the Association for Behavioral and Cognitive Therapies, New York, NY.
24. Sadler, J., **Brady, C. E.**, Zoromski, A., Light, C., Schultz, B., & Evans, S. (October 2009). *Treatment of high school students with ADHD: Adolescent, parent, and teacher satisfaction*. Poster presented at the 14<sup>th</sup> annual conference on Advancing School Mental Health, Minneapolis, MN.
25. Sadler, J., **Brady, C. E.**, Zoromski, A., & Evans, S. (October 2009). *Does mastery of goal effect outcomes in a psychosocial intervention?* Poster presented at the 14<sup>th</sup> annual conference on Advancing School Mental Health, Minneapolis, MN.
26. Eid, R. K., Hawkins, M. E., Davis, H. I., Redford, E. S., Ross, J. M., Sadler, J. M., **Brady, C. E.**, & Evans, S. W. (August 2009). *Parental Perspective on ADHD: Household Issues that Predict Strain & Conflict*. Poster presented at the American Psychological Association Conference, Toronto, ON Canada.
27. **Brady, C. E.**, Sadler, J. M., Evans, S. W., Koch, J. R., Lane, C., Mays, S., Meszaros, P., & Meyer, B. (April 2009). *The Effectiveness of SFP for Youth with Psychiatric Disorders*. Poster presented at the Virginia Forum on Youth Tobacco Use: Translating Research into Policy and Practice Conference, Richmond, VA.
28. Serpell, Z. N., Evans, S. W., & **Brady, C. E.** (November 2008). *Preventing Youth Tobacco Use by Treating the Risk-Factor of ADHD: A Follow-up Study of Adolescents*

*with ADHD*. Symposium presented at the Virginia Youth Tobacco Project Research Coalition Meeting, Richmond, VA.

29. Sadler, J.M., Christensen, O.A., **Brady, C.E.**, Sax, K., Rainear, C., & Evans, S.W. (November 2008). *The Effect of Pacing on Academic Interventions in a Six-Week Summer Treatment Program*. Poster presented at the Association for Behavioral and Cognitive Therapy Conference, Orlando, FL.
30. Sadler, J.M., **Brady, C.E.**, Neugroschel, R.A., Moore, S., Evans, S.W., Koch, J.R., & Meszaros, P.S. (September 2008). *Current Practices and Best Practices for Substance Use Prevention in Schools: Implications for Training*. Poster presented at the 13<sup>th</sup> Annual Conference on Advancing School Mental Health, Phoenix, AZ.
31. Christensen, O.A., Sadler, J.M., **Brady, C.E.**, Schultz, B.K., & Evans, S.W. (August 2008). *Teacher Satisfaction with a School-Based Treatment for Adolescents with ADHD*. Poster presented at the 116<sup>th</sup> annual American Psychological Association Conference, Boston, MA.
32. Davis, H., Sax, K., & **Brady, C.E.** (March 2008). *Parental Strain in Relation to the Characteristics of Children with ADHD*. Poster presented at the 7<sup>th</sup> annual Raising the Bar Conference, Harrisonburg, Va. and the 2008 Psychology Student Symposium, Harrisonburg, VA.
33. Chen, C., Christensen, O., Hawkins, M., **Brady, C.E.**, Schultz, B., & Evans, S.W. (March 2008). *Interactive Media Games: A Fun New Treatment for ADHD?* Poster presented at the 7<sup>th</sup> annual Raising the Bar Conference, Harrisonburg, VA.
34. Neugroschel, R., Sadler, J.M., & **Brady, C.E.** (March 2008). *Factors Associated with the Implementation of Evidence Based Practices for Substance Use Prevention*. Poster presented at the 7<sup>th</sup> annual Raising the Bar Conference, Harrisonburg, VA.
35. Evans, S. W., Serpell, Z. N., Sibley, M. H., Van Eck, K., **Brady, C. E.**, Sadler, J. M., & Schultz, B. (November, 2007). Developing interventions targeting social skills for youth with ADHD. In J. Langberg (Chair), *Innovations in the Assessment and Measurement of Children and Adolescents With ADHD: Implications for Developing Effective Interventions*. Symposium conducted at the annual Association for Behavioral Cognitive Therapy Conference, Philadelphia, PA.
36. **Brady, C. E.**, Sadler, J. M., Van Eck, K., & Evans, S. W. (November, 2007). *New directions in social skills interventions for youth with ADHD: Results of a pilot study*. Poster presented at the Association for Behavioral Cognitive Therapy Conference, Philadelphia, PA.

37. Van Eck, K., Christenson, O. A., **Brady, C. E.**, Sadler, J. M., Evans, S. W. (October, 2007). *Helping children with ADHD get a JumpStart on the school year*. Poster presented at the 12<sup>th</sup> Annual Conference on Advancing School Mental Health, Orlando, FL.
38. Blom, D., **Brady, C. E.**, Kremer, M. & Potts, H. (April 2005) *Virtual Pavlov 2000: Assessing Effectiveness of Computer Simulators*. Paper presented at Virginia Psychological Association, Williamsburg, VA.
39. **Brady, C. E.**, Donaghy, J. M., Tucker, K. D., Yuen, N. C., & Kerr, N. A. (April 2005) *The importance of performance feedback on self-efficacy and intrinsic motivation*. Poster presented at the Virginia Psychological Association, Williamsburg, VA.

## VI. GRANT FUNDING

None

## VII. CLINICAL TRIALS

None

## VIII. PATENTS

None

## IX. EDITORIAL SERVICE

### Ad Hoc Reviewer

- 2022 – present *Journal of the American Medical Association*
- 2022 – present *Perspectives on Psychological Science*
- 2011– 2014 *School Mental Health: A Multidisciplinary Research and Practice Journal*
- 2014– 2015 *Journal of Pediatric Psychology*
- 2014 *Pain Letter*

## X. SERVICE AS GRANT REVIEWER

None

## XI. UNIVERSITY ADMINISTRATIVE SERVICE

**CARE (Center for Asian Health Research and Education) Scholar Mentor, Stanford University** (Provide research mentorship to three scholars and one implementation science fellow on the Cultural Characteristics of Families Seeking Gender Care study)

**Supervisor Parent Mentor Program Gender Clinic, Stanford Children’s Health** (The Parent Mentor program is a Family-Centered Care service. It matches parents of children who are being cared for at Lucile Packard Children's Hospital with trained, veteran

parents. In my role, I trained and now supervise the mentorship activities of two parent mentors) (2022 – present)

**eQuality Steering Committee** (a University of Louisville School of Medicine project aimed at improving medical school education by infusing 200+ hours of LGBTQ+ content into the curriculum, I served as a representative from pediatrics/psychiatry) (2018 - 2019)

**Co-Director, Pediatric Gender Clinic University of Louisville** (2017 - 2019)

**Director Pediatric Consultation Liaison Service University of Louisville** (2019)

## **XII. SERVICE TO PROFESSIONAL ORGANIZATIONS**

Co-chair APA Division 54 Special Interest Group Consultation-Liaison (2018-2020)

American Psychological Association (APA) – Division 54 Pediatric Psychology (member) (2014 – present)

World Professional Association for Transgender Health (WPATH) (member) (2015 – present)

## **XIII. INVITED PRESENTATIONS**

### **Ground Rounds:**

1. Brady, C. E. (August 2022). “Working with Caregivers of Gender Diverse Youth” Behavioral Health ECHO.
2. **Brady, C. E.** (December 2021). “Gender Diverse Youth” Grand Rounds El Camino Hospital Mountain View, CA.
3. **Brady, C. E., & Aye, T.** (August 2021). “Supporting LGBTQ+ Youth.” Webinar Stanford Corporate Partners Palo Alto, CA.
4. **Brady, C. E.** (July 2021). “Gender 101: A crash course on terminology, current research and affirmative care.” Grand Rounds Dominican Hospital, Santa Cruz, CA.
5. **Brady, C. E.** (April 2021). “Gender 101: A crash course on terminology, current research and affirmative care.” Invited Educational Seminar Bayside Medical Group, Berkley, CA.
6. **Brady, C. E.** (November, 2017). “Mental health issues and the LGBT community across the lifespan.” Psychiatry Grand Rounds of the University of Louisville School of Medicine, Louisville, KY.

### **National and Regional Meetings:**

1. **Brady, C. E.** (April, 2022). *Fireside Chat: Personal Gender Journeys*. Moderated panel given as part of the Diversity, Equity and Inclusion Panel for the Stanford University Department of Pathology. Stanford, CA.
2. **Brady, C. E.** (June, 2019). *Ethical Dilemmas in Pediatric LGBTQI Care*. Ethics workshop given as part of the Kentucky Psychological Association continuing education series. Louisville, KY.
3. **Brady, C. E.** (November, 2018). *Transgender and Gender Nonconforming Youth: Current Research and Best Practices*. Presentation given at the 7<sup>th</sup> annual Pediatric Behavioral and Mental Health Symposium in Louisville, KY.
4. **Brady, C. E., & Kingery, S. E.** (November 2018). *Complex Cases: Ethics, Diversity and Legal Issues in Transgender Care*. Presentation given at the 7<sup>th</sup> annual Pediatric Behavioral and Mental Health Symposium in Louisville, KY.
5. **Brady, C. E.** (February, 2018). *Transgender and Gender Creative Youth: Mental Health and Evidence-Based Treatments*. Invited talk given at the LGBT Healthcare Summit sponsored by Humana, Louisville, KY.

### **Lectures:**

**Psychology internship seminar, CAP2 lectures, psychology fellow seminar, San Mateo Psychiatry Residency Program lecture series,**

## **IX. TRAINEES**

### **Psychiatry Fellows:**

**Janet Baek, MD**, 2022 – present, Child and Adolescent Psychiatry Fellow

**Jack Turban III, MD**, 2021-2022, Child and Adolescent Psychiatry Fellow

### **Psychology Practicum Students:**

**Agatha Barnowski, MS**, 2022, Stanford University Psychology Graduate Program

**Samantha Sims, MS**, 2022, Stanford University Psychology Graduate Program

**Yoonhee Kim, MS**, 2021, Stanford University Psychology Graduate Program

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\*Admitted *pro hac vice*

*Attorneys for Plaintiffs*

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**UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF IDAHO  
SOUTHERN DIVISION**

**PAM POE**, by and through her parents and next friends,  
Penny and Peter Poe; **PENNY POE**; **PETER POE**; **JANE  
DOE**, by and through her parents and next friends, Joan and  
John Doe; **JOAN DOE**; **JOHN DOE**,

*Plaintiffs,*

v.

