

APPEAL NO. 23-2807
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

REBECCA ROE, by and through her parents and next friends, et al.,

Plaintiffs-Appellants,

v.

DEBBIE CRITCHFIELD, in her official capacity as Idaho State Superintendent of
Public Instruction, et al.,

Defendants-Appellees.

On Appeal from the United States District Court
for the District of Idaho
Case No. 1:23-cv-00315-DCN
Hon. David C. Nye, D.J.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

REBECCA ROE, et al.,)	
)	
Plaintiffs,)	Case No.
)	1:23-cv-00315-DCN
vs.)	
)	
DEBBIE CRITCHFIELD, in her)	
official capacity as Idaho State)	
Superintendent of Public)	
Instruction, et al.,)	
)	
Defendants.)	
_____)	

REMOTE VIDEOTAPED DEPOSITION OF STEPHANIE BUDGE, PH.D.
August 16, 2023

Reported by:
Rebecca Martin, CSR #1108, RPR, CRR

1 REMOTE VIDEOTAPED DEPOSITION OF STEPHANIE BUDGE, PH.D.

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Stephanie Budge, Ph.D. August 16, 2023

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E X A M I N A T I O N

STEPHANIE BUDGE, PH.D. PAGE
By: MR. WILSON 6

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P R O C E E D I N G S

(Deposition Exhibit No. 1 was marked.)

THE VIDEOGRAPHER: So we are recording and we are on the record. Today's date is August 16th, 2023. The time is 8:05 a.m. Mountain Time.

For the record, this is the remote videotaped deposition of Dr. Stephanie Budge. It's taken by the defendants in the matter of Roe, et al., versus Debbie Critchfield, et al. It is Case Number 1:23-cv-00315-DCN. It is in the United States District Court for the District of Idaho.

The videotaped deposition is being held remotely via Zoom videoconference. The videotaped deposition is being recorded by Chris Ennis and reported by Becky Martin of Associated Reporting and Video, a Veritext company.

And if Counsel will please state their appearances and any stipulations for the record.

MR. WILSON: Lincoln Wilson for the Idaho Attorney General's Office, representing the defendant.

MS. BORELLI: Tara Borelli for the plaintiffs.

MR. DROZ: Rafael Droz, Attorney General's

1 Office -- Idaho Attorney General's Office for
2 defendants.

3 MR. RENN: Peter Renn for the plaintiffs.

4 MR. ROSEN: Max Rosen for the plaintiffs.

5 MR. LINNET: Sam Linnet for the plaintiffs.

6 MR. MARTIN: Paul Martin for the plaintiffs.

7 MS. PAEK: Christina Paek for the
8 plaintiffs.

9 THE VIDEOGRAPHER: And if the court reporter
10 will please swear the witness.

11 STEPHANIE BUDGE, PH.D.,
12 a witness having been first duly sworn to tell the
13 truth, the whole truth and nothing but the truth,
14 was examined and testified as follows:

15

16 EXAMINATION

17 BY MR. WILSON:

18 Q. Good morning.

19 Would you please state your name for the
20 record?

21 A. Yes. My name is Stephanie Budge.

22 Q. Thank you, Dr. Budge.

23 We've been introduced off the record.

24 My name is Lincoln Wilson. I'm with the Idaho
25 Attorney General's Office and will be taking your

1 deposition in this case today.

2 I know this isn't your first rodeo as
3 far as depositions are concerned, so I will skip
4 over some of the standard preliminaries and I'll
5 just say maybe a couple of them.

6 First of all, have you done a video
7 deposition before?

8 A. I have.

9 Q. Okay. So you're even used to this
10 format on some level.

11 And I think the only thing we have to be
12 mindful of in particular here is to take extra
13 special care not to speak over one another and wait
14 'til I finish a question before giving an answer,
15 just so that we make things nice and easy for the
16 court reporter and the record that we have here.

17 And make sure that you're giving verbal
18 answers and not sort of, you know, nodding your
19 head or uh-huh, mm-hmm, because that's the sort of
20 thing that won't come across very clearly on the
21 transcript.

22 Does that make sense?

23 A. That does make sense.

24 Q. All right. Thank you.

25 So I have circulated before what we'd

1 like to mark as Exhibit 1 to your deposition.

2 Have you received the e-mail that I
3 sent?

4 A. Yes.

5 Q. And can you tell me what this is that's
6 attached to that e-mail?

7 A. It is my expert declaration for this
8 case.

9 Q. Are you able to tell me whether this
10 declaration is a complete and accurate statement of
11 the opinions that you intend to give in this case
12 in relation to Plaintiff's motion for a preliminary
13 injunction?

14 A. It is.

15 Q. And so any opinions that you have that
16 are relevant to that motion would be stated in this
17 declaration; is that correct?

18 A. That's correct.

19 MS. BORELLI: Counsel, let me just interpose
20 an objection, which is: Briefing obviously isn't
21 complete and this wouldn't encompass any rebuttal
22 opinions that Dr. Budge would be offering, so I
23 want to make sure the record is clear on that
24 point.

25 MR. WILSON: Appreciate that clarification.

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1 Q. (BY MR. WILSON) And if there are any
2 authorities that you relied on in forming the
3 opinions that are stated in your declaration, they
4 would be included within that declaration; is that
5 correct?

6 A. That's correct. And I still might be
7 able to add some additional components at some
8 point in time related to this case.

9 Q. But to the extent that it's already
10 relating to an opinion that you've already formed,
11 those authorities would be listed in this
12 declaration; is that correct?

13 A. That's correct.

14 Q. Thank you.

15 If you'd take a look --

16 MS. BORELLI: If I can just -- I don't mean
17 to be too interruptive here, but I just want to
18 clarify that of course Dr. Budge is a clinician,
19 has a great deal of clinical experience, and so
20 would be relying on clinical experience and other
21 related authorities that she would use in her
22 day-to-day clinical practice.

23 MR. WILSON: So I don't think that's a
24 proper objection because it seems to be supplying
25 an answer. Your point taken, not an issue here,

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1 but I'd just like to make sure that we're not
2 adding to the record through objections.

3 But I think we can move forward.

4 Q. (BY MR. WILSON) If you'd take a look at
5 paragraph 3 of your declaration and let me know
6 when you're there.

7 A. I'm there.

8 Q. The paragraph begins, it says: I have
9 been retained by counsel for the plaintiffs in the
10 above-captioned matter to provide expert opinions
11 about.

12 And then it lists five topics under
13 separate headings; is that correct?

14 A. That's correct.

15 Q. And are those the opinions that you're
16 offering in this case at this time in relation to
17 the preliminary injunction motion?

18 A. That's correct.

19 Q. And you don't have at this time any
20 other opinions than those that are stated here; is
21 that correct?

22 A. I'll be opining on the things that were
23 listed in this statement. If there are components
24 that are related to it, I will be offering some
25 evidence that's related to that within the context

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1 of what I was hired to do.

2 Q. I certainly understand. Thanks for that
3 clarification.

4 To be clear, you did not examine the
5 plaintiffs -- or the plaintiff in this case; is
6 that correct?

7 A. That's correct.

8 Q. And would it be fair to say that you are
9 not giving an opinion about the particular minor
10 plaintiff or the particular plaintiff organization
11 in this case? Is that also correct?

12 A. My opinions are related to them, but I
13 have not met with them personally.

14 Q. Yeah. I'm just trying to clarify. Let
15 me see if I can maybe phrase that in a better way.

16 You're giving opinions that are sort of
17 general opinions about psychological and medical
18 phenomena, not about these specific people. Now,
19 they may -- is that correct?

20 MS. BORELLI: Lincoln, I just want to
21 interpose an objection to the extent that the
22 testimony submitted relates to the PI. So if we're
23 talking more broadly about the case, obviously we
24 haven't disclosed opinions related more broadly to
25 the case. I want to make sure we're talking about

1 the same thing, which is just the scope of the
2 preliminary injunction motion.

3 Are we on the same page?

4 MR. WILSON: We're on the same page.

5 MS. BORELLI: Thanks.

6 Q. (BY MR. WILSON) Let me see if I can --
7 I'm really just trying to clarify here that your
8 opinions are general opinions that are about your
9 understanding of the science and medicine and
10 psychology of these issues, they're not directed to
11 these specific plaintiffs; is that correct?

12 MS. BORELLI: Objection; compound and vague.

13 Q. (BY MR. WILSON) You can answer.

14 A. My answers relate to the plaintiffs.

15 Q. I'm just trying to clarify here, though.
16 Maybe I'll just leave the second part out of it.

17 These opinions are general opinions that
18 are -- you would maintain that they are true as a
19 general matter and also with reference to these
20 specific plaintiffs, but you were giving these
21 opinions as a general matter; is that correct?

22 MS. BORELLI: Compound and vague.

23 Q. (BY MR. WILSON) You can answer.

24 A. That's correct.

25 Q. Okay. Just to clarify that when -- your

1 counsel may object, but you can continue to answer
2 if you have an answer to the question.

3 Now, at least one of those opinions, if
4 you look at that paragraph 3, subsection D says
5 you're giving an opinion about "the harms caused by
6 excluding transgender students from using
7 sex-separated facilities that are aligned with
8 their gender identity."

9 Did I read that correctly?

10 A. That's correct.

11 Q. And would it be fair to say, then, that
12 you were giving a causation opinion --

13 MS. BORELLI: Objection --

14 Q. (BY MR. WILSON) -- in that regard?

15 MS. BORELLI: -- vague.

16 THE WITNESS: I will be, and I'm opining
17 around the harms that are related to the exclusion
18 of transgender students from the sex-segregated
19 facilities.

20 Q. (BY MR. WILSON) When you say you're
21 opining about the harms caused by excluding
22 transgender students, you aren't necessarily giving
23 an opinion about causation; is that correct?

24 MS. BORELLI: Objection; vague.

25 Q. (BY MR. WILSON) You can answer.

1 A. Yes. I'm talking about the harm that's
2 directly related to the discrimination and
3 exclusion of transgender students.

4 Q. And would it be fair to say that for
5 subsection C -- let me just read that first. I'll
6 ask my question differently.

7 Subsection C says you're opining about:
8 The importance of access to sex-separated
9 facilities as part of social transition.

10 Did I read that correctly?

11 A. Yes.

12 Q. Would it be fair to say that that is
13 also a causation opinion, that you're saying that
14 the access to sex-separated facilities as part of
15 social transition causes certain benefits to
16 transgender persons?

17 MS. BORELLI: Objection; compound and vague.

18 Q. (BY MR. WILSON) You can answer.

19 A. Will you repeat the question, please?

20 Q. Is your opinion in subsection C, is that
21 an opinion that access to sex-separated facilities
22 causes certain benefits to transgender persons or
23 persons with gender dysphoria?

24 MS. BORELLI: Objection; vague.

25 THE WITNESS: The component that I'm opining

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1 about here is that social transition is an
2 essential component of transgender adolescence
3 experience, and that having access to sex
4 segregated spaces is an important component of
5 that.

6 Q. (BY MR. WILSON) And is it an important
7 component because it causes -- or you maintain that
8 it causes benefits to those persons?

9 MS. BORELLI: Objection; misstates
10 testimony.

11 THE WITNESS: My opinion is that it's --
12 that being able to access sex-segregated facilities
13 for transgender adolescents is something that is
14 just, like, a natural component for them that
15 maintains, you know, a baseline level of mental
16 health that would be the same for any adolescent.

17 Q. (BY MR. WILSON) So you are not opining
18 that doing that causes any particular benefits for
19 transgender persons; is that correct?

20 MS. BORELLI: Objection; vague.

21 THE WITNESS: My opinion is that -- I mean,
22 it's the same kind of benefit that would exist for
23 cisgender youth as well. I don't actually
24 understand what the definition of "benefit" is in
25 this case.

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1 Q. (BY MR. WILSON) That they're better off
2 having that access than not having that access; is
3 that correct, that you are opining that that causes
4 benefits for them?

5 MS. BORELLI: Compound, vague.

6 THE WITNESS: I am opining that transgender
7 adolescents are better off for them -- you know, in
8 the sense that they will be harmed if they are not
9 allowed access to those spaces.

10 Q. (BY MR. WILSON) Okay. I think that's
11 the clarification that I needed. Thank you.

12 You describe the method that you used to
13 reach the opinions that you state in this
14 declaration?

15 MS. BORELLI: Objection; vague.

16 Q. (BY MR. WILSON) You can answer.

17 A. I describe my qualifications as a
18 component of the declaration, and that component of
19 my qualifications indicates my level of expertise
20 and my areas of expertise, and I use that area --
21 those levels and areas of expertise to assist with
22 the process of writing the report.

23 Q. Other than that, is there any other
24 aspect of the method that you used to reach these
25 opinions in this case?

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1 MS. BORELLI: Objection; vague.

2 THE WITNESS: I used the same method that I
3 use for all psychological and scientific processes
4 in terms of reviewing the full extent of the
5 literature, ensuring that I'm including all of the
6 evidence-based information.

7 So I have an extensive level of training
8 regarding how to consider scientific evidence, and
9 I use all of that expertise in my process of
10 identifying the information for the report.

11 Q. (BY MR. WILSON) Thank you.

12 So you said that you use -- you reviewed
13 the full extent of the literature in forming your
14 opinions in this case; is that correct?

15 MS. BORELLI: Objection; misstates
16 testimony.

17 Q. (BY MR. WILSON) You can answer.

18 A. Yes. I used the same process of
19 searching for scientific literature and
20 understanding the scope of the scientific
21 literature.

22 Q. What was your method for searching for
23 relevant studies on this issue to use in your
24 report?

25 MS. BORELLI: Objection; vague.

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1 THE WITNESS: For the process of researching
2 for this particular case, I used scientific
3 databases and academic databases to be able to
4 search for the scientific literature.

5 Q. (BY MR. WILSON) And the literature that
6 you reviewed in forming your opinions is noted and
7 cited in your report or included as references at
8 the end of it; is that correct?

9 MS. BORELLI: Objection; vague.

10 THE WITNESS: Can you restate the question,
11 please?

12 Q. (BY MR. WILSON) So the scientific
13 literature that you reviewed in forming your
14 opinion would either be cited in your declaration
15 or included as one of your references at the end;
16 is that correct?

17 A. When relevant. So, you know, I reviewed
18 a lot of different components that wouldn't have
19 been relevant to the questions at hand, but when
20 relevant, I did include those articles in this
21 particular declaration.

22 Q. So you were applying a scientific
23 process to form the opinions that you stated in
24 this case; is that correct?

25 MS. BORELLI: Objection; vague.

1 THE WITNESS: Yes. I used a scientific
2 process to inform my methodology for finding the
3 articles and scientific literature for this
4 declaration.

5 Q. (BY MR. WILSON) Are you familiar with
6 the Federal Judicial Center's reference manual on
7 scientific evidence?

8 MS. BORELLI: Objection; vague.

9 THE WITNESS: I am not.

10 Q. (BY MR. WILSON) So in terms of thinking
11 about science, would you agree that it's the
12 testing of hypotheses to see if they can be
13 falsified that distinguishes science from other
14 fields of human inquiry?

15 MS. BORELLI: Objection; lacks foundation,
16 calls for a legal conclusion.

17 Q. (BY MR. WILSON) You can answer.

18 A. That's a general statement around
19 science, yes.

20 Q. Sorry, just to be clear, was your answer
21 "yes" there? I didn't quite hear it.

22 MS. BORELLI: Objection; misstates prior
23 testimony.

24 Q. (BY MR. WILSON) I missed it over the
25 objection.

1 Was your answer yes?

2 A. I said generally. Generally, yes.

3 Q. Would you also agree that an association
4 is not equivalent to causation?

5 MS. BORELLI: Objection; calls for legal
6 conclusion, vague.

7 THE WITNESS: Associations in scientific
8 literature indicate direct relationships; and
9 therefore, you can make conclusions regarding those
10 types of relationships. So they're variations of
11 similar processes.

12 Q. (BY MR. WILSON) But you would agree that
13 an association is not equivalent to causation; is
14 that correct?

15 MS. BORELLI: Objection; vague.

16 THE WITNESS: They're not exactly the same
17 thing.

18 Q. (BY MR. WILSON) What's your
19 understanding of the term "cherry-picking" when
20 it's used in scientific research?

21 MS. BORELLI: Objection; vague.

22 THE WITNESS: My understanding of that
23 terminology is that that is when people choose
24 evidence or different kinds of information that
25 fits a very particular component.

1 Q. (BY MR. WILSON) What do you mean
2 by "component"?

3 A. Well, I think it may depend on what
4 people are talking about with cherry-picking, but
5 in this instance, perhaps it could be something
6 where someone is choosing evidence or information
7 that fits an idea.

8 Q. Like, a particular conclusion?

9 MS. BORELLI: Objection; vague.

10 Q. (BY MR. WILSON) Fair to say?

11 MS. BORELLI: Same objection.

12 THE WITNESS: That could be.

13 Q. (BY MR. WILSON) Would you agree that
14 sound scientific methodology requires a scientist
15 to consider all of the scientific evidence when
16 making causation determinations?

17 MS. BORELLI: Objection; vague, calls for a
18 legal conclusion.

19 THE WITNESS: I do think that scientists
20 should take into account all of the information
21 when making conclusions.

22 Q. (BY MR. WILSON) Would you agree that
23 coming to a firm conclusion first and then doing
24 the research to support it is the antithesis of a
25 scientific method?

1 MS. BORELLI: Objection; vague, compound,
2 calls for legal conclusion.

3 THE WITNESS: Well, typically scientists
4 have hypotheses or research questions that they
5 come up with, and when they do that, they look at
6 relevant theory, they understand the relevant
7 theory, and then they look through the relevant
8 scientific evidence, and after they've done those
9 pieces, then they engage in the science.

10 Q. (BY MR. WILSON) But is the objective
11 with the hypothesis to test it to prove it false or
12 to test it to prove it true?

13 MS. BORELLI: Objection; vague, compound.

14 THE WITNESS: Well, there are multiple ways
15 to test hypotheses. So you can look at null
16 hypotheses, which is a component of -- you know,
17 it's making a statement and then trying -- and then
18 determining exactly if that -- what you're testing
19 does not actually fit.

20 And so, you know, it depends on the type
21 of hypothesis that someone might be describing in
22 terms of hypothesis testing in science.

23 Q. (BY MR. WILSON) Regardless of how the
24 hypothesis is defined, isn't the procedure always
25 designed to see whether it can be falsified?

1 MS. BORELLI: Objection; vague, assumes
2 facts not in evidence.

3 THE WITNESS: The process is trying to test
4 a research question to determine the extent of the
5 research question or what -- or what the
6 conclusions are related to that.

7 Q. (BY MR. WILSON) Is a research question
8 different than a hypothesis?

9 MS. BORELLI: Objection; vague.

10 THE WITNESS: They can be the same thing,
11 but they can be different as well.

12 Q. (BY MR. WILSON) Can you describe the
13 difference between a research question and a
14 hypothesis?

15 MS. BORELLI: Objection; vague.

16 THE WITNESS: There are multiple different
17 types of hypotheses and research questions, and so,
18 you know, I guess part of this is that it's not
19 just a simple "this is what a hypothesis is and
20 this is what a research question is."

21 But like I said, sometimes they can
22 overlap. Research questions are often more kind of
23 broader, "What is the landscape of this particular
24 phenomenon," and then a hypothesis often does test
25 directionality, but that doesn't have to be true

1 necessarily for either one of those. Sometimes
2 they can be the same thing.

3 Q. (BY MR. WILSON) Can you describe what
4 you mean by "directionality"?

5 A. Uh-huh.

6 So in hypotheses, we often indicate if
7 something may be more or less or how something may
8 be related to one thing or another.

9 Q. I think I understand what you mean.

10 Would you agree that it's wrong for a
11 scientist to selectively discuss studies most
12 supportive of her conclusions and fail to account
13 adequately for contrary evidence?

14 MS. BORELLI: Objection; vague, compound.

15 THE WITNESS: I do think that scientists
16 should understand the scope of their evidence and
17 that they should understand the literature and that
18 they should use the literature that is the most
19 scientifically sound in understanding and
20 explaining scientific concepts.

21 Q. (BY MR. WILSON) Would you agree that a
22 theory that fails to explain information that would
23 otherwise tend to cast doubt on that theory is
24 inherently suspect?

25 MS. BORELLI: Objection; vague, compound.

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1 THE WITNESS: Can you repeat the question,
2 please?

3 Q. (BY MR. WILSON) Would you agree that any
4 theory that fails to explain information that
5 otherwise would tend to cast doubt on that theory
6 is inherently suspect?

7 MS. BORELLI: Same objections.

8 THE WITNESS: I don't think I understand
9 your question.

10 Q. (BY MR. WILSON) That's fine. We can
11 move along.

12 So if you take a look at paragraph 9 of
13 your declaration, you refer to an open clinical
14 trial that you're working on.

15 Could you just tell me about that
16 clinical trial, how it's designed and what it's
17 studying?

18 MS. BORELLI: Objection; compound, vague.

19 THE WITNESS: In this particular clinical
20 trial, we are looking at the feasibility and
21 acceptability of the process of understanding
22 access to mental health care for transgender
23 people.

24 We are also testing a particular type of
25 psychotherapy and we're testing longitudinally the

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1 effects of that psychotherapy.

2 Q. (BY MR. WILSON) So can you describe the
3 clinical trial, how the control group is set up and
4 the test group?

5 MS. BORELLI: Objection; compound.

6 THE WITNESS: In an open clinical trial --
7 the definition of an open clinical trial is that
8 there is not a control group. So there is only one
9 group that's included in an open clinical trial,
10 and that's to test feasibility and acceptability.

11 Q. (BY MR. WILSON) Thanks for clarifying
12 that.

13 Can you explain to me why clinical
14 trials that have a control group, why that is
15 preferred, if you agree that it is preferred?

16 MS. BORELLI: Objection; assumes facts not
17 in evidence, speculation.

18 THE WITNESS: In this particular instance,
19 we conducted a randomized controlled trial prior to
20 this particular open clinical trial, and there were
21 components and research questions that we had based
22 on the randomized controlled trial that led to
23 research questions that were only focused on one
24 particular group.

25 In terms of, for example, testing a

1 specific type of psychotherapy training module and
2 testing the feasibility and acceptability of the
3 research process, you don't need comparison groups
4 for those types of research questions.

5 For the randomized controlled trial that
6 we conducted previous to that, we did have
7 questions regarding the effectiveness and efficacy
8 of one treatment compared to another. So a lot of
9 these designs just depend on the types of questions
10 that you're testing.

11 Q. (BY MR. WILSON) Thank you.

12 I'm thinking just a little bit more
13 generally.

14 Apart from that particular study that
15 you were doing, why is it that researchers like to
16 use controlled trials as opposed to open trials?

17 MS. BORELLI: Objection; vague, assumes
18 facts not in evidence.

19 THE WITNESS: My experience isn't that
20 researchers like to use one over the other. It
21 really just depends on what the research questions
22 are and what you're trying to test.

23 Q. (BY MR. WILSON) What would be the
24 advantage of a controlled clinical trial?

25 MS. BORELLI: Objection; assumes facts not

1 in evidence, vague.

2 THE WITNESS: Honestly, it depends on what
3 the research question is. Like I said, in
4 questions where you're trying to determine is one
5 treatment better than another treatment -- for
6 example, in the randomized controlled trial that we
7 did, we were trying to determine: Is one type of
8 psychotherapy more effective than another type of
9 psychotherapy?

10 You need to be able to randomize for
11 that particular design, but for the open clinical
12 trial, we weren't testing the efficacy of a
13 specific type of treatment. We were testing the
14 feasibility and acceptability of the process.

15 So there isn't one design that's
16 necessarily going to be better than the other in
17 general. Really what you need to do is say: What
18 is the research question at hand, and what's going
19 to be the best design for those research questions?

20 Q. (BY MR. WILSON) So supposing all else
21 being equal, if we had a given research question
22 that could be studied through a randomized
23 controlled trial or an open trial, would you agree
24 that the controlled trial is preferred?

25 MS. BORELLI: Objection; vague, compound,

1 assumes facts not in evidence, misstates testimony,
2 calls for a hypothetical, speculative.

3 MR. WILSON: You gave me the whole laundry
4 list there.

5 MS. BORELLI: I did.

6 Q. (BY MR. WILSON) You can answer, though,
7 Dr. Budge.

8 A. Yeah. My previous testimony was such
9 that the research design depends on what the
10 research question is at hand.

11 Q. I'm saying: Suppose if you have a
12 situation where the research question can be
13 studied through either form, is the randomized
14 controlled trial preferred?

15 MS. BORELLI: Objection; calls for
16 speculation, assumes facts not in evidence.

17 THE WITNESS: My answer remains the same.
18 Really -- the design really depends on what the
19 research question is and what's being tested.

20 Q. (BY MR. WILSON) So I guess the question
21 maybe would be: You do agree that study design is
22 important for the reliability of a study; is that
23 correct?

24 MS. BORELLI: Objection; vague, asked and
25 answered.

1 THE WITNESS: In general, my statement would
2 be that reliability is an important component of
3 research and, I would say, again, it depends on the
4 exact research design and what the questions are at
5 hand.

6 Q. (BY MR. WILSON) And you agree that
7 researchers should design their studies to be as
8 reliable as possible to study the given question
9 they're confronting; is that correct?

10 MS. BORELLI: Objection; misstates
11 testimony, calls for speculation, vague.

12 THE WITNESS: I agree that quantitative
13 studies should ensure that there is reliability at
14 hand. Like I said, there are different kinds of
15 research questions, qualitative research, for
16 example, and some other components that use
17 different methods for rigor in their methodology.
18 So a lot of it does depend on what the research
19 questions are and what the design is.

20 Q. (BY MR. WILSON) And the conclusions that
21 we can draw from research should be in proportion
22 to the reliability of the processes that led to it;
23 is that correct?

24 MS. BORELLI: Objection; vague, calls for
25 speculation, lacks foundation.

1 THE WITNESS: Yeah. I think we might be
2 using different definitions of reliability.

3 So, you know, in my expertise and the
4 way that I was trained -- you know, I have a
5 master's degree in educational psychology, I have a
6 Ph.D. in counseling psychology, I have years of
7 experience learning the process of conducting
8 qualitative and quantitative research, and there
9 are really specific ways of ensuring methodological
10 rigor in all aspects of research.

11 Reliability is one particular component
12 that can be included in certain components of
13 quantitative research. But I think -- you know,
14 and what I would say is that scientists do need to
15 have methodological rigor in their process of how
16 they're conducting research.

17 Q. (BY MR. WILSON) So is it fair to say
18 that you don't believe that reliability is
19 essential to your research? Is that correct?

20 MS. BORELLI: Objection; misstates
21 testimony.

22 THE WITNESS: That's not correct. That's
23 not what I'm saying.

24 Q. (BY MR. WILSON) So you do believe that
25 reliability is essential to your research?

1 MS. BORELLI: Objection; misstates
2 testimony --

3 Q. (BY MR. WILSON) Is that correct?

4 MS. BORELLI: -- asked and answered, vague.

5 THE WITNESS: I already answered the
6 question. Reliability can be an essential
7 component and a lot of it depends on what the
8 research design and the questions are.

9 Q. (BY MR. WILSON) Well, if it can be
10 essential, then it is not necessarily essential; is
11 that correct?

12 MS. BORELLI: Objection; calls for
13 speculation, vague, asked and answered.

14 THE WITNESS: I answered the question
15 already.

16 Q. (BY MR. WILSON) Is reliability always
17 essential to your research?

18 MS. BORELLI: Objection; calls for
19 speculation, vague.

20 THE WITNESS: It depends on the type of
21 research and the research questions.

22 Q. (BY MR. WILSON) So your answer would be
23 no, it is not always essential to your research; is
24 that correct?

25 MS. BORELLI: Objection; misstates

1 testimony, argumentative, asked and answered.

2 THE WITNESS: In the quantitative studies
3 that I have conducted, all of them have included
4 reliability.

5 Q. (BY MR. WILSON) But it is not essential
6 to all of your research; is that correct?

7 MS. BORELLI: Objection; vague, asked and
8 answered, argumentative.

9 Q. (BY MR. WILSON) Is that correct?

10 MS. BORELLI: Same objections.

11 THE WITNESS: I would say, for the
12 qualitative research that I conduct, even though
13 "reliability" isn't a term that we use for
14 qualitative research, and the qualitative research
15 is conducted in the most methodologically rigorous
16 way that is possible and that it follows all of the
17 journal article reporting standards and all of the
18 scientific methodologies that are included within
19 that.

