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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY, Plaintiff, v. **ROBERT W. FERGUSON**, in his official capacity as Attorney General for the State of Washington; **UMAIR A. SHAH**, in his official capacity as Secretary of Health for the State of Washington; and **KRISTIN PETERSON** in her official capacity as Assistant Secretary of the Health Systems Quality Assurance division of the Washington State Department of Health, Defendants.	Civil No. ____-________ **EXPERT DECLARATION OF DR. STEPHEN B. LEVINE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION**

ALLIANCE DEFENDING FREEDOM
15100 N. 90th Street
Scottsdale, Arizona 85260
(480) 444-0020

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I. CREDENTIALS & SUMMARY 1

II. BACKGROUND ON THE FIELD 7

A. The biological baseline of sex 7

B. Definition and diagnosis of gender dysphoria 9

C. Impact of gender dysphoria on minority and vulnerable groups 13

D. Three competing conceptual models of gender dysphoria and transgender identity 14

E. Four competing models of therapy 19

(1) The "watchful waiting" therapy model 19

(2) The psychotherapy model: Alleviate distress by identifying and addressing causes (model #3) 20

(3) The affirmation therapy model (model #4) 23

F. Patients differ widely and must be considered individually. 26

III. GENDER IDENTITY, GENDER DYSPHORIA, AND THERAPIES FOR GENDER DYSPHORIA IN YOUNGER CHILDREN 27

A. Natural desistance is by far the most frequent resolution of gender dysphoria in young children absent social transition. 27

B. Social transition of young children is a powerful psychotherapeutic intervention that changes outcomes. 29

C. The administration of puberty blockers to children as a treatment for gender dysphoria is experimental, presents obvious medical risks, and appears to affect identity outcomes. 33

IV. THE AVAILABLE DATA DOES NOT SUPPORT THE CONTENTION THAT "AFFIRMATION" OF TRANSGENDER IDENTITY IN CHILDREN AND ADOLESCENTS REDUCES SUICIDE OR RESULTS IN BETTER PHYSICAL OR MENTAL HEALTH OUTCOMES GENERALLY. 37

V. KNOWN, LIKELY, OR POSSIBLE DOWNSIDE RISKS ATTENDANT ON MOVING QUICKLY TO "AFFIRM" TRANSGENDER IDENTITY IN CHILDREN AND ADOLESCENTS. 46

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A. Physical risks associated with transition 48
B. Social risks associated with transition 51
C. Mental health costs or risks 52
D. The risk of regret following transition 56

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I, Dr. Stephen B. Levine, declare as follows:

I. CREDENTIALS & SUMMARY

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

2. Since July 1973, my specialties have included psychological problems and conditions relating to individuals' sexuality and sexual relations, therapies for sexual problems, and the relationship between love, intimate relationships, and wider mental health. In 2005, I received the Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research which "recognizes extraordinary contributions to clinical sexuality and/or sexual research over the course of a lifetime and achievement of excellence in clinical and/or research areas of sexual disorders."[1] I am a Distinguished Life Fellow of the American Psychiatric Association.

3. I have served as a book and manuscript reviewer for numerous professional publications. I have been the Senior Editor of the first (2003), second (2010), and third (2016) editions of the *Handbook of Clinical Sexuality for Mental Health Professionals*. In addition to five previously solo-authored books for

[1] Society for Sex Therapy & Research Awards, https://sstarnet.org/awards/.

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professionals, I have recently published *Psychotherapeutic Approaches to Sexual Problems* (2020). The book has a chapter titled "The Gender Revolution."

4. I first encountered a patient suffering what we would now call gender dysphoria in July 1973. In 1974, I founded the Case Western Reserve University Gender Identity Clinic and have served as Co-Director of that clinic since that time. Across the years, our Clinic treated hundreds of patients who were experiencing a transgender identity. An occasional child was seen during this era. I was the primary psychiatric care-giver for several dozen of our patients and supervisor of the work of other therapists. As the incidence of gender dysphoria has increased among children and youth in recent years, larger numbers of minors presenting with actual or potential gender dysphoria have presented to our clinic. I currently am providing psychotherapy for several minors in this area. I also counsel distressed parents of these teens.

5. I was an early member of the Harry Benjamin International Gender Dysphoria Association (now known as the World Professional Association for Transgender Health or WPATH) and served as the Chairman of the committee that developed the 5th version of its Standards of Care. The vast majority of the 6th version contains the exact prose that my committee wrote for the 5th version. In 1993 our Gender Identity Clinic was renamed, moved to a new location, and became independent of Case Western Reserve University. I continue to serve as Co-Director.