**RAÚL LABRADOR**, in his official capacity as Attorney  
General of the State of Idaho; **JAN M. BENNETTS**, in her  
official capacity as County Prosecuting Attorney for Ada,  
Idaho; and the **INDIVIDUAL MEMBERS OF THE  
IDAHO CODE COMMISSION**, in their official capacities,

*Defendants.*

Case No. 1:23-cv-00269-CWD

**EXPERT DECLARATION OF KARA CONNELLY, MD**

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Ariella C. Barel\*  
Kyle Bersani\*  
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*Attorneys for Plaintiffs*

I, Kara Connelly, MD, hereby declare and state as follows:

1. I am over 18 years of age and competent to testify.
2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinions.
4. In preparing this declaration, I reviewed Idaho State Legislature House Bill 71 (hereinafter, “Ban”). My opinions contained in this declaration are based on my training as a pediatric endocrinologist; my clinical experience as a pediatric endocrinologist, including my experience treating youth and young adults with hormonal therapies for a variety of conditions, including gender dysphoria; my knowledge of peer-reviewed research relevant to the treatment of gender dysphoria and other medical conditions for which hormonal therapies are provided; and my knowledge of the clinical practice guidelines for the treatment of gender dysphoria set forth by professional organizations including the World Professional Association for Transgender Health (“WPATH”) and the Endocrine Society, as well as clinical practice guidelines for the treatment of a wide range of conditions within the field of endocrinology.
5. I am being compensated at a rate of \$350 per hour for the time I spend on this case. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.
6. In the past four years, I have not given expert testimony at trial or deposition in any cases.

**I. BACKGROUND AND QUALIFICATIONS**

7. I received my medical doctor degree from the University of Texas Health Science Center at San Antonio in 2007. I completed my residency in pediatrics and fellowship in pediatric endocrinology at Oregon Health and Science University (“OHSU”).

8. Since completing my fellowship in 2013, I have been a pediatric endocrinologist at OHSU, holding faculty appointments in the Division of Pediatric Endocrinology in the Department of Pediatrics (I am currently an Associate Professor of Pediatrics) and serving as an attending physician in Doernbecher Children’s Hospital at OHSU. I am currently the medical director of the Doernbecher Gender Clinic and co-founder of the Doernbecher Sexual Development Program.

9. I have extensive experience treating a variety of endocrine conditions in children and adolescents and special expertise in treating youth with differences in sex differentiation as well as youth with gender dysphoria. I have attended specialized training sessions on these topics and routinely review the literature to remain knowledgeable of and familiar with all emerging research.

10. I have been providing medical care for youth with gender dysphoria since 2014. In 2015, I founded the Doernbecher Gender Clinic, which has grown over the years to an interdisciplinary team providing comprehensive medical and mental health care for youth with gender dysphoria and their families. In 2022, our team cared for 993 youth and their families. I have personally delivered care to over 700 patients with gender dysphoria.

11. I have been providing medical care for children and adolescents with intersex traits since 2010. In 2016, I co-founded the Doernbecher Sexual Development program. I have personally cared for nearly 100 intersex youth through this program.

12. I have published research on a variety of pediatric endocrine issues, including the treatment of gender dysphoria, in peer-reviewed scholarly journals. I also serve as a reviewer for scholarly journals in my field.

13. I am an active member of the Oregon Pediatric Society, American Academy of Pediatrics, Pediatric Endocrine Society, World Professional Association of Transgender Health (WPATH), and the United States Association of Transgender Health. I've also served as a faculty member for WPATH's General Education Initiative and have been an invited speaker on gender-affirming care for the Pediatric Endocrine Society. I have given numerous lectures on the treatment of gender dysphoria and other endocrine issues at meetings of medical professional associations.

14. Further information about my professional background and experience is outlined in my curriculum vitae, a true and accurate copy of which is attached as **Exhibit A** to this declaration.

## **II. TREATMENT PROTOCOLS FOR GENDER DYSPHORIA**

15. The Endocrine Society, in partnership with the Pediatric Endocrine Society, and WPATH have published clinical practice guidelines for the treatment of gender dysphoria that are based on systematic reviews of research and the expert opinions of clinicians in the field. The first version of the WPATH guidelines, known as the Standards of Care, was published in 1979, and the most recent version—version 8—was released in 2022.<sup>1</sup> The first clinical practice

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<sup>1</sup> Coleman, E., et al. (2022). Standards of Care for Health of Transgender and Gender Diverse People, Version 8. *Int J Transgender Health*. 23:S1–S258. Available at <https://doi.org/10.1080/26895269.2022.2100644> (hereinafter, “WPATH guideline”).

guideline for the treatment of gender dysphoria issued by the Endocrine Society was published in 2009, and the most recent update was released in 2017.<sup>2</sup>

16. Like other clinical practice guidelines issued by the Endocrine Society and other professional medical organizations regarding the treatment of other medical conditions, the WPATH and Endocrine Society guidelines on the treatment of gender dysphoria provide recommendations to healthcare providers about how to approach treatment of a condition based on the best available evidence.

17. Under the WPATH and Endocrine Society guidelines, prior to onset of puberty, there are no medical interventions that are indicated or recommended for children with gender dysphoria.

18. For adolescents—youth who have started puberty—and adults, medical interventions may be appropriate to treat gender dysphoria depending on the patient’s individual needs. These interventions may include medication to delay puberty, hormone therapy (e.g., testosterone for transgender boys and testosterone suppression and estrogen for transgender girls), and surgeries. These interventions are often collectively referred to as gender-affirming medical care.

19. The WPATH and Endocrine Society guidelines on the treatment of gender dysphoria are recognized as authoritative by the major medical and mental health professional organizations in the United States, including the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, the American Psychological Association, the American Academy of Child & Adolescent Psychiatry, the American Academy

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<sup>2</sup> Hembree, W.C., et al. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *JCEM*. 102(11):3869–3903. Available at <https://doi.org/10.1210/jc.2017-01658> (hereinafter, “Endocrine Society Guideline”).

of Family Physicians, and the American College of Obstetricians and Gynecologists. These organizations all support the provision of gender-affirming medical care to adolescent patients with gender dysphoria when indicated.<sup>3</sup>

20. Gender-affirming medical care is provided to adolescents with gender dysphoria in many other countries. While some European national health authorities have issued guidelines recommending caution about providing such care, or providing that such care should occur in clinical research settings, care is provided when deemed appropriate for adolescents.

21. Gonadotropin releasing hormone agonists (GnRHa) can be used to suppress puberty and delay the development of secondary sex characteristics that are not in alignment with the individual's gender identity. These medications have been used successfully to delay pubertal changes in youth with central precocious puberty. If treatment is stopped, endogenous puberty resumes.

22. Under the Endocrine Society Guideline, adolescents with gender dysphoria may be eligible for pubertal suppression if they meet the following criteria:

1. A qualified mental health professional has confirmed that:
  - a. the adolescent has demonstrated a long-standing pattern of gender nonconformity, gender incongruence or gender dysphoria (whether suppressed or expressed),
  - b. gender dysphoria worsened with the onset of puberty,

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<sup>3</sup> In contrast with the broad support of the medical community for gender-affirming medical care for adolescents with gender dysphoria, cosmetic genital surgeries on infants with intersex traits, which are permitted under the Ban, are highly controversial and many children's hospitals and major medical organizations such as the American Medical Academy have recommended that these surgeries be deferred until children are old enough to assent to these procedures. *See* Mulkey, N., Streed, C.G., & Chubak, B.M. (2021). A Call to Update Standard of Care for Children with Differences in Sex Development, *AMA J Ethics*. 23(7):E550–556.

- c. any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
  - d. the adolescent has sufficient emotional capacity and maturity to give informed consent to this (reversible) treatment,
2. And the adolescent:
- a. has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
  - b. has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
- a. agrees with the indication for GnRH agonist treatment,
  - b. has confirmed that puberty has started in the adolescent, and
  - c. has confirmed that there are no medical contraindications to GnRH agonist treatment.<sup>4</sup>

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<sup>4</sup> Endocrine Society Guideline at 3878.

23. Hormone therapy—testosterone for transgender males and estrogen and anti-androgens (to suppress testosterone) for transgender females—can be used to initiate puberty consistent with a patient’s gender identity.

24. Under the Endocrine Society Guideline, adolescents may be eligible for gender-affirming hormone therapy if they meet the following criteria:

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

- a. agrees with the indication for sex hormone treatment, and
- b. has confirmed that there are no medical contraindications to sex hormone treatment.<sup>5</sup>

25. The WPATH standards of care have similar recommendations concerning eligibility of adolescents for pubertal suppression and gender-affirming hormone therapy.

26. Surgical care for gender dysphoria is rarely provided to youth under 18. If surgical services are offered, they are almost always gender-affirming chest surgeries for youth assigned female at birth—also known as gender-affirming mastectomy.<sup>6</sup> Under the Endocrine Society Guideline, genital surgery is not recommended to patients under age 18. The WPATH standards of care do not provide an age delineation for vaginoplasty, but strongly caution about the need to ensure that the patient has the maturity to make this decision.

27. Both the WPATH and Endocrine Society guidelines emphasize the importance of a comprehensive mental health evaluation prior to the initiation of gender-affirming medical care for adolescents. This evaluation should include an assessment of the youth's gender identity development; the presence of any co-occurring mental health conditions and whether symptoms may interfere with diagnosis or functioning to the extent that decision-making is compromised; and emotional maturity and decision-making capacity.

28. Gender-affirming medical interventions are not indicated for all individuals who present for care. Overall, about one-third of our patient population continues to see our team for support without accessing medical interventions.

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<sup>5</sup> *Id.*

<sup>6</sup> Surgery is not offered before an individual has reached their final adult height, and only after other attempts to relieve dysphoria are pursued.