20 MR. WILSON: Tara, just to interject, I've
21 been giving you a bit of latitude on sort of the
22 speaking objections. I don't think they're proper.
23 I think objection is going to be sufficient to
24 preserve your record, and I just want to make sure
25 that we're staying away from coaching the witness

1 from how to answer.

2 I certainly understand why you're saying
3 those things, but I'd like to ask that we just keep
4 that to "objection" going forward.

5 MS. BORELLI: Look, let me object to that
6 characterization. Improper speaking objections,
7 coach the witness, I'm not doing anything of the
8 sort. I have a duty to preserve the objections.
9 I'm stating them simply and clearly to make sure
10 that they're preserved.

11 MR. WILSON: I think only objections to the
12 form would be the issue here, and all that's
13 required to preserve the objection to the form is
14 to say "objection" or "object to the form," and
15 that's the only thing that you need to preserve
16 here.

17 So I would ask that you limit your
18 objections to just saying "objection."

19 MS. BORELLI: Lincoln, identifying the
20 nature of the objection is proper. We're allowed
21 to articulate the problem, and there are Courts
22 that often require that you articulate the basis of
23 the objection, and so I want to make sure that I've
24 done so. I'm doing so simply and clearly. It's
25 not an improper speaking objection.

1 MR. WILSON: We'll agree to disagree on
2 that, but I think that we can progress through this
3 deposition in a friendly and collegial manner.

4 MS. BORELLI: I agree.

5 MR. WILSON: Good.

6 Q. (BY MR. WILSON) So would you agree that
7 for preserving the reliability of research, it's
8 important to be able to account for the role of
9 chance?

10 MS. BORELLI: Objection; vague.

11 THE WITNESS: In quantitative research, we
12 do understand that they're -- and look at the level
13 of chance that can be included via statistical
14 processes.

15 Q. (BY MR. WILSON) And would you also agree
16 that for scientific research it's important to
17 account for the role of bias?

18 MS. BORELLI: Objection; vague.

19 THE WITNESS: I do think it's important to
20 account for specific types of bias and to
21 understand how bias can impact the research
22 process.

23 Q. (BY MR. WILSON) And do you agree that
24 it's also important to account for the role of
25 confounding in scientific research?

1 MS. BORELLI: Objection; vague.

2 THE WITNESS: In most of the quantitative
3 research that I have conducted, confounding
4 variables are included as a part of the process
5 that we look into. It is important to understand
6 variables that can impact different components of
7 variability statistically.

8 Q. (BY MR. WILSON) Would you agree that
9 observational studies are lower-quality evidence
10 than clinical trials?

11 MS. BORELLI: Objection; vague, compound,
12 assumes facts not in evidence.

13 THE WITNESS: I think depending on what the
14 research questions are at hand and what kind of
15 ethical processes can take place. It depends on
16 what kinds of research design that you can conduct.
17 There are some questions and some processes that
18 can't be conducted via randomized controlled trial,
19 either ethically or just based on research design.

20 So my answer is that it depends on what
21 the research question is based on the type of
22 research design that needs to be used.

23 Q. (BY MR. WILSON) Would you agree that
24 clinical trials of all the available tools are the
25 best at eliminating the role of chance, bias, and

1 confounding?

2 MS. BORELLI: Objection; vague, compound,
3 assumes facts not in evidence.

4 THE WITNESS: Depending on the type of
5 research question that is at hand, randomized
6 controlled trials can provide very important
7 information regarding the effectiveness and
8 efficacy of certain types of treatments, but it
9 also -- like I said, it depends. There are lots of
10 research questions that can't be discussed by
11 randomized controlled trials.

12 For example, like, do transgender kids
13 experience harm in bathrooms? That's not something
14 that can actually be studied via randomized
15 controlled trial. So my answer is that it kind of
16 depends on what the research question is.

17 Q. (BY MR. WILSON) Would you agree that
18 surveys are lower-quality evidence than
19 observational studies as a scientific matter?

20 MS. BORELLI: Objection; vague, calls for
21 speculation.

22 THE WITNESS: My answer is such that the
23 research questions that are being asked need to
24 follow -- you know, need to be followed by the most
25 appropriate methodology. So if a research question

1 is specific to some -- to an observational study or
2 longitudinal study, then those are the designs that
3 need to be used.

4 If there is a question regarding
5 effectiveness or efficacy of treatments, then
6 designs related to that will be used.

7 So my answer is that it kind of -- it
8 just depends on what the research questions are.

9 Q. (BY MR. WILSON) Can surveys be used to
10 effectively test a hypothesis?

11 MS. BORELLI: Objection; vague, calls for
12 speculation.

13 THE WITNESS: In general, surveys can be
14 used to test hypotheses.

15 Q. (BY MR. WILSON) Surveys are less
16 effective than observational studies at controlling
17 for the risks of chance, bias, and confounding; is
18 that correct?

19 MS. BORELLI: Objection; vague, compound,
20 assumes facts not in evidence, calls for
21 speculation.

22 THE WITNESS: I would say it depends on what
23 the study -- what the research question is and
24 what's being studied.

25 Q. (BY MR. WILSON) And when you referred to

1 "qualitative evidence" before, would you include
2 surveys as a form of qualitative evidence?

3 MS. BORELLI: Objection; vague, misstates
4 testimony.

5 THE WITNESS: No. Typically surveys are not
6 qualitative research.

7 Q. (BY MR. WILSON) They have a qualitative
8 component; is that correct?

9 MS. BORELLI: Objection; vague.

10 THE WITNESS: Unless we have a different
11 understanding of what this is.

12 So in my experience, qualitative
13 research is research where open-ended questions are
14 being asked.

15 And in general, surveys are closed-ended
16 questions that usually include numbers.

17 Q. (BY MR. WILSON) Thanks for that
18 clarification.

19 Let's move on to paragraph 19 of your
20 declaration, and just let me know when you're
21 there.

22 A. I'm there.

23 Q. Great.

24 So paragraph 19 says: The term "gender
25 identity" is a well-established concept in

1 psychology and medicine referring to a person's
2 internal or psychological sense of having a
3 particular gender. All human beings have a gender
4 identity. People usually begin to explore and
5 understand their gender identity at around the age
6 of 3, with some variation, although some
7 transgender individuals may not begin to recognize
8 or express their gender identity until later in
9 life.

10 Apart from a small hiccup, did I read
11 that correctly?

12 A. Yes, what I heard was correct.

13 MR. WILSON: Okay. Great.

14 MS. BORELLI: Lincoln.

15 MR. WILSON: Yes.

16 MS. BORELLI: Since we're moving on to a new
17 paragraph and new topic, does it make sense to take
18 a short break? We'd appreciate it.

19 MR. WILSON: Yeah, that's fine.

20 MS. BORELLI: Great.

21 THE VIDEOGRAPHER: Okay. So the time is
22 8:51 a.m. Mountain Time, and we are off the record.

23 (A recess was taken from 8:51 a.m. to 9:03 a.m.)

24 THE VIDEOGRAPHER: All right. So we are
25 recording. The time is 9:03 a.m. Mountain Time,

1 and we are back on the record.

2 Q. (BY MR. WILSON) Dr. Budge, I'd actually
3 like to jump ahead to paragraph 22 of your
4 declaration.

5 It says: Every individual sex is
6 multifaceted and composed of many distinct
7 biologically-influenced characteristics, including
8 but not limited to: Chromosomal make-up, hormones,
9 internal and external reproductive organs,
10 secondary sex characteristics, and gender identity.

11 Where there is a divergence between
12 these characteristics, gender identity is the most
13 important and determinative factor.

14 Did I read that correctly?

15 A. That's correct.

16 Q. If someone wanted to design an
17 experiment to test whether that statement was true,
18 how would they design that experiment?

19 MS. BORELLI: Objection; vague, calls for
20 speculation.

21 THE WITNESS: So there are multiple
22 components that are included in that paragraph, so
23 I am -- would you like me to share different types
24 of research questions that are answering different
25 components of that paragraph?

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1 Q. (BY MR. WILSON) No. I'm wanting to
2 know -- let's just take the first sentence.

3 That first sentence is a statement,
4 correct?

5 MS. BORELLI: Objection; vague, compound.

6 Q. (BY MR. WILSON) It ends in a period and
7 it's a statement; is that correct?

8 MS. BORELLI: Same objections.

9 THE WITNESS: Yes, it's a sentence.

10 Q. (BY MR. WILSON) And if we wanted to test
11 whether that statement was false with a scientific
12 procedure, how would we design that scientific
13 procedure?

14 MS. BORELLI: Objection; vague, calls for
15 speculation, compound.

16 THE WITNESS: So there are a lot of
17 different ways to test this. Would you like for me
18 to share multiple components?

19 Q. (BY MR. WILSON) Why don't you go ahead
20 and share one and we can talk about it.

21 A. For the whole statement or for
22 components of it?

23 MS. BORELLI: Just restating objections that
24 this is vague and compound, calls for speculation.

25 Q. (BY MR. WILSON) Go ahead.

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1 A. Oh, I'm sorry, I was clarifying a
2 question. So I guess I'll just choose a component
3 of this.

4 So there are pieces related to hormones,
5 for example, that you can test what somebody's
6 hormone levels are. So you can have questions
7 related to what are the levels of hormones in
8 someone's body, and then you can go about testing
9 that question, for example.

10 Regarding gender identity, you can also
11 go about different components related to the gender
12 dysphoria diagnosis and use measures that are
13 specific to gender dysphoria to be able to
14 determine levels of gender dysphoria that are
15 included within gender identity for people who are
16 transgender.

17 You know, there are lots of different
18 pieces that are included in this particular
19 paragraph.

20 Q. I think that's a separate question.
21 That seems to be about how do we measure those
22 things, not how do we know that those things
23 determine sex.

24 If you're asserting that these things
25 determine sex, how do we test whether that's true?

1 MS. BORELLI: Objection; misstates
2 testimony, vague.

3 THE WITNESS: I've included the definition
4 that is used in every medical -- major medical and
5 psychological organization. These statements are
6 based on scientific and psychological scientific
7 inquiry.

8 This is a broad component, so there are
9 a lot of different studies that go into the factors
10 of making up this particular definition.

11 So I'm using the large authoritative
12 bodies that describe these pieces in indicating
13 what I shared here.

14 Q. (BY MR. WILSON) Hold on for just a
15 second here.

16 So is it your testimony that this is a
17 widespread accepted definition of sex?

18 MS. BORELLI: Objection; misstates
19 testimony, vague.

20 THE WITNESS: My testimony is such that this
21 definition is based on the major medical and
22 psychological organizations and how they describe
23 these components.

24 Q. (BY MR. WILSON) And you don't cite any
25 support for this statement in this paragraph, do

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1 you?

2 MS. BORELLI: Objection; vague, misstates
3 the document.

4 THE WITNESS: In this particular paragraph,
5 I don't provide a citation.

6 Q. (BY MR. WILSON) Now, you referred to --
7 in your declaration, to the concept of sex assigned
8 at birth; is that correct?

9 A. That's correct.

10 Q. What would you say to someone who said
11 that, "Well, we took a NIP test of a fetus in utero
12 and we determined the fetus's sex in utero," is
13 that something that you believe to be a correct
14 scientific process?

15 MS. BORELLI: Objection; vague, compound,
16 calls for speculation.

17 THE WITNESS: My understanding of the NIP
18 test is that you can get different types of
19 chromosomes from that test, so that -- chromosomes
20 are considered a component of sex.

21 Q. (BY MR. WILSON) So if someone said,
22 based on a NIP test, that they conclusively
23 determined the gender of the fetus -- I'm sorry,
24 conclusively determined the sex of the fetus based
25 on the test, would you say that was not correct?

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1 MS. BORELLI: Objection; vague, assumes
2 facts not in evidence.

3 THE WITNESS: I would say that there are a
4 lot of different components that go into sex, and
5 so chromosomes are considered one component.

6 Q. (BY MR. WILSON) And you don't cite
7 anything for that in your report, do you?

8 MS. BORELLI: Objection; vague, misstates
9 the document.

10 THE WITNESS: I provide a lot of citations
11 in this particular declaration that are supportive
12 of my conclusions and what I opine on.

13 Q. (BY MR. WILSON) But you don't cite
14 anything in support of this concept of sex assigned
15 at birth, do you?

16 MS. BORELLI: Objection; asked and answered.

17 THE WITNESS: The citations that I include
18 talk about sex assigned at birth, and it's a
19 concept that's discussed by all of these major
20 medical and psychological organizations. It's a
21 concept that is well-known and well-understood
22 within these organizations and within our broader
23 field and how we understand how this works.

24 Q. (BY MR. WILSON) I'd like you to take a
25 look at paragraph 34 of your declaration.

1 It says: For transgender people, social
2 transition can be an important aspect of treatment
3 to reduce the symptoms of gender dysphoria. As
4 part of a social transition, the individual will
5 typically, among other things, use a name and
6 pronouns congruent with their gender identity,
7 dress and groom in a manner typically associated
8 with their gender identity and use sex-designated
9 facilities, such as restrooms, that align with
10 their gender identity.

11 To be clinically effective at
12 alleviating the distress associated with gender
13 dysphoria, the social transition must be respected
14 consistently across all aspects of a transgender
15 individual's life, for example, at home, in school,
16 and at work.

17 Did I read that correctly?

18 A. That's correct.

19 Q. And you don't cite any studies in
20 support of the statements in this paragraph, do
21 you?

22 MS. BORELLI: Objection; vague, misstates
23 the document.

24 THE WITNESS: I provide citations in the
25 paragraph below. So this paragraph, 35, was kind

1 of an overarching component that's related to the
2 science and understanding of social transition, and
3 then I include more context and information
4 throughout the document, but even specifically in
5 the paragraph below it.

6 Q. (BY MR. WILSON) Would you agree that
7 sometimes gender dysphoria desists?

8 MS. BORELLI: Objection; vague, calls for
9 speculation.

10 THE WITNESS: In my clinical experience, I
11 have not -- I have not worked with an adolescent
12 who has identified as transgender and who has
13 detransitioned.

14 Q. (BY MR. WILSON) Have you had in your
15 clinical experience anyone who identified as
16 transgender and their gender dysphoria desisted?

17 MS. BORELLI: Objection; vague, compound.

18 THE WITNESS: In my clinical experience,
19 when somebody -- so there is the experience of
20 someone who is trans who then starts -- let's say,
21 for example, starts to go through a social
22 transition and maybe goes through some type of
23 medical transition, like hormone therapy, their
24 gender dysphoria would decrease because that's
25 being treated.

1 So when the gender dysphoria is being
2 treated, it does decrease, and that's what we know
3 from the data. So I have had that experience
4 happen.

5 Q. (BY MR. WILSON) Let me rephrase or
6 clarify terms by what I mean by "desist" and maybe
7 you can tell me it's a different term.

8 A. Okay.

9 Q. Not that someone feels that -- not that
10 their gender dysphoria abates because they feel
11 that they are now congruent with what they believe
12 to be their gender identity, but rather, that they
13 feel -- that they no longer have those feelings
14 because they feel they're living consistent with
15 what you call their sex assigned at birth.

16 That's what I'm referring to
17 by "desist?" Are we clear on the definition that
18 I'm using there?

19 MS. BORELLI: Objection; vague.

20 THE WITNESS: Yes.

21 Q. (BY MR. WILSON) Okay. And is that
22 something that you have seen in your clinical
23 experience?

24 A. I have not --

25 MS. BORELLI: Objection; vague, compound.

1 Q. (BY MR. WILSON) I'm sorry?

2 A. I have not had any patients who have
3 desisted or detransitioned.

4 Q. And you are aware that desistance does
5 occur; is that correct?

6 MS. BORELLI: Objection; vague, assumes
7 facts not in evidence.

8 THE WITNESS: So in my experience of
9 understanding desistance within the scientific
10 literature, is that when it was first brought up in
11 the scientific literature, it was talked about
12 regarding children who did not actually identify as
13 transgender. For many of them, they were children
14 who were gender-nonconforming but were classified
15 in some way, shape, or form as transgender in the
16 literature, even though a lot of these kids didn't
17 actually identify as transgender or that, you know,
18 the previous DSM diagnoses were used, and those
19 were a lot different from the ones that we use
20 right now.

21 And so some of the data that talk about
22 this desistance actually does not capture, for the
23 most part, transgender children and adolescents.
24 And so when I'm answering your question, I'm
25 thinking about that scientific literature in mind.

1 Q. (BY MR. WILSON) So in your clinical
2 practice, in what percentage of the cases where
3 someone comes to you with gender dysphoria who is a
4 minor, in what percentage of the cases do you
5 recommend social transition?

6 MS. BORELLI: Objection; vague, compound.

7 THE WITNESS: In my experience, social
8 transition isn't something that's recommended
9 necessarily. It's something that where when a
10 transgender adolescent comes in to the office and
11 starts indicating, you know, "Hey, this isn't what
12 my identity is, this is where my distress is, this
13 is how all of my pieces can fit within this gender
14 dysphoria diagnosis," then based on -- you know, in
15 conversations with caregivers and with other
16 supportive people, we go through the process of
17 discussing with that transgender youth and the
18 family what the process will look like in terms of
19 ensuring that this young person's distress can be
20 decreased.

21 So I would say, you know, in my
22 experience, social transition is something that has
23 been very effective for all of the clients who have
24 come in and indicated that they're -- and who are
25 transgender, and so -- but that social transition

1 will be specific to the family and to the specific
2 processes that are needed.

3 Q. (BY MR. WILSON) Have you ever had a case
4 where someone came to you and they had gender
5 dysphoria and you said, "Social transition is not
6 appropriate here"?

7 MS. BORELLI: Objection; vague.

8 THE WITNESS: In my clinical experience, all
9 of the clients who I've worked with who are
10 transgender have gone through a social transition
11 process, or at least were needing to go through
12 that process, and sometimes they might have been
13 barred from that process if, for example, you know,
14 they didn't have supportive families or things like
15 that.

16 But maybe just to say that in the
17 instances where transgender adolescents or adults
18 who I've worked with have needed to social
19 transition but perhaps maybe couldn't have because
20 of social components that were barring them from
21 moving forward.

22 Q. (BY MR. WILSON) Now, if we wanted to
23 study how a transgender identity adheres to an
24 adolescent, could we conduct a cohort study where
25 we followed a group of people over time to see if

1 their gender identity remained constant over time?

2 MS. BORELLI: Objection; vague, compound,
3 assumes facts not in evidence.

4 THE WITNESS: In my experience with the
5 scientific literature -- so there are a lot of
6 researchers who are researching transgender
7 adolescents longitudinally, and in fact, you know,
8 a lot of these kind of larger-scale clinicians that
9 work with transgender children and adolescents are
10 following a lot of these patients through the
11 process of transitioning.

12 And so we do have data regarding the
13 longitudinal nature and aspect of transgender
14 adolescents' identity processes and their mental
15 health and other outcomes that follow.

16 Q. (BY MR. WILSON) Would it be possible to
17 study whether that transgender -- oh, sorry, let me
18 rephrase that.

19 Would it be possible to study whether
20 that gender dysphoria would desist over time in the
21 absence of any clinical intervention?

22 MS. BORELLI: Objection; vague, compound,
23 assumes facts not in evidence.

24 THE WITNESS: There are some studies that
25 have followed transgender adolescents regarding if

1 they have been able to receive any kind of
2 treatment or not, and in those studies, you know,
3 studies follow youth who have both received
4 treatment and some youth who did not or were not
5 able to. And so there are some study designs that
6 would be able to determine what the process of a
7 transgender adolescent's trajectory would be, like,
8 mental health processes.

9 Q. (BY MR. WILSON) In fact, there have been
10 11 of those studies, haven't there?

11 MS. BORELLI: Objection; vague, assumes
12 facts not in evidence.

13 THE WITNESS: I can't tell you exactly how
14 many there are. In fact, I think that there are
15 probably more than that. So I'm not sure where
16 you're getting that number from.

17 Q. (BY MR. WILSON) And in the cohort
18 studies that have followed youth with gender
19 dysphoria without intervention, in each one of
20 those studies, the majority of the patients have
21 seen their gender dysphoria desist; is that
22 correct?

23 MS. BORELLI: Objection; vague, compound,
24 assumes facts not in evidence, lacks foundation.

25 THE WITNESS: That is not my understanding

1 of the data.

2 Q. (BY MR. WILSON) There are studies that
3 follow those people with gender dysphoria and that
4 have reported that their gender dysphoria desists
5 over time without intervention; is that correct?

6 MS. BORELLI: Objection; vague, compound,
7 assumes facts not in evidence.

8 THE WITNESS: My understanding of those
9 studies is that the majority of transgender youth
10 who are followed who do not receive any kind of
11 social transition or medical intervention, that
12 their distress remains or increases over time.
13 That is -- that's what the data typically say.

14 Q. (BY MR. WILSON) Are you aware of studies
15 like those that I've described where the gender
16 dysphoria desists over time for the majority of the
17 adolescent patients?

18 MS. BORELLI: Objection; vague, compound,
19 assumes facts not in evidence.

20 Lincoln, if we're going to continue
21 going down this line of questioning, we would ask
22 that you present the study or studies that you're
23 referring to so that Dr. Budge can review them.
24 Lacks foundation.

25 MR. WILSON: I might present them. At this

1 point it's just a question of whether Dr. Budge is
2 aware of those studies.

3 MS. BORELLI: Again, object to the vagueness
4 of that question without any study having been
5 identified.

6 THE WITNESS: I am not aware of any study
7 that has followed transgender adolescents who never
8 received any kind of social transition or medical
9 transition treatment whose gender identity was --
10 you know, the majority of whom were no longer
11 transgender anymore. I'm not aware of any study
12 that says that.

13 Q. (BY MR. WILSON) Are you aware of the
14 Lebovitz 1972 study on: Feminine Behavior in Boys:
15 Aspects of its outcome?

16 MS. BORELLI: Objection. We'd restate the
17 request to present the study if you're going to ask
18 her questions about it. Lacks foundation.

19 MR. WILSON: I'm just asking if she's aware
20 of it.

21 THE WITNESS: I am not aware of a
22 50-year-old study on what you described.

23 Q. (BY MR. WILSON) Are you aware of the
24 study by Zuger in 1978, Effeminate behavior present
25 in boys from childhood: Ten additional years of

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1 follow-up?

2 MS. BORELLI: Same objections.

3 THE WITNESS: Is this Zucker, Z-u-c-k-e-r?

4 Q. (BY MR. WILSON) Z-u-g-e-r.

5 A. Okay.

6 No.

7 Q. Are you aware of the Money study from
8 1979, Homosexual Outcome of Discordant Gender
9 Identity/Role in Childhood: Longitudinal
10 Follow-Up?

11 MS. BORELLI: Same objections.

12 THE WITNESS: I'm aware of that study.

13 Q. (BY MR. WILSON) It's not cited in your
14 report, though, is it?

15 A. There's no way for any expert witness to
16 indicate hundreds of thousands of studies,
17 especially ones that are old and that actually
18 don't fit the questions that are at hand.

19 Q. Are you aware that in the Money study,
20 out of nine patients with gender dysphoria, all
21 nine identified as gay at the conclusion of the
22 study, and not as trans?

23 MS. BORELLI: Objection; assumes facts not
24 in evidence, lacks foundation.

25 Again, if you continue asking questions

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1 about these articles, we would request you give her
2 an opportunity to review the articles.

3 MR. WILSON: She said she was familiar with
4 this study, so I'm asking questions about it.
5 We'll see where it goes.

6 THE WITNESS: I would need to see -- that's
7 exactly what I was about to say. Sorry. I would
8 need to see this one.

9 Q. (BY MR. WILSON) Is it correct that the
10 Money study is not cited in your declaration?

11 A. That's correct.

12 Q. Would a study that showed that patients
13 who previously identified as trans ultimately all
14 identified as gay be relevant to the question of
15 desistance?

16 MS. BORELLI: Objection; vague, assumes
17 facts not in evidence, lacks foundation.

18 We would request that you present a copy
19 of the study.

20 THE WITNESS: These studies are very old,
21 and they don't actually talk about the concepts in
22 the way that we understand them right now. And
23 even -- so these studies that I've mentioned that
24 talk about desistance, again, like I said, the way
25 that they categorized people in terms of identity

1 is very different than how we understand it now.

2 And so the studies that you're citing
3 tend to have a very different way of talking about
4 gender and talking about these processes, just by
5 way of them being outdated.

6 Q. (BY MR. WILSON) Are you aware of the
7 2021 study by Singh titled: A Follow-Up Study of
8 Boys with Gender Identity Disorder, Frontiers in
9 Psychiatry?

10 MS. BORELLI: Objection; vague.

11 We request that you present the study.

12 MR. WILSON: I'm just asking if she's aware
13 of it first.

14 MS. BORELLI: Same objections.

15 THE WITNESS: I would need to see it to see
16 if it's one that I've read.

17 Q. (BY MR. WILSON) You would not classify a
18 2021 study as an old study, would you?

19 MS. BORELLI: Objection; assumes facts not
20 in evidence, lacks foundation.

21 THE WITNESS: In general, no, I would not
22 call a 2021 study old.

23 Q. (BY MR. WILSON) And would a study that
24 in following 139 patients in 2021 in which 122
25 patients identified as cis at the conclusion of the

1 study, would that be relevant to the question of
2 desistance of gender dysphoria?

3 MS. BORELLI: Objection.

4 Lincoln, we're getting into substantive
5 questions about the article. We have asked that
6 you mark the article and present the witness with
7 it. If she's going to answer further questions
8 about this article, it needs to be marked an
9 exhibit. She needs to be given an opportunity to
10 review it.

11 MR. WILSON: I'm just asking if that would
12 be relevant to the outcome here.

13 MS. BORELLI: Lincoln, that question builds
14 so many assumptions into it. I just don't know how
15 she can accurately answer that. She said she would
16 like to see the article. We would ask that you
17 mark it and present it to the witness.

18 MR. WILSON: Let me ask the question, and
19 we'll see if we want to discuss it further.

20 MS. BORELLI: So just to be clear, you're
21 refusing to --

22 MR. WILSON: I'm not refusing to present it.
23 Please don't interrupt me while I'm in the middle
24 of a sentence.

25 Q. (BY MR. WILSON) I'm going to ask the

1 question: Would a 2021 study showing that the
2 majority of patients no longer identified as trans
3 at the conclusion be relevant to the question of
4 desistance?

5 MS. BORELLI: Objection.

6 Lincoln, we've allowed a lot of leeway.
7 You've asked questions about awareness of articles.
8 You're now asking about the substance of the
9 article. I've requested several times that you
10 present -- mark the study and present it to the
11 witness so that she can look at it and answer that
12 question with the information in front of her.

13 We would ask that you mark -- is there a
14 reason that you don't seem to want to mark it and
15 present it to the witness?

16 MR. WILSON: I'm getting there --

17 MS. BORELLI: It's a reasonable request.

18 MR. WILSON: I'm getting there. I'd like an
19 answer to the question of whether this would be
20 relevant.

21 MS. BORELLI: Objection. I just don't know
22 how she can answer that without seeing the study.

23 MR. WILSON: I'm not appreciating these
24 speaking objections to the question I'm asking.

25 Q. (BY MR. WILSON) So the question is:

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1 Would this be relevant?

2 MS. BORELLI: Objection; calls for
3 speculation, hypothetical, lacks foundation,
4 assumes facts not in evidence.

5 THE WITNESS: I would need to see the
6 article to be able to answer your question.

7 Q. (BY MR. WILSON) Dr. Budge, you were
8 designated as -- you were designated as an expert
9 in the Bridge case in Oklahoma; is that correct?

10 A. That's correct.

11 Q. And Dr. Cantor served a rebuttal to your
12 report in that case, didn't he?

13 A. That's correct.

14 Q. Do you recall that he identified all
15 these studies in that report?

16 MS. BORELLI: Objection; vague.

17 THE WITNESS: I would need to see his
18 report.

19 Q. (BY MR. WILSON) So I'm going to put a
20 pin in this for the moment and we might come back
21 to it.

22 Can we take a look at paragraph 39 of
23 your report -- or your declaration, and let me know
24 when you're there.

25 A. Okay.

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1 Q. Paragraph 39 says: Before gender
2 identity and gender dysphoria were well understood
3 by the medical and psychological communities, there
4 were attempts to use psychotherapy to try to change
5 the individual's gender identity to match their sex
6 assigned at birth. This has been referred to as
7 "conversion" or "reparative therapy" in much of the
8 academic or clinical literature. Such efforts were
9 found to be ineffective and harmful and are
10 therefore now considered unethical, and their use
11 on minors is now illegal in numerous states.