1 6. In 2006, Judge Mark Wolf of the Eastern District of Massachusetts
2 asked me to serve as an independent, court-appointed expert in litigation involving
3 the treatment of a transgender inmate within the Massachusetts prison system. I
4 have been retained by the Massachusetts Department of Corrections as a
5 consultant on the treatment of transgender inmates since 2007.
6
7 7. In 2019, I was qualified as an expert and testified concerning the
8 diagnosis, understanding, developmental paths and outcomes, and therapeutic
9 treatment of transgenderism and gender dysphoria, particularly as it relates to
10 children, in the matter of *In the Interest of J.A.D.Y. and J.U.D.Y.*, Case No. DF-15-
11 09887-S, 255th Judicial District, Dallas County, TX.
12
13 8. A fuller review of my professional experience, publications, and awards
14 is provided in my curriculum vitae, a copy of which is attached hereto as Exhibit A.
15
16 9. My many years of experience in working with adults or older young
17 adults who are living in a transgender identity or who suffer from gender dysphoria
18 provide a wide lifecycle view which, along with my familiarity with the literature
19 concerning them, provides an important cautionary perspective. The psychiatrist or
20 psychologist treating a trans child or adolescent of course seeks to make the young
21 patient happy, but the overriding consideration is the creation of a happy, highly
22 functional, mentally healthy person for the next 50 to 70 years of life. I refer to
23 treatment that keeps this goal in view as the "life course" perspective.
24
25 10. A summary of the key points that I explain in this statement is as
26 follows:
27

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

b. The diagnosis of "gender dysphoria" encompasses a diverse array of conditions, with widely differing pathways and characteristics depending on age of onset, biological sex, mental health, intelligence, motivations for gender transition, socioeconomic status, country of origin, etc. Data from one population (e.g., adults) cannot be assumed to be applicable to others (e.g., children). (Section II.B.) Generalizations about the treatment children in one country (e.g., Holland) do not necessarily apply to another (e.g., United States).

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

d. A majority of children (in several studies, a large majority) who are diagnosed with gender dysphoria "desist"—that is, their gender dysphoria

does not persist—by puberty or adulthood unless transgender-affirming therapeutic or medical interventions modify the normal course of maturation. It is not currently known how to distinguish children who will persist from those who will not. (Section III.)

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

f. Typically, social transition is a first step in gender affirmation. It is itself an important intervention with profound implications for the long-term mental and physical health of the child. When a mental health professional (MHP) evaluates a child or adolescent and then recommends social transition, that professional should be available to help with interpersonal, familial, and psychological problems that may already exist and will likely arise after transition. However, today many children are started on puberty blockers, and adolescents are medically transitioned, without a thorough, long-lasting mental health assessment and psychological ongoing care, leaving themselves and their families on their own to deal with ongoing and subsequent problems. (Sections III, V.)

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

h. There are no studies that show with any methodological and statistical validity that affirmation of transgender identity in young children reduces suicide or suicidal ideation, or improves long-term outcomes as compared to other therapeutic approaches. Meanwhile, multiple studies show that adult individuals living transgender lives suffer much higher rates of suicidal ideation, completed suicide, and negative physical and mental health conditions than does the general population before and after transition, hormones, and surgery. There are no randomized studies that compare outcomes among older teens and adults with gender dysphoria who have affirmation treatment with those who do not. (Section IV.)

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

j. Putting a child or adolescent on a pathway towards life as a transgender person puts that individual at risk of a wide range of long-term or even life-long harms, including: sterilization (first chemical, then surgical) and associated regret and sense of loss; inability to experience orgasm (for

trans women); physical health risks associated with exposure to elevated levels of cross-sex hormones; surgical complications and life-long after-care; alienation of family relationships; inability to form lasting romantic relationships and attract a desirable mate; and elevated mental health risks of depression, anxiety, and substance abuse. (Section V.)

II. BACKGROUND ON THE FIELD

A. The biological baseline of sex

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

12. The self-perceived gender of a child, in contrast, arises in part from how others label the infant: "I love you, son (daughter)." This designation occurs thousands of times in the first two years of life when a child begins to show

awareness of the two possibilities. As acceptance of the designated gender corresponding to the child's sex is the outcome in >99% of children everywhere, anomalous gender identity formation begs for understanding. Is it biologically shaped? Is it biologically determined? Is it the product of how the child was privately regarded and treated? Does it stem from trauma-based rejection of maleness or femaleness, and if so, flowing from what trauma? Does it derive from a tense, chaotic interpersonal parental relationship without physical or sexual abuse? Is it a symptom of another, as of yet unrevealed, emotional disturbance or neuropsychiatric condition such as autism? The answers to these relevant questions are not scientifically known.

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

14. Despite the increasing use of cross-sex hormones and various surgical procedures to reconfigure some male bodies to visually pass as female, or vice versa, the biology of the person remains as defined by his (XY) or her (XX) chromosomes,

including cellular, anatomic, and physiologic characteristics and the particular disease vulnerabilities associated with that chromosomally-defined sex. For instance, the XX (genetically female) individual who takes testosterone to stimulate certain male secondary sex characteristics will nevertheless remain unable to produce sperm and father children. Thus in critical respects, gender affirmation changes can only be anatomically "skin deep." Contrary to assertions and hopes that medicine and society can fulfill the aspiration of the trans individual to become "a complete man" or "a complete woman," this is not biologically attainable.[2] It is possible for some adolescents and adults to pass unnoticed in daily life as the opposite sex that they aspire to be—but with limitations, costs, and risks, as I detail later. These risks include a continuing sense of inauthenticity as a member of the opposite sex.

B. Definition and diagnosis of gender dysphoria

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

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

defines it with separate sets of criteria for adolescents and adults on the one hand, and children on the other.

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

17. Gender dysphoria has very different characteristics depending on age and sex at onset. Young children who are living a transgender identity commonly suffer materially fewer symptoms of concurrent mental distress than do older patients.[3] The developmental and mental health patterns for each of these groups are sufficiently different that data developed in connection with one of these populations cannot be assumed to be applicable to another.

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

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