29. The WPATH and Endocrine Society guidelines also highlight the importance of informing the patient and their parents of the potential risks and benefits of treatment, including the potential risk to fertility and options for fertility preservation, and obtaining informed consent from the parents or legal guardians. The WPATH guideline also recommends that doctors inform families of the limitations of the research and the possibility that some patients will come to experience their gender differently.

### **III. GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS IS EFFECTIVE**

30. Gender-affirming medical care has been provided to adolescents for decades, and clinicians have seen the significant benefits of such treatment to patients.

31. In our clinic, when adolescents present for care, they often present with high degrees of anxiety, depression, and suicidal ideation. Most of our patients also come in experiencing challenges with social isolation, school attendance, and lack of desire to engage in relationships with family and peers. Most of these mental health and social challenges are linked to gender dysphoria and experiences of minority stress. While the social and political environment may continue to negatively impact a patient's mental health, we see dramatic improvements in our patients after they begin gender-affirming medical care. Depression, anxiety, self-harm, and suicidal ideation are significantly reduced, based on the screening tools, PHQ-9 and GAD-7, which patients complete at every visit. Patients routinely comment about finally feeling like themselves and being able to engage with the rest of their world. Parents regularly tell our clinical team that gender-affirming medical care has resulted in great improvement in their children's psychological well-being, school performance, and relationships. As treatment helps address their gender dysphoria, our patients feel motivated to apply for

college, join the military, and pursue employment and creative outlets. Many become leaders in their schools and communities.

32. Research conducted by investigators in the United States and around the world has evaluated a variety of mental health outcomes for minors with gender dysphoria who have been treated with puberty blockers, hormone therapy, or both, and their findings are consistent with what we experience in clinic—that treatment is associated with improvement in mental health.<sup>7</sup>

33. Research also demonstrates the negative impacts of not receiving treatment, or having to delay treatment into adulthood. For example, a study of 20,619 transgender adults found that access to pubertal suppression during adolescence resulted in lower odds of lifetime suicidal ideation (Turban 2020). Another survey of 11,914 transgender and nonbinary youth demonstrated that individuals who had access to gender-affirming hormones had lower odds of depression and suicidality (Green 2022).

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<sup>7</sup> See, e.g., de Vries, A.L., et al. (2011). Puberty Suppression in Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study. *J Sex Med.* 8(8):2276–2283; de Vries, A.L., et al. (2014). Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment. *Pediatrics.* 134(4):696–704; Turban, J., et al. (2020). Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics.* 145(2):e20191725; van der Miesen, A.I., et al. Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *J Adolesc Health.* 66(6):699–704; Achille, C., et al. (2020). Longitudinal Impact of Gender-Affirming Endocrine Intervention on the Mental Health and Well-Being of Transgender Youths: Preliminary Results. *Int J Pediatr Endocrinol.* 2020:8; Chen, D., et al. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England J Med.* 388:240–250; Allen, L.R., et al. (2019). Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clin Pract Ped Psychol.* 7(3):302–311; de Lara, D.L., et al. (2020). Psychosocial Assessment in Transgender Adolescents. *Anales de Pediatría (Eng Ed).* 93(1):41–48; Green, A.E., et al. (2022). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. *J Adol Health.* 70(4):643–649.

34. Research also shows the benefit of access to care during adolescence as opposed to waiting until adulthood. A study of 27,715 transgender and nonbinary adults revealed lower lifetime odds of suicidality for those who were able to access gender-affirming care during adolescence compared to those who could not access care until adulthood.<sup>8</sup>

35. The findings of the research on adolescents who receive gender-affirming hormone therapy are consistent with findings of the body of research on treatment of adults. Numerous studies have found that hormone therapy is effective at alleviating gender dysphoria and improving mental health in adults.<sup>9</sup>

#### **IV. GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS IS SAFE**

36. Pubertal suppression with GnRHa medications, hormone therapy, and mastectomy are treatments that have been used for many years for a range of conditions in adolescents.

37. GnRHa medications have been used for 40 years to treat central precocious puberty (CPP), a condition that causes early pubertal development in children. The medications pause pubertal development until the child reaches the typical age for puberty, at which point the medication is stopped, endogenous hormone production resumes, and typical secondary sex characteristics develop. GnRHa medications are also used to treat endometriosis, uterine

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<sup>8</sup> Turban, J.L., et al. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS ONE* 17(1):e0261039.

<sup>9</sup> See, e.g., van Leerdaam, T.R., Zajac, J.D., & Cheung, A.S. (2023). The Effect of Gender-Affirming Hormones on Gender Dysphoria, Quality of Life, and Psychological Functioning in Transgender Individuals: A Systematic Review, *Transgender Health*. 8(1); Colizzi, M., Costa, R., & Todarello., O. (2014). Transsexual patients' psychiatric comorbidity and positive effect of cross-sex hormonal treatment on mental health: results from a longitudinal study. *Psychoneuroendocrinology*. 39:65–73.

leiomyoma, ovarian cancer, fertility preservation in women with cancer, premenstrual syndrome, and as an adjunct to growth hormone therapy in youth with idiopathic short stature.

38. Some adolescents have medical conditions (i.e., ovarian failure, Turner syndrome, hypogonadotropic hypogonadism, Klinefelter syndrome, or constitutional delay of puberty) which require the use of sex steroid hormone therapy. Cisgender girls also utilize estrogen-containing medications to manage menstrual cycles and prevent pregnancy.

39. Cisgender girls with polycystic ovarian syndrome (“PCOS”) utilize spironolactone—an anti-androgen medication—to manage the increased facial and body hair that is often associated with that condition.

40. Mastectomy is a commonly performed and widely accepted surgical procedure to treat gynecomastia in adolescent cisgender boys. Gynecomastia is enlargement of the breast tissue in cisgender boys or men.

41. In some cases, these medications or surgical treatments are aimed at bringing cisgender adolescent patients’ bodies into alignment with their gender. For example, mastectomy is often provided to cisgender boys with gynecomastia to address the distress related to being a boy with breasts. And for some cisgender girls with PCOS, treatment with spironolactone addresses distress related to being a girl with facial hair.

42. Children and adolescents of all gender identities often need the assistance of medicine when their bodies start puberty too early, they are delayed in starting puberty or not able to start puberty at all, they experience the development of secondary sex characteristics that do not accord with their cisgender identity, or they start a puberty that causes secondary sex characteristics causing or exacerbating gender dysphoria.

43. GnRHa medications for pubertal suppression, testosterone, estrogen, and anti-androgens have all been demonstrated to be safe in clinical experience and research studies. The same is true of mastectomies.

44. There are risks and benefits to any medical treatment; gender-affirming medical treatments are not an exception.

45. The risks of puberty blockers are decreased bone density with prolonged use, sterile abscess at an injection site, and, very rarely, prolonged cardiac QT and increased intracranial hypertension. These risks are the same for youth receiving treatment for gender dysphoria as those being treated for central precocious puberty and other conditions.

46. Pubertal suppression does not result in any permanent changes to the body and has no permanent impact on fertility as a stand-alone medication.

47. Risks of estrogen therapy include blood clots, elevated blood pressure, diabetes, and migraine headaches. These risks are not higher than for the general population in the absence of individual or family history, or the use of nicotine. These risks exist whether the treatment is for transgender girls with gender dysphoria or for cisgender girls with ovarian failure, or any other hypogonadal condition.

48. Risks of testosterone therapy include increased red blood cells, liver inflammation (research studies show that risk of liver inflammation is very low), high cholesterol, high blood pressure, and heart disease, especially with a positive family history. These same risks exist whether the treatment is for transgender boys with gender dysphoria or for cisgender boys with testicular failure or any other hypogonadal condition.

49. For all of these medications, the risks are well-managed when care is provided and monitored by a healthcare provider. The risks become more significant when patients resort

to self-treatment. There are well-documented stories, including those we have witnessed in our own clinic, where adolescents were unable to access this care through a doctor and instead turned to black markets or took medications from friends/family to self-treat. Self-treatment can result in non-therapeutic hormone levels, which can negatively impact mood and increase several health risks, such as blood clots, cardiovascular problems, and liver and kidney dysfunction.

50. Gender-affirming hormone therapy may have an impact on future fertility potential,<sup>10</sup> although treatment can be tailored to minimize that risk if maintaining fertility is important to the family and there are options for fertility preservation. Impairment of fertility is not unique to gender-affirming hormone therapy. For example, treatments for some pediatric cancers cause likely loss of fertility. Some youth with intersex traits have their gonads surgically removed if they are at high risk of developing gonadal cancer.

51. As with all medical treatments, doctors are expected to fully inform patients and their parents, based on the available evidence, of the potential risks, benefits, and alternatives to treatment so that the families can weigh them and make an informed decision about whether to pursue treatment. The informed consent process is the hallmark of medical decision-making. Patients—and if minors, their parents—make the decision after being provided the information necessary to make an informed decision. The informed consent process for gender-affirming

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<sup>10</sup> Many individuals assigned female at birth who take testosterone are able to achieve pregnancy or use assisted reproductive technology to conceive after discontinuing testosterone. *See, e.g.,* Light, A.D., et al. (2014). Transgender Men Who Experienced Pregnancy after Female to Male Gender Transitioning, *Obstetrics & Gynecology*, 124(6):1120–1127. In addition, testosterone is not an effective form of contraception and some transgender men have conceived while taking testosterone. *See, e.g.,* Thornton, K.G. & Mattatall, F. (2021). Pregnancy in transgender men. *CMAJ*. 193(33):E1303. Some transgender women may elect to use only anti-androgen medications without estrogen to preserve sperm production and fertility potential. Sperm production may resume in some transgender women. *See, e.g.,* Jiang, D.D., et al. (2019). Effects of Estrogen on Spermatogenesis in Transgender Women. *Urology*. 132:117–122.

medical care for minors is no different than how medical decision-making for minors occurs in other areas of medicine.

52. As discussed above, the WPATH and Endocrine Society guidelines offer recommendations about information that should be provided to families regarding gender-affirming medical care, including information about limitations in research—what is known and unknown; the potential impacts of some gender-affirming medical interventions on fertility; and the rare but potential possibility of returning to living consistently with their birth-assigned gender.<sup>11</sup>

53. Informed consent is a dynamic process; frequent assessment of the benefits of medications, and whether they continue to align with the individual’s goals and outweigh risks, occurs in both medical and behavioral health follow-up visits.