12 Did I read that correctly?

13 A. That's correct.

14 Q. This paragraph doesn't cite any support
15 for these assertions, does it?

16 MS. BORELLI: Objection; vague.

17 THE WITNESS: I do not include any citations
18 in this particular paragraph.

19 However, the -- a lot of the information
20 that I include throughout the declaration is
21 supportive of this, especially specific types of
22 citations, like the James, et al., study.

23 So there are a lot of studies that I
24 cite in this particular document that support this,
25 and this is also part of my clinical experience as

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1 well.

2 Q. (BY MR. WILSON) And when it says that
3 "such efforts were found to be ineffective and
4 harmful," it doesn't say who found them to be
5 ineffective and harmful, does it?

6 MS. BORELLI: Objection; argumentative.

7 THE WITNESS: I didn't provide that
8 information here. The American Psychological
9 Association, for example, has published a full
10 statement with guidelines and information about the
11 unethical nature of conversion or reparative
12 therapy, and many other organizations have followed
13 in suit.

14 But the American Psychological
15 Association is one of the primary sources I use in
16 terms of rigor to the data and in how that process
17 is assessed.

18 Q. (BY MR. WILSON) And you mentioned that
19 these therapies are illegal in numerous states,
20 correct?

21 MS. BORELLI: Objection; misstates the
22 document.

23 Q. (BY MR. WILSON) The document says:
24 These therapies are illegal in numerous states.

25 Is that correct?

1 A. It says: Their use on minors is now
2 illegal in numerous states.

3 Q. I'm sorry, that is correct. I didn't
4 mean to miss the "on minors" clause.

5 So, Dr. Budge, you believe that in --
6 there are certain circumstances where surgical
7 therapies are appropriate for minors with gender
8 dysphoria; is that correct?

9 MS. BORELLI: Objection; misstates
10 testimony, calls for speculation.

11 THE WITNESS: In my clinical experience,
12 surgeries on minors are pretty rare and not usually
13 the typical course of treatment, and that if there
14 is a surgery that is performed on a minor that's
15 related to gender-affirming care, that that is a
16 very, very specific process that that particular
17 youth and the family must go through in terms of
18 providing consent and assent and being assessed
19 regarding the psychological process underlying the
20 medical necessity for that.

21 Q. (BY MR. WILSON) You have had patients
22 where you believe that that was an appropriate
23 therapy; is that correct?

24 MS. BORELLI: Objection; vague, compound,
25 assumes facts not in evidence.

1 THE WITNESS: I have had a small number of
2 patients in which surgery was appropriate when they
3 were older minors.

4 Q. (BY MR. WILSON) And that is now illegal
5 in numerous states as well; is that correct?

6 MS. BORELLI: Objection; calls for
7 speculation and a legal conclusion.

8 THE WITNESS: When you say "that," I -- so
9 it seems my understanding is that there are some
10 states that have put forward some bans for
11 gender-affirming care for transgender youth, that
12 some of those bans are in place and some of them
13 have been paused. It depends on the state.

14 Q. (BY MR. WILSON) So I'd like to take a
15 look at paragraphs 22 and 25 of your declaration.

16 First, 22. We already talked about this
17 one. Just take a quick look at it. Can you
18 confirm that you're familiar with this paragraph
19 that we've discussed before?

20 A. Yes.

21 Q. Then paragraph 25 says that: Gender
22 dysphoria, codified in the American Psychiatric
23 Association's 2022 Diagnostic and Statistical
24 Manual of Mental Disorders Fifth Edition Text
25 Revision (DSM-5-TR), is the psychiatric diagnosis

1 for the distress associated with gender
2 incongruence. Individuals who are diagnosed with
3 gender dysphoria can experience a number of
4 different symptoms. When individuals with distress
5 related to gender incongruence do not obtain
6 competent and necessary treatment, serious and
7 debilitating psychological distress (for example,
8 suicidal ideation, substance abuse, depression,
9 anxiety, and self-harm) often occurs.

10 Did I read that correctly?

11 MS. BORELLI: Objection.

12 Lincoln, I think you may have said
13 "substance abuse" instead of "substance use."

14 MR. WILSON: I'm sorry. If I did not read
15 it correctly, I'm glad you noted that.

16 Q. (BY MR. WILSON) Apart from Tara's
17 eagle-eye read of the text there, is there anything
18 else I missed?

19 A. No.

20 Q. Okay. So what I'm trying to understand
21 is paragraph 22 describes sex as relating primarily
22 to gender identity, that someone's sex is their
23 gender identity, it's the most important and
24 determinative factor; is that correct?

25 MS. BORELLI: Objection; misstates

1 testimony.

2 THE WITNESS: So what paragraph 22 says:
3 When there's a divergence between these
4 characteristics, gender identity is the most
5 important and determinative factor.

6 Q. (BY MR. WILSON) Then paragraph 25
7 describes a condition and the treatments that you
8 maintain are necessary for that condition; is that
9 correct?

10 MS. BORELLI: Objection; misstates
11 testimony, the document speaks for itself.

12 Q. (BY MR. WILSON) You can answer.

13 A. Paragraph 25 indicates the importance
14 of, you know, obtaining competent and necessary
15 treatment for people who have the incongruence
16 that's described in paragraph 22.

17 Q. So what I'm trying to understand is:
18 Are you describing these therapies as treatments
19 for a condition that people have or as things that
20 are making them become what they are?

21 MS. BORELLI: Objection; vague, misstates
22 the testimony, compound.

23 THE WITNESS: So for the diagnosis of gender
24 dysphoria, the distress is related to the
25 incongruence. So that's how we conceptualize and

1 understand gender dysphoria, that that incongruence
2 that somebody has, it is what causes the distress,
3 not the gender identity itself.

4 Q. (BY MR. WILSON) So is that incongruence
5 a condition that needs to be treated?

6 MS. BORELLI: Objection; vague.

7 THE WITNESS: Gender dysphoria is a
8 diagnosis that can be treated with different
9 components, such as social transition and medical
10 transition procedures.

11 Q. (BY MR. WILSON) Is it primarily an
12 identity or a condition?

13 MS. BORELLI: Objection; misstates
14 testimony, vague, compound.

15 THE WITNESS: Gender dysphoria is the
16 diagnosis and transgender is the identity.

17 Q. (BY MR. WILSON) If we did a Venn diagram
18 of gender dysphoria and transgender identity, is it
19 the same circle, in your view?

20 MS. BORELLI: Objection; vague.

21 Q. (BY MR. WILSON) I know you're pretty
22 smart, so I think you know what I mean, but if you
23 don't know what I mean, let me know.

24 A. Well, as an expert in this area, what I
25 can tell you is that the gender dysphoria is the

1 actual diagnosis, and that in order to receive the
2 diagnosis, you do need to be transgender.

3 But the identity itself is not -- is not
4 the component that is what you're trying to say,
5 like, a condition. The identity is not a
6 condition, right? But the distress that's related
7 to the incongruence is the diagnosis. That's how
8 we conceptualize it.

9 Q. So is it true that the two things are
10 coextensive, that all transgender people have
11 gender dysphoria and all people with gender
12 dysphoria are transgender?

13 MS. BORELLI: Objection; vague, compound,
14 asked and answered.

15 THE WITNESS: In order to receive a
16 diagnosis of gender dysphoria, one must be
17 transgender.

18 Q. (BY MR. WILSON) And if one is
19 transgender, one should receive a diagnosis of
20 gender dysphoria.

21 Is that also correct?

22 MS. BORELLI: Objection; vague, assumes
23 facts not in evidence.

24 THE WITNESS: The majority of people who are
25 transgender, at least in my clinical practice, have

1 been diagnosed with gender dysphoria. It's
2 possible that there -- it could be a -- you know, a
3 minor -- small group of people who are transgender
4 who do not meet criteria for gender dysphoria.

5 MR. WILSON: That's a helpful clarification.

6 I think we're probably at a good place
7 for another break.

8 And, Tara, just for -- well, we can go
9 off the record, if that's all right with you.

10 MS. BORELLI: Sure.

11 THE VIDEOGRAPHER: Okay. So the time is
12 9:46 a.m. Mountain Time, and we are off the record.

13 (A recess was taken from 9:46 a.m. to 9:58 a.m.)

14 THE VIDEOGRAPHER: All right. So we are
15 recording. The time is 9:58 a.m. Mountain Time,
16 and we are back on the record.

17 Q. (BY MR. WILSON) Dr. Budge, would it be
18 fair to say that you believe in the importance of
19 gender-affirming care?

20 MS. BORELLI: Objection; vague.

21 THE WITNESS: It would be fair to say that
22 the evidence indicates that gender-affirming care
23 is the component that we attribute to improved
24 mental health and identity congruence for
25 transgender people.

1 Q. (BY MR. WILSON) And because you believe
2 in doing the things that improve those things, you
3 believe in the importance of gender-affirming care;
4 is that correct?

5 MS. BORELLI: Objection; vague, misstates
6 testimony.

7 THE WITNESS: I mean, I would say, when I
8 read the evidence and the evidence that I have seen
9 that's done in the most rigorous way and the way
10 that seems -- that focuses on all of the components
11 that are supposed to be included in scientific
12 study, that my read of the data for
13 gender-affirming care is that it is the most
14 effective treatment.

15 Q. (BY MR. WILSON) To clarify our terms,
16 when we say "gender-affirming care," we mean that
17 you would do therapies that would affirm someone's
18 gender identity, even if it is incongruent with
19 their biological sex; is that correct?

20 MS. BORELLI: Objection; vague, compound,
21 misstates testimony.

22 THE WITNESS: If there is a transgender
23 person in my office who comes to see me clinically,
24 I do affirm that transgender identity, that that's
25 something that -- you know, if they indicate that

1 they are trans, that's the process that we go
2 through in terms of using care and techniques that
3 are supportive of that identity.

4 Q. (BY MR. WILSON) You would do that for
5 minors as well as for adults; is that correct?

6 MS. BORELLI: Objection; vague.

7 THE WITNESS: Yes. If a transgender
8 adolescent comes into my office and indicates that
9 they're transgender, the -- I use similar processes
10 regarding psychotherapy techniques and also
11 assessment processes for gender-affirming care.

12 MR. WILSON: So I just sent around, via
13 e-mail, the study that you were dying to see. It's
14 Exhibit 2. So just let me know when you've got it
15 in front of you.

16 (Deposition Exhibit No. 2 was marked.)

17 MS. BORELLI: Thank you, Lincoln.

18 THE WITNESS: I have it in front of me.

19 MS. BORELLI: Actually, can I ask us just to
20 pause? I unfortunately have not received it.

21 MR. WILSON: Sorry if our Internet is slow
22 in Idaho.

23 MS. BORELLI: I suspect it's Atlanta
24 Internet.

25 All right. Thank you. I just received

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1 it.

2 MR. WILSON: Yeah.

3 Q. (BY MR. WILSON) So Kenneth Zucker is a
4 name you're familiar with in your research
5 community; is that correct, Dr. Budge?

6 A. That's correct.

7 MS. BORELLI: Objection; vague.

8 Q. (BY MR. WILSON) Are you also familiar
9 with Dr. Susan Bradley and Dr. Devita Singh?

10 MS. BORELLI: Compound.

11 THE WITNESS: I have seen both of their
12 names.

13 Q. (BY MR. WILSON) So this is a study that
14 -- it says in the first sentence of the abstract
15 that it: Reports follow-up data on the largest
16 sample to date of boys clinic-referred for gender
17 dysphoria (N equals 139) with regard to gender
18 identity and sexual orientation.

19 Did I read that correctly?

20 A. Did you include the N in there?

21 Q. I think I did.

22 A. Okay.

23 MS. BORELLI: Lincoln, I just want to pause
24 for a moment. One of our primary objections was
25 that there wasn't an ability to review it, but that

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1 also means meaningful time to review it.

2 Can we pause so that Dr. Budge can
3 familiarize herself with the study before we
4 continue with questions?

5 MR. WILSON: Why don't we say, if it's all
6 right with you, let's take a break. So I don't
7 want this time to count against us, especially
8 since there's a dispute about how time will count.
9 So let's go off the record. She can take -- you
10 can take whatever time you need, and then we'll go
11 back on. Is that okay?

12 MS. BORELLI: That's fine. Just while we're
13 on the record, before we go off, I do want to make
14 sure that we've memorialized our positions about
15 the dispute that you refer to. Let's make sure
16 that we're clear. I understand that to be
17 Plaintiff's position that the federal rules allow a
18 total of seven hours of deposition time, and our
19 position is also of course that this deposition
20 time would count against that total and that any
21 remaining time would be confined to the total of
22 seven hours minus the time spent today. That's
23 Plaintiff's position.

24 Is that the dispute that you're
25 referring to?

1 MR. WILSON: That's the dispute we're
2 referring to, and I'm going to state our position
3 super fast because I don't want to waste any time.

4 But our position is that if the witness
5 serves another report at a later stage in the case,
6 that we would be entitled to seven hours on that
7 report as well. We're not going to use our full
8 seven hours today, though, in an abundance of
9 caution in not knowing how this issue is going to
10 sort out.

11 With that, can we go off the record?

12 MS. BORELLI: I think we've preserved our
13 positions. Let's go off the record.

14 THE VIDEOGRAPHER: Okay. So the time is
15 10:05 a.m. Mountain Time, and we are off the
16 record.

17 (A recess was taken from 10:05 a.m. to 10:11 a.m.)

18 THE VIDEOGRAPHER: Okay. So we are
19 recording. The time is 10:11 a.m. Mountain Time,
20 and we are back on the record.

21 Q. (BY MR. WILSON) So, Dr. Budge, as the
22 DSM criteria for gender dysphoria have changed over
23 time, have the criteria become more broad or more
24 strict for a diagnosis?

25 MS. BORELLI: Objection; vague, compound.

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1 THE WITNESS: The criteria are more specific
2 about gender identity.

3 Q. (BY MR. WILSON) And diagnoses of gender
4 dysphoria have increased over time on the whole; is
5 that correct?

6 MS. BORELLI: Objection; assumes facts not
7 in evidence, vague.

8 THE WITNESS: We have -- so the diagnosis of
9 gender dysphoria was only introduced in the DSM-5
10 in 2013, so we only have data regarding that
11 specific diagnosis from 2013 until now.

12 Q. (BY MR. WILSON) And the corresponding
13 terms of gender identity disorder in prior DSMs,
14 there are more diagnoses with gender dysphoria now
15 than there were for that prior diagnosis; is that
16 correct?

17 MS. BORELLI: Objection; vague, compound.

18 THE WITNESS: Well, they are different
19 diagnoses.

20 Q. (BY MR. WILSON) Is it your position that
21 there's no correspondence between a diagnosis of
22 gender identity disorder in the DSM-3 and the
23 gender dysphoria in the DSM-5?

24 MS. BORELLI: Objection; lacks foundation.

25 You can answer.

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1 THE WITNESS: The diagnosis has become more
2 specific.

3 Q. (BY MR. WILSON) Is there correspondence,
4 though, between those diagnoses?

5 MS. BORELLI: Objection; vague, misstates
6 testimony.

7 THE WITNESS: Well, I don't know if
8 "correspondence" is the word that I would use.

9 I would say that gender dysphoria has
10 built upon or that we understand more about gender
11 dysphoria because of what we know from previous
12 diagnoses, specifically becoming more -- more
13 specific about what the actual diagnosis is, like
14 making sure that we're actually including
15 transgender people in the diagnosis.

16 Q. (BY MR. WILSON) If we did that Venn
17 diagram thing again, the circle that's the gender
18 dysphoria circle is a bigger circle than the gender
19 identity disorder circle; is that correct?

20 MS. BORELLI: Objection; vague.

21 Q. (BY MR. WILSON) Again, I think you're
22 smart and you know what I mean, but if you don't,
23 then I can try to be less dumb.

24 A. I believe I am smart related to this; I
25 don't understand what your question is.

1 Q. Okay. So is the subset of -- are those
2 who are diagnosed with gender dysphoria under
3 DSM-5, is that a larger set of people than those
4 who were diagnosed with gender identity disorder
5 under DSM-3?

6 MS. BORELLI: Objection; vague, compound.

7 THE WITNESS: The data say, right now, that
8 there has been an increase in diagnoses related to
9 gender dysphoria, and our understanding of that is
10 because there is more visibility regarding
11 transgender identity, and not that there's a change
12 in how many people are actually transgender, that
13 the change is actually in how -- in what type of
14 visibility and the kinds of access to medical care
15 that's available now.

16 Q. (BY MR. WILSON) So would you expect that
17 if the DSM-5 criteria had been applied back in the
18 1980s and 1990s, that we would see more diagnoses
19 with gender dysphoria than we did of gender
20 identity disorder at that time?

21 MS. BORELLI: Objection; vague, compound,
22 calls for speculation.

23 THE WITNESS: I would predict -- so right
24 now, we're in a very different time period than it
25 was in the '80s and '90s, so it's impossible to

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1 actually answer your question.

2 I think if all things were exactly the
3 same as they are right now, I would predict that
4 would see the same thing in the '80s and '90s.

5 Q. (BY MR. WILSON) What do you mean by "the
6 same thing"?

7 A. Like, the same level of diagnoses, same
8 number. But that would have to include all the
9 same social processes, visibility, greater
10 understanding.

11 Q. The Singh study that we are talking
12 about, it states in the abstract, midway down the
13 page: Of the 139 participants, 17, that's 12.2
14 percent, were classified as persisters, and the
15 remaining 122, 87.8 percent, were classified as
16 desisters.

17 Did I read that correctly?

18 A. I didn't follow where you were in the
19 end. What part are you at? What does the
20 sentence --

21 Q. Well, it's a little bit above halfway
22 through the first paragraph.

23 A. Okay. Does it start with "Of"?

24 Q. Yes.

25 Of the 139 participants, 17, 12.2

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1 percent, were classified as persisters, and the
2 remaining 122, 87.8 percent, were classified as
3 desisters.

4 Did I read that correctly?

5 A. You read that correctly.

6 Q. And under your approach, all of these
7 people, if they were diagnosable with gender
8 dysphoria from the outset, should have been treated
9 with gender-affirming care; is that correct?

10 MS. BORELLI: Objection; misstates
11 testimony, vague.

12 THE WITNESS: Can you say that question
13 again, please?

14 Q. (BY MR. WILSON) Under your approach, all
15 of these participants, if they were diagnosed with
16 gender dysphoria, should have been treated with
17 gender-affirming care; is that correct?

18 MS. BORELLI: Objection; vague, misstates
19 testimony, lacks foundation.

20 THE WITNESS: I can't believe that this
21 study got published. When I was reading through
22 the study, the participants are from 1975 to 2006,
23 and they've classified these -- the kids are as
24 boys. And so the thing is is that none of these
25 kids that I could even see potentially -- they

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1 couldn't even be classified as transgender from my
2 read of how they talk about these children in this
3 article.

4 And so it's impossible to talk about
5 where we are right now with our understanding of
6 gender dysphoria and transgender identity and to
7 compare that with what was happening in this
8 particular article.

9 Q. (BY MR. WILSON) I'll just repeat my
10 question.

11 Under your approach, these 139
12 participants, if they were diagnosable with gender
13 dysphoria, they should have all been treated with
14 gender-affirming care; is that correct?

15 MS. BORELLI: Objection; vague, lacks
16 foundation, misstates testimony, asked and
17 answered.

18 THE WITNESS: It's impossible for me to
19 answer the question because the kids who were
20 included in the study, from my read, don't --
21 aren't actually transgender. None of them were
22 transgender from the way that they're described in
23 the article.

24 So if a kid who is not transgender comes
25 into my office and indicates that they are not

1 transgender, then I wouldn't move forward with
2 this -- with gender-affirming care. It's really
3 the gender-affirming care and the gender-affirming
4 treatment is specific to transgender adolescents
5 and transgender adults.

6 Q. (BY MR. WILSON) Are you saying that
7 because they ultimately did not have a gender
8 identity that was incongruent with their biological
9 sex, that you were determining that they are not
10 transgender?

11 A. Oh, they weren't classified --

12 MS. BORELLI: Dr. Budge, let me just make
13 sure I get my objections in.

14 Objection; vague, misstates testimony,
15 lacks foundation, compound.

16 You can answer.

17 THE WITNESS: This article never says that
18 any of these children were transgender at the
19 start.

20 Q. (BY MR. WILSON) And what's your basis
21 for concluding that they were not?

22 A. The article does not state that any of
23 the children were transgender when they began to be
24 seen at the clinic.

25 Q. It says they were all referred for

1 gender identity disorder; is that correct?

2 MS. BORELLI: Objection; vague, misstates
3 the document.

4 THE WITNESS: Can you point me to the
5 referral piece?

6 Q. (BY MR. WILSON) The first sentence:
7 This study reports follow-up data on the largest
8 sample to date of boys clinic-referred for gender
9 dysphoria.

10 A. Sure. They -- yeah, right. This
11 article, when you talk about it, these kids were
12 assessed at a clinic, but they were never
13 identified as transgender.

14 Q. Is today the first day you've read this
15 study?

16 A. I can't recall if this is the first time
17 that I've read this study.

18 Q. Are you aware that it was cited in
19 Dr. Cantor's rebuttal to your report in Oklahoma?

20 MS. BORELLI: Objection; lacks foundation.

21 THE WITNESS: I would need to see the
22 report.

23 Q. (BY MR. WILSON) And this report is not
24 cited in your expert report, is it?

25 A. Which report are you referring to?

1 Q. Sorry.

2 This study, the Singh study, is not
3 cited in your declaration, is it?

4 A. That's correct. It's not cited in my
5 declaration.

6 Q. And you were not aware of it until
7 today; is that correct?

8 MS. BORELLI: Objection; lacks foundation,
9 misstates testimony.

10 THE WITNESS: I don't recall when or if I've
11 seen this previously, but it's possible that I have
12 seen it, especially if it was cited in a previous
13 declaration that I've read.

14 Q. (BY MR. WILSON) You say that it should
15 not have been published; is that correct?

16 A. That's correct.

17 Q. And you don't believe that it's
18 reliable; is that correct?

19 MS. BORELLI: Objection; vague.

20 THE WITNESS: My critique of this article is
21 that they don't follow transgender adolescents or
22 children.

23 And also my other critique is that this
24 is old. It's old data that don't follow the
25 procedures and understandings that we now have

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1 regarding the best practices for transgender
2 adolescents, the -- yeah.

3 Q. (BY MR. WILSON) Now, do you think that a
4 researcher who disagrees with other conclusions in
5 the literature needs to give an account of those
6 conclusions when expressing an opinion?

7 MS. BORELLI: Objection; vague, calls for
8 speculation.

9 THE WITNESS: Can you repeat the question,
10 please?

11 Q. (BY MR. WILSON) When a researcher is
12 expressing an opinion on an issue, they need to
13 give an account for contrary findings in the
14 literature; isn't that correct?

15 MS. BORELLI: Same objections.

16 THE WITNESS: When researchers are providing
17 information about the research questions and the
18 hypotheses, it's most typical that we talk about
19 the theories, the theory testing that's happening,
20 and that we also provide literature that indicates
21 supportive pieces.

22 Typically, in the discussion of an
23 article when we're publishing our results, we can
24 provide and do provide articles that either
25 contradict or don't agree with the findings that we

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1 have in order to talk about the scope of the data.
2 So that's a very typical practice.

3 Q. (BY MR. WILSON) If I told you that
4 Dr. Cantor's report in the Bridge matter rebutting
5 you was served on November 16th, 2022, would you
6 have any reason to disagree with that?

7 MS. BORELLI: Objection; lacks foundation.

8 THE WITNESS: I would need to see the date.

9 Q. (BY MR. WILSON) But you have no reason
10 to think that it's any date other than that, do
11 you?

12 MS. BORELLI: Same objection.

13 THE WITNESS: No.

14 Q. (BY MR. WILSON) And your report was
15 dated July 6th, 2023; is that correct -- or filed
16 at that time?

17 A. There were two reports for the Bridge
18 case.

19 Q. I'm sorry.

20 Your declaration in this case was --
21 actually, we'll go down to the bottom here and get
22 the signature date.

23 It was executed the 12th of May 2023; is
24 that correct?

25 A. For this case?

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1 Q. Yes.

2 A. Yes.

3 Q. And you didn't cite the Singh study, did
4 you?

5 MS. BORELLI: Objection; argumentative,
6 asked and answered.

7 THE WITNESS: I did not cite the Singh
8 study.

9 Q. (BY MR. WILSON) In fact, Dr. Cantor's
10 report identified 11 cohort studies regarding
11 persistence of gender dysphoria in adolescents, and
12 you didn't cite any of them in your declaration in
13 this case, did you?

14 MS. BORELLI: Objection; assumes facts not
15 in evidence, lacks foundation.

16 THE WITNESS: I would need to see the
17 citations that he included to answer that question.

18 Q. (BY MR. WILSON) So the law that's at
19 issue in this case, Senate Bill 1100, it provides
20 for an accommodation to individuals, whether they
21 have gender dysphoria or otherwise, that would
22 allow them to use a single-user restroom if they're
23 not comfortable using the restroom that correlates
24 with their biological sex.

25 Is that your understanding?

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1 MS. BORELLI: Objection; compound, vague.

2 THE WITNESS: That's my understanding of one
3 component of the bill.

4 Q. (BY MR. WILSON) And is it your opinion
5 that that accommodation is not adequate?

6 MS. BORELLI: Objection; vague.

7 THE WITNESS: It is my opinion that that is
8 not an appropriate -- it's not even an
9 accommodation.

10 In this instance, it's denying access to
11 a facility that relates to someone's gender
12 identity that's different from their sex assigned
13 at birth.

14 Q. (BY MR. WILSON) Now, if we wanted to
15 study how that affects people with gender
16 dysphoria, then we could do a study that compared
17 the results for those who had access to those
18 single-user facilities and those who did not and
19 see if there was a statistically significant
20 difference; is that right?

21 MS. BORELLI: Objection; vague, compound,
22 calls for speculation.

23 THE WITNESS: When I had mentioned before
24 that you're using controlled studies for
25 treatments, this is not the instance in which you

1 would use a control group.

2 We have a lot of data that indicate that
3 it is harmful for transgender students to be forced
4 to use a bathroom that does not align with their
5 gender identity, and that's -- the data are robust
6 and there are many studies that have indicated that
7 that's the case.

8 Q. (BY MR. WILSON) So is there anything
9 that would be improper, though, about that type of
10 a study, about single-user restrooms, that I've
11 described?

12 MS. BORELLI: Objection; vague, calls for
13 speculation.

14 THE WITNESS: From a research ethics
15 perspective, I don't -- I can't imagine that an
16 institutional review board would approve that
17 because we know that it's harmful to have -- or
18 force a transgender youth to use a bathroom that
19 isn't in alignment with their identity.

20 We also have a lot of data regarding
21 that youth -- that these bathrooms are often not
22 easily available. They're often far away from
23 their classrooms, they have to hold their urine, or
24 it outs them to be able to have to use a bathroom
25 that they're made to use because they are trans.

1 So there are a lot of things that we
2 know in the data why that would be a harmful
3 process, and institutional review boards, when they
4 review data, they look at the ethics surrounding
5 the design. And so this -- that would be a
6 component that institutional review boards would
7 consider as part of the research design.

8 Q. (BY MR. WILSON) So if you take a look at
9 paragraph 52 of your report.

10 A. Hold on just a second.

11 Q. Let me know when you're there.

12 A. Okay.

13 Q. So if you go after the paragraph with
14 all the numbers, it says: In addition, when -- I'm
15 sorry, the sentence with all the numbers.

16 A. Okay.

17 Q. It says: In addition, when
18 accommodations are offered to transgender
19 individuals that require them to use a separate
20 restroom that is not usually designated for their
21 group (e.g., sending a high school student to a
22 faculty or nurse's restroom) or when a transgender
23 person, unlike others, is told that they, but not
24 their peers, must use a single-user restroom, that
25 individual, likewise, is being told not only that

1 their gender identity is invalid, but that they are
2 something "other" and must be separated from all
3 their peers because of who they are.

4 Numerous research studies have confirmed
5 the negative psychological impact of being
6 invalidated and "othered" in these ways.