54. There is nothing unique about gender-affirming medical care that warrants departing from the normal principles of medical decision-making for youth that parents make the decision after being informed of the risks, benefits, and alternatives by physicians.

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<sup>11</sup> Both clinical experience and research show that adolescents and adults who have received gender-affirming medical care rarely later come to identify with their sex assigned at birth and/or regret the care. For example, a prospective longitudinal study by de Vries, et al. found that none of the 55 adults who had initiated puberty blockers and hormones in adolescence reported regret with any of their treatment (de Vries 2014). Wiepjes, et al. (2018) found that 0.6% of transgender women and 0.3% of transgender men experienced regret (n=6793) related to gender-affirming medical interventions. Their study also noted that in many of those cases, the regret was “social regret”—regret related to rejection, loss of community, or threats of violence. See Wiepjes, C.M., et al. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets. *J Sexual Med.* 15(4):582–590. See also Brik, T., et al. (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. *Archives of Sexual Behavior.* 49(7):2611–2618 (finding that 3.5% of study cohort discontinued GnRHa and did not go on to hormone therapy because they no longer wished gender-affirming treatment); Wiepjes, et al. (2018) (finding 1.9% of cohort discontinued GnRHa but reasons not provided); Olson, K.R., et al. (2022). Gender Identity 5 Years After Social Transition. *Pediatrics.* 150(2) (2.5% of study cohort returned to cisgender identity by five years after their initial social transition).

**V. THE EVIDENCE SUPPORTING GENDER-AFFIRMING CARE IS COMPARABLE TO EVIDENCE SUPPORTING MANY OTHER MEDICAL TREATMENTS**

55. The studies on gender-affirming medical care for adolescents (and adults) use a variety of commonly used research methods including prospective observational and retrospective cross-sectional studies comparing individuals who receive treatment to those who do not, and longitudinal studies that follow individuals over a period of time. These research methods are widely used in the field of medicine to evaluate the efficacy of treatment.

56. While randomized controlled clinical trials (“RCTs”) can provide especially strong evidence in medical research by limiting confounding variables, given that such studies require that outcomes of a particular treatment are compared to outcomes of patients not receiving the treatment, it is frequently not feasible or ethical to rely on RCTs. Thus, many medications used to treat medical conditions in both pediatrics and adults are used based only on observational and retrospective research studies—or clinical experience alone—without randomized controlled clinical trials. For example, insulin, the hormone discovered in the 1920s as a treatment for type 1 diabetes mellitus, was used successfully to prevent death in several patients with diabetic ketoacidosis. Based on the outcomes of these clinical experiences, insulin became widely accepted as the standard treatment for type 1 diabetes mellitus; a randomized controlled trial would have been unethical given the high rate of death associated with other earlier attempted treatments.<sup>12</sup> Because pubertal suppression and gender-affirming hormones to treat gender dysphoria are now widely accepted in the medical field based on decades of clinical experience and research studies demonstrating efficacy, denying this care for a population of youth to serve as the “control,” or comparison, group for an RCT would be unethical.

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<sup>12</sup> Rosenfeld, L. (2002). Insulin: discovery and controversy. *Clin Chem.* 48:2270–2288.

57. While the body of research on gender-affirming medical care for adolescents continues to grow, we presently have sufficient clinical and research evidence in both youth and adult populations that shows the risks and benefits of providing this care, in addition to the risks of not providing care. The evidence is comparable in quantity and quality to evidence we have in support of many other medical interventions.

58. Some who oppose gender-affirming medical care have asserted that this care is “experimental,” suggesting this is an area of medicine where there is no clear understanding of the impact of an intervention. Here, we have decades of experience providing care and a growing body of research also supporting the efficacy and safety of this care, in addition to substantial evidence about the use of these medications in other areas of medicine.

59. Once the Food and Drug Administration (“FDA”) has approved a medication as safe and effective for an indication, prescribers are generally free to prescribe it for other indications. The fact that the FDA has not approved puberty blockers, testosterone, or estrogen specifically for the treatment of gender dysphoria does not mean that the treatment is experimental or unproven. The use of medication for indications that have not received FDA approval—often called “off-label use”—is a widely accepted practice in medicine. This practice is legal, ethical, and common. The Agency for Healthcare Research and Quality estimates that one in five medications prescribed is prescribed off-label. Off-label use is even more common in pediatrics: 45% of pediatric outpatient prescriptions are off-label, and nearly 80% of hospitalized children receive at least one drug off-label.<sup>13</sup> Off-label use is so common because it is often not worth the cost to pharmaceutical companies to pursue approval for additional indications once a

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<sup>13</sup> Antoon, J.W., et al. (2023). . Advancing pediatric medication safety using real-world data: Current problems and potential solutions. *J Hosp Med*. doi:10.1002/jhm.13068. Epub ahead of print. PMID: 36855275.

medication has been approved by the FDA. For example, Gabapentin has an FDA indication for treating seizures and fibromyalgia, but is often (more than 80% of the time) used off-label to treat bipolar disorder, subacute low back pain, neuropathy, as migraine prophylaxis, and for additional indications.<sup>14</sup> Some of the same medications used off-label in gender-affirming medical care are also widely used off-label for other purposes. Spironolactone, which was approved by the FDA for controlling blood pressure, is used in cisgender women and girls off-label to control side effects of PCOS. And GnRHa medications have been approved for the treatment of precocious puberty but not for many other indications for which they are commonly used, including ovarian cancer, premenstrual syndrome, fertility preservation in women and adolescent girls with cancer, and as an adjunct to growth hormone therapy in youth with idiopathic short stature.

## **VI. HARM TO ADOLESCENTS WITH GENDER DYSPHORIA AND THEIR FAMILIES IF THE BAN TAKES EFFECT**

60. We know from clinical experience and research that delaying or denying patients gender-affirming medical care when needed comes with an increase in emotional harm. Social transition can offer many benefits, but social transition alone does not prevent an adolescent from experiencing the trauma of seeing their body change in ways that do not align with their gender identity. Additionally, many of these body changes would require major surgical interventions in the future to address, and some are not fully treatable by future medical intervention. For example, once vocal cords are exposed to testosterone, only vocal training can potentially shift the deepening of the voice, but this treatment has mixed success. Pubertal

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<sup>14</sup> See Fukada C., et al. (2012). Prescribing gabapentin off label: perspectives from psychiatry, pain and neurology specialists. *Can Pharm J (Ott)*. 145:280–284.e1.

suppression prevents this psychological trauma and the need for more invasive medical interventions in the future.

61. As previously discussed, clinical experience and research have shown that gender-affirming medical care improves mental health outcomes; the converse is also true—that being unable to access care increases mental health distress. We see a marked difference in the social functioning, emotional wellness, and psychological stability of our patients after they are able to access pubertal suppression and hormone therapy when indicated.

62. Additionally, our older adolescent patients who have experienced at least some secondary sex characteristics not aligned with their identity report higher levels of depression and anxiety, lower participation in school, and less ability to engage in social relationships.

63. Adolescents in Idaho who are already receiving gender-affirming medical care will be forced to medically detransition by the Ban. Abruptly discontinuing hormone therapy can result in emotional instability and dysregulation as well as adverse medical outcomes such as profound fatigue, hot flashes, and difficulty concentrating.

64. If this Ban takes effect, patients who have had the benefit of pubertal suppression and/or hormone therapy will see their bodies change in ways that will cause profound distress. And for some, discontinuing care will not return their body to match their assigned sex but will leave them with a mix of typically male and female phenotype. Adolescents assigned male at birth who have been treated with pubertal suppression and estrogen will have had permanent breast development from the estrogen and suppression of testosterone. Once these medications are stopped, endogenous testosterone becomes the dominant hormone, leading to masculinizing physical changes. Patients assigned female at birth who have taken testosterone may have experienced permanent voice deepening, masculinized facial structure, and facial and body hair

growth. Discontinuing care would be followed by breast development and resumption of menses, which often cause significant distress.

65. Psychologically, adolescents who have been receiving care for years and have to discontinue treatment will see a return of, or dramatic increase in, distress related to gender dysphoria. Based on what we know about patients' experiences prior to receiving care, if care is cut off or denied, we will see increased rates of depression, anxiety, suicidal ideation, and hospitalizations for suicide attempts. We also will likely see the tragedy of lives ended by suicide.

66. Patients may be the most directly and seriously harmed by these care bans, but their families are also suffering. At our clinic in Oregon, we are already seeing the impact on families who have already or are planning to leave their states because of healthcare bans; there are also families deciding to attempt to seek care in states where the care is available. Our clinic has already received inquiries from Idaho families wanting to travel for care. We do not yet have a clear answer of whether or how we will have the capacity to be able to meet the care needs of these patients. Idaho parents and providers are calling in states of desperation and hopelessness, unable to confirm that they will have access to care in Oregon.

67. Parents are having to make the difficult decision to relocate the family so that their children can continue to access care. In some cases, it is more financially viable to relocate, rather than to regularly travel. In others, the families are afraid that traveling for care and bringing medications back to a state with a ban may put their providers or their family at risk. The need to relocate removes patients and families from their support systems at a time when direct emotional and material support is most needed. Financial resources are drained and family units are split up. For example, in one family from another state that we see in the clinic, one

parent was able to secure a job in Oregon, but the other parent has not yet and has stayed behind with the cisgender sibling. The family is paying for a mortgage, plus the cost of relocation and temporary housing. Another clinic family that came to Oregon from a state with a ban does not have the means to afford housing and is living in a camper van in a city where they are at risk of being ticketed and towed.

68. Parents of families from out of state are often in a state of grief, unable to believe that the state that they've called home, many for generations, is harming their children. The emotional and logistical burden for parents is high, and the areas that they are moving to do not have the infrastructure or resources to absorb the increasing demand and severity of mental health issues. Many existing clinics are challenged in getting patients in on a timeline that will not result in a gap in treatment. As parental stress increases, we've seen parental mental health declines and the overall health of the family system decrease.

69. Adolescents are painfully aware of the sacrifices their families are making to get them care and many see this as evidence that they are a burden; belief of the adolescent that they are a burden is an intrusive thought that drives suicidal ideation and attempts.<sup>15</sup>

70. We are seeing these scenarios unfold as families move to Oregon from Texas, Tennessee, Arkansas, Iowa, Florida, Alabama, and Idaho. Others are exploring traveling to Oregon for care. Our clinic wait-times continue to increase, which increases patient distress (for both existing Oregonians and those relocating to Oregon) and risk for psychological harm.