7 Then there's a few citations.

8 Did I read that correctly?

9 A. Yes.

10 Q. And are these the citations that you
11 were referring to when you said there was robust
12 data on this question?

13 MS. BORELLI: Objection; misstates the
14 document.

15 THE WITNESS: These studies are all
16 methodologically sound and indicate the harm
17 regarding being required to use a bathroom that
18 doesn't match your gender identity.

19 Q. (BY MR. WILSON) How many of these
20 studies specifically addressed single-user
21 restrooms?

22 MS. BORELLI: Objection; vague.

23 THE WITNESS: I would have to read through
24 them. My recollection is that at least two of them
25 discuss the concept of single-user restrooms, but I

1 would have to go back to those studies to look
2 specifically at what they say.

3 MR. WILSON: I'm sending another document
4 here. I've just sent what's being marked as
5 Exhibit 3.

6 (Deposition Exhibit No. 3 was marked.)

7 Q. (BY MR. WILSON) This is the Price-Feeney
8 study, the first study cited there.

9 Let me know when you received it.

10 A. I received it.

11 MS. BORELLI: It's my Atlanta Internet.
12 Unfortunately, it hasn't come through. It will be
13 just a minute.

14 MR. WILSON: Let me know when you've got it,
15 Tara.

16 MS. BORELLI: Also, so as not to slow you
17 down, I don't know if you're able to upload to the
18 chat as well. That way I would be able to access
19 it directly. But I'm also happy to do e-mail to
20 keep things simple. I'm just recognizing it seems
21 to have a delay on my end.

22 MR. WILSON: I think we're okay, but I
23 appreciate you being sensitive to my time.

24 Q. (BY MR. WILSON) Now, a single-user
25 bathroom is gender-neutral; is that correct?

1 MS. BORELLI: Objection; vague.

2 THE WITNESS: That's a term that we
3 sometimes use for them. It's usually just a
4 single-stall bathroom that anybody can use.

5 MR. WILSON: Tara, are you still waiting for
6 the article on your end?

7 MS. BORELLI: Unfortunately.

8 MR. WILSON: Now you're forcing me to
9 actually know how to use Zoom and that's never a
10 good idea. I'll try again here.

11 (Clarification by the court reporter.)

12 MR. WILSON: That's because Veritext wants
13 us to use Exhibit Share, right?

14 (Clarification by the court reporter.)

15 MR. WILSON: Okay. Yeah. Well, the State
16 of Idaho is really cheap and we don't do that.

17 MS. BORELLI: Has anybody else gotten it?
18 Could anyone re-forward it to me? Or we could go
19 off the record if you prefer, Lincoln.

20 MR. WILSON: Yeah. Why don't we just go off
21 the record for a second.

22 MS. BORELLI: Okay. Thanks.

23 THE VIDEOGRAPHER: Okay. So the time is
24 10:35 a.m. Mountain Time, and we are off the
25 record.

1 (A recess was taken from 10:35 a.m. to 10:36 a.m.)

2 THE VIDEOGRAPHER: Okay. So we are
3 recording. The time is 10:36 a.m. Mountain Time,
4 and we are back on the record.

5 Q. (BY MR. WILSON) Dr. Budge, if you'd take
6 a look at the second page of this PDF marked 1143
7 at the top, this is the Price-Feeney article cited
8 in your declaration.

9 Do you see the first full paragraph on
10 the left-hand column on that page?

11 A. Yes.

12 Q. Okay. And if you look at the fourth
13 sentence down, it says: Specifically, providing
14 gender-neutral bathrooms or allowing youths to use
15 the bathroom that corresponds to their gender
16 identity can be viewed as part of gender-affirming
17 support and care.

18 Did I read that correctly?

19 A. Yes.

20 Q. Do you disagree with that statement?

21 MS. BORELLI: Objection; vague, misstates
22 the document.

23 THE WITNESS: For that statement, that
24 applies -- my interpretation of that is that it
25 applies to youth who desire to use a gender-neutral

1 bathroom, not to youth who are being required to
2 use a bathroom that doesn't align with their
3 gender.

4 Q. (BY MR. WILSON) Right.

5 So do you disagree that it can be viewed
6 as gender-affirming care to provide a
7 gender-neutral bathroom?

8 MS. BORELLI: Objection; vague, misstates
9 the document.

10 THE WITNESS: Yeah. My -- so in my field
11 and the way that we talk about this, it is
12 considered affirming care for a transgender youth
13 where that is something that they desire and that
14 they want, but not if they're being restricted from
15 using the bathrooms that align with their gender
16 identity.

17 Q. (BY MR. WILSON) So this study, you
18 cited, correct?

19 And you said that it was so clear that
20 gender-neutral bathrooms were not an adequate
21 accommodation that we couldn't even get a review
22 board to approve a study about them.

23 But this study says that they are
24 properly viewed as gender-affirming care; is that
25 correct?

1 MS. BORELLI: Objection; vague compound,
2 misstates testimony.

3 THE WITNESS: What I said was that I can't
4 imagine that an institutional review board would
5 approve a study regarding youth who were told that
6 they are banned from using a bathroom that aligns
7 with their gender identity and that they then had
8 to use a single-stall bathroom.

9 That's different than youth who elect to
10 use a gender-neutral bathroom.

11 Q. (BY MR. WILSON) We could also do an
12 observational study where we had data on people who
13 had access to a gender-neutral bathroom and data on
14 those who had only sex-separated bathrooms and
15 compare the two; is that correct?

16 MS. BORELLI: Objection; vague, compound,
17 assumes facts not in evidence.

18 THE WITNESS: There are a lot of things that
19 are included in this. I would say if youth are
20 being told that they are banned from using a
21 bathroom that aligns with their gender identity as
22 part of this process, that would be an unethical
23 component related to a research process.

24 So it's impossible to actually answer
25 the question given the context that's at hand.

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1 Q. (BY MR. WILSON) So I'm referring to sort
2 of a retrospective study on what's already
3 happened, because there are places that only allow
4 for sex-separated restrooms; is that correct?

5 MS. BORELLI: Objection; vague.

6 THE WITNESS: Is the question that there are
7 places that only allow gender-neutral bathrooms?

8 Q. (BY MR. WILSON) No. Let me try to break
9 it down.

10 There are some places in America that
11 only allow sex-separated restrooms and do not allow
12 those with gender dysphoria to use a bathroom
13 different than their biological sex; is that
14 correct?

15 MS. BORELLI: Objection; vague.

16 THE WITNESS: They don't allow people to
17 use...

18 I mean, I would imagine that that would
19 be an instance. I think that you're saying that in
20 some places in the United States, that there are
21 places that there are only sex-segregated bathrooms
22 where trans people aren't allowed to use the
23 bathroom that aligns with their gender identity.

24 Is that what you're asking?

25 Q. (BY MR. WILSON) Yes.

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1 A. I mean, that's possible.

2 Q. I think I'm okay on this.

3 As you sit here today, you don't know
4 whether any of the other articles cited in your
5 report specifically studied gender-neutral or
6 single-sex restrooms; is that correct?

7 A. Well, I would need to see them, but
8 this --

9 MS. BORELLI: Let me just interpose on
10 objection.

11 Objection; misstates her testimony and
12 the document.

13 You can answer.

14 THE WITNESS: I would need to see them, but
15 this Price-Feeney article does -- is inclusive of
16 transgender youth who were required to use a
17 single-stall bathroom in place of, you know, a
18 sex-designated bathroom that aligned with their
19 gender identity, given -- the research question
20 that was at hand regarding bathroom discrimination
21 was inclusive of this scenario that's described in
22 the bill.

23 Q. (BY MR. WILSON) I'm going to have you
24 take a look at paragraph 30 of your report.

25 Let me know when you're there.

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1 A. Okay.

2 Q. So it's referring to the WPATH standards
3 of care, and it says in the last sentence of the
4 paragraph: These standards are developed by the
5 foremost experts in the field of transgender health
6 based on systematic review of the evidence-based
7 research on transgender health.

8 Is that correct?

9 A. That's correct.

10 Q. Did you conduct your own systematic
11 review in this case to determine what the
12 appropriate standards of care are for individuals
13 with gender dysphoria?

14 MS. BORELLI: Objection; vague.

15 THE WITNESS: I've been an expert in this
16 field for many years, so I've been able to conduct
17 a host of systematic reviews regarding the field of
18 evidence for transgender care, and so that is
19 something that is a part of my expertise.

20 Q. (BY MR. WILSON) Are any of those
21 articles published?

22 MS. BORELLI: Objection; misstates the
23 testimony, vague.

24 Q. (BY MR. WILSON) Let me rephrase.

25 Are any of those systematic reviews that

1 you've conducted published?

2 MS. BORELLI: Same objection.

3 THE WITNESS: Yes. I published a systematic
4 review with Dr. Elliott Tebbe in 2022.

5 Q. (BY MR. WILSON) In paragraph 31, it
6 says: Every major medical and mental health
7 organization within the United States that has
8 taken a position on gender-affirming care -- and
9 then it lists several examples -- agrees with WPATH
10 and the Endocrine Society that, when clinically
11 indicated, puberty-delaying medication and
12 gender-affirming hormones are appropriate and
13 medically necessary treatments for adolescents.

14 Did I read that correctly?

15 A. Yes.

16 MS. BORELLI: Objection; document speaks for
17 itself.

18 THE WITNESS: Did you hear my response?

19 I'm sorry, I said yes.

20 MR. WILSON: I believe -- yeah, you said
21 yes. Thank you.

22 Hold on just a second here. I gotta
23 check something.

24 Now, I'm going to send another article
25 around here. This is going to be Exhibit 4. If

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1 you let me know when you got it. And, Tara, you as
2 well.

3 (Deposition Exhibit No. 4 was marked.)

4 MS. BORELLI: Will do.

5 THE WITNESS: I've received it.

6 MR. WILSON: Tara, you got it yet?

7 MS. BORELLI: It looks like I'm going to
8 need another minute. Thank you for bearing with.

9 I've received it. Thank you.

10 Q. (BY MR. WILSON) Dr. Budge, this is an
11 article in the New York Times dated August 3rd,
12 2023, by Azeen Ghorayshi; is that correct -- or
13 Ghorayshi. I'm sorry.

14 A. That's correct.

15 Q. It refers to a recent decision by the
16 American Academy of Pediatrics; is that correct?

17 A. That's correct.

18 Q. Are you familiar with --

19 MS. BORELLI: Sorry, Lincoln, can I just
20 take a moment?

21 Dr. Budge, have you had a chance to
22 review the document? I just want to make sure
23 you've had a chance to look at it. I don't know if
24 you've seen it previously.

25 THE WITNESS: I have seen it previously, but

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1 I haven't had a chance to review it.

2 MS. BORELLI: Could we give her a moment
3 just to review it?

4 MR. WILSON: Should we go off the record?

5 Q. (BY MR. WILSON) Do you need more than a
6 few moments or...

7 A. It shouldn't -- it's short. It
8 shouldn't take very long.

9 MR. WILSON: Okay. Tara, I assume that if
10 we come back for a fight over an extra five minutes
11 at the end of all this case, you're going to give
12 it to me, but maybe you play hardball. I don't
13 know.

14 Q. (BY MR. WILSON) Are we close enough
15 there or should we go off the record?

16 A. I'm almost done.

17 Okay.

18 Q. So, Dr. Budge, are you familiar with the
19 decision by the American Academy of Pediatrics
20 that's referred to in this article?

21 A. Yes.

22 Q. And the American Academy of Pediatrics
23 has commissioned a systematic review of the
24 evidence concerning the efficacy for puberty
25 blockers in treating gender dysphoria; is that

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1 correct?

2 MS. BORELLI: Objection; vague.

3 THE WITNESS: My understanding is that every
4 five years the AAP guidelines for any medical
5 condition or component, that they do a review every
6 five years, so this is just -- my reading of it is
7 that it's standard practice.

8 Q. (BY MR. WILSON) They review their
9 position statements every year, but they don't
10 commission a systematic review every five years; is
11 that correct?

12 MS. BORELLI: Objection -- sorry.
13 Objection; form.

14 THE WITNESS: I mean, I would need to review
15 all of the procedures that the AAP does. My
16 understanding is that this is not limited -- doing
17 systematic reviews is not limited to this
18 particular component, this particular diagnosis.

19 Q. (BY MR. WILSON) And there's a
20 reference -- let me ask it a different way.

21 Gender dysphoria isn't just something
22 that happens in America, right?

23 MS. BORELLI: Objection; vague.

24 THE WITNESS: The diagnosis that we use in
25 the DSM is based on the American Psychiatric

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1 Association. Worldwide, usually the ICD
2 classification is used for gender incongruence.

3 Q. (BY MR. WILSON) But the phenomenon is a
4 worldwide phenomenon; is that correct?

5 MS. BORELLI: Objection; vague.

6 THE WITNESS: Transgender people exist
7 everywhere.

8 Q. (BY MR. WILSON) And there's data from
9 other countries and commissioned by other countries
10 on the question; is that correct?

11 MS. BORELLI: Objection; compound, lacks
12 foundation.

13 THE WITNESS: On the question? Can you be
14 more specific, please?

15 Q. (BY MR. WILSON) Regarding gender
16 dysphoria and transgender people; is that correct?

17 MS. BORELLI: Same objections.

18 THE WITNESS: Can you restate the whole
19 question, please?

20 Q. (BY MR. WILSON) Other countries besides
21 America have studied these issues; is that correct?

22 MS. BORELLI: Objection; vague.

23 THE WITNESS: So my read of other countries
24 describing gender-affirming care is that all of
25 them so far, that I have read, indicate a support

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1 for -- specifically if we're talking about
2 transgender adolescents, support for transgender
3 adolescents, and especially the ones in Europe that
4 are talked about in this particular article, none
5 of them have banned any particular care.

6 Q. (BY MR. WILSON) So if you look at the
7 second paragraph from the bottom on page 1, it
8 says: In June, England's National Health Service
9 announced that it would restrict the use of puberty
10 blockers to clinical trials because there's not
11 enough evidence to support their safety or clinical
12 effectiveness as a routinely available treatment.

13 Did I read that correctly?

14 A. Yes.

15 Q. Do you disagree with that position that
16 the National Health Service has taken in England?

17 MS. BORELLI: Objection; assumes facts not
18 in evidence, lacks foundation.

19 THE WITNESS: When I've read some of the
20 statements regarding what is happening in England,
21 as I mentioned, the statements are in support of
22 transgender adolescents and that there is no ban
23 regarding the care that's involved.

24 Q. (BY MR. WILSON) So you agree, then -- if
25 you don't disagree, you agree there's not enough

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1 evidence to support the safety or clinical
2 effectiveness of puberty blockers as routinely
3 available treatment?

4 MS. BORELLI: Objection; misstates
5 testimony.

6 THE WITNESS: I do not agree that there is
7 not enough evidence. The evidence that we have is
8 strong, it's robust, and indicates that it is not
9 unsafe for youth, and in fact, that it is
10 lifesaving.

11 Q. (BY MR. WILSON) So that came out in
12 June of this year; is that right?

13 MS. BORELLI: Objection; lacks foundation.

14 THE WITNESS: In the article, it says: In
15 June.

16 Q. (BY MR. WILSON) And then it says: Last
17 year Sweden's national healthcare oversight body
18 similarly determined that, on the basis of its
19 systematic review, the risks of puberty-inhibiting
20 and gender-affirming hormone treatment for those
21 under 18 currently outweigh the possible benefits.

22 Did I read that correctly?

23 MS. BORELLI: Objection -- sorry.

24 Let me just finish this before you --
25 and then you can answer the question, Dr. Budge.

1 Assumes facts not in evidence, lacks
2 foundation, vague.

3 THE WITNESS: Yes.

4 Q. (BY MR. WILSON) And were you aware of
5 these two determinations by the National Health
6 Service and by Sweden around the time that they
7 happened?

8 MS. BORELLI: Objection; assumes facts not
9 in evidence, lacks foundation, vague, compound.

10 THE WITNESS: Yes.

11 Q. (BY MR. WILSON) And you disagree with
12 Sweden's determination, just like you disagree with
13 the National Health Service's determination; is
14 that correct?

15 MS. BORELLI: Objection; vague, misstates
16 testimony.

17 THE WITNESS: These particular sentences are
18 taken out of context for the entirety of the
19 report. The report doesn't say that transgender
20 adolescents shouldn't receive care.

21 And in fact, the -- when these reports
22 are being written, they are talked about in terms
23 of the evidence that does exist. I think that
24 these -- these particular reports are indicating
25 that, you know -- that they want to gather more

1 data and more information, and that's my read of
2 what they're calling for.

3 Q. (BY MR. WILSON) And so do you agree or
4 disagree with the statement that, "The risks of
5 puberty-inhibiting and gender-affirming hormone
6 treatment for those under 18 currently outweigh the
7 possible benefits"?

8 MS. BORELLI: Objection; vague, lacks
9 foundation.

10 THE WITNESS: The evidence for transgender
11 adolescents right now regarding puberty-delaying
12 hormones and gender-affirming hormone treatment all
13 indicate that they are improve -- improve mental
14 health and improve the quality of life for
15 transgender adolescents, and that's the large body
16 of research that we're finding, especially in the
17 longitudinal data.

18 So the body of evidence that I know and
19 that I have reviewed is indicative that it is
20 important for transgender adolescents to receive
21 this treatment.

22 Q. (BY MR. WILSON) So you disagree with
23 what Sweden says; is that correct?

24 MS. BORELLI: Objection; vague, misstates
25 testimony.

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1 THE WITNESS: As I mentioned previously, the
2 entirety of the report that you're describing, that
3 there are -- that one sentence isn't exactly the
4 conclusion of the entirety report.

5 Q. (BY MR. WILSON) But you disagree with
6 that particular conclusion; is that correct?

7 MS. BORELLI: Objection; vague, asked and
8 answered, misstates testimony.

9 THE WITNESS: The evidence that I have
10 reviewed indicates that -- it's that the benefits
11 of gender-affirming care, especially related to
12 hormones and puberty-delaying treatments, outweigh
13 risks.

14 Q. (BY MR. WILSON) And you would agree that
15 it says: Significant development for two European
16 countries to have reached these conclusions.

17 Is that correct?

18 MS. BORELLI: Objection; vague, lacks
19 foundation, assumes facts not in evidence.

20 THE WITNESS: My read of the situation with
21 these reports is that they are -- again, like I
22 said, actually, both reports say that it's
23 important to support transgender adolescents and
24 that care should not be banned.

25 And so, you know, these reports are not

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1 indicating that transgender adolescents should not
2 receive any kind of treatment and that, in general,
3 they indicate the importance of that process of
4 supporting transgender adolescents.

5 Q. (BY MR. WILSON) And you didn't cite
6 either of these systematic reviews by the National
7 Health Service or by Sweden in your report, did
8 you?

9 MS. BORELLI: Objection; vague, lacks
10 foundation.

11 THE WITNESS: I did not.

12 How are we doing on time, everybody?

13 MR. WILSON: Yeah. Can we do this? I
14 think -- first of all, let's just go off the
15 record.

16 THE VIDEOGRAPHER: Okay. So the time is
17 10:59 a.m., and we are off the record.

18 (A recess was taken from 10:59 a.m. to 11:09 a.m.)

19 THE VIDEOGRAPHER: All right. So we are
20 recording. The time is 11:09 a.m. Mountain Time,
21 and we are back on the record.

22 MR. WILSON: I've just got to handle one
23 thing here.

24 Okay. I'm going to send another
25 exhibit. This will be Exhibit 5.

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1 (Deposition Exhibit No. 5 was marked.)

2 Q. (BY MR. WILSON) Dr. Budge, just let me
3 know when you've received it.

4 A. I've received it.

5 MS. BORELLI: I need one more minute.
6 Sorry.

7 MR. WILSON: I'm just going to ask a
8 foundation question, if it's all right, Tara, while
9 we're waiting?

10 MS. BORELLI: I received it.

11 MR. WILSON: Okay. Great. You got it.
12 We're moving faster now.

13 Q. (BY MR. WILSON) Dr. Budge, do you
14 recognize this article I just sent?

15 A. I do.

16 Q. This is an article about your lab at
17 UW-Madison; is that correct?

18 MS. BORELLI: Objection; vague.

19 THE WITNESS: That's correct.

20 Q. (BY MR. WILSON) That's your picture with
21 three other people at the top, right?

22 A. Yes.

23 Q. If you head down to the third page of
24 the PDF, there's a heading that says: UW-Madison's
25 Trans Research Lab doesn't work only on research.

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1 Members of the lab aren't shy about their advocacy
2 and activism, something that is unusual in
3 research.

4 Did I read that correctly?

5 A. Yes.

6 MS. BORELLI: Objection; misstates the
7 document, lacks foundation.

8 Q. (BY MR. WILSON) And it says, "Budge
9 isn't concerned about tainting the lab's work or
10 how some might view it as biased. 'I think all
11 research is biased in some way, shape, or form.
12 It's just what you do to ensure that all of that is
13 out on the table,' Budge says."

14 Did I read that correctly?

15 A. Yes.

16 Q. Was that an accurate quote of you in
17 this article?

18 MS. BORELLI: Objection; vague.

19 THE WITNESS: I do believe that in some way,
20 shape, or form that there is bias that's involved
21 in all aspects of life because we're human.

22 Q. (BY MR. WILSON) Is it also true that you
23 aren't concerned about tainting the lab's work or
24 how some might view it as biased?

25 MS. BORELLI: Objection; vague, misstates

1 the document.

2 THE WITNESS: Can you say that again,
3 please?

4 Q. (BY MR. WILSON) Do you also agree with
5 the statement that "Budge isn't concerned about
6 tainting the lab's work or how some might view it
7 as biased"?

8 A. Yeah, what I meant there --

9 MS. BORELLI: Objection; misstates the
10 document.

11 You can answer.

12 THE WITNESS: What I meant there is that we
13 are transparent about our process and about who we
14 are and the work that we do. Insofar that that
15 information is available for people to see and to
16 understand and that I -- the way that we now talk
17 about bias related to science and research is that
18 it's important for you to put out all of the
19 information about different components of the work
20 so that that way people can understand how research
21 questions come about and how they're understood and
22 also how that information is communicated.

23 And as you can see right below that
24 statement, I say that that particular component, it
25 is a part of the rigorous part of our approach and

1 that we use all of the best evidence-based practice
2 guidelines and processes in the way that we conduct
3 research.

4 Q. (BY MR. WILSON) So in disclosing a
5 potential bias, in academia that's typically done
6 through a conflict disclosure at the beginning of
7 an article; is that correct?

8 MS. BORELLI: Objection; vague.

9 THE WITNESS: Yeah. I think the bias that
10 I'm talking about here is different from a conflict
11 of interest.

12 So bias -- the way that I'm defining
13 bias in this particular quote is just that, you
14 know, humans in general -- like, there is not a
15 human who doesn't have any level of bias at all,
16 and everybody in this room is included, every human
17 being has it.

18 I think that our -- our goal as
19 researchers and as scientists is to describe the
20 science and to do the science in the most rigorous
21 way possible so that any type of bias that may
22 exist from any human being can be taken out of that
23 equation or understood within the context of how
24 the research is conducted.

25 Q. (BY MR. WILSON) It says, a couple

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1 paragraphs down: Aside from its research, lab
2 members meet once a week to engage in activism. In
3 some meetings, members write letters to elected
4 officials on issues, such as healthcare and
5 nondiscrimination. Lab researchers met two
6 UW-Madison employees who sued the state and the UW
7 system over their refusal to pay for gender
8 reassignment surgery, Budge says. The lab also
9 does educational training on transgender issues for
10 community groups and organizations.

11 Did I read that correctly?

12 A. You did.

13 Q. And that's a bit more than just sort of
14 the basic bias that everybody inherently has,
15 right?

16 MS. BORELLI: Objection; misstates the
17 document, assumes facts not in evidence.

18 THE WITNESS: No. So the thing is is that
19 when there is discrimination at hand, the
20 scientists who I know who study discrimination,
21 that it's an ethical duty that we have as
22 scientists to ensure that discrimination doesn't
23 continue.

24 And so in that instance, that's how
25 scientists function and how they engage in the

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1 work.

2 Q. (BY MR. WILSON) If someone were an
3 activist, an admitted activist on a question, do
4 you think that's something they should disclose
5 when they write an academic paper on the subject of
6 their activism?

7 MS. BORELLI: Objection; vague.

8 THE WITNESS: I think it depends on what the
9 activism is. In this instance, it's advocacy work,
10 which is something that is included within any kind
11 of, you know, scientific academic work regarding
12 when people's rights are being -- are not being
13 maintained, that that kind of advocacy is part and
14 parcel of the work and it's also part of my
15 institution's mission.

16 Q. (BY MR. WILSON) So when you wrote this
17 article with Dr. Tebbe, the systematic review, you
18 didn't disclose that you're an activist on these
19 questions, did you?

20 MS. BORELLI: Objection; vague, assumes
21 facts not in evidence.

22 THE WITNESS: I don't have any conflicts of
23 interest that were needed -- that needed to be
24 disclosed.

25 Q. (BY MR. WILSON) And you didn't disclose

1 that you're an activist in that article, did you?

2 MS. BORELLI: Objection; asked and answered,
3 argumentative, assumes facts not in evidence,
4 vague.

5 THE WITNESS: I did not indicate that I was
6 an activist in that article.

7 Q. (BY MR. WILSON) And you are an activist
8 on this question; is that correct?

9 MS. BORELLI: Objection; asked and answered,
10 argumentative, misstates testimony, lack of
11 foundation.

12 THE WITNESS: I would describe my work more
13 as advocacy and that that advocacy is something
14 that is included within understanding the ways in
15 which discrimination is experienced and how it
16 comes about and that my work is to reduce the level
17 of discrimination, and that's the advocacy that I
18 engage in.

19 Q. (BY MR. WILSON) So is this article wrong
20 when it says that you aren't shy about your
21 advocacy and activism?

22 MS. BORELLI: Objection; vague, misstates
23 the document.

24 THE WITNESS: I would describe my work more
25 as advocacy, but I would say, you know, that this

1 is how the journalist decided to write that
2 information.

3 Q. (BY MR. WILSON) And in fact, you -- a
4 correction was submitted to this journal -- it's
5 noted at the bottom -- after this article was
6 published; is that correct?

7 A. Sorry --

8 MS. BORELLI: Lincoln, I'm sorry, where are
9 you?

10 MR. WILSON: If you go down to Editor's Note
11 at the bottom, it says: Editor's Note: This
12 article originally stated that 30 people have
13 agreed to have their therapy sessions monitored by
14 the lab. The lab has not yet started recruiting
15 people for the study, but the goal is to monitor 30
16 people's sessions.

17 Did I read that correctly?

18 A. You did.

19 Q. That would have been a correction that
20 would have come from your lab after the original
21 version of the article was published; is that
22 correct?

23 MS. BORELLI: Objection; vague.

24 THE WITNESS: That's correct.

25 Q. (BY MR. WILSON) But you didn't ask them

1 to correct the statement that you're not shy about
2 your advocacy and activism, did you?

3 MS. BORELLI: Objection; vague,
4 argumentative, misstates testimony.

5 THE WITNESS: I did not.

6 Q. (BY MR. WILSON) I'd love to end there,
7 but I have to ask one more question.

8 So, Dr. Budge, I just want to clarify
9 for the record that in the adolescent patients that
10 you've seen for gender dysphoria, have you ever
11 been presented with a case where it was not
12 appropriate for the patient to go through a social
13 transition, in your view?

14 MS. BORELLI: Objection; vague, compound.

15 THE WITNESS: In my clinical practice, I
16 have not seen a transgender adolescent who has
17 not -- where it's not been appropriate to move
18 forward with a social transition.

19 MR. WILSON: I have no further questions,
20 subject to anything that Tara has.

21 MS. BORELLI: Let's go ahead and take a
22 break, then, go off the record and take a break,
23 and we will confer and come back to let you know
24 whether we have any questions of our own.

25 MR. WILSON: All right. Sounds good.

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1 Is this a five-minute? Ten-minute?

2 MS. BORELLI: Let's do at least ten minutes.

3 MR. WILSON: Okay.

4 MS. BORELLI: We'll come back sooner if
5 we're able to finish earlier.

6 MR. WILSON: All right.

7 THE VIDEOGRAPHER: Okay. So the time is
8 11:21 a.m. Mountain Time, and we are off the
9 record.

10 (A recess was taken from 11:21 a.m. to 11:32 a.m.)

11 THE VIDEOGRAPHER: All right. So we are
12 recording. The time is 11:32 a.m. Mountain Time,
13 and we are back on the record.

14 MS. BORELLI: Thank you. The plaintiffs
15 have no further questions for Dr. Budge at this
16 point, and we will read and sign.

17 MR. WILSON: (Inaudible.)

18 MS. BORELLI: I'm sorry, could you say that
19 again?

20 MR. WILSON: I said it poorly.

21 That concludes the deposition, then.
22 Thank you.

23 MS. BORELLI: Thank you, Lincoln.

24 We will read and sign.

25 THE VIDEOGRAPHER: Okay. So then this

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1 concludes our video deposition with Dr. Stephanie
2 Budge. It is August 16th, 2023. The time is
3 11:33 a.m. Mountain Time, and we are off the
4 record.

5

6 (The deposition concluded at 11:33 a.m.)

7

* * *

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(Signature was requested.)

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VERIFICATION

STATE OF _____)
) ss.
COUNTY OF _____)

I, STEPHANIE BUDGE, PH.D., being first duly sworn on my oath, depose and say:

That I am the witness named in the foregoing deposition taken the 16th day of August, 2023, consisting of pages numbered 1 to 122, inclusive; that I have read the said deposition and know the contents thereof; that the questions contained therein were propounded to me; that the answers to said questions were given by me, and that the answers as contained therein (or as corrected by me therein) are true and correct.

Corrections Made: Yes_____ No_____

STEPHANIE BUDGE, PH.D.

Subscribed and sworn to before me this ____ day of _____, 2023, at _____.

Notary Public for
Residing at_____,
My Commission Expires: _____

Stephanie Budge, Ph.D. August 16, 2023

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I, REBECCA MARTIN, Certified Shorthand Reporter and Notary Public in and for the State of Idaho, do hereby certify:

That prior to being examined, the witness named in the foregoing deposition was duly sworn remotely by me to testify to the truth, the whole truth and nothing but the truth;

That said deposition was taken down by me in shorthand at the time and place therein named and thereafter reduced to typewriting under my direction, and that the foregoing transcript contains a full, true and verbatim record of said deposition.

I further certify that I have no interest in the event of the action.

WITNESS my hand and seal this 16th day of August, 2023.



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Changing the culture

UW-Madison lab is pioneering research on transgender issues

BY PETER COUTU

SEPTEMBER 21, 2017

RSS



LAUREN JUSTICE

Members of UW-Madison’s Trans Research Lab (left to right) Sidra Dillard, Ben Andert, director Stephanie Budge, and Morgan Sinnard outside the Education Building.

After graduating from Guilford College in Greensboro, North Carolina, Sidra Dillard wanted to continue studying, and hoped to focus future research on transgender-related topics.

This, unfortunately, left few choices.

“I was talking to my psychology advisor in my undergrad who did research in some LGBT fields, not so much the T, though, and I asked her, ‘How do I apply for graduate school?’ She said, ‘Really apply for places that have faculty that are interested in what you’re interested in.’ That didn’t give me a lot of options.”

So Dillard made a short list of institutions that fit that description, and UW-Madison, home to the largest transgender research lab in the nation, ended up at the top of the list.

The UW-Madison’s **Trans Research Lab** has no physical space, a budget that consists only of grant money, and it only recently launched a website. Nevertheless, the lab is at the forefront of transgender studies and is attracting researchers to the university.

department. “There are only five other professors in the country in psychology who are really specializing in this work.”



Elliot Tebbe is one of those specialists. A University of Nebraska-Lincoln professor of educational psychology, he calls Budge a “pioneer.”

“[The lab] is changing the culture of the field,” Tebbe says. “When you have such a large, productive research lab that is doing really good work, coming up with new models that are helpful in training, that will happen.”

Both students and community members can volunteer at the lab and help with research. And although the lab has no regular schedule or location, it’s nevertheless generated significant interest. Budge gets emails every month from people interested in working there.

This word-of-mouth has led to a steady growth in membership since the lab started a few years ago. There are currently about 20 unpaid volunteer members, mostly students, doing research at the lab, Budge says. She hopes this number will continue to grow.

The lab conducts what Budge describes as “affirmative research.”

In 2016, the lab **published research** on the relationship between geographic location and level of anxiety and depression among transgender populations in America. Morgan Sinnard — a doctoral student in the counseling psychology department at UW and one of the authors of the research — says a review of survey data found that transgender people had the highest rates of anxiety in Southwestern states, such as Texas and Arkansas.

“It was a significantly higher difference than almost every other division of the U.S. So, we thought maybe this was because of social differences in attitudes toward trans people, cultural differences,” Sinnard says. “But, ultimately, we can’t know because we didn’t compare it to a control group.”

The lab is now focusing on studying the use of psychotherapy for transgender people — Budge says there’s little research in this area — with the aim of improving therapy practices.

To do this, the lab will monitor and record therapy sessions with transgender people conducted by members of the counseling psychology department, including clinical psychologists and doctoral students. The lab hopes to recruit 30 people to have their therapy monitored. Researchers will then analyze the sessions, noting and cataloguing what problems and struggles people experience and how they respond to therapy.

Budge has been researching transgender-related issues for more than a decade. In 2011, she founded the **TSTAR** lab at the University of Louisville — which she says was

little research being done in the area, Budge says, was often “really bad and really offensive,” with researchers often using outdated and offensive terminology.



After Budge came to UW-Madison in 2014, TSTAR severed its ties with the university. It now exists as a community group.

UW-Madison’s Trans Research Lab doesn’t only work on research. Members of the lab aren’t shy about their advocacy and activism — something that is unusual in research.

Budge isn’t concerned about tainting the lab’s work or how some might view it as biased. “I think all research is biased in some way, shape or form. It’s just what you do to ensure that all of that is out on the table,” Budge says. “We’re really transparent about what we do, so I’m not really concerned about [our work coming across as biased].”

She says she believes in the “rigor of their approach” and that there is nothing the lab does “that is not based in science.”

Aside from its research, lab members meet once a week to engage in activism. In some meetings, members write letters to elected officials on issues such as health care and non-discrimination. Lab researchers met two UW-Madison employees who sued the state and the UW System over their refusal to pay for gender reassignment surgery, Budge says. The lab also does educational training on transgender issues for community groups and organizations.

Dillard wanted to work with Budge, in part because Budge understands the importance of activism and practicing self-care.

“Stephanie wouldn’t be the leader of the lab that she is if she wasn’t so cognizant of how social events and political events impact the people of the lab,” Dillard says.

After just a few years of steady growth, UW-Madison’s lab has served as a model for similar, smaller labs throughout the country.

Jayvien McNeill, now a senior at the California State University, interned for UW-Madison’s Trans Research Lab this summer. Without the lab, McNeill never would have come to Wisconsin, due to “how white” the campus is.

But after completing the internship, McNeill is now hoping to export what makes UW-Madison’s trans research lab so successful back to California’s lab, a small space that has roughly five active student-researchers.

“When I [came to Madison], I realized this is totally unique,” McNeill says. “I definitely think that there is nothing like what is happening with [UW-Madison’s] Trans Research Lab. It’s influencing all of my work decisions now.”

“I came here because Stephanie was here, first and foremost,” says Dillard, who identifies as a transmasculine nonbinary individual. “I think now the lab is also nice for me because I think it’s the biggest gathering of queer and trans folks that I have in Madison. It gives me the opportunity to spend more time with queer and trans folks.”

Following years of research and data collection into psychology-related issues, Budge says the problems facing the transgender community are just now coming into focus, and she’s hoping the lab will help address them.

“Trans people tend to experience more depression, anxiety, suicidality,” Budge says. “Now that the health disparity is set,” she adds, “what do we do about that?”

Editor’s note: This article originally stated that 30 people have agreed to have their therapy sessions monitored by the lab. The lab has not yet started recruiting people for the study, but the goal is to monitor 30 people’s sessions.

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A Follow-Up Study of Boys With Gender Identity Disorder

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This study reports follow-up data on the largest sample to date of boys clinic-referred for gender dysphoria ($n = 139$) with regard to gender identity and sexual orientation. In childhood, the boys were assessed at a mean age of 7.49 years (range, 3.33–12.99) at a mean year of 1989 and followed-up at a mean age of 20.58 years (range, 13.07–39.15) at a mean year of 2002. In childhood, 88 (63.3%) of the boys met the DSM-III, III-R, or IV criteria for gender identity disorder; the remaining 51 (36.7%) boys were subthreshold for the criteria. At follow-up, gender identity/dysphoria was assessed via multiple methods and the participants were classified as either persisters or desisters. Sexual orientation was ascertained for both fantasy and behavior and then dichotomized as either biphilic/androphilic or gynephilic. Of the 139 participants, 17 (12.2%) were classified as persisters and the remaining 122 (87.8%) were classified as desisters. Data on sexual orientation in fantasy were available for 129 participants: 82 (63.6%) were classified as biphilic/androphilic, 43 (33.3%) were classified as gynephilic, and 4 (3.1%) reported no sexual fantasies. For sexual orientation in behavior, data were available for 108 participants: 51 (47.2%) were classified as biphilic/androphilic, 29 (26.9%) were classified as gynephilic, and 28 (25.9%) reported no sexual behaviors. Multinomial logistic regression examined predictors of outcome for the biphilic/androphilic persisters and the gynephilic desisters, with the biphilic/androphilic desisters as the reference group. Compared to the reference group, the biphilic/androphilic persisters tended to be older at the time of the assessment in childhood, were from a lower social class background, and, on a dimensional composite of sex-typed behavior in childhood were more gender-variant. The biphilic/androphilic desisters were more gender-variant compared to the gynephilic desisters. Boys clinic-referred for gender identity concerns in childhood had a high rate of desistance and a high rate of a biphilic/androphilic sexual orientation. The implications of the data for current models of care for the treatment of gender dysphoria in children are discussed.

Keywords: gender dysphoria, gender identity disorder, gender non-conformity, sexual orientation, DSM-5

INTRODUCTION

Gender identity is considered to be, for most people, a central aspect of one's sense of self (1–6).¹ By around 3 years of age, if not earlier, most children can self-label themselves as either a boy or a girl (11–14) although cognitive-developmental gender theory suggests that the understanding of gender as an “invariant” aspect of the self does not occur until early to middle childhood, with the achievement of concrete operational thought (12, 15, 16). Gender differences in the adoption of gender role behavior, i.e., behavior associated with cultural definitions of masculinity and femininity, also emerge during the preschool years, if not earlier. These behaviors span various domains, including peer, toy, role play, and activity preferences [e.g., (3, 17, 18)]. Normative developmental research has long documented that, on average, both gender identity and gender role behaviors show significant and substantial between-sex differences (19–21). Later in development, sexual orientation also shows a substantial between-sex difference, i.e., most males are sexually attracted to females and most females are sexually attracted to males (19, 22).

In the 1950s and 1960s, a small clinical literature began to describe the phenomenology of children who displayed marked gender-variant behavior, including the strong desire to be of the other gender [e.g., (23–27)]. Subsequent volumes by Stoller (28) and Green (29) provided more comprehensive descriptions of such children. These early works were the sequel to the introduction of the diagnostic term Gender Identity Disorder (GID) of Childhood to the psychiatric nomenclature in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-III; (30)], currently termed Gender Dysphoria (GD) in the DSM-5 (31). Since 1980, empirical research has examined a number of parameters pertaining to GID/GD: epidemiology, diagnostic and assessment methods, associated psychopathology, causal mechanisms, and therapeutic approaches [for reviews, see, e.g., (32–39)].

An additional parameter (the focus of the present study) pertains to the developmental course of GID in children. In the early literature, it was posited by some that pervasive gender-variant behavior in children might be a predictor of GID in adulthood (termed Transsexualism in the DSM-III) [e.g., (26, 40)]. At the same time, it was also recognized that gender-variant behavior in childhood was associated with sexual orientation (in males, androphilia, i.e., sexual attraction to men; in females, gynephilia, i.e., sexual attraction to women), but without co-occurring gender dysphoria [see, e.g., (41, 42); for a meta-analytic review, see (43)].

To date, there have been at least 10 follow-up studies of children whose behavior was consistent with the DSM diagnosis

of GID (or GD per DSM-5) (44–53). Across these studies, the year at the time of first evaluation in childhood ranged from 1952 (49) to 2008 (51). For the 9 studies that included boys, the sample sizes (excluding those lost to follow-up) ranged from 6 to 79 (Mean age, 26 years). Most of these studies also provided the age at the time of first evaluation in childhood, which ranged from a mean of 7 years (47) to a mean of 9 years (48), with an age range from 4 to 12 years.

At the time of follow-up, using different metrics (e.g., clinical interview, maternal report, dimensional measurement of gender dysphoria, a DSM diagnosis of GID, etc.), these studies provided information on the percentage of boys who continued to have gender dysphoria (herein termed “persisters”) and the percentage of boys who did not (herein termed “desisters”).² Of the 53 boys culled from the relatively small sample size studies (Bakwin, Davenport, Kosky, Lebovitz, Money and Russo, Zuger), the percentage classified as persisters was 9.4% (age range at follow-up, 13–30 years). In Green (47), the percentage of persisters was 2% (total $n = 44$; Mean age at follow-up, 19 years; range, 14–24); in Wallien and Cohen-Kettenis (52), the percentage of persisters was 20.3% (total $n = 59$; Mean age at follow-up, 19.4 years; range, 16–28); and in Steensma et al. (51), the percentage of persisters was 29.1% (total $n = 79$; Mean age at follow-up, 16.1 years; range, 15–19). Across all studies, the percentage of persisters was 17.4% (total $N = 235$), with a range from 0 to 29.1%.³

These studies also provided information on the sexual orientation of the boys at the time of follow-up. In the early studies, sexual orientation was ascertained from various sources (e.g., open-ended interviews with the patient, parent-report, chart information, etc.). In the more recent studies, sexual orientation was assessed in a more systematic manner, such as the use of a structured interview to assign a Kinsey-based rating of sexual orientation in fantasy and a rating of sexual orientation in behavior, dummy coded where a 0 = gynephilia and a 6 = androphilia [e.g., (47)].

Of the 53 boys culled from the relatively small sample size studies (op. cit.), 13 (34.2%) of the patients were classified as gynephilic and 25 (65.8%) were classified as biphilic/androphilic.⁴ In the remaining 15 patients (28.3% of the combined samples), their sexual orientation was either uncertain or unknown.

²The terms persistence and desistance have been used for a long time in clinical developmental psychiatry and psychology [e.g., (54)]. Zucker (55) was the first to apply these terms to describe the developmental psychosexual trajectories of children diagnosed with GID.

³The percentages provided here differ somewhat from other summary reviews [(39), pp. 285–286, (56, 57)] because we have excluded patients who were seen for the first time in adolescence [for this reason, data from Zuger (58) are also not included]. One other follow-up study was conducted by Nakamura (59). Unfortunately, this dissertation is not available for purchase at ProQuest (Ann Arbor, MI) and is only available for loan at the University of Essex library. Due to COVID-19 restrictions, it is currently inaccessible (K. Clarke, personal communication to G. Rieger, June 15, 2020). The director of the clinic at the time when the data were collected does not have a copy of the dissertation (D. Di Ceglie, personal communication, June 15, 2020).

⁴As pointed out by Reviewer 1, biphilic is a dubious neologism, combining Latin and Greek derivatives. Diphilic would be the more accurate derivative. However, introducing this term would probably confuse many readers, so we have retained the term biphilic (see https://en.wikipedia.org/wiki/Androphilia_and_gynephilia).

¹In one study, Turner and Brown (7) found that school-age children rarely mentioned their gender when providing open-ended self-descriptions; the most frequent descriptor pertained to activities and preferences. Turner and Brown suggested that it might be the case that gender is so central to one's self-concept that it “goes without saying” (p. 709). In contemporary times in the West, a very small number of parents choose to not “gender” their children (“theybies”) by not referring to them as boys or girls (and, at times, not even announcing to others the child's biological sex), dressing them in gender-neutral ways, etc. Little is known about the gender identity and gender role patterns of these children (8–10).

In Green's (47) study, 11 (25%) of the boys were classified as gynephilic (Kinsey ratings of 0–1) and 33 (75%) were classified as biphilic/androphilic in fantasy (Kinsey ratings of 2–6). For behavior, 6 (20%) were classified as gynephilic and 24 (80.0%) were classified as biphilic/androphilic. The remaining 14 boys (31.8% of the total sample) could not be classified with regard to behavior because they had had no interpersonal sexual experiences. In Green's study, the sexual orientation of a comparison group of boys, who had been recruited from the community, was also assessed: 100% of these boys ($n = 35$) were classified as gynephilic in fantasy and 96% ($n = 25$) were classified as gynephilic in behavior.

In the Wallien and Cohen-Kettenis (52) study, sexual orientation was assessed for attraction (2 items), fantasy (2 items), behavior (4 items), and sexual identity (1 item) using a self-developed Sexual Orientation Questionnaire. As in Green, Kinsey-type ratings were used in the analysis. Depending on the metric, data on sexual orientation were not available for anywhere between 22 and 40 (27.2–67.7%) patients. For attraction, 32% were classified as gynephilic and 68% were classified as androphilic (total $N = 37$); for fantasy, 19% were classified as gynephilic, 19% were classified as biphilic, and 62% were classified as androphilic (total $N = 21$); for behavior, 21% were classified as gynephilic, 16% were classified as biphilic, and 63% were classified as androphilic (total $N = 19$); lastly, for sexual identity, 19% were classified as gynephilic ("heterosexual"), 19% were classified as biphilic ("bisexual"), and 62% were classified as androphilic ("homosexual") (total $N = 27$). Steensma et al. (51) used the same metrics as Wallien and Cohen-Kettenis. Depending on the metric, data on sexual orientation were not available for anywhere between 25 and 40 (31.6%–50.6%) patients. For attraction, 19.2% were classified as gynephilic, 15.4% were classified as biphilic, and 65.4% were classified as androphilic (total $N = 52$); for fantasy, 14% were classified as gynephilic, 22% were classified as biphilic, and 64% were classified as androphilic (total $N = 50$); for behavior, 35.9% were classified as gynephilic, 12.8 were classified as biphilic, and 51.3% were classified as androphilic (total $N = 39$); lastly, for sexual identity, 13% were classified as gynephilic ("heterosexual"), 27.8% were classified as biphilic ("bisexual"), and 59.3% were classified as androphilic ("homosexual") (total $N = 54$).

In recent years, there have been various criticisms of these follow-up studies [see, e.g., (60–63); for a rebuttal, see (64)], particularly with regard to the putatively high percentage of desistance. It has been questioned, for example, to what extent the patients in these studies truly had GID/GD. For example, in the early studies, prior to the publication of DSM-III, one could reasonably argue that the diagnostic status of the patients was unclear because there were no formal diagnostic criteria to rely upon. However, one could argue in return that the behavior of these boys was phenomenologically consistent with the subsequent DSM criteria.

Consider, for example, the systematic study by Green [(47), Figure 1.2]. Green reported that 15% of the feminine boys, per parent-report, had "never" expressed the desire to be a girl or a woman at the time of the baseline assessment, 60% "occasionally" had such a desire, and only 25% had such a desire

"frequently." Thus, a conservative critic might argue that only the last group would have met one of the key indicators for the GID/GD diagnosis in the DSM.⁵ On the other hand, suppose a boy "occasionally" voiced the desire to be a girl over a period of several years. One might want to make the case that this would be consistent with the DSM descriptors of "persistently" or "repeatedly," etc. Of course, one could debate what would genuinely count as "occasionally" (in Green's trichotomous metric, it would be anything more than "never" and less than "frequently"). In any case, it is probably reasonable to argue that, in Green's study, some boys were threshold and some boys were subthreshold for the equivalent of a DSM diagnosis. Given that in Green's study only one boy persisted with gender dysphoria at the time of follow-up, the threshold-subthreshold distinction would not really matter.

Studies that employed DSM criteria for GID/GD allow for a more formal examination of the "No True Scotsman" argument (https://en.wikipedia.org/wiki/No_true_Scotsman).

In the Wallien and Cohen-Kettenis (52) study, the DSM-III-R criteria were used to diagnose GID. Of the 12 persisters, all met the criteria for GID at the time of the baseline assessment; in contrast, only 68% of the 47 desisters met the criteria for GID; the remainder were deemed subthreshold for the diagnosis. Thus, in their study, the threshold-subthreshold distinction appears to have been an important one in predicting outcome; nonetheless, it should be noted that 68% of the desisters had been threshold for the diagnosis in childhood—perhaps a strong rebuttal to the No True Scotsman argument. In Steensma et al. (51), the DSM-IV-TR criteria were used. Of the 23 persisters, 21 (91.3%) met the criteria for GID; in contrast, only 22 (39.3%) of the 56 desisters were threshold for the diagnosis, suggesting an even more substantial difference in the threshold-subthreshold distinction than was found in Wallien and Cohen-Kettenis. Although the latter percentage was lower than what was found in Wallien and Cohen-Kettenis, that almost 40% of the desisters met the criteria for GID in childhood still argues in favor that the children were desisting from something.⁶

From Wallien and Cohen-Kettenis (52) and Steensma et al. (51), one predictor of outcome, therefore, was the distinction between being threshold or subthreshold for the GID diagnosis in childhood. Dimensional measures of gender-variant behavior have also proven useful. In both Wallien and Cohen-Kettenis and Steensma et al., dimensional measures of sex-typed behavior in childhood also significantly discriminated between the persisters and desisters, with the former group having, on average, more severe gender-variant behavior at the time of the childhood

⁵The situation is compounded even further because in the DSM-IV, unlike in the DSM-III and DSM-III-R (65), the stated desire to be of the other gender was not a necessary criterion for the diagnosis [for the rationale, see (66), pp. 483–486]. In DSM-5, the desire to be of the other gender does not require explicit verbalization; the clinician is allowed leeway in drawing inferences based on other sources of information [see (67), pp. 904–905].

⁶In the follow-up study by Drummond et al. (46) of 25 girls from our clinic, the desistance rate was 88%. Of the 22 desisters, 13 (59.0%) met the DSM-III, III-R or IV criteria for GID. In Wallien and Cohen-Kettenis (52), of the 9 girls who desisted, 55.5% met the DSM-III-R criteria for GID. In Steensma et al. (51), of the 24 girls who desisted, 58.3% met the DSM-IV criteria for GID.

assessment. Steensma et al. found two other predictors of persistence: boys who were assessed at an older age and boys who had made either a partial or complete gender “social transition” [see (68–70)]. Of the 12 boys who had partially or completely transitioned prior to puberty, 10 (83.3%) were classified as persisters. In contrast, of the 67 boys who had not socially transitioned, only 13 (19.4%) were classified as persisters.

In the present study, we provide follow-up data with regard to both gender identity (persistence vs. desistance) and sexual orientation (gynephilia vs. biphilia/androphilia) on the largest sample of boys studied to date. Apart from providing percentage data on these two variables, which will be discussed in a comparative perspective in relation to the prior studies and the epidemiological literature, we also examine the predictors of outcome in relation to both demographic and sex-typed behavior measures (including whether or not the boys were threshold or subthreshold for GID) collected at the time of the baseline assessment in childhood.

METHOD

Participants

The participants were 139 boys (“birth-assigned males”)⁷ who, in childhood, had been referred to and then assessed in the Gender Identity Service, Child, Youth, and Family Program at the Centre for Addiction and Mental Health (CAMH) in Toronto, Ontario between 1975 and 2009 (Mean year of assessment, 1989.36) and were adolescents or adults at follow-up (Mean year at follow-up, 2002.35).⁸

Participants entered the follow-up study through two methods of recruitment. The majority of participants (77%) were recruited for research follow-up. There were two main waves of participant recruitment through research contact, from 1986 to 1993 ($n = 32$) and then from 2009 to 2011 ($n = 71$). During the period of data collection, 32 patients re-contacted the service for clinical reasons (eight for gender dysphoria, six for sexual orientation, and 18 for heterogeneous concerns) [for details, see (77), Appendix E]. They were informed about the opportunity to participate in the follow-up study and subsequently completed the study protocol. The majority of the patient-initiated participants had contacted the clinic between the two main waves of research recruitment. Thus, from 1994 to 2008, the participants who entered the study were primarily those who had contacted the service for clinical reasons.

In the early wave of follow-up, a lower-bound age for participation was set at 14 years, but by the mid-1990s this was

changed to a lower-bound age of 16 years. In total, 110 (79.1%) participants were at least 16 years of age and 29 (20.9%) were younger than 16. Across the entire period of data collection, eligible participants, after review of the medical chart, were contacted at random (other than the participants who had returned to the service for clinical reasons). Due to lack of study resources and time constraints, contact with 162 other eligible participants was not attempted.

In total, 145 patients were approached about the follow-up study, either through research contact ($n = 113$) or following their clinical involvement with the Gender Identity Service ($n = 32$). Six patients declined, which yielded a participation rate of 95.9%. For those recruited for research purposes, initial contact, by telephone, letter or email, was first made with the parents because the patients were minors at the time of the childhood assessment and may have had no recollection of their clinic attendance. A total of 19 (14.3%) potential participants could not be reached/traced through previous addresses, registrars, and personal contacts.

Of the 139 participants, 110 were seen for a face-to-face assessment. For various reasons, the remaining 29 patients could not be seen for the face-to-face assessment (e.g., lived in another province or country, “too busy,” severe mental health issues). For some patients, they provided some information over the phone or information was provided by the parents; thus, for these patients, it was possible to obtain some follow-up data about their gender identity and sexual orientation.

The demographic characteristics of the participants, including their age at assessment in childhood and at the time of follow-up, are shown in **Table 1**. The GID diagnosis in childhood was based on the DSM-III ($n = 53$), DSM-III-R ($n = 46$), or DSM-IV ($n = 40$) criteria applicable at the time of assessment.⁹ A total of 88 (63.3%) boys met complete DSM criteria for GID in childhood. The remaining 51 (36.7%) boys were subthreshold for a DSM diagnosis, but all had some indicators of GID, and, based on the historical information provided during the assessment, some would have met the complete DSM criteria at some point in their lives prior to their assessment in childhood.¹⁰ The percentage who met the complete DSM criteria for GID did not differ significantly as a function of DSM edition, $\chi^2_{(2)} < 1$.

Procedure

The majority of participants who completed the face-to-face assessment were evaluated on a single day. Three participants were seen twice. In these instances, the participants completed the self-report measures during their second visit as the complexity of their clinical presentation extended the duration of the assessment. Participants were provided a stipend for their participation in the follow-up assessment and reimbursement for travel expenses. For participants followed-up prior to 2009 ($n = 68$), the data were collected by the third author; for those followed-up between 2009 and 2011, the data were collected

⁹For boys seen prior to the publication of DSM-III in 1980, the draft criteria were used.

¹⁰In DSM-III, termed Atypical Gender Identity Disorder; in DSM-III-R and DSM-IV, termed Gender Identity Disorder Not Otherwise Specified.

⁷Two reviewers asked why we chose to use the noun “boys” instead of the noun “males.” In our view, the question was reasonable but also a matter of semantics and taste. The third edition of *The Oxford Dictionary of Current English* (71) defines boy as “a male child...” Thus, we believe that the two words can be used synonymously. Males can refer to any age in the life-span whereas boys connote childhood. The participants in our study were coded as male at the time of their birth in the hospital delivery record, of which we had the actual birth records for the majority of the participants in the current study (72). As per Bouman et al. (73), one would say that the participants were “assigned male at birth” and then declared socially to be “boys” (74).

⁸The clinic was established in 1975 at the Clarke Institute of Psychiatry (75, 76), which became part of the CAMH in 1998.

TABLE 1 | Demographic characteristics (*N* = 139).

Characteristic	<i>M</i>	<i>SD</i>	Range	%
From childhood				
Age (in years)	7.49	2.66	3.33–12.99	
Year of birth	1981.87	7.50	1966–1996	
Year of assessment	1989.36	7.50	1975–2004	
IQ ^a	105.93	15.47	69–138	
Social class ^b	40.74	15.15	8.0–66.0	
Marital status ^c				
Two-parent family				64.7
Other				35.3
Caucasian				84.9
At follow-up				
Age (in years)	20.58	5.22	13.07–39.15	
Year of follow-up	2002.35	9.08	1986–2011	
Follow-up interval (in years) ^d	12.88	6.07	2.77–29.29	
IQ ^{e,f}	105.88	16.03	65–138	

^aFull-Scale IQ was obtained with age-appropriate Wechsler intelligence scales.