71. Idaho families that have reached out to our clinic are already suffering and feeling the impact of this Ban, even before it goes into effect. We are receiving an increasing number of

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<sup>15</sup> See, e.g., Chu, C., et al. (2017). The interpersonal theory of suicide: A systematic review and meta-analysis of a decade of cross-national research, *Psychol Bull.* 143(12):1313–1345.

calls and emails requesting care from families and providers in Idaho and other states who are desperate to continue the care their adolescents need. Providers are distraught because they will be forced to abandon their patients and/or force them to medically detransition, which directly violates their code of medical ethics—to do no harm.

72. It is often the most well-connected and resourced families that are able to relocate. If the Ban goes into effect, Idaho families will feel the pain more deeply and Idaho will continue to lose medical providers and other front-line healthcare staff, business owners, teachers, first responders, and individuals in the hospitality industry, to name a few of the occupations held by parents who are seeking to relocate.

73. For those families that are less resourced and unable to move or travel out of state for care, they will have to watch as their children are withdrawn from treatment that has enabled them to flourish and see them return to the suffering that brought them to care. We know that gender diverse people from communities of color and families living in poverty have significantly worse mental health outcomes than their white and financially resourced peers.<sup>16</sup>

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: 7/14/2023



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Kara Connelly, MD

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<sup>16</sup> James, S.E., et al. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

# Exhibit A

**CURRICULUM VITAE  
OREGON HEALTH & SCIENCE UNIVERSITY**

<b>NAME</b>	<b>Kara Jeanne Connelly, MD, MCR</b>	<b>DATE</b>	<b>4/2023</b>

**I. PRESENT POSITION AND ADDRESS**

<b>Academic Rank:</b>	<b>Associate Professor</b>
<b>Department/Division:</b>	<b>Pediatrics/Endocrinology</b>
<b>Professional Address:</b>	<b>707 S.W. Gaines Road, CDRC-P Portland, Oregon 97239-3098</b>
<b>E-Mail Address:</b>	<b>connellk@ohsu.edu</b>

**II. EDUCATION**

**Undergraduate and Graduate:**

1997-2001 Tulane University, New Orleans, LA  
B.S. – 2001

2003-2007 University of Texas Health Science Center at San Antonio, San Antonio, TX  
M.D. – 2007

2010-2017 Oregon Health and Science University, Portland, OR  
Master of Clinical Research – 2017

**Postgraduate:**

2007-2008 Pediatric Internship  
Doernbecher Children’s Hospital, Oregon Health & Science University, Portland, OR  
H. Stacy Nicholson, M.D, M.P.H., Chairman, Department of Pediatrics

2008-2010 Pediatric Residency  
Doernbecher Children’s Hospital, Oregon Health & Science University, Portland, OR  
H. Stacy Nicholson, M.D, M.P.H., Chairman, Department of Pediatrics

2010-2013 Fellow, Pediatric Endocrinology  
Doernbecher Children's Hospital, Oregon Health & Science University, Portland, OR  
Bruce Boston, M.D., Division Head

**Honors:**

Pediatric Resident Humanism Award  
OHSU, Dept of Pediatrics, Doernbecher Children's Hospital, 2008

Outstanding Pediatric Resident Award  
Emanuel Hospital, 2009

Clinical Research Fellowship and Mentor Award in Women's Health  
Endocrine Society, 2013

Joseph B. Bilderback Fellow Teaching Award  
OHSU, Dept of Pediatrics, Doernbecher Children's Hospital, 2013

Michael Miller Faculty Teaching Award  
OHSU, Dept of Pediatrics, Doernbecher Children's Hospital, 2019

Outstanding Mentorship of Pediatric Fellows  
OHSU, Dept of Pediatrics, Doernbecher Children's Hospital, 2019

Outstanding Leader for Electives in Clinical Experiences  
OHSU School of Medicine, 2019

Gold Humanism Honor Society member, 2022

**Certification:**

American Board of Pediatrics

General Pediatrics: No. 97042, October 18, 2010 (exp 2020)

Pediatric Endocrinology: No. 1494, November 13, 2013 (exp 2023)

**Licensure:**

Current Oregon no. MD151770

**III. PROFESSIONAL EXPERIENCE**

**Faculty Appointments:**

2013-2018 Assistant Professor  
Division of Pediatric Endocrinology, Department of Pediatrics  
Oregon Health and Science University, Portland, Oregon

2018-present Associate Professor

Division of Pediatric Endocrinology, Department of Pediatrics  
Oregon Health and Science University, Portland, Oregon

**Hospital Staff Appointments:**

2013-Present Attending Physician  
Doernbecher Children's Hospital  
Oregon Health and Science University, Portland, Oregon

**Hospital Administrative Appointments:**

2013-Present Rotation Director, Pediatric Residency Endocrinology Rotation  
Doernbecher Children's Hospital, Oregon Health & Science University

2016-Present Medical Director, Doernbecher Gender Clinic  
Doernbecher Children's Hospital, Oregon Health & Science University  
Provided clinical and programmatic leadership for the development of a multidisciplinary clinical program dedicated to providing comprehensive medical and mental health services for transgender and gender diverse youth. This is occurring under the umbrella of the OHSU Transgender Health Program.

2016-Present Co-founder, Doernbecher Sex Development Program and DUETT (Doernbecher Urology and Endocrinology Treatment Team) Clinic  
Doernbecher Children's Hospital, Oregon Health & Science University  
Provided leadership in the initiation of an interdisciplinary program involving clinicians from pediatric endocrinology and pediatric urology providing care for children with disorders of sexual differentiation (DSD). Developed an inpatient DSD response team to evaluate newborns with suspected DSDs and established an outpatient clinical program. Applied for and awarded acceptance into the national DSD Translational Research Network, funded by federal grant number 5RO1HD068138 awarded by the NIH/NICHD

**IV. SCHOLARSHIP**

**Area(s) of Research/Scholarly Interest:**

Transgender Healthcare for youth: I am interested in conducting research pertaining to evaluating outcomes of current gender transition treatments available for transgender youth and developing improved treatment modalities.

**Grants and Contracts:**

Source: Eli Lilly USA, LLC  
Program Director: Elisa Razzoli, M.D.  
Title: GeNesis: Genetics and Neuroendocrinology of Short Stature International Study  
Role: Site PI  
Entire Project: 1999-2015

The goal of this prospective observational study is to evaluate the safety and tolerability of Humatrope by determining the incidence of type 2 diabetes mellitus in Humatrope-treated children, the incidence of de novo neoplasia in Humatrope-treated children without a prior history of neoplastic disease, and to optimize the outcome in Humatrope-treated patients by identifying factors associated with final height.

Pending Funding:

Source: NIH/NICHD

National Director: Eric Vilain, MD, David Sandberg, PhD

Role: Site PI

Title: National Disorders in Sexual Differentiation Translational Research Network

Pending Funding:

Source: Nike

National Director: Kate Ackerman, MD

Role: Site PI

Title: Transgender athlete study

**Publications/Creative Work:**

Peer Reviewed Manuscripts

1. **Connelly KJ**, Boston BA, Pearce EN, Sesser D, Pino S, Braverman LA, Snyder D, LaFranchi S. Congenital hypothyroidism caused by excess prenatal maternal iodine ingestion. *Journal of Pediatrics*. 161(4):760-2, 2012. PMID 22841183 doi 10.1016/j.peds.2012.05.057
2. **Connelly KJ** and LaFranchi SH. Detection of neonates with mild congenital hypothyroidism (primary) or isolated hyperthyrotropinemia: an increasingly common management dilemma. *Expert Review of Endocrinology and Metabolism*. 9(3):263-271, 2014.
3. **Connelly KJ**, Larson EA, Marks DL, Klein RF. Neonatal estrogen exposure results in biphasic age-dependent effects on the skeletal development of male mice. *Endocrinology*. 156(1):193-202, 2015 PMID:25330099 doi: 10.1210/en.2014-1324.
4. Shatzel JJ, **Connelly KJ**, DeLoughery TG. Thrombotic issues in Transgender Medicine: A Review. *American Journal of Hematology*. 92(2):204-208, 2017 PMID 27779767 doi: 10.1002/ajh.24593
5. **Connelly KJ**, Pierce M, Hanna CE, LaFranchi SH. Detecting Congenital Central Hypothyroidism by Newborn Screening: Difficulty in Distinguishing from Congenital Thyroxine-Binding Globulin Deficiency. *Horm Res Pediatr*. 88(5):331-338, 2017. PMID:28910808 doi: 10.1159/000479367
6. Coghlan RF, Oberdorf JA, Sienko S, Aiona MD, Boston BA, **Connelly KJ**, Bahney C, LaRouche J, Almubarak SM, Coleman DT, Girkontaite I, von der Mark K, Lunstrum GP, Horton WA. A degradation fragment of type X collagen is a real-time biomarker for bone growth velocity. *Sci Transl Med*. 9(419), 2017. PMID:29212713 doi: 10.1126/scitranslmed.aan4669.
7. Moyer DN, **Connelly KJ**, Holley AL. Using the PHQ-9 and GAD-7 to screen for acute distress in transgender youth: findings from a pediatric endocrinology clinic. *J Ped Endocrin Metab*. 32(1):71-74, 2018.
8. Cantu AL, Moyer DN, **Connelly KJ**, Holley AL. Changes in Acute Distress from Intake to First Follow-up among Transgender Youth in a Pediatric Endocrinology Clinic. *Transgender Health*. 5(2):1-5, 2020.