^bHollingshead's (78) Four Factor Index of Social Status (absolute range, 8–66).

^cOther included the following family constellations: single parent, separated, divorced, living with relatives, or in the care of a child protection agency.

^dInterval denotes the time between childhood assessment and follow-up assessment.

^eFull Scale IQ estimated using four subtests: Vocabulary, Comprehension, Block Design, and Object Assembly.

^fAn IQ score was available only for participants who completed the face-to-face assessment. Of these, scores were not available for one participant.

by the first author (*n* = 71). The study was approved by the Institutional Review Boards at the Clarke Institute of Psychiatry (subsequently the Centre for Addiction and Mental Health; Protocol #198/2008–2011) and the University of Toronto.

Measures

Below, we describe the measures from assessment and follow-up of relevance for this article. A list of all measures used in the follow-up study can be found in Singh [(77), Table 4].

Childhood Assessment

Cognitive Functioning

Based on the child's age at the time of assessment, the appropriate version of the Wechsler Intelligence Scale for Children was administered (WPPSI-R or the WISC-R/WISC-III/WISC-IV). Full scale IQ scores were used to characterize level of cognitive functioning.

Behavioral and Emotional Problems

Parents completed the Child Behavior Checklist (CBCL), a measure of behavioral and emotional problems (79). Although not the focus of the present study, it is noted here because we used three CBCL indices (sum of all behavior problems and Internalizing and Externalizing *T* scores) as part of an internal validity analysis when comparing participants vs. non-participants (see Results).

Sex-Typed Behavior

Five child informant and two parent informant measures were used to assess the participants' sex-typed behavior in childhood: (1) Draw-a-Person [DAP] test (80); (2) a free-play task (81); (3) the Playmate and Playstyle Preferences Structured Interview (PPPSI) (82, 83); (4) sex-typed responses on the Rorschach test (84); (5) the Gender Identity Interview for Children (GIIC) (85–87); (6) the Gender Identity Questionnaire for Children (GIQC) (88–90); and (7) a measure of activity level/extraversion [(39); see also (91)]. These child and parent informant measures all have established discriminant validity, that is, they significantly differentiated the boys clinic-referred for gender identity concerns from control boys [for reviews, see (18, 92)]. A Childhood Sex-Typed Behavior Composite was subsequently computed for each participant (see below).

Follow-Up Assessment

Cognitive Functioning

Four subtests from the age-appropriate version of the Wechsler Intelligence Scales were administered (Vocabulary, Comprehension, Block Design, and Object Assembly). The standard scores from the subtests were averaged to form a prorated IQ score for cognitive functioning (93).

Concurrent Gender Identity

Concurrent gender identity was evaluated using a semi-structured interview and self-report questionnaires. During an audiotaped interview, each participant was asked to describe their current feelings about being a biological male. They were also asked to describe positive and negative aspects about their gender identity. For example, participants who reported a "male" gender identity were asked to describe positive and negative aspects of being male. The semi-structured interview also included questions based on the adolescent and adult GID criteria outlined in the DSM-III-R or DSM-IV (65, 94). Participants were asked to respond to these questions according to the last 12 months with *No*, *Sometimes*, or *Yes* [for details, see (77), Appendix G].

Two self-report measures were also used to assess current gender identity and gender dysphoria: (1) The Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (GIDYQ-AA) (95–97) or (2) the Gender Dysphoria/Identification questionnaire (GDIQ) (98). The GDIQ was developed prior to the GIDYQ-AA. As such, the GIDYQ-AA was introduced to the protocol subsequent to the GDIQ and, as a result, the more recent participants completed the GIDYQ-AA while earlier participants completed the GDIQ.

The male version of the GIDYQ-AA was completed. This 27-item questionnaire measures gender identity and gender dysphoria in adolescents or adults; participants over the age of 17 completed the adult version and younger participants completed the adolescent version. The adolescent and adult versions are identical except that, in the adult version, the words "man" and "woman" are used instead of "boy" and "girl." Each item was rated on a 1–5 point response scale with verbal anchor points ranging from *Never* to *Always* based on a time frame of the past 12 months. Coding was such that a "lower" score signified more gender dysphoria. Item examples include the following:

“In the past 12 months, have you felt unhappy about being a man?” and “In the past 12 months, have you had the wish or desire to be a woman?” Principal axis factor analysis identified a one-factor solution that accounted for 61.3% of the variance. All factor loadings were ≥ 0.30 (median, 0.86; range, 0.34–0.96). The GIDYQ-AA has strong evidence for discriminant validity and a high threshold for specificity (i.e., low false positive rate for non-GID individuals) [see (95, 96, 99–102)].

The GDIQ (98) contains 8 items pertaining to gender identity and gender dysphoria. Factor analysis identified two factors, accounting for 31.4 and 12.5% of the variance, respectively (all factor loadings ≥ 0.45). Factor 1 consisted of five items pertaining to gender dysphoria and Factor 2 consisted of three items pertaining to gender role identification. For the present study, only the questions for Factor 1 were used. Each item was rated on a 3-point or 5-point scale for the past 12 months (see **Appendix 1** in **Supplementary Material**).

Participants were classified as having persistent gender dysphoria if their mean score on the GIDYQ-AA was ≤ 3.00 , in line with sensitivity and specificity analyses from other data sets (95, 96). For participants who did not complete the GIDYQ-AA, the GDIQ was used. A participant was classified as a persister if two or more of the following five items on the GDIQ were endorsed: wish to have been born a girl (Item 1), wish to have surgery to change body (Item 2), feel more like a girl than a boy (Item 3), wonder if would be happier as a girl (Item 4), and somewhat or very dissatisfied with being a boy (Item 5).

Information regarding participants' gender identity/gender dysphoria was also obtained during the semi-structured clinical interview and, therefore, allowed for cross-validation of these questionnaire data. For those participants who did not complete the face-to-face interview, clinical information regarding gender identity/gender dysphoria was obtained through self- or parent-report or chart review. Across the entire sample, the GIDYQ-AA was used to classify persistence or desistence for 64 participants, the GDIQ for 42 participants, and interview/chart data/parent report for 33 cases.

Sexual Orientation

Sexual orientation in fantasy was assessed with specific questions from an audiotaped face-to-face interview and the self-report Erotic Response and Orientation Scale (EROS) (103).

The interview asked about four types of sexual fantasy over the past 12 months: (1) crushes on other people; (2) sexual arousal to visual stimuli (e.g., acquaintances, partners, and individuals from movies, television, etc.); (3) sexual content of night dreams; and (4) sexual content of masturbation fantasies. During the interview, participants were not asked directly about the gender of the person or persons who elicited sexual arousal, thus allowing time for the participant to provide this information spontaneously. Directed questions about the gender of the person(s) who elicited sexual arousal were asked only if the participant did not volunteer specific information about whether their arousal was directed to same-sex or opposite-sex individuals, or both. By the end of the interview, each participant provided information about sexual arousal to both same-sex and opposite-sex individuals. Using the Kinsey scale criteria

(104), the interviewer assigned Kinsey ratings that ranged from 0 (exclusively gynephilic in fantasy) to 6 (exclusively androphilic in fantasy) for each question. A dummy score of 7 denoted that the participant did not experience or report any fantasies. A global fantasy score was also derived based on ratings from the four questions. Kinsey ratings for sexual orientation in fantasy were available for 129 participants.

Inter-rater reliability on Kinsey ratings for sexual orientation in fantasy was examined for 29 participants, selected at random. The second scorer listened to the audio recordings of the semi-structured interview, with specific attention to the information collected on sexual orientation. The inter-rater agreement on the Kinsey global fantasy rating was very good ($\kappa = 0.95$) and the kappa values for the four specific components ranged from 0.81 to 1.00.

The EROS is a 16-item self-report measure assessing sexual orientation in fantasy over the past 12 months. Half of the questions pertained to gynephilic fantasy (e.g., “How often have you noticed that you had sexual feelings [even the slightest] while looking at a woman?”) and the other half pertained to androphilic fantasy (e.g., “How often have you noticed that you had sexual feelings [even the slightest] while looking at a man?”). Participants who were 18 years and older completed the adult version and younger participants completed the adolescent version. The adolescent and adult versions are identical except that, in the adult version, the words “man” and “woman” were used instead of “boy” and “girl.” Each item was rated on a 5-point scale for frequency of occurrence, ranging from 1 (“none”) to 5 (“almost every day”). Mean androphilic and gynephilic fantasy scores were derived for each participant. In the present study, we calculated a difference score between the participants' mean androphilic and gynephilic scores. Previous use of the EROS has shown good evidence of discriminant validity (98, 101).

Sexual orientation in behavior was assessed with specific questions during the face-to-face interview and with a modified version of the Sexual History Questionnaire (SHQ) (105). In the interview, questions asked about five types of sexual behavior: (1) dating; (2) holding hands in a romantic manner; (3) kissing; (4) genital fondling or touching a woman on the breasts, and (5) intercourse (penile-vaginal and anal). Kinsey ratings for behavior in the past 12 months were made in the same manner as fantasy ratings. Kinsey ratings for sexual orientation in behavior were available for 108 participants. Inter-rater reliability on Kinsey ratings for sexual orientation in behavior was examined for the same 29 participants. There was perfect inter-rater agreement on the Kinsey global behavior rating ($\kappa = 1.0$) and the kappa values for the five specific components ranged from 0.91 to 1.00.

The modified SHQ consists of 20 questions. Ten questions pertained to gynephilic experiences (e.g., “How many women have you kissed on the lips in a romantic way?”) and 10 questions pertained to androphilic experiences (e.g., “How many men have you kissed on the lips in a romantic way?”). Participants who were 18 years and older completed the adult version and younger participants completed the adolescent version. The adolescent and adult versions are identical except that, in the adult version, the words “man” and “woman” were used instead of “boy” and “girl.” Each item was rated on a 5-point scale for frequency

of occurrence, ranging from 1 (“none”) to 5 (“11 or more”), based on a time frame of the past 12 months. Mean total scores for gynephilic and androphilic experiences were derived. In the present study, we calculated a difference score between the participants’ mean androphilic and gynephilic scores.

On the basis of Kinsey ratings, participants who completed the face-to-face interview were classified, similar to Green (47), into the following three sexual orientation groups for both fantasy and behavior: (1) gynephilic (Kinsey global ratings of 0–1); (2) biphilic/androphilic (Kinsey global ratings of 2–6), and (3) no sexual fantasy or behavior.

Social Desirability

Social desirability refers to the desire to cast a favorable impression on others. It can threaten the validity of self-report scales if in answering questions respondents seek social approval or try to represent themselves in a favorable manner (106). People scoring high on social desirability tend to provide socially acceptable answers regardless if their response accurately describes them. Participants 18 years and older completed the Marlow-Crowne Social Desirability Scale (M-CSDS) (107), which consists of 33 true-false items. The scale contains 18 culturally acceptable but unlikely statements keyed in the true direction and 15 socially undesirable but probable statements keyed in the false direction for a maximum possible score of 33. Participants 17 years and under were given a shorter version of the M-CSDS (108), containing 20 items that consist of 12 culturally acceptable but improbable statements keyed in the true direction and eight socially undesirable but probable statements keyed in the false direction for a maximum possible score of 20. For the present study, the percentage of endorsed socially desirable items was calculated for each participant. In order to integrate the data from both versions of the M-CSDS, participants’ percentage score on each measure was converted to a proportion score which ranged from 0 to 1, which was used in all analyses. A higher proportion score indicates a greater propensity to give socially desirable responses. Several studies have found that the M-CSDS is a reliable and valid measure of social desirability (107, 109, 110).

RESULTS

Preliminary Analyses

Participants vs. Non-participants

Given that not all eligible participants were seen for follow-up, it is important to see to what extent the participants vs. non-participants were similar with regard to baseline characteristics, in part to gauge the internal validity of the sample (111).

The non-participants consisted of three subgroups: (1) patients who were eligible to participate in the study but were not contacted ($n = 163$), (2) patients who declined to participate ($n = 6$), and (3) patients who were not successfully traced ($n = 19$). Two sets of analyses were conducted to compare study participants vs. non-participants. First, the participants were compared to the patients who were eligible but not contacted. Second, the participants were compared to those who declined to participate and to those where contact was attempted but not successfully traced. Group comparisons were conducted on

five demographic variables (age at assessment in childhood, IQ, ethnicity, and parents’ marital status and social class), parent-report of behavior problems on the CBCL (three indices), and nine measures of childhood sex-typed behavior.

Of these 17 variables, there was only one significant difference between the 139 boys in the study compared to the 163 boys who were eligible to participate but were not contacted: participants had a higher IQ than non-participants, $t_{(289)} = 2.01$, $p = 0.046$.¹¹ The effect size for this comparison was small (unpooled $d = 0.22$) [for details, see (77), Tables 5, 6]. When compared to the six cases where participation in the study was declined and to the 19 cases where the families could not be traced, there was also only one significant difference: parent’s marital status, $\chi^2_{(2)} = 9.02$, $p = 0.011$. The participants did not differ significantly from the non-participants who refused; however, they differed significantly from the cases that could not be traced, $\chi^2_{(1)} = 6.39$, $p = 0.012$. The participants were more likely to have originated within a two-parent household than those who could not be traced. The comparison between the non-participants who refused and those who could not be traced approached significance ($p = 0.056$, Fisher’s exact test). Again, the non-participants who could not be traced were more likely to have come from a family composition that was not two-parent. A further summary of comparisons between the participants and those who declined or could not be traced can be found in the **Supplementary Material**.

Participants: Method of Recruitment

Using t -tests or chi-square tests, the 107 participants who entered the study through research contact were compared to the 32 participants who were recruited into the study after they had re-contacted the clinic for clinical reasons on the demographic variables, CBCL behavior problems in childhood, and the measures of childhood sex-typed behavior. There were no significant differences between the two groups on the demographic variables of age at assessment, ethnicity or parents’ social class and marital status ($ps > 0.05$). The comparison on childhood IQ approached significance, $t_{(137)} = 1.97$, $p = 0.051$, with the research entry participants having, on average, a higher IQ than the clinical entry participants. On the CBCL, there was a significant difference on Internalizing problems only, $t_{(137)} = -2.02$, $p = 0.046$, with the clinical entry participants rated by their parents as having more internalizing problems compared to the research entry participants. Of the nine measures of childhood sex-typed behavior, the two groups differed significantly on three: (1) free play, $t_{(119)} = -2.11$, $p = 0.037$, (2) the Gender Identity Interview for Children, $t_{(83)} = -2.09$, $p = 0.04$, and (3) the Gender Identity Questionnaire for Children, $t_{(95)} = 2.39$, $p = 0.019$, with the clinical entry participants having, on average, more childhood cross-gender behavior than the research entry participants. The percentage of clinical entry participants who were threshold for the diagnosis of GID in childhood did not differ significantly from the research entry participants (75.8 vs. 59.8%), $\chi^2_{(1)} = 1.83$. Of the 32 clinical entry participants, 8 had re-contacted the clinic because

¹¹IQ data were not available for 11 of the 163 boys who were eligible for the study but were not contacted.

of gender dysphoria. The above-described comparisons were repeated to compare the research and clinical entry participants but with these 8 participants excluded. With the eight participants who contacted the clinic for gender dysphoria removed, there were no significant group differences on demographic variables, CBCL behavior problems, and measures of childhood sex-typed behavior (all $ps > 0.05$).

Gender Identity at Follow-Up

Appendix 2 in Supplementary Material shows the follow-up data for gender identity and sexual orientation for each participant. Of the 139 participants, 17 (12%) were classified as persisters and the remaining 122 (88%) were classified as desisters. The age at the time of follow-up did not differ significantly between the persisters (Mean, 20.12 years; SD = 5.54) and desisters (Mean, 20.64 years; SD = 5.19), $t_{(137)} < 1$. Of the 107 participants who, for research purposes only, were contacted for the follow-up study, 10 (9%) were classified as persisters; of the 32 participants who were recruited into the study after they were seen for some type of clinical concern, 7 (22%) were classified as persisters. The difference in persistence rate as a function of recruitment entry type was not significant, $\chi^2_{(1)} = 2.53$, $p = 0.112$. The difference in persistence rate between those patients seen for the face-to-face assessment vs. those who were not (14.5 vs. 3.4%) was also not significant, $\chi^2_{(1)} = 1.70$, $p = 0.192$. **Supplementary Table 1** summarizes information on some domains of gender role outcome for the 17 participants classified as having persistent gender dysphoria.

For the 42 participants where the GDIQ was used to determine gender identity status at follow-up, four were classified as persisters and 38 were classified as desisters. Of the 38 desisters, three endorsed one item and the remainder endorsed none of the items.¹² The four participants classified as persisters endorsed between three and five items.

For the 64 participants where the GIDYQ-AA was used to determine gender identity status at follow-up, 12 were classified as persisters and 52 were classified as desisters. All 52 desisters had a mean score > 3.00 on the GIDYQ-AA. Of the 12 persisters, 10 had a mean score ≤ 3.00 and two had mean scores that were > 3.00 . In spite of having mean scores on the GIDYQ-AA that were above the recommended cutoff for caseness (95), these two participants were considered persisters because their clinical interview data indicated that they were experiencing significant gender dysphoria. Thus, clinical judgment was used to make the final classification for these two participants.

For the remaining 33 participants, clinical interview, parent-report or chart data were used to classify the percentage who were persisters ($n = 1$; 3%) or desisters ($n = 32$; 97%).

The persistence rate of gender dysphoria was examined as a function of participants' GID diagnostic status in childhood (threshold vs. subthreshold). Of the 88 participants who met the full diagnostic criteria for GID in childhood, 12 (13.6%) were classified as persisters and the remaining 76 (86.4%) were

not. Of the 51 participants who were subthreshold for the GID diagnosis in childhood, 5 (9.8%) were classified as persisters and the remaining 46 (90.2%) were not. A chi-square analysis indicated that the rate of persistence did not differ significantly between the threshold and subthreshold groups, $\chi^2_{(1)} < 1$.

Over the years, prevalence rates for gender dysphoria in adults have varied considerably. The variation is likely a function of many factors, including definition, time period, and source of ascertainment. For example, in the Standards of Care of the World Professional Association for Transgender Health (112), probably relying on an estimate given in the DSM-IV-TR, the prevalence of gender dysphoria in adult males was estimated to be 1 in 30,000. In the meta-analysis by Arcelus et al. (113), the prevalence in adult males was estimated at 1 in 14,705. Lastly, Zhang et al.'s (114) review of recent population-based surveys estimated the prevalence of a self-reported transgender identity in adults to range between 0.33 and 0.53% (males and females combined). Regardless of which base rate figure one might choose to use as a point of comparison, the persistence rate of 12% (while low in an absolute sense) would be considerably higher than what one would detect in the general population.

Sexual Orientation at Follow-Up

Table 2 shows the Kinsey ratings for sexual orientation in fantasy. Data were not available for 10 participants, all of whom were desisters with regard to gender dysphoria. Based on the global rating for sexual orientation in fantasy, 43 (33.3%) participants were classified as gynephilic in fantasy and 82 (63.6%) were classified as biphilic/androphilic in fantasy. In the remaining four (3.1%) cases, the participants were classified as having no sexual fantasies and, therefore, a Kinsey rating could not be assigned.¹³ In all four cases, the participants were desisters. Of the 17 participants classified as persisters, 1 (5.9%) was gynephilic in fantasy and 16 (94.1%) were biphilic/androphilic in fantasy. For participants assigned a Kinsey rating between 0 and 6 in fantasy, we correlated the interviewer's Kinsey rating with the participants' responses on the EROS in which their mean gynephilic score was subtracted from their mean androphilic score. This yielded an $r(101) = 0.86$, $p < 0.001$.

Table 2 also shows the Kinsey ratings for sexual orientation in behavior. Data were available for 108 participants. Based on the global rating for sexual orientation in behavior, 29 (26.9%) participants were classified as gynephilic and 51 (47.2%) were classified as biphilic/androphilic. The remaining 28 (25.9%) participants did not report any sexual behaviors in the 12 months preceding the follow-up assessment. For participants assigned a Kinsey rating between 0 and 6 in behavior, we correlated the

¹³For 104 participants, the Kinsey rating in fantasy was based on the information provided in the face-to-face interview. For 21 other participants, the Kinsey rating in fantasy was based on self-report (by telephone), information available in the participant's health record, or parent-report. Participants were assigned a Kinsey rating of 6 if the participant self-identified as "gay" or if the health record indicated that the patient was "homosexual" or gay, etc. Participants were assigned a Kinsey rating of 0 if the patient self-identified as "straight" or "heterosexual," etc. A chi-square test showed that the percentage of participants who were classified as Kinsey 0-1 vs. 2-6 did not differ significantly as a function sexual orientation ascertainment method, $\chi^2_{(1)} = 1.49$.

¹²By "endorsed," we mean that the participants answered other than "never" on Items 1-4 or response options d-e for Item 5 (see **Appendix 1** in Supplementary Material).

TABLE 2 | Kinsey ratings for sexual orientation in fantasy and behavior.

Variable	Kinsey rating (fantasy) ^a															
	0		1		2		3		4		5		6		No fantasy	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Crush	36	36.7	0	0	2	2.0	4	4.1	2	2.0	11	11.2	29	29.6	14	14.3
Visual	31	31.6	1	1.0	2	2.0	10	10.2	3	3.1	12	12.2	29	29.6	10	10.2
Dreams	13	13.3	1	1.0	1	1.0	4	4.1	3	3.1	3	3.1	27	27.6	46	46.9
Masturbation	21	21.9	2	2.1	3	3.1	6	6.3	2	2.1	7	7.3	33	34.4	22	22.9
Global fantasy rating	40	31.0	3	2.3	3	2.3	8	6.2	2	1.6	14	10.9	55	42.6	4	3.1

Variable	Kinsey rating (behavior) ^a															
	0		1		2		3		4		5		6		No sexual behavior	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Holding hands	26	26.3	0	0	0	0	5	5.1	1	1.0	1	1.0	35	35.4	31	31.3
Kissing	21	21.2	0	0	0	0	6	6.1	2	2.0	2	2.0	34	24.3	34	34.3
Genital/breast contact	13	13.1	0	0	0	0	3	3.0	2	2.0	1	1.0	35	35.4	45	45.5
Intercourse	8	8.2	0	0	0	0	3	3.1	2	2.0	0	0	27	27.6	58	59.2
Global behavior rating	28	25.9	1	0.9	0	0	4	3.7	3	2.8	1	0.9	43	39.8	28	25.9

^a0 = Exclusively gynephilic to 6 = Exclusively androphilic.

interviewer’s Kinsey rating with the participants’ responses on the SHQ in which their mean gynephilic score was subtracted from their mean androphilic score. This yielded an $r(75) = 0.79, p < 0.001$.

For those participants who could be assigned a Kinsey rating (i.e., excluding those participants who did not report any sexual fantasies or behavior or for whom data were not available), the correlation between Kinsey global fantasy and global behavior ratings was very strong, $r(78) = 0.92, p < 0.001$.

Group Classification as a Function of Gender Identity and Sexual Orientation in Fantasy at Follow-Up¹⁴

Combining gender identity (i.e., persistor or desister) and sexual orientation in fantasy (i.e., gynephilic or biphilic/androphilic) at follow-up, the participants were classified into one of four outcome groups (for which we had all of the relevant data): (1) persistence of gender dysphoria with a biphilic/androphilic sexual orientation ($n = 16$); (2) desistance of gender dysphoria with a biphilic/androphilic sexual orientation ($n = 66$); (3) desistance of gender dysphoria with a gynephilic sexual orientation ($n = 42$); and (4) persistence of gender dysphoria with a gynephilic sexual orientation ($n = 1$). The participants who reported no sexual fantasies ($n = 4$) could not be included in this outcome classification. Given that only one participant was classified as gender dysphoric with a co-occurring gynephilic sexual orientation (Group 4), this category was excluded from subsequent analyses that compared these outcome groups.

¹⁴Given the strong correlation between Kinsey fantasy and behavior ratings and that there were fewer missing data on the Kinsey fantasy variable, participants were classified into one of the four outcome groups based on their fantasy ratings.

Demographic Characteristics in Childhood as a Function of Gender Identity and Sexual Orientation in Fantasy

Table 3 shows the demographic variables in childhood as a function of group. One-way ANOVAs and chi-square were conducted to evaluate whether the outcome groups differed on these variables. The groups differed significantly on four of the five childhood demographic variables. Duncan’s multiple range test for unequal Ns showed that the biphilic/androphilic persisters were, on average, significantly older at the time of the childhood assessment than both the gynephilic desisters and the biphilic/androphilic desisters, who did not differ significantly from each other. The biphilic/androphilic desisters had, on average, a higher IQ than the biphilic/androphilic persisters but did not differ significantly from the gynephilic desisters. There was no significant difference in childhood IQ score between biphilic/androphilic persisters and gynephilic desisters. The biphilic/androphilic persisters were significantly more likely to come from a lower social class background compared to the gynephilic desisters and the biphilic/androphilic desisters, who did not differ significantly from each other (see also Figure 1). The biphilic/androphilic desisters were more likely to be living with both parents compared to the biphilic/androphilic persisters. There was no significant difference on marital status between the two desister groups.

The demographic variables from childhood on which the three groups differed—age at assessment, IQ, social class, and marital status—were significantly correlated (r s ranged from $|0.32-0.58|$) [see Table 12 in (77)]. To evaluate the predictive status of these variables on group outcome at follow-up, a multinomial logistic regression was performed. Table 4 shows the results. For these analyses, the biphilic/androphilic desisters served as the reference

TABLE 3 | Demographic characteristics as a function of group.

Variable		Group			F or χ^2	p	η^2 or Cramer's V
		Persisters Biphilic/ Androphilic (n = 16)	Desisters Biphilic/ Androphilic (n = 66)	Desisters Gynephilic (n = 42)			
Childhood							
Age (in years)	M	8.85	6.96	7.49	3.57	0.031	0.06
	SD	1.67	2.69	2.62			
IQ ^a	M	101.63	110.20	103.18	3.77	0.026	0.06
	SD	14.81	14.56	15.16			
Social class ^b	M	23.76	44.97	39.44	15.30	<0.001	0.20
	SD	10.22	13.64	15.91			
Marital status^c							
Two-parent	N (%)	7 (43.8)	49 (74.2)	24 (57.1)	6.74	0.034	0.23
Other	N (%)	9 (56.3)	17 (25.8)	18 (42.9)			
Ethnicity							
Caucasian	N (%)	14 (87.5)	58 (87.9)	32 (76.2)	2.77	0.250	0.14
Other	N (%)	2 (12.5)	8 (12.1)	10 (23.8)			
Follow-up							
Age at follow-up (in years) ^d	M	20.32	22.13	17.85	10.41	<0.001	0.15
	SD	5.67	4.97	3.95			
IQ at follow-up ^{a,e,f}	M	99.07	110.47	104.19	3.82	0.025	0.07
	SD	16.29	13.54	17.50			
Follow-up interval (in years)	M	11.47	15.17	10.36	9.63	<0.001	0.04
	SD	6.77	6.03	4.85			
Social desirability ^g	M	0.44	0.43	0.52	3.07	0.051	0.07
	SD	0.17	0.18	0.19			

^aFull-Scale IQ was obtained with age-appropriate Wechsler intelligence scales.

^bHollingshead's (78) Four Factor Index of Social Status (absolute range, 8–66).

^cOther included the following family constellations: single parent, separated, divorced, living with relatives, or in the care of a child protection agency.

^dInterval denotes the time between childhood assessment and follow-up assessment.

^eFull Scale IQ was estimated using four subtests: Vocabulary, Comprehension, Block Design, and Object Assembly.

^fAn IQ score was available only for participants who completed the face-to-face assessment.

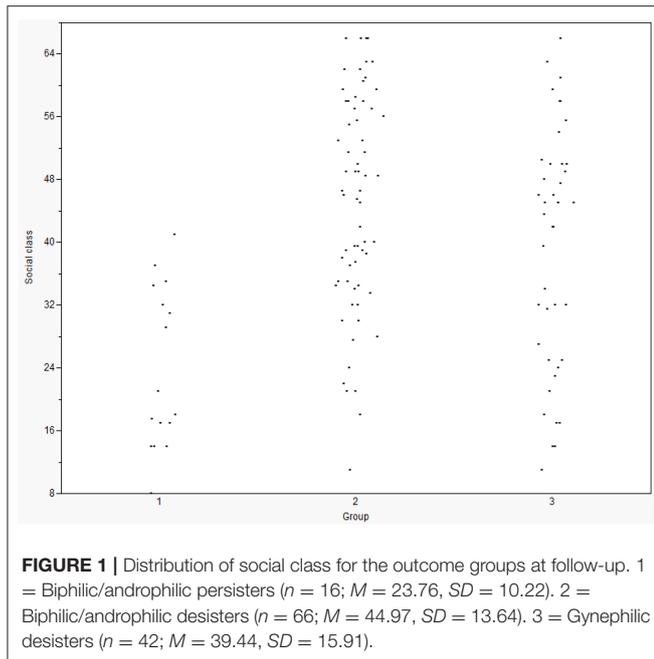
^gAbsolute range, 0.00–1.00. Higher score indicates a greater propensity to give socially desirable responses. Age at follow-up, IQ at follow-up, social class, and parent's marital status were co-varied.

group. Each coefficient, *B*, represents the change in the log odds for Group for a 1-unit increase in the corresponding predictor, controlling for all other predictors in the model. The next column presents the standard error (SE) for each *B*. The Wald statistic was the quantity used to determine the significance level of each predictor variable. The quantity, e^B , is the multiplicative change in the odds of being classified as a biphilic/androphilic persister (Model 1) or a gynephilic desister (Model 2) for a 1-unit increase in the corresponding predictor, and thus $100 \times (e^B - 1)$ represents the percentage change in the odds ratio for a 1-unit increase in that predictor (115).

It can be seen from **Table 4** that only social class had a significant contribution to the prediction of group outcome at follow-up (see also **Figure 1**). The biphilic/androphilic persisters had a 13% increase in odds of coming from a lower social class background compared to the biphilic/androphilic desisters.

However, social class did not predict outcome when the two desister groups were compared.

Table 3 also shows the variables of age, IQ, and social desirability scores at follow-up as a function of group. One-way ANOVAs revealed that both age and IQ differed significantly among the three groups ($ps < 0.01$), but social desirability scores did not. Duncan's multiple range test for unequal Ns showed that the gynephilic desisters were, on average, younger than both the biphilic/androphilic persisters and the biphilic/androphilic desisters (both $ps < 0.05$), who did not differ significantly from each other. Regarding IQ at follow-up, the results were similar to those for IQ in childhood. The biphilic/androphilic desisters had, on average, a higher IQ than the biphilic/androphilic persisters ($p < 0.05$) but did not differ significantly from the gynephilic desisters. There was no significant difference in IQ between the biphilic/androphilic persisters and the gynephilic desisters.



Childhood Sex-Typed Behavior as a Function of Gender Identity and Sexual Orientation at Follow-Up Supplementary Table 2 shows the means or percentage scores (for dichotomous measures) of the nine sex-typed measures obtained at the assessment in childhood as a function of the three outcome groups. ANCOVAs (with age at assessment, IQ, social class, and marital status covaried) or chi-square were used to examine whether the groups differed on any of these variables.¹⁵ There was a significant difference between the groups on four child-report measures (first drawn person on the Draw-a-Person, free play, Gender Identity Interview, and cross-sex peer preference on the Playmate and Play Style Preferences Structured Interview, and one parent-report measure (Gender Identity Questionnaire for Children). A statistical summary of these individual measures can be found in the **Supplementary Text** and the data are shown in **Supplementary Table 2**.

The childhood sex-typed behavior measures on which the groups differed were all significantly correlated (r s ranged from $|0.30-0.76|$) [reported in (77), Table 15].¹⁶ From these six measures (first drawn person on the Draw-a-Person, free play, Gender Identity Interview, cross-sex peer preference on the Playmate and Play Style Preferences Structured Interview, cross-sex toy preference on the Playmate and Play Style Preferences Structured Interview, and the Gender Identity Questionnaire for Children), a composite score of childhood sex-typed behavior was derived for each participant by taking the average of the

six variables (each expressed as z -scores).¹⁷ A higher composite z -score indicates more cross-gender behavior at the assessment in childhood.

To evaluate the influence of childhood sex-typed behavior and demographic variables on group outcome at follow-up, a multinomial logistic regression was performed using the composite score and the demographic variables on which the groups differed—age at assessment, IQ, and social class—as predictor variables. It can be seen from **Table 5** that both social class and the composite score of childhood sex-typed behavior were significant predictors of group outcome at follow-up in the first model, which compared the biphilic/androphilic persisters to the biphilic/androphilic desisters.

The biphilic/androphilic persisters had a 274% increase in odds of having a higher composite score (i.e., more childhood cross-gender behavior) and an 11% reduction in the odds of coming from a higher social class compared to the biphilic/androphilic desisters. Age at childhood assessment and IQ did not have a significant effect on group outcome (both p s > 0.05). In the second model, which compared the gynephilic desisters to the biphilic/androphilic desisters, the only significant predictor of group outcome was the composite measures of sex-typed behavior. The biphilic/androphilic desisters had a 48% increase in odds of having a higher composite score compared to the gynephilic desisters.

DISCUSSION

Methodological Issues

We were not able to recruit into the study all eligible patients; however, our analyses which compared the participants vs. the non-participants did not show any substantive or pervasive differences with regard to the baseline assessment characteristics, suggesting that the internal validity of the sample was not grossly compromised (111). The majority of follow-up participants were recruited for research purposes; however, a minority entered the study after having been seen in adolescence for some clinical issue. There was some evidence that the patients who were enrolled in the study after recontacting the clinic were, on average, more extreme in their gender-variant behavior in childhood; however, the percentage who were threshold for the GID diagnosis in childhood did not differ significantly between the two subgroups. Although the percentage of persisters was higher in the subgroup that had recontacted the clinic than the subgroup recruited for research purposes only (22% vs. 9%), the difference was also not statistically significant. If anything, the direction of the difference would suggest that the overall rate of persistence may have been slightly overestimated had we relied entirely on a “research-only” follow-up sample.

Another methodological issue is that we relied on different metrics to assess gender identity and gender dysphoria at follow-up. For example, we replaced the GDIQ with the GIDYQ-AA as we viewed the latter as a better measure; in some instances,

¹⁵The ANCOVA model was adjusted to accommodate a categorical covariate.

¹⁶Although the groups did not differ significantly on cross-sex toy preference on the PPPSI, this measure is included here because there was a trend in the direction of a significant group difference.

¹⁷For some participants, data were not available on all six measures. In these cases, the composite score was the average of the number of variables for which there were data.

TABLE 4 | Multinomial logistic regression of group outcome at follow-up.

Predictor	Biphilic/Androphilic persisters					Gynephilic desisters				
	B	SE	Wald	p	e ^B	B	SE	Wald	p	e ^B
Age at assessment	0.11	0.14	0.62	0.433	1.12	-0.02	0.09	0.03	0.856	0.98
IQ	0.02	0.03	0.85	0.358	1.02	-0.02	0.02	1.91	0.167	0.98
Social class	-0.14	0.04	13.66	<0.001	0.87	-0.01	0.02	0.13	0.716	0.99
Marital status	0.76	0.80	0.88	0.349	0.47	-0.43	0.52	0.70	0.402	1.54

Reference group is the Biphilic/Androphilic Desisters. This group was chosen as the reference because it had the largest group size.

TABLE 5 | Multinomial logistic regression predicting group outcome at follow-up.

Predictor	Biphilic/Androphilic persisters					Gynephilic desisters				
	B	SE	Wald	p	e ^B	B	SE	Wald	p	e ^B
Age at assessment	0.26	0.16	2.90	0.09	1.30	-0.14	0.11	1.55	0.21	0.87
IQ	0.02	0.03	0.58	0.45	1.02	-0.03	0.01	2.77	0.10	0.97
Social class	-0.12	0.03	12.28	<0.001	0.89	-0.01	0.01	0.51	0.47	0.99
Composite z-score	1.32	0.55	5.82	0.02	3.74	-0.66	0.31	4.38	0.04	0.52

Reference group is the Biphilic/Androphilic Desisters. This group was chosen as the reference because it had the largest group size. A preliminary analysis with marital status included as a predictor variable showed that it did not have a significant effect and was, therefore, excluded in the final regression model. As suggested by Reviewer 3, per Benjamin et al. (116), for the “discovery of new effects,” p-values between 0.05 and 0.005 should be viewed as “suggestive” (i.e., informative, but cautiously interpreted), and p-values < 0.005 as “significant” (i.e., stronger evidence for the implausibility of a difference merely by chance).

we relied solely on interview data or information available in the patient’s medical chart. However, we did not detect any substantive difference in the percentage of persisters across these different sources of information and thus do not believe that such method variance challenges the validity of the findings.

Although a minority of participants were seen on more than one occasion for follow-up, the majority were not. Thus, our results and interpretation of the follow-up data are largely limited to one “moment in time,” at a mean age of 20.58 years. It would, of course, be of value to have additional follow-up of the patients as they move further into adulthood in order to assess the stability (or lack thereof) of the data with regard to both gender identity and sexual orientation. In our own clinical experience, for example, we have observed that some of the patients seen during adolescence “fluctuated” between self-identifying as transgender and self-identifying as gay. Others have noted that a small number of apparent or presumed desisters during adolescence subsequently identified as transgender when seen at a later point in time (117).

Summary of Key Findings

The present study provided follow-up data with regard to gender identity and sexual orientation in boys referred clinically for gender dysphoria. There were three key findings: (1) the persistence of gender dysphoria was relatively low (at 12%), but obviously higher than what one would expect from base rates in the general population; (2) the percentage who had a biphilic/androphilic sexual orientation was very high (in fantasy: 65.6% after excluding those who did not report any sexual fantasies; in behavior: 63.7% after excluding those who did not have any interpersonal sexual experiences), markedly higher than what one would expect from base rates in the general

population; (3) we identified some predictors (from childhood) of long-term outcome when contrasting the persisters with a biphilic/androphilic sexual orientation with the desisters with a biphilic/androphilic sexual orientation and when contrasting the desisters with a biphilic/androphilic sexual orientation and the desisters with a gynephilic sexual orientation.

The 12% persistence rate was somewhat lower than the overall persistence rate of 17.4% from the prior follow-up studies of boys combined. When compared to the three most methodologically sound follow-up studies, the persistence rate was higher than the 2.2% rate found by Green (47), but lower than the 20.3% rate found by Wallien and Cohen-Kettenis (52) and the 29.1% rate found by Steensma et al. (51). There is one methodological caveat regarding the Steensma et al. study that is worth noting. In their study, the mean interval between assessment and follow-up was relatively short (7.21 years). The patients were eligible for follow-up if they were at least 15 years of age. Given the relatively short interval between the assessment in childhood and the follow-up assessment in adolescence, this meant that patients who had been assessed at younger ages in childhood would not have been old enough to participate in the follow-up assessment. Given that Steensma et al. found that (older) age at the time of the assessment in childhood was a significant predictor of persistence, it is conceivable that their persistence rate was an overestimate. Nonetheless, in the broadest sense, our data were quite consistent with the general finding from the prior follow-up studies that desistance from gender dysphoria is by far the more common outcome.

In our study, we did not find that persistence was more common among boys who were threshold for the diagnosis of GID when compared to the boys who were subthreshold (13.6% vs. 9.8%) although the pattern was in the same direction

as that found by Wallien and Cohen-Kettenis (52) and Steensma et al. (51). We would, therefore, argue that the threshold-subthreshold distinction should not be abandoned in future follow-up studies although such studies might profit from using a symptom count of DSM indicators in addition to the dichotomous coding of the diagnosis as threshold vs. subthreshold. Consistent with both Wallien and Cohen-Kettenis and Steensma et al., our composite measure of sex-typed behavior in childhood was a significant predictor of outcome in that the patients classified as persisters with a biphilic/androphilic sexual orientation had more severe gender-variant behavior than the patients classified as desisters with a biphilic/androphilic sexual orientation; in addition, desisters with a biphilic/androphilic sexual orientation had more gender-variant behavior than the desisters with a gynephilic sexual orientation. Thus, dimensional measurement of gender identity and gender role behaviors from childhood provides added nuance in characterizing longer term trajectories with regard to both gender identity and sexual orientation.

With regard to sexual orientation at follow-up, the percentage of patients with a biphilic/androphilic sexual orientation in either fantasy or behavior was reasonably similar to those reported on in the prior follow-up studies which included standardized assessment measures (47, 51, 52). This finding also converges with three representative, general population prospective studies (118–120) and many retrospective studies (43) which document a significant association between patterns of gender-typed behavior in childhood and later sexual orientation.

The multinomial logistic regression analysis (**Table 4**) also showed a trend for the persisters with a biphilic/androphilic sexual orientation to be older at the time of the assessment in childhood compared to the desisters with a biphilic/androphilic sexual orientation; however, when the composite measure of sex-typed behavior in childhood was added to the equation (**Table 5**), age at assessment in childhood no longer showed such a trend [cf. Steensma et al. (51)]. In our smaller study of girls with GID (46), the persisters were, on average, 2.5 years older than the desisters at the time of the assessment in childhood (11.08 vs. 8.59 years) although the difference was not significant. It is our view that age at the time of a childhood assessment in relation to long-term outcome should continue to be examined in future follow-up studies.

Social class was a significant predictor of outcome: the persisters with a biphilic/androphilic sexual orientation were from a lower social class background compared to the desisters with a biphilic/androphilic sexual orientation (even after controlling for the other demographic variables). Why might this be the case? Because we had not made formal a priori predictions of outcome regarding any of our demographic variables, it is, of course, important to see whether or not it will be replicated in new follow-up studies. At present, our interpretation of the social class effect reflects on its relationship to other literatures.

One possibility pertains to the notion that acceptance of a gay or homosexual sexual identity is less in “working class” subculture (121). If this is, in fact, the case, it has been argued that transitioning from male to female—the so-called “homophobic” hypothesis with regard to gender dysphoria in adults (122)—would allow an androphilic sexual orientation to be more

acceptable. Future studies would need to systematically examine whether boys with persistent GID first attempt to live as gay men before transitioning to the female gender role and whether or not this temporal sequence, when it occurs, is related to social class background.

In the present study, it could be hypothesized that the parents of persisters held less favorable views of androphilia (homosexuality) compared to the desisters and thus predisposed to persistence in order to “normalize” one’s sexual orientation. However, this is simply a conjecture as parental attitudes toward homosexuality were not measured in the study sample. Indeed, none of the follow-up studies to date on boys with gender dysphoria have specifically examined attitudes toward homosexuality as a predictor of outcome.

Social class could also be a proxy for other explanatory factors. For example, in the present study, a lower social class background was significantly correlated with age at assessment in childhood ($r = 0.44$) and families where there had been a separation/divorce, etc. ($r = 0.58$). If one wanted to make the case that a later age at assessment might be associated with persistence (for a variety of reasons), perhaps social class is associated with a “delay” in seeking out an assessment and possible treatment (e.g., family stress, various other mental health challenges in the child and/or the family, etc.). In one study comparing the demographic characteristics of children vs. adolescents clinic-referred for gender dysphoria, it was found that the adolescents were more likely than the children to come from a lower social class background and from families in which there had been a separation/divorce, etc. (123).

Clinical Implications

What clinical implications might be drawn from our data on the persistence and desistence rates of gender dysphoria in children? First, it should be recognized that the boys in the current study were seen during a period of time when treatment recommendations, if such were made, often aimed to reduce the gender dysphoria between the child’s felt gender identity and biological sex. If one peruses the treatment literature, such recommendations were carried out using many therapeutic modalities: psychotherapy or psychoanalysis, behavior therapy, group therapy, parent-counseling, and interventions in the naturalistic environment, such as encouragement of same-sex peer relations [see, e.g., (124–126); for reviews, see (127, 128)].¹⁸

¹⁸This “broad stroke” summary of therapeutic goals is not meant to minimize the complexity of ethical issues regarding how treatment has been conceptualized over the years [see, e.g., (129–133)]. In the early years, treatment recommendations included other goals: for example, Bakwin (44) wrote that “Suggestions for management... [were]... designed to encourage gender appropriate behavior and to prevent homosexuality” [p. 620, emphasis added; see also (134)]. Rekers (135) was subsequently quite transparent regarding the influence of his own religious beliefs in formulating treatment goals, sometimes congruent with parents’ religious beliefs (see p. 131). Prayer appears to have guided Rekers’ selection of behavior therapy as a treatment modality for the treatment of his patients with childhood GID (p. 131). Money and Russo (50) wondered what the course of psychosexual differentiation might be if “a group of boys with discordance of gender identity/role [were] transferred from the home of origin to, say, a children’s recovery center or foster home... as happens in the case of child-abuse dwarfism...” (p. 40). In our own clinic, although some parents might have desired or requested that treatment be designed in order to prevent homosexuality, this was a goal that we never endorsed [see (136), pp. 391–393]. Over the years, many secular-minded

In our own sample, the kinds of treatments that the boys received, if any, were quite variable but it is beyond the scope of this article to describe them in general [however, for examples, see (136, 140, 141)]. It can, however, be said with certainty that the vast majority of boys were seen during a particular period of time when the therapeutic approach of recommending or supporting a gender social transition prior to puberty was not made. Indeed, in the current study, there was only one patient who had socially transitioned prior to puberty (at the suggestion and support of the professionals involved in this individual's care) and this particular patient was one of the persisters with a biphilic/androphilic sexual orientation. Second, it should also be recognized that, for the boys seen in the current study, none who were in late childhood and had (likely) entered puberty (Tanner Stage 2) had received puberty-blocking hormone treatment (GnRH analogs) to suppress somatic masculinization (142, 143) until sometime during adolescence.

In contrast, in recent years, it has become more common for some clinicians to recommend a gender social transition prior to puberty [e.g., (69, 144–147); for discussion, see (148–150)]. It has also become more common for parents to have already implemented a gender social transition on their own, without any formal input from a health professional (151). As argued by Zucker (64, 152), this is a very different type of psychosocial treatment designed to reduce gender dysphoria when compared to the other kinds of treatments noted above that have been recommended over the years.

The study by Steensma et al. (51), which found the highest rate of persistence, included some patients who had made a partial or complete gender social transition prior to puberty and this variable proved to be a unique predictor of persistence (see the Introduction). Rae et al. (153) recruited from a variety of community groups a sample of 85 markedly gender non-conforming children (Mean age, 7.5 years), none of whom had socially transitioned at a baseline assessment. At the time of follow-up, at a mean of 2.1 years later, 36 (42.3%) had socially transitioned and 49 (57.6%) had not. Using a composite of various metrics of gender identity and gender role behaviors, Rae et al. found that those who subsequently socially transitioned had more extreme gender-variant behavior at baseline than those who had not. Thus, this short-term follow-up study was consistent

clinicians—although clearly opposed to any type of preventive efforts with regard to sexual orientation—argued in favor of reducing gender dysphoria vis-à-vis natal sex, if that was feasible. Meyer-Bahlburg (125), for example, wrote: "... we cannot rule out the possibility that early successful treatment of childhood GID will diminish the role of a continuation of GID into adulthood. If so, successful treatment would also reduce the need for the long and difficult process of sex reassignment which includes hormonal and surgical procedures with substantial medical risks and complications" (p. 362). Along similar lines, Cohen-Kettenis and Pfäfflin (33) remarked: "Relatively little dispute exists regarding the prevention of transsexualism, though evidence about the effectiveness of treatment in preventing adult transsexualism is also virtually nonexistent" (p. 120). In more recent years, what the best-practice should be for the treatment of gender dysphoria in children has been widely discussed and debated, which highlight the various limitations of treatment effectiveness studies (137–139).

with the longer-term findings reported on by Wallien and Cohen-Kettenis (52), Steensma et al. (51), and the present study.

To date, however, there are no long-term follow-up studies of clinic-referred samples of children who had all socially transitioned prior to puberty. Future follow-up studies should be able to capture a much larger subgroup of such children and compared to those who have not with regard to long-term outcome with regard to persistence and desistance [e.g., (154)]. The persistence-desistance rates found in this study and the ones preceding it can be used as a comparative benchmark for samples in which a social transition took place prior to puberty.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The research protocol was reviewed and approved by Clarke Institute of Psychiatry (subsequently the Centre for Addiction and Mental Health) and the University of Toronto. All participants who completed the face-to-face assessment gave written informed consent.

AUTHOR CONTRIBUTIONS

DS contributed to the conceptualization, data collection, data analysis, interpretation, and writing of the paper. SB contributed to the conceptualization and interpretation of the study. KZ contributed to the conceptualization, data collection, data analysis, interpretation, and writing of the paper. All authors contributed to the article and approved the submitted version.

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SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: <https://www.frontiersin.org/articles/10.3389/fpsy.2021.632784/full#supplementary-material>

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Original article

Impact of Bathroom Discrimination on Mental Health Among Transgender and Nonbinary Youth

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ABSTRACT

Purpose: Nascent research has found that transgender and/or nonbinary (TGNB) youths experience higher rates of poor mental health outcomes than cisgender youths. The minority stress model highlights experiences of rejection and discrimination on mental health disparities for TGNB individuals.

Methods: Using data from a quantitative cross-sectional survey of TGNB youth aged 13–24 years, we examined the association between experiencing bathroom discrimination and depressive mood, seriously considering suicide, and attempting suicide.

Results: Overall, 58% of TGNB youths in this sample reported being prevented or discouraged from using a bathroom that corresponds to their gender identity. Among the TGNB youth who experienced bathroom discrimination, 85% reported depressive mood and 60% seriously considered suicide. Furthermore, 1 in three TGNB youths who experienced bathroom discrimination reported a past-year suicide attempt, with 1 in five reporting multiple suicide attempts. After adjusting for demographic variables and general discrimination due to one's gender identity, bathroom discrimination significantly increased the odds of reporting depressive mood (adjusted odds ratio [aOR] = 1.34), seriously considering suicide (aOR = 1.40), a suicide attempt (aOR = 1.66), and multiple suicide attempts (aOR = 1.71).

Conclusions: These findings suggest that preventing TGNB youths from accessing appropriate bathrooms is associated with harmful mental health indicators. Addressing the suicide disparities for TGNB youths requires structural change. Policies and procedures need to be in place to ensure that all youths have equal access to appropriate bathrooms.

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IMPLICATIONS AND CONTRIBUTION

Understanding factors contributing to mental health outcomes is crucial for addressing disparities for transgender and nonbinary youths. Transgender and nonbinary youths who experienced bathroom discrimination were at increased odds of depressed mood and suicidality, suggesting that preventing transgender and nonbinary youths from accessing appropriate bathrooms is associated with harmful mental health indicators.

Considerable research has found that lesbian, gay, bisexual, queer, and questioning (LGBTQ) youths disproportionately experience negative mental health outcomes. LGBTQ youths are more likely to report depression, anxiety, and other forms of emotional distress [1,2] as well as self-harm, suicidal ideation,

and attempted suicide compared with straight cisgender youths [3–5]. The few studies that have examined mental health outcomes among transgender and nonbinary (TGNB) youths, those whose sex assigned at birth is different from their current gender identity, find that they are at increased risk of poor mental health outcomes compared with their cisgender peers. Transgender youths report higher rates of depression, self-harm, and suicidality than their cisgender peers [6–8]. More recently, studies comparing TGNB youths with their cisgender lesbian, gay, or bisexual peers found that TGNB youths were at highest risk for

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depressive symptoms and suicidality [9,10]. Disparities in mental health outcomes between TGNB youths and their cisgender peers are thought to stem from chronic stress as a result of the marginalized social status that TGNB individuals have in society [11–13]. Distal stressors (external events and conditions) include rejection, victimization, and discrimination, which are experienced by TGNB youths at higher rates compared with their cisgender peers [14–16]. One form of discrimination specific to TGNB individuals is the denial of access to appropriate bathrooms.

TGNB youths often report bathroom access as one of their most pressing challenges [17,18]. National attention was brought to this issue in the United States when North Carolina passed the Public Facilities Privacy & Security Act, also known as HB2, restricting the use of government building bathrooms to those that correspond with the sex listed on an individual's birth certificate and the resultant legislative battles and advocacy efforts to fight it. Access to bathrooms that match their gender identity affords broad benefits including prevention from harm and reduced dysphoria. Specifically, providing gender-neutral bathrooms or allowing youths to use the bathroom that corresponds to their gender identity can be viewed as part of gender-affirming support and care. Gender-affirming care for TGNB youths may involve social, medical, and legal aspects. Social transition involves encouraging TGNB youths to present in the way that feels most genuine to them. TGNB children who have socially transitioned demonstrate comparable levels of self-worth and depression as non-TGNB children [19,20]. Social transitioning can also reduce suicide ideation and attempts in transgender individuals [21,22]. Inclusive bathroom policies support TGNB youths in their social transition by allowing them to present authentically and affirming their doing so [23].

However, TGNB students often report that school staff place limitations on their bathroom or locker room use [15,24–26]. A national study found that 26% of TGNB people were denied access to gender-appropriate bathrooms across all educational settings and 22% of TGNB people were denied access in the workplace [27]. When using gendered-segregated restrooms, TGNB individuals report verbal and physical harassment [28]. TGNB youths report having challenges using public bathrooms and feeling unsafe in public bathrooms [29,30], and youths whose bathroom and locker room use are restricted to their sex assigned at birth report higher rates of sexual assault [24]. These bathroom experiences, or the anticipation of experiencing them, have serious impacts on TGNB youths. They may lead to physical health consequences for TGNB youths, related to avoiding using the bathroom in public and drinking less fluids and social consequences resulting from avoiding going out in public altogether [28]. In addition, studies of transgender students' access to college bathrooms and housing found that denial of either of these spaces was significantly related to attempted suicide, even after controlling for interpersonal victimization [26]. Among transgender high-school students, lack of bathroom safety mediated the disparities in feelings of overall school safety, self-esteem, and academic achievement compared with cisgender youths [31]. Overall, the findings of previous research suggest that failing to provide TGNB youths with access to adequate bathrooms places them at risk for both physical and psychological harm.

Although previous studies have contributed to our understanding of how bathroom access can impact transgender youths, there are still some shortcomings that should be addressed. Most of the studies fail to include nonbinary youths; however, using a

space predicated on the assumption that gender is binary, is inherently problematic for youths who are nonbinary. In addition, previous studies have only used regional samples. Finally, many of the previous studies only examine youths' bathroom experiences specific to school and workplace settings. The present study contributes to our current understanding of factors associated with increased rates of negative mental health outcomes among TGNB youths by examining the impact of bathroom discrimination on depressive mood, seriously considering suicide, and suicide attempts in a large, national sample of LGBTQ youth aged 13–24 years. We hypothesize that experiencing bathroom discrimination will be related to greater reports of negative mental health in the past year.

Methods

Participants and procedures

A sample of youths between the ages of 13 and 24 years residing in the United States were recruited through targeted Facebook and Instagram ads from February 2018 to September 2018. The ads were targeted at those who interacted with material considered to be relevant to the LGBTQ community. Recruitment was conducted to attempt to obtain adequate sample sizes with respect to geography (representation from each state in the United States). Participants completed a secure online questionnaire that included up to 110 questions, depending on skip logic. Consistent with Institutional Review Board protocol, a statement was included before mental health and suicidality questions that directed participants to call The Trevor Project's 24/7 Lifeline if they wanted to talk to someone about their mental health or thoughts of suicide. Survey completion took an average of 32 minutes, and respondents who completed the survey were eligible to be entered into a drawing for a \$50 Amazon gift card by providing their e-mail address after being routed to a separate survey. The research proposal and protocol were approved by an independent institutional review board, Solutions Institutional Review Board. A waiver of parental consent was granted to protect youths from having their LGBTQ identity disclosed to a parent, which could potentially place them at risk for psychological or physical harm or result in a sample of youths who only have parents who are supportive.

Measures

Bathroom discrimination. Youths' lifetime experiences with bathroom discrimination were assessed by asking, "Have you ever been prevented or discouraged from using a bathroom that corresponds to your gender identity?"

Gender identity–based discrimination. To control for the impact of reports of general gender identity discrimination, youths were asked, "Have you ever been the subject of discrimination because of your gender identity?"

Depressive mood. Past-month depressed mood was measured using an item based on the Center for Disease Control and Prevention's (CDC) Youth Risk Behavior Surveillance System (YRBS) [4]. Youths were asked, "During the past 12 months, did you ever feel so sad or hopeless almost every day for 2 weeks or more in a row that you stopped doing some usual activities?"

Seriously considered suicide. Youths' reports of seriously considering suicide in the past 12 months were assessed using an item based on CDC's YRBS [4]. Youths were asked, "During the past 12 months, did you ever seriously consider attempting suicide?"