9. Eshragh N, Doan LV, **Connelly KJ**, Denniston S, Willis S, LaFranchi SH. Outcome of Newborn Screening for Congenital Adrenal Hyperplasia at Two Time Points. *Horm Res Pediatr*. 13:1-9, 2020.
10. Lee J, Eimecke T, Rehm J, Roberts S, **Connelly KJ**. Providing gender-affirmative care during the SARS-CoV-2 pandemic era: Experiences and perspectives from pediatric endocrinologists in the United States. *Transgender Health*. 7(2):179-174, 2022.
11. Hedrik H, **Connelly KJ**, Guerriero J, Moyer D. New Virtual Reality: Benefits and Barriers to Providing Pediatric Gender-Affirming Healthcare Virtually During the COVID-19 Pandemic. *Transgender Health*. 7(2):144-149, 2022.
12. **Connelly KJ**, Parks J, LaFranchi SH. History of the Thyroid. *Horm Res Pediatr*, 95(6):546-556, 2022.
13. Dy G, **Connelly KJ**. Multi-disciplinary care for transgender individuals seeking feminizing gender-affirming surgery after pubertal suppression: a retrospective review and proposed clinical pathway. *Pediatrics*, submitted.
14. Baines H, **Connelly KJ**. Subcutaneous (SQ) and Intramuscular (IM) Testosterone Injections Equally Effective in Pubertal Induction of Transgender Male Adolescents, *Transgender Health*, submitted
15. Downing JM, **Connelly KJ**, McConnell J. Access to Gender Affirming Care for Youth Enrolled in Oregon's Medicaid Program. *JAMA Ped*, submitted
16. Dunbar A, **Connelly KJ**, Moyer D. Not the destination, but the journey (mapping): A public health evaluation of an interdisciplinary pediatric gender clinic and the role of psychology in improving health equity. *In preparation*

#### Chapters

1. **Connelly KJ**, Steiner RD. Osteogenesis Imperfecta. In M. Cabana, P. Brakeman, M. Curran, L. Dimeglio, W. Golden, R. Goldsby, A. Hartman, T. Kind, J. Lightdale, C. Sabella, and R. Tanel (Eds.), *The 5-Minute Pediatric Consult* (7<sup>th</sup> ed). Philadelphia, PA: Wolters Kluwer Health – Lippincott Williams & Wilkins, 2015.

#### Workshops

1. Blaschke G, Weddle M, Green S, Crossen E, Stevenson E, Nolt D, **Connelly K**, Phillipi C. Tales From Portlandia II: Navigating the Unconventional In General Pediatrics. Workshop, Pediatric Academic Societies Meeting. April 2015.
2. Burleton J, **Connelly KJ**. Holistic Partnerships: Supporting Affirming Care for Transgender and Gender Nonconforming Youth and their Families. Workshop, US Professional Association for Transgender Health annual meeting, San Diego, CA, 2017.
3. Guerriero J, Baines H, **Connelly KJ**, Penkin A. Centralized Intakes to Improve Outcomes in Multi-Disciplinary Pediatric Gender Clinic. Workshop, UCSF 2017 National Transgender Health Summit, San

Francisco, CA, 2017

4. Jacobs M, **Connelly KJ**. Histrelin acetate subcutaneous implant for gender affirming care: hands-on training for outpatient procedure. Workshop, Society for Adolescent Health & Medicine annual meeting, 2020

Abstracts: Oral Presentations

1. **Connelly KJ**, Boston B, Pearce E, Sesser D, LaFranchi S. Congenital hypothyroidism caused by excess maternal iodine ingestion. Western Society for Pediatric Research (WSPR). Carmel-by-the-Sea, CA. January 2012.
2. Burleton J, **Connelly KJ**. "Working with Transgender Youth and Teens." The LGBTQ Meaningful Care Conference, Portland, OR, 2014.
3. Pierce MJ, Penkin A, Usher C, **Connelly KJ**. Utilization of mental health providers in gender clinics and barriers to access. Oral Presentation, US Professional Association for Transgender Health annual meeting, San Diego, CA, 2016.
4. Penkin A, Blenning C, Baunach C, Milano C, Dugi D, Rae-StockLynn J, Burleton J, Berli J, Lager-Mesulam J, **Connelly KJ**, Shaffer L, Haque, N. OHSU: The Journey Towards a Comprehensive Transgender Health Program Serving Oregon and Beyond. Mini-Symposium, US Professional Association for Transgender Health annual meeting, San Diego, CA, 2016.
5. Guerriero J, Baines H, Burleton J, Connelly KJ. A Natural Variation: Holistic Care for Transgender Children and Youth. The LGBTQ Meaningful Care Conference, Portland, OR, 2016.
6. **Connelly KJ**, Guerriero J, Penkin A, Berli J, Dugi D. A Model for Family-Centered Decision-Making Regarding Gender Affirming Surgery for Minors. US Professional Association for Transgender Health Annual Meeting, Washington, DC 2019.
7. Baines H, **Connelly KJ**. Subcutaneous (SQ) and Intramuscular (IM) Testosterone Injections Equally Effective in Pubertal Induction of Transgender Male Adolescents. US Professional Association for Transgender Health Annual Meeting, Washington, DC 2019.
8. Gallet de St. Aurin C, Guerriero J, Penkin A, Baker R, **Connelly KJ**. Future State: Strategies for Improved health and wellness for Oregon's Gender Diverse Youth. LGBTQ Meaningful Care Conference, Portland, OR, 2020.
9. Guerriero J, **Connelly KJ**. One Team, One Mission: Reducing Barriers for Youth and Families through Interdisciplinary Care. LGBTQ Meaningful Care Conference, Portland, OR, 2020.
10. Sandberg S, Moyer D, Guerriero J, Kerwin T, **Connelly KJ**. BREAKING BARRIERS: INCREASING PATIENT RETENTION AND SATISFACTION IN AN INTERDISCIPLINARY PEDIATRIC GENDER CLINIC. World Professional Association for Transgender Health Annual Meeting, 2020.

11. Downing J, **Connelly KJ**. ACCESS TO GENDER-AFFIRMING CARE FOR YOUTH ENROLLED IN OREGON'S MEDICAID PROGRAM. World Professional Association for Transgender Health Annual Meeting, 2020.
12. Arndt A, Jacobs M, Baines H, **Connelly KJ**. Retrospective comparison of two GnRH agonist subdermal implants for pubertal suppression for pediatric gender affirming care. World Professional Association for Transgender Health Annual Meeting, 2020.
13. Dy G, Peters B, Baines H, Moyer D, Guerriero J, Dugi D, **Connelly KJ**. Vaginoplasty After Pubertal Suppression: A Multi-Disciplinary Approach. Mini symposium presented to the annual convention for the US Professional Association for Transgender Health, 2021.
14. Guerriero J, Moyer D, Baines H, **Connelly KJ**. Beyond "Born in the Wrong Body:" Challenging our Biases to Provide Inclusive Care for Nonbinary Youth. Mini symposium presented to the annual convention for the US Professional Association for Transgender Health, 2021.
15. Dy G, Peters B, Baines H, Moyer D, Guerriero J, Dugi D, **Connelly KJ**. Vaginoplasty After Pubertal Suppression: A Multi-Disciplinary Approach. 2SLGBTQ+ Meaningful Care Conference, 2022
16. Guerriero J, Moyer D, Baines H, **Connelly KJ**. Beyond "Born in the Wrong Body": Challenging our Biases to Provide Inclusive Care for Nonbinary Youth. 2SLGBTQ+ Meaningful Care Conference, 2022
17. **Connelly KJ**, Guerriero J, Baines H, Moyer D. CARE AS UNIQUE AS YOU ARE: EXPLORING INDIVIDUAL PATHWAYS OF CARE FOR YOUTH WHO IDENTIFY BEYOND THE GENDER BINARY. World Professional Association for Transgender Health Annual Meeting, 2022.

Abstracts: Poster Presentations

1. **Connelly KJ**, Boston B, Pearce E, Sesser D, Pino S, Braverman L, Snyder D, LaFranchi S: Congenital hypothyroidism caused by excess prenatal maternal iodine ingestion: Endocrine Society annual meeting, Houston, TX, June 2012.
2. **Connelly KJ**, Larson E, Klein RK. Early-Life Exposure of Male Mice to Estrogen Alters the Trajectory of Somatic Growth and Skeletal Development: American Society for Bone and Mineral Research (ASBMR), Minneapolis, MN, October 2012.
3. **Connelly KJ**, Marks DL, Klein RF. Impact of neonatal estrogen exposure on skeletal development in pre-pubertal male mice: Endocrine Society annual meeting, San Francisco, CA, June 2013.
4. **Connelly KJ**, Huang, S, Krol A, Jugo, R, LaFranchi, SH. Hypothyroidism in an infant with a fibrosarcoma expressing type 3 deiodinase (D3). American Thyroid Association annual meeting, Coronado, CA, Nov 2014.
5. **Connelly KJ**, Selva KA. Expanded Insurance Coverage for Pediatric Gender Dysphoria Results in More Children Receiving Pubertal Suppression. Pediatric Academic Societies Annual Meeting, Baltimore, MD, May 2016.

6. Pierce ME, **Connelly KJ**, Hanna CE, LaFranchi SH. Misleading TBG Levels in Separation of Central Congenital Hypothyroidism from TBG Deficiency in Neonates Detected by Newborn Screening. Pediatric Academic Societies Annual Meeting, Baltimore, MD, May 2016.
7. Baines, HK, LaFranchi SH, Boston BB, **Connelly KJ**. Lipoid congenital adrenal hyperplasia (LCAH) first presenting at 7 months with acute salt-wasting crisis. International Meeting of Pediatric Endocrinology, Washington, DC, 2017
8. Deane M, **Connelly KJ**. Redesigning Testosterone Prescribing in the Doernbecher Gender Clinic: Interdisciplinary Process Improvement Results in Enhanced Patient Experience. Pediatric Academic Societies Annual Meeting, Toronto, CA, May 2018.
9. Baines HK, Guerriero J, Penkin A, **Connelly KJ**. Quality improvement efforts to create patient-centered individualized intake process in a large pediatric gender clinic results in improved patient satisfaction and reduced barriers to care. Pediatric Academic Societies Annual Meeting, Toronto, CA, May 2018.
10. Cantu AL, **Connelly KJ**, Moyer DN, Holley AL. Examining Changes in PHQ-9 and GAD-7 Scores in Transgender & Gender Nonconforming Youth Receiving Care in a Pediatric Endocrinology Clinic. SPPAC Annual Meeting, New Orleans, LA 2019.
11. O'Neill A, Seideman C, **Connelly KJ**. Standardizing Urology Follow-Up and Patient Education for Girls with Classical Congenital Adrenal Hyperplasia. Pediatric Academic Societies Annual Meeting, Baltimore, MD 2019.
12. Baines H, **Connelly KJ**. Comparison of clinical and biochemical effects of subcutaneous and intramuscular testosterone injections in transgender male adolescents. Pediatric Academic Societies Annual Meeting, Baltimore, MD 2019.
13. Doan L, Baines H, Boston BA, **Connelly KJ**, Guttman-Bauman I, LaFranchi SH, Livett T, Madison L, Nicol L, Woods K. Hypertension In Pediatric Diabetes Patients at OHSU: Quality Improvement Process to Improve Detection of Abnormal Blood Pressures. Pediatric Academic Societies Annual Meeting, Baltimore, MD 2019.
14. Eshragh N, Doan L, **Connelly KJ**, LaFranchi SH. Severity and natural history of congenital adrenal hyperplasia detected on the second versus first newborn screen in the Northwest Regional Newborn Screening Program. Pediatric Academic Societies Annual Meeting, Baltimore, MD 2019.
15. Berry A, **Connelly KJ**. The Influence of Discrimination, Gender Assumption, and (Trans)-Misogyny on Psychological Distress and Suicidality in Non-Binary Participants of the 2015 US Transgender Survey, US Professional Association for Transgender Health Annual Meeting, Washington, DC 2019.
16. Guerriero J, **Connelly KJ**. Impacts of scheduled v. spontaneous intakes and follow along in patient retention for a pediatric gender clinic. US Professional Association for Transgender Health Annual Meeting, Washington, DC 2019.

17. Berman, AM, Klees, AM, Heyerman TA, Harrison R, **Connelly KJ**, Hoffman LM. From Farm to Patient: A Novel Community-Based Health Promotion Program to Support Patients with Diabetes Experiencing Food Insecurity During in the COVID-19 Pandemic. SGIM annual meeting
18. Mullin R, Baines H, **Connelly KJ**. Congenital Disorder of Glycosylation 1b: Rare cause of hyperinsulinemic hypoglycemia treated with oral mannose therapy. Pediatric Endocrine Society annual meeting, 2021.
19. Hedrick H, Glover N, **Connelly KJ**, Guerriero J, Moyer DN. Virtual visits: Benefits and barriers to providing pediatric gender affirming care via telehealth. US Professional Association for Transgender Health annual meeting, 2021.
20. Battison E, Murphy C, Moyer D, **Connelly KJ**, Dy G, Holley A, Wilson A. Pain and Psychosocial Risk in Adolescents and Young Adults Receiving Gender Affirming Surgery. International Association for the Study of Pain annual meeting, 2022

## **V. SERVICE**

### **Membership in Professional Societies:**

Pediatric Endocrine Society, 2011-present  
The Endocrine Society, 2011-2015  
American Thyroid Association, 2013  
Oregon Pediatric Society

### **Committees:**

#### Department of Pediatrics

2013-present Resident Education Committee, member  
2014-present Doernbecher Gender Clinic Workgroup, chair  
2016-present Doernbecher Sex Development Team Workgroup, co-chair

#### OHSU

2013-2016 OHSU Healthcare Transitions for Adolescents with Diabetes Committee, member  
2013-present OHSU Transgender Health Program Committee, member  
2015-present OHSU Transgender Health Program Advisory Board, member  
2017-present OHSU Transgender Health Program Multidisciplinary Surgical Planning Workgroup, member

#### Local

2013-2018 TransActive Gender Center Health Care Advisory Committee, member

#### National

2015-present Pediatric Endocrine Society Transgender Special Interest Group, member  
2017-present Disorders of Sex Development Translational Research Network (DSD-TRN) Leadership Group, member  
2018-present Disorders of Sex Development Translational Research Network (DSD-TRN) Endocrine Workgroup Co-Lead

2018-2021 Pediatric Endocrine Society Transgender Special Interest Group, Co-Chair  
2020-present Pediatric Endocrine Society Equity, Diversity & Committee, member

**Invited Reviewer:**

Journal Adolescent Health  
J Andrology  
Transgender Health

**Community Service:**

1998 Project Coordinator, Save the Children Nicaragua. Managua, Nicaragua.  
1999-2001 Emergency Medical Technician and Assistant Director of Operations. Tulane  
Emergency Medical Service, New Orleans, LA.  
2005 Medical Volunteer, Hurricane Katrina Relief. San Antonio, TX.  
2004-2007 Steering Committee member and volunteer, UTHSCSA Student-run Free Clinic  
Program. San Antonio, TX.  
2010 Volunteer Physician, Casa Base de Salud. Managua, Nicaragua.  
2010-present Camp Physician, Gales Creek Camp for children with diabetes. Tillamook, OR.

**Interviews/Submissions for Public Media**

The Atlantic. Delaying Puberty with the Help of the State. October 22, 2014  
Portland Monthly. Let's Talk About Gender. March 2016  
OPB  
Podcast (Camp Wildheart) x 2  
Science Friday  
Portland Tribune  
KGW  
Portland Mercury  
Reuters  
NY Times  
OHSU Now

**Clinical Responsibilities:**

2013-present Attending, Pediatric Endocrinology Service: 9 weeks per year  
2013-present Attending, Pediatric Endocrinology Clinic: 1 session per week  
2013-present Attending, Pediatric Diabetes Clinic: 1 session per week  
2013-present Medford Outreach Pediatric Endocrinology Clinic: 8 sessions per year  
2015-present Eugene Outreach Pediatric Endocrinology and Telehealth Clinic: 8 sessions per year  
2016-2021 Salem Outreach Pediatric Endocrinology Clinic: 12 days per year  
2021-present Doernbecher Gender Clinic HV: 2 sessions per week

**Honors and Awards in Service:**

2017 OHSU Professional Staff Award – Outstanding Contribution to Innovation in New Models of  
Clinical Care and Interdisciplinary Teams  
2022 Gold Humanism Honor Society, member  
2023 Oregon Pediatric Society – Annual Meeting Special Recognition Award

**VI. TEACHING (Also see attached OHSU Educators Portfolio):****Overview of Your Role as an Educator:**

Educational activity includes: (1) Didactic teaching of housestaff (residents and fellows), medical students, physician assistant students, dental residents, pharmacy residents, and ancillary staff, (2) Small group clinical teaching of housestaff and medical students. (3) As-needed education of OHSU staff on topics related to infectious diseases, infection prevention and control, including hospital infection control policy (4) Regional and national education conferences to provide medical education to healthcare providers and trainees

**Scholarship of Teaching:**Curriculum Development and Instructional Design

- 2010 Developed and implemented online case-based teaching tool that was used by pediatric residents and medical students on pediatric endocrinology rotation.
- 2016-2019 Teaching Communication Skills through Video Self-Observation and Feedback. IRB STUDY00015211. Randomized controlled trial of use of video self-observation and feedback on development of communication skills in pediatric residents.

**Educational Activity (Also see attached OHSU Educators Portfolio):**Teaching Activity: Invited Lectures**Institutional**

- 2013 "Pediatric Endocrinology Challenging Clinical Case." Pediatric Grand Rounds,
- 2013 "Pediatric Diabetes." Family Nurse Practitioner Program
- 2014 "Principles of Sexual Differentiation." OHSU School of Medicine
- 2015 "Care of Transgender and Gender Non-Conforming Youth." OHSU School of Medicine
- 2016 "Care of the Transgender Child/Adolescent." OHSU School of Medicine
- 2016 "Care of the Transgender Child/Adolescent." Child Psychology Program
- 2017 "Panel Discussion: Care of Transgender Patients." OHSU School of Medicine
- 2017 "Care of the Transgender Child/Adolescent." Doernbecher Child Psychology Program
- 2017 Department of Pediatrics Quality Grand Rounds
- 2017 "Care of the LGBTQ Patient" OHSU School of Medicine Developing Human Course
- 2018 "Care of the LGBTQ Patient" OHSU School of Medicine Developing Human Course
- 2018 "Principles of Sexual Differentiation." OHSU School of Medicine Developing Human Course
- 2019 "Gender Affirming Hormone Therapy." OHSU Physician Assistant Program
- 2019 "Care of the LGBTQ Patient" OHSU School of Medicine Developing Human Course
- 2019 "Principles of Sexual Differentiation." OHSU School of Medicine Developing Human Course
- 2020 "Affirming and Informed." Training for OHSU Behavioral Health Consultants
- 2020 "Trauma Informed Care." OHSU Pediatric Urology Program
- 2020 "Gender Affirming Care for Youth." Doernbecher Child Psychology Program
- 2020 "Growth Disorders in Children." OHSU Family Medicine Residency Program
- 2020 "Care of the LGBTQ Patient" OHSU School of Medicine Developing Human Course
- 2020 "Principles of Sexual Differentiation." OHSU School of Medicine Developing Human Course

- 2021 More than Medicine: Creating Safety Nets for Gender Diverse Youth. OHSU School of Medicine Health Equity series
- 2021 "Beyond Born in the Wrong Body: Challenging our Biases to Provide Inclusive Care for Nonbinary Youth." Department of Pediatrics Grand Rounds
- 2021 "More than Medicine: Creating Safety Nets for Gender Diverse Youth." Doernbecher Children's Hospital Perioperative Anesthesia
- 2021 "More than Medicine: Creating Safety Nets for Gender Diverse Youth." OHSU Foundation.
- 2022 "More than Medicine: Empowering Providers to Create Safety Nets for Gender Diverse Youth." Invited lecture for OHSU Pediatric Hematology/Oncology Grand Rounds

**Local**

- 2015 "The Pediatric Transgender Patient: What Primary Care Physicians Need to Know." Trans Health Provider training sponsored by Family Care and Health Share of Oregon
- 2017 "Care of the Transgender and Gender Diverse Pediatric and Adolescent Patient." Metropolitan Pediatrics CME presentation
- 2018 "Care of the Transgender and Gender Diverse Pediatric and Adolescent Patient." Metropolitan Pediatrics CME presentation
- 2018 Transgender Health Program – Ob/Gyn Grand Rounds
- 2018 "Care of the Transgender and Gender Diverse Pediatric and Adolescent Patient." Pacific Medical Group CME presentation
- 2019 "Affirming Care for Gender Expansive Youth." Portland State University School of Public Health
- 2020 "Affirming Care for Gender Expansive Youth." Portland State University School of Social Work
- 2020 "More than Medicine: Creating Safety Nets for Gender Diverse Youth" Department of Pediatrics Grand Rounds
- 2021 "Caring for Gender Expansive Youth." Lewis & Clark College
- 2022 "Creating Safety Nets for Gender Diverse Youth." Invited speaker, Clackamas County School Nurses meeting

**Regional**

- 2014 "Medical Care of Transgender Youth." Kaiser Grand Rounds
- 2014 "Medical Care of Transgender Youth." OHSU 9<sup>th</sup> Annual Pediatric Review & Update
- 2015 "Culturally Sensitive and Respectful Interdisciplinary Care of Transgender Patients." Pacific University College of Health Professions Interdisciplinary Case Conference
- 2016 "Transgender and Gender-Diverse Youth: What Primary Care Providers Need to Know." Medford, OR
- 2016 "Transgender and Gender-Diverse Youth: What Primary Care Providers Need to Know." PeaceHealth Pediatric Grand Rounds, Eugene, OR
- 2016 "Medical Options for Youth with Gender Dysphoria." Affirmative Mental Health Care for Transgender and Gender Non-conforming Youth Training
- 2016 "Culturally Sensitive and Respectful Interdisciplinary Care of Transgender Patients." Pacific University College of Health Professions Interdisciplinary Case Conference
- 2016 "Transgender and Gender-Diverse Youth: What Primary Care Providers Need to Know." OHSU 47<sup>th</sup> Annual Primary Care Review
- 2017 "Culturally Sensitive and Respectful Interdisciplinary Care of Transgender Patients." Pacific University College of Health Professions Interdisciplinary Case Conference

- 2017 "Caring for Transgender and Gender Diverse Youth" OHSU Annual Pediatric Review and Update
- 2017 "Comprehensive Affirming Care for Transgender and Gender Diverse Patients Across the Lifespan." 44<sup>th</sup> Annual Acute and Critical Care Nursing Symposium
- 2017 "Care of the Transgender and Gender Diverse Pediatric and Adolescent Patient." Oregon Chapter of the National Society of Pediatric Nurse Practitioners (NAPNAP) Fall Symposium.
- 2018 "Many Doors One Path: A Model for a Patient/Family Centered Care in the Pediatric Endocrinology Environment." The LGBTQ Meaningful Care Conference
- 2018 "Building Affirming Environments for Gender Expansive Youth." Invited speaker, Oregon Pediatric Society Annual Meeting
- 2018 "Considerations for Trans and Gender Diverse Youth in Accessing Medical Transition." Invited speaker, Basic Rights Oregon Annual Trans Health Forum
- 2018 "Medical Options for Gender Expansive Youth." Healthcare for the Transgender Individual CME training. Bend, Oregon.
- 2018 "Affirming Healthcare for Gender Expansive Youth: Review and Update" Invited Speaker, Pacific NW Pediatric CME Symposium. Portland, OR
- 2019 "Transgender and Gender Diverse Patients: Building Affirming Care Environments." Invited Speaker, Mountain States Hemophilia Network Annual Regional Meeting
- 2019 "Affirming Care for Gender Expansive Youth" Invited Speaker, Southern Oregon LGBTQ+ Health and Wellness Summit
- 2019 "Pubertal Suppression and gender affirming hormone therapy for youth/adolescents" Introduction to Transgender Health For Medical and Mental Health Professionals: OHSU Transgender Health Program CME Event
- 2019 Taking a Sexual History, Fertility Counseling/Preservation, and Reproductive Health." Introduction to Transgender Health For Medical and Mental Health Professionals: OHSU Transgender Health Program CME Event
- 2020 "One Team, One Mission: Reducing Barriers for Youth and Families through Interdisciplinary Care." Pediatric Endocrine Association for Research and Learning (PEARL) Annual Regional CME meeting
- 2020 "OneTeam, One Mission: Reducing Barriers for Youth and Families through Interdisciplinary Care, The LGBTQ Meaningful Care Conference
- 2020 FUTURE STATE: Strategies for improved health and wellness for Oregon's Gender Diverse Youth, The LGBTQ Meaningful Care Conference
- 2020 "More than Medicine: Creating Safety Nets for Gender Diverse Youth" Hot Topics in Nursing
- 2021 "Supporting and affirming gender diverse youth." Invited lecture for the regional Mama Dragons group.
- 2021 "Pubertal Suppression." Invited lecture, OHSU Transgender Health ECHO
- 2022 "More than Medicine: Empowering Providers to Create Safety Nets for Gender Diverse Youth." Invited lecture for Oregon Pediatric Society annual meeting
- 2022 "Youth SAVE: Suicide Prevention Training for Primary Care." Trainer for 2-day training
- 2022 Gender-Affirming Care Advocacy Panel for medical students at Western University of Health Sciences
- 2022 Invited panelist with Gina Sequeira
- 2022 "Safe Binding and Tucking for Gender Diverse Youth." Invited speaker, Indian Health Board ECHO series

2023 "Navigating Stress and Burnout Given Anti-Trans Propaganda and Laws Denying Healthcare." Indian Health Board ECHO series

**National**

2015 "Newborn Screening for congenital adrenal hyperplasia." Webinar, Association of Public Health Laboratories: NewSTEPS Short Term Follow Up.

2016, 2017, "Medical Options for Youth with Gender Dysphoria."

2018, 2019 "Affirmative Mental Health Care for Transgender and Gender Non-conforming Youth" Training

2020 "Double trouble: Let's talk about sex (of rearing) and gender identity in a complex case of XY, DSD." Case presentation for the Disorders of Sex Development Translational Research Network (DSD-TRN).

2021 "More than Medicine: Creating safety nets for gender diverse youth." Half-day seminar presented to national audience organized by Corvallis Samaritan Health.

2021 Transgender & Non-Binary Surgery Allied Research Collective (TRANS-ARC). Invited member of the research resource team.

2021 "Safe binding and tucking for gender diverse youth." Invited lecturer, National Indian Health Board Transgender ECHO

2022 Transgender Health Doc in The Box session. Invited speaker for the Pediatric Endocrine Society Annual Meeting

**International**

2013 "Autoimmune Hyperthyroidism." European Society of Pediatric Endocrinology Summer School Program, Lago di Maggio, Italy, September 2013.

2018 "Growth Problems in Children." Neonatal Review Course 2018 American Pediatric Meeting, Lithuania

2018 "Hypothyroidism in Children." Neonatal Review Course 2018 American Pediatric Meeting, Lithuania

2018 "Puberty: What is Normal and When to Worry." Neonatal Review Course 2018 American Pediatric Meeting, Lithuania

2018 "Affirming Medical Care for Gender Expansive Youth." World Professional Association for Transgender Health Global Health Initiative, Portland OR.

2018 "Child and Adolescent Workshop: Fertility and Reproductive Options." World Professional Association for Transgender Health Global Health Initiative, Portland OR.

2021 World Professional Association for Transgender Health Global Education Initiative, invited faculty

2021 World Professional Association for Transgender Health Global Education Initiative, invited faculty

Advisor/Mentoring

2013-2016 Faculty advisor for pediatric resident: Abbie Bauer, MD; faculty member, pediatric nephrology, OHSU

2016-2019 Faculty advisor for pediatric resident: Sasha Ondusko, MD; currently clinical fellow in Neonatology at OHSU

2016-2019 Faculty mentor for OHSU School of Medicine scholarly project: Mackenzie Deane

2016-2019 Faculty mentor for OHSU Pediatric Endocrinology Fellowship scholarly project: Hayley Baines, MD

2017-2020 Faculty advisor for pediatric resident: Terry Kho, MD

- 2017-2019 Faculty mentor for OHSU pediatric resident: Alison O'Neill, MD; currently clinical fellow in pediatric endocrinology at CHOP
- 2018-2021 Faculty advisor for pediatric resident: Jordan Frei, MD
- 2019-2020 Faculty mentor for OHSU School of Medicine scholarly project: Alisha Berry
- 2019-2022 Faculty mentor for OHSU School of Medicine scholarly project: Corey Gallet De St Aurin
- 2019-2022 Faculty mentor for OHSU School of Medicine scholarly project: Alec Berman
- 2021-2022 Faculty mentor for OHSU School of Medicine scholarly project: Abraham Rickett
- 2021-2022 Faculty mentor for OHSU School of Medicine scholarly project: Marie Piatski
- 2020-present Faculty mentor for OHSU pediatric resident: Kim Vidmar, MD
- 2022-present Max Sutherland

**Effectiveness of Educational Activity:**

Please see OHSU Educators Portfolio for summary of completed evaluations

**Educational Administration: Leadership and Service:**

- 2013-present Pediatric Endocrinology Resident and Medical Student Education Rotation Director
- 2014 Pediatric Endocrine Association for Research and Learning Regional (PEARL) CME meeting – Program Director/Organizer
- 2013-2016 Pediatric residency program interviewer (approximately 8-11 hours per year)
- 9/2015, Affirmative Mental Health Care for Transgender and Gender Non-Conforming Youth Training
- 1/2016, Course – Program Director/Organizer (September 2015, January 2016)
- 9/2016,
- 11/2017,
- 5/2018
- 2015-2020 OHSU School of Medicine College Program Lead, OHSU School of Medicine
- 2019 Introduction to Transgender Health For Medical and Mental Health Professionals: OHSU Transgender Health Program CME Event – Program Director/Organizer
- 2021 OHSU Transgender Health Program CME Grand Rounds Series – Program Organizer

**Honors and Awards for Education:**

- 2013 Joseph B Bilderback Fellow Teaching Award, Doernbecher Children's Hospital
- 2019 OHSU School of Medicine Continuing Professional Development Honored Planner Award
- 2019 OHSU School of Medicine Outstanding Leader in Electives for Clinical Experiences Award

PROFESSIONAL DEVELOPMENT

Formal Training

- 2016-2017 Certificate, Education Scholars Program, Oregon Health & Science University, Portland, OR  
A nine-month, longitudinal program designed to facilitate clinical educators' deeper understanding of teaching and learning so that each will be prepared to effectively and adaptively teach in multiple settings, mentor others in the development of teaching skills, contribute to the scholarship of teaching, and serve as educational leaders of courses, units, departments, and schools.