Suicide attempts. Based on CDC's YRBS [4], youth were asked "During the past 12 months, how many times did you actually attempt suicide?" with responses for "attempted suicide" coded as no attempts compared with 1 or more attempts and "multiple suicide attempts" coded as zero or 1 attempt compared with two or more attempts.

Sociodemographics. We also assessed sociodemographic variables that were thought to impact the mental health outcomes in this group. Youths' sexual orientation was assessed using a question from the National Center for Health Statistics [32]. Respondents were asked, "Do you think of yourself as" with the options (1) gay or lesbian; (2) straight, that is not gay or lesbian; (3) bisexual; (4) something else; and (5) do not know. Youths were asked to select their age using whole numbers from 13 to 24, and they were categorized as 13–17 and 18–24 to reflect minor status. Ethnicity was assessed by asking youths, "Do you consider yourself to be Hispanic or Latino?" Race was separately assessed by asking youths, "What race or races do you consider yourself to be?" Race/ethnicity was recoded as white non-Hispanic versus youth of color for the logistic regression analyses. To assess sex assigned at birth [33], youths were asked, "What sex were you assigned at birth? (meaning the sex showing on your original birth certificate)," with options of male or female. Youths were also asked, "What is your gender identity? Please select all that apply," with options (1) man; (2) woman; (3) transmale/transman; (4) transfemale/transwoman; (5) gender queer/gender nonconforming; and (6) different identity (please state). Youths who responded that their sex assigned at did not birth matched their current gender identity were coded as TGNB.

Data analysis

Identifying the analytical sample. A total of 34,808 youths consented to complete the online survey. Youths who lived outside of the United States (n = 475) and those who were both straight and

cisgender (n = 294) were removed from the sample as they did not meet study criteria. In addition, a filter was applied such that any youth who a) responded to less than half the survey items or b) reached the end of the survey within 3 minutes (n = 8,091) were removed from the sample. The remaining data were examined for validity, and 52 (.15%) youth who provided highly unlikely answers (e.g., selecting all possible religious affiliations and race/ethnicity categories) and/or those who provided obvious anti-LGBTQ speech in the open-responses options were also removed for a sample of 25,896 LGBTQ youths. However, given our focus on TGNB youths' experiences with bathroom discrimination, these analyses excluded cisgender youths whose assigned sex at birth was consistent with their current gender identity (n = 17,031), youths who did not respond to the assessment of gender (n = 498), and youths who did not respond to the assessment of bathroom discrimination (n = 997). This resulted in a final analytical sample of 7,370 TGNB youths.

Analytic procedure. Bivariate comparisons were run comparing TGNB youths who experienced bathroom discrimination and those who did not on all predictor and outcome variables. Chi-square analyses were used to examine the difference in mental health between TGNB youths who experienced bathroom discrimination and those who had not. Logistic regression, controlling for the impact of demographic variables known to be associated with mental health as well as the impact of gender identity–based discrimination, was used to determine the relative odds of a poor mental health outcome among TGNB youths.

Results

Descriptive analyses

Of the 7,370 TGNB youths in the sample, 44% were transgender, 82% were assigned female at birth, 45% were 18–24 years of age, 12% Hispanic, and 73% White (See Table 1). In addition, 27% of the TGNB youths in this sample reported their sexual orientation as gay or lesbian, 29% as bisexual, 2% as straight, and 42% said it was "something else." Overall, 58% of TGNB youths in the sample reported ever having experienced bathroom discrimination. Transgender youths reported higher rates of bathroom discrimination (86%) than nonbinary youths (36%).

Table 1
 Sample characteristics (n = 7,370)

% (n)	All TGNB youths (n = 7,370)	TGNB youths who did not experience bathroom discrimination (n = 3,099)	TGNB youths who experienced bathroom discrimination (n = 4,262)	p value
Age 18–24 years	44.9 (3,309)	47.9 (1,486)	42.7 (55.1)	$\chi^2(1) = 19.95, p < .001$
Assigned female at birth	82.2 (6,050)	76.3 (2,363)	86.5 (3,687)	$\chi^2(1) = 128.99, p < .001$
Race/Ethnicity				$\chi^2(5) = 25.88, p < .001$
Hispanic	12.3 (892)	12.7 (389)	12.0 (503)	
White	73.2 (5,297)	72.1 (2,203)	74.0 (3,094)	
Black/African American	2.1 (154)	2.9 (90)	1.5 (64)	
Asian/Pacific Islander	2.7 (192)	3.1 (95)	2.3 (97)	
American Indian/Alaskan Native	.8 (61)	.9 (27)	.8 (34)	
More than one race	8.8 (638)	8.2 (251)	9.3 (387)	
Sexual Orientation				$\chi^2(3) = 75.01, p < .001$
Gay or lesbian	26.9 (1,913)	30.6 (925)	24.1 (988)	
Straight	2.5 (177)	1.2 (35)	3.5 (142)	
Bisexual	29.1 (2,067)	29.5 (890)	28.7 (1,177)	
Something else	41.6 (2,958)	38.7 (1,170)	43.7 (1,788)	

Table 2
 Mental health indicators among TGNB youths who experienced bathroom discrimination and those who did not

Mental health outcomes % (n)	All TGNB youth	TGNB youths who did not experience bathroom discrimination	TGNB youths who experienced bathroom discrimination	p-value
Depressive mood (n = 6,675)	82.6 (5,514)	78.8 (2,174)	85.3 (3,340)	$\chi^2 (1) = 48.26, p < .001$
Seriously considered suicide (n = 6,493)	54.3 (3,524)	45.5 (1,228)	60.5 (2,295)	$\chi^2 (1) = 141.41, p < .001$
Attempted suicide (n = 6,493)	29.1 (1,887)	20.3 (547)	35.3 (1,340)	$\chi^2 (1) = 172.10, p < .001$
Multiple suicide attempts (n = 6,493)	15.9 (1,030)	10.1 (272)	20.0 (758)	$\chi^2 (1) = 151.17, p < .001$

Bivariate analyses

TGNB youths who were younger (13–17 years) and TGNB youths assigned female at birth reported significantly higher rates of having experienced bathroom discrimination in the past year compared with older (18–24 years) TGNB youths and those assigned male at birth (Table 1). In addition, TGNB youths who identified as straight reported significantly higher rates of bathroom discrimination than TGNB youths who were gay or lesbian, bisexual, or identified as something else.

While 83% of youths overall reported depressive mood, youth who experienced bathroom discrimination reported significantly higher rates of depressive mood (85%) than those who did not (79%, $\chi^2 [1] = 48.26, p < .001$, See Table 2). Similarly, while 54% of all TGNB youths reported having considered suicide in the past 12 months, significantly more youths who experienced bathroom discrimination (60%) reported having considered suicide compared with youths who did not (45%), $\chi^2 (1) = 141.41, p < .001$. In addition, 29% reported a past-year suicide attempt; however, 35% of TGNB youths who experienced bathroom discrimination reported a past-year suicide attempt compared with 20% who did not, $\chi^2 (1) = 172.10, p < .001$. Finally, 16% of the sample reported multiple suicide attempts with twice as many youths who experienced bathroom discrimination reporting multiple suicide attempts (20%) compared with youths who did not experience bathroom discrimination (10%), $\chi^2 (1) = 151.17, p < .001$.

Associated mental health indicators

After adjusting for age, sex assigned at birth, race/ethnicity, sexual orientation, and gender identity–based discrimination, experiencing bathroom discrimination significantly increased

the odds of depressive mood (adjusted odds ratio [aOR] = 1.34, confidence interval [CI] = 1.15–1.58; $p < .001$) and seriously considering suicide (aOR = 1.40, CI = 1.24–1.59, $p < .001$, Table 3). In addition, TGNB youths who experienced bathroom discrimination were nearly twice as likely to report both a suicide attempt (aOR = 1.67, CI = 1.45–1.93, $p < .001$) and multiple suicide attempts (aOR = 1.71, CI = 1.42–2.05, $p < .001$) in the past 12 months.

Discussion

The present study found that TGNB youths who reported bathroom discrimination experienced significantly higher rates of depressive mood, seriously considering suicide, attempted suicide, and multiple suicide attempts experienced in the past year than TGNB youths not exposed to this specific form of discrimination. These findings are particularly alarming given that rates of poor mental health outcomes are already higher among TGNB youths than among cisgender, straight youths [6,8] and even compared with cisgender LGBTQ peers [9]. The overall finding that bathroom discrimination is associated with poor mental health indicators is consistent with previous studies of transgender students and young adults [26] but goes further to establish its association with the risk of suicide in one of the largest national samples of both transgender and nonbinary youths. Furthermore, these findings are above and beyond the impact of more general gender identity–based discrimination experienced by TGNB youths.

Rates of bathroom discrimination were higher among youths who identified as transgender than among youths who identified as nonbinary and also among TGNB youths who identified as straight compared with those who identified as LGB. While we did not assess enough in the present study to determine the specific reason for these discrepancies in rates, it could be related

Table 3
 Multivariate logistic regression models: adjusted odds ratios (aOR) of experiencing poor mental health outcomes

Variables	Depressive mood (n = 5,584) aOR (95% CI)	Seriously considered suicide (n = 5,440) aOR (95% CI)	Attempted suicide (n = 5,440) aOR (95% CI)	Multiple suicide attempts (n = 5,440) aOR (95% CI)
Sex assigned at birth	1.66 (1.40, 1.97)	1.20 (1.04, 1.40)	1.05 (.89, 1.25)	1.22 (.98, 1.53)
Youth of color	1.14 (.97, 1.34)	1.22 (1.07, 1.38)	1.34 (1.18, 1.54)	1.32 (1.12, 1.55)
Age (18–24 year)	.55 (.47, .63)	.51 (.45, .57)	.39 (.35, .45)	.33 (.28, .39)
Sexual Identity				
Straight	(Ref)	(Ref)	(Ref)	(Ref)
Gay or lesbian	.92 (.60, 1.42)	.85 (.60, 1.20)	.68 (.46, 1.00)	.73 (.45, 1.18)
Bisexual	1.08 (.89, 1.30)	1.06 (.91, 1.23)	.89 (.76, 1.05)	.92 (.75, 1.12)
Something else	1.09 (.91, 1.30)	1.01 (.88, 1.15)	.86 (.74, 1.00)	.89 (.74, 1.07)
Gender identity–based discrimination	1.42 (1.19, 1.69)	1.90 (1.64, 2.21)	2.05 (1.71, 2.47)	1.95 (1.52, 2.49)
Bathroom discrimination	1.34 (1.15, 1.58)	1.40 (1.24, 1.59)	1.67 (1.45, 1.93)	1.71 (1.42, 2.05)

Bolded adjusted odds ratios are significant at $p < .05$.

to the way in which youths interpret the question and the interconnectedness of sexual orientation and gender identity. Nonbinary youths may not consider not having access to nonbinary bathroom options as having been prevented from using the bathroom that corresponds with their gender identity compared with binary transgender youths being forced to use a different bathroom. Furthermore, owing to the increased rates of transgender youths identifying as straight compared with nonbinary youths, these rates are also higher among straight youths. Despite these differences in rates of experiencing bathroom discrimination, we performed the analyses separately for transgender and nonbinary youths and the impact of bathroom discrimination on mental health was similar for both groups. These findings align with our previous analyses that found high and comparable rates of depressive symptoms and suicidality across subgroups of transgender and nonbinary youth identities [9]. The same holds true for analyses performed separately for 13- to 17-year-old and 18- to 24-year-old TGNB youths. Conclusively, the impact of bathroom discrimination is comparable for both transgender and nonbinary youths of all ages.

The primary concern expressed when adopting policies that allow the use of bathrooms appropriate to an individual's gender identity without regard to sex assigned at birth is the fear that cisgender individuals in the restroom might be harmed by someone whose genitals do not match the ones presumed by the signage or that predators will pose as TGNB and prey on cisgender individuals in the restroom [34]. It is also the case that, particularly in schools, parents fear their children will be "confused by" or "encouraged by" TGNB youths [35]. However, not only do previous studies refute the idea that TGNB youth are predators by demonstrating that sexual assault is actually sustained by TGNB youths [24,28], as opposed to perpetrated by them, there is also no support that youths' gender identity can be impacted by peers in restroom interactions. These unfounded claims of harm to cisgender youths are greatly outweighed by the current empirical findings that not being afforded equal access to bathrooms is associated with suicidality among TGNB youths.

Gendered bathrooms, when viewed through the lens of the minority stress model, represent a distal stressor that is built into the everyday lives of TGNB youths. Bathroom accessibility can arguably be addressed and has the potential to benefit TGNB youths in a dramatic way. In fact, gender-inclusive bathrooms not only signal identity safety for TGNB individuals but signal egalitarianism across many other stigmatized identities, such as race, as well [36].

Future research should continue to examine the impact of bathroom discrimination among TGNB youths, particularly from a longitudinal perspective, as it is of particular interest if policy changes directly decrease TGNB youths' suicidality. In addition, as it was not clear in the present study where the discrimination occurred (e.g., school, work, another public place) and who perpetrated it (e.g., friends, parents or other family members, staff, teachers at their school), future studies should provide a more nuanced examination of this form of discrimination.

Limitations

These findings, though important, should be considered in the context of limitations. These data are cross-sectional and therefore restrict our ability to determine temporality. They are also self-reported and completed entirely online by the youth themselves, which may lend itself to common-method bias. Furthermore, all of

the measures of mental health are single-item constructs. While this is less of a concern for questions of suicidality, our assessment of depressive mood may have resulted in an undercount of rates of depression among TGNB youths. In addition, the recruitment strategy for the larger study does not lend for a truly representative sample, and thus, conclusions related to prevalence cannot be drawn from these data. However, a truly representative sample is complicated by the recruitment of LGBTQ youths for studies involving sensitive topics such as suicidality [37]. That said, the proportion of LGB youth who reported having attempted suicide in the past 12 months in CDC's YRBS (24%) [4] is comparable with age-matched LGBTQ youths in the present study (23%). Finally, this study is limited by the assessment of discrimination. Our assessment of bathroom discrimination is based on lifetime reports while our measures of mental health challenges are in the past year, which could mean this relationship is even stronger for those who are currently experiencing bathroom discrimination. Furthermore, although bathroom discrimination remained significantly related to mental health indicators after we controlled for gender identity–based discrimination, the assessment of gender identity–based discrimination could have, in part, included bathroom discrimination.

Conclusion

Offering gender-neutral bathrooms, avoiding restrictive policies, and providing private places to change clothes in locker rooms may not only improve mental health for these youths but could potentially save TGNB youths' lives. Because sex-segregated bathrooms are typically not an issue in youths' homes, this is a policy issue that needs to be addressed in places where youth spend time outside of the home, such as schools (e.g., restrooms, lockers rooms, dormitories), workplaces, restaurants, health care settings, and other public places. School administrators and teachers should explicitly support the right of students to use a bathroom that matches their identity and efforts to establish gender-neutral facilities on campuses. Employers should consider the implementation of gender-neutral bathrooms as not only a signal of safety for their TGNB employees but also as an overall indicator of an environment of equity for all employees.

Mental health care providers should consider bathroom discrimination as a possible contributor to psychological distress, physical health outcomes, and risk behaviors among TGNB youths. They should screen for bathroom safety and support youths in their endeavors to advocate for their own bathroom safety. Furthermore, clinicians and providers should ensure that the spaces in which they work have gender-neutral bathrooms so as to not contribute an additional barrier to care for TGNB youths. While there are many contributors to poor mental health in youths, and specifically for TGNB youths, this one is addressable.

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EXPERT REPORT

Andrew Bridge, et al.

- v -

Oklahoma State Department of Education, et al.

**Submitted by
James M. Cantor, PhD
November 16, 2022**

SER-156

EXHIBIT

5

2/16 gay	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. <i>American Journal of Psychiatry</i> , 128, 1283–1289.
4/16 trans-/crossdress	
10/16 straight/uncertain	
2/16 trans-	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. <i>Comprehensive Psychiatry</i> , 19, 363–369.
2/16 uncertain	
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0/9 trans-	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. <i>Journal of Pediatric Psychology</i> , 4, 29–41.
9/9 gay	
2/45 trans-/crossdress	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. <i>Journal of Nervous and Mental Disease</i> , 172, 90–97.
10/45 uncertain	
33/45 gay	
1/10 trans-	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. <i>Archives of Sexual Behavior</i> , 15, 511–517.
2/10 gay	
3/10 uncertain	
4/10 straight	
1/44 trans-	Green, R. (1987). <i>The “sissy boy syndrome” and the development of homosexuality</i> . New Haven, CT: Yale University Press.
43/44 cis-	
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8/8 cis-	
21/54 trans-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 47, 1413–1423.
33/54 cis-	
3/25 trans-	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. <i>Developmental Psychology</i> , 44, 34–45.
6/25 lesbian/bi-	
16/25 straight	
47/127 trans-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 52, 582–590.
80/127 cis-	
17/139 trans-	Singh, D., Bradey, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. <i>Frontiers in Psychiatry</i> . doi: 10.3389/fpsy.2021.632784
122/139 cis-	

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

REBECCA ROE, by and through her
parents and next friends, Rachel and Ryan
Roe; SEXUALITY AND GENDER
ALLIANCE, an association

Plaintiffs,

v.

DEBBIE CRITCHFIELD, in her official
capacity as Idaho State Superintendent of
Public Instruction, et al.,

Defendants.

Case No. 1:23-cv-00315-DCN

**DECLARATION OF GREG
WILSON**

I, Greg Wilson, do declare under penalty of perjury as follows:

1. I am over 18 years old and competent to make this declaration.
2. I have personal knowledge of all statements made herein.

3. I am the Chief of Staff for Debbie Critchfield, the Superintendent of the Idaho State Department of Education.
4. In that role, I have familiarity with the policies of Idaho school districts regarding sex separation in restrooms, changing facilities, and overnight accommodations.
5. The state of Idaho has 115 traditional public school districts, without counting public charter schools.
6. To the best of the State Education Department's estimation, even before the enactment of SB 1100, the vast majority of Idaho public school districts (approximately three-quarters of school districts) maintained sex-separated restrooms, changing facilities, and overnight accommodations and did not have any policy that would permit the relief that Plaintiffs seek here.

DATED: August 4, 2023.

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

GREG WILSON
Chief of Staff to Debbie Critchfield
Superintendent of the Idaho State
Department of Education

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on August 4, 2023, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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

REBECCA ROE, et al.,

Plaintiffs,

v.

DEBBIE CRITCHFIELD, et al.,

Defendants.

Case No. 1:23-cv-315

**PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION**

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Pursuant to Federal Rule of Civil Procedure 65, Plaintiffs Rebecca Roe and Sexuality and Gender Alliance, by and through their undersigned counsel, respectfully move this Court for a preliminary injunction enjoining Defendants, as well as their officers, employees, agents, and all persons acting in concert or participation with them, from enforcing Idaho Senate Bill 1100 (“S.B. 1100”), which excludes transgender people from public school restrooms and facilities matching their gender identity as of July 1, 2023. Plaintiffs also move this Court for an order waiving the requirement for bond or security from Plaintiffs.

This motion is based on the Memorandum in Support of Plaintiffs’ Motion for Preliminary Injunction, the accompanying declarations and exhibits, all the pleadings and papers on file, and any argument the Court may consider. S.B. 1100 violates the Equal Protection and Due Process Clauses of the Constitution and Title IX of the Education Amendments of 1972. A preliminary injunction is warranted because Plaintiffs are likely to succeed on the merits of their claims; they will suffer irreparable harm to their constitutional and statutory right to equal treatment, their fundamental right to privacy, and their health and well-being; the balance of equities tips sharply in Plaintiffs’ favor; and a preliminary injunction is in the public interest.

Dated: July 6, 2023

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Robyn K. Bacon
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Nicholas R. Sidney
Paul Martin
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Respectfully Submitted

/s/ Samuel L. Linnet
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 6th day of July, 2023, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

Not Applicable (no defendant has yet appeared)

AND I FURTHER CERTIFY that on such date I served the foregoing on the following non-CM/ECF Registered Participants via U.S. first class mail, postage prepaid addressed as follows:

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Boise, ID 83702

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Independent School District of Boise City #1; Dave Wagers; Maria Greeley; Nancy Gregory; Elizabeth Langley; Beth Oppenheimer; Shiva Rajbhandari; Coby Dennis
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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

REBECCA ROE, by and through her parents
and next friends, Rachel and Ryan Roe;
SEXUALITY AND GENDER ALLIANCE,
an association,

Plaintiffs,

v.

DEBBIE CRITCHFIELD, in her official
capacity as Idaho State Superintendent of
Public Instruction; IDAHO STATE BOARD
OF EDUCATION; LINDA CLARK,
WILLIAM G. GILBERT JR., DAVID HILL,
SHAWN KEOUGH, KURT LIEBICH,
CALLY J. ROACH, and CINDY
SIDDOWAY, in their official capacities as
members of the Idaho State Board of

Case No. 1:23-cv-315

**COMPLAINT FOR DECLARATORY
AND INJUNCTIVE RELIEF**

Education; INDEPENDENT SCHOOL DISTRICT OF BOISE CITY #1; DAVE WAGERS, MARIA GREELEY, NANCY GREGORY, ELIZABETH LANGLEY, BETH OPPENHEIMER, SHIVA RAJBHANDARI, in their official capacities as members of the Independent School District of Boise City #1 Board of Trustees; COBY DENNIS, in his official capacity as Superintendent of Independent School District of Boise City #1,

Defendants.

COMPLAINT

1. This lawsuit challenges Idaho Senate Bill 1100 (“S.B. 1100”), a sweeping law that excludes Idaho’s transgender students from school restrooms and other facilities matching their gender identity beginning on July 1, 2023, and thereby denies them the equal dignity and respect that Idaho affords to non-transgender youth. S.B. 1100 will hurt Idaho’s transgender youth—damaging their health, subjecting them to stigma and harassment in their schools, and increasing their risk of anxiety, depression, and suicide. And it will do so even though the Legislature that passed S.B. 1100 could not identify evidence supporting its purported findings that S.B. 1100 is necessary to protect the safety and privacy of non-transgender students. To the contrary, numerous Idaho schools have had inclusive facilities policies that respect the gender identity of transgender students for almost a decade. Such schools have had no reported instances that such policies threatened the privacy or safety of non-transgender students. As numerous federal courts across the United States have held for years in regard to similar policies, S.B. 1100 violates the fundamental promise of equality enshrined in the Equal Protection Clause of the United States Constitution, among other protections, as well as Title IX of the Education Amendments of 1972.

2. S.B. 1100 is a solution in search of a problem. Many schools across Idaho have allowed transgender students to use facilities matching their gender identity for years without incident. There is no evidence that these policies and practices have harmed any non-transgender student. Nevertheless, S.B. 1100 imposes a blanket statewide ban that schools must follow, strips transgender students of equal access to communal facilities, and subjects them to profound harm—in the name of protecting non-transgender students from privacy and safety harms that do not exist.

3. S.B. 1100 does not stop there. It also places a “bounty” on the heads of transgender students by allowing any student to recover thousands of dollars in minimum statutory damages any time they encounter a transgender student using a facility barred by the law (i.e., in alignment with their gender identity). That private right of action, coupled with a substantial quantum of statutory damages, encourages peers of transgender students to search them out. And it sends a message to Idaho youth that merely sharing the same communal space as a transgender student inherently harms other students. That is, as a matter of fact and settled law, simply wrong. *See Parents for Privacy v. Barr*, 949 F.3d 1210, 1228-29 (9th Cir. 2020) (“Plaintiffs allegedly feel harassed by the mere presence of transgender students in locker and bathroom facilities. This cannot be enough [to state a claim for violation plaintiffs’ rights].”)

4. The exclusion of transgender youth from communal facilities matching their gender identity is deeply stigmatizing. It also contravenes well-established standards of care for the appropriate treatment of gender dysphoria, which is the clinically significant distress that can be associated with the divergence between one’s gender identity and the sex one was assigned at birth. Treatment for gender dysphoria generally entails living in a manner consistent with one’s gender identity in all aspects of life—including using restrooms and related facilities that align

with that gender identity. Prohibiting transgender youth from using those restrooms is nothing short of depriving them of the medical care they need, and it will expose vulnerable Idaho youth to a range of serious health consequences including depression, anxiety, and suicidality.

Furthermore, depriving transgender students of equal access to facilities necessary for basic bodily functions can also lead to physical harms, from dehydration to infection (caused when transgender youth avoid using restrooms that negate their gender identity—a documented and common phenomenon), and, further, rob them of equal access to the benefits of education. And excluding transgender youth from the facilities aligned with their gender identity can force them to come out to others every time they use, or explain to others why they cannot use, certain facilities—causing transgender youth to disclose their transgender status involuntarily in situations where they would otherwise keep that information private. Such forcible outing will subject these youth to an increased of risk of harassment and even bodily harm in violation of their basic right to privacy.

5. The Idaho Legislature exhibited callous disregard for these harms on transgender youth in legislative proceedings. It passed S.B. 1100 based on stereotypes, prejudice, and antipathy against transgender people, rather than any evidence that the law actually served any legitimate purpose. The political landscape leading to the law’s adoption was rife with villainizing comments painting transgender people as threats, and the law was ultimately enacted based on false and unsubstantiated assertions that it was necessary to stop sexual assault, molestation, and rape. In fact, as the bill’s supporters admitted, and as numerous experts agree, there was and is no material evidence that allowing transgender students to use the facilities that match their gender identity has ever caused the harms the law purports to address. Instead, it is transgender students who face harm when exposed to greater risk of harassment and violence

when forced to use facilities inconsistent with their gender identity; when they are forced to out themselves as transgender to fellow students who may not have otherwise known; and when they are not allowed to live in a manner consistent with the recommendations of health professionals. The Legislature failed to give any consideration to these realities. Indeed, it passed the law a mere month after introduction, based entirely on animus and speculation.

6. The Legislature, further, acknowledged in its findings that federal courts have repeatedly held that similar policies excluding transgender students from facilities matching their gender identity violate the Constitution. It nevertheless refused to adhere to those rulings.

7. Unless enjoined by this Court, S.B. 1100 will irreparably harm transgender youth across Idaho. That includes Plaintiff Rebecca Roe, who is entering seventh grade, a pivotal time in adolescence, as well as members of Plaintiff Sexuality and Gender Alliance (“SAGA”), a student organization at Boise High School, whose transgender members stand in harm’s way.

8. For all of these reasons, Plaintiffs seek preliminary and permanent injunctive relief, declaratory relief, as well as nominal damages resulting from Defendants’ discriminatory actions—to protect transgender people across the state, including Plaintiffs themselves, from the devastating impact of S.B. 1100.

JURISDICTION AND VENUE

9. This action arises under 42 U.S.C. § 1983 to redress the deprivation of rights secured by the United States Constitution under the color of state law, and under Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, *et seq.* (“Title IX”).

10. This court has original subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343 because this action arises under 42 U.S.C. § 1983, the Constitution of the United States, and Title IX. Declaratory relief is authorized by 28 U.S.C. §§ 2201 and 2202.

11. Venue lies in this District pursuant to 28 U.S.C. § 1391 as the Plaintiffs and Defendants are located in this District and a substantial part of the events or omissions giving rise to the action occurred in this District.

PARTIES

12. Plaintiff Rebecca Roe (“Rebecca”) is a 12-year-old girl enrolled as a student within Boise School District. Because Rebecca is transgender, S.B. 1100 bars her from using the girls’ facilities at school. Rebecca is a resident of Idaho and brings this action pursuant to Federal Rules of Civil Procedure 17(c) by and through her parents and next friends, Rachel and Ryan Roe. Rebecca, Rachel, and Ryan all proceed anonymously in this action.¹

13. Plaintiff Sexuality and Gender Alliance (“SAGA”), an unincorporated association, is a student organization at Boise High School, a public high school in the Boise School District for grades ten through twelve. One of SAGA’s goals is to ensure that lesbian, gay, bisexual, transgender, and queer (LGBTQ) students are safe and welcome at school. SAGA is open to all high school students at Boise High School, and its membership includes students who are transgender and would be harmed by S.B. 1100.

14. Defendant Debbie Critchfield is Superintendent of Public Instruction in Idaho. The Superintendent of Public Instruction is responsible for carrying out policies, procedures, and duties authorized by law regarding educational matters, including the provisions of S.B. 1100. Idaho Code § 33-125. The Superintendent of Public Instruction is also a member of the Idaho State Board of Education. *Id.* § 33-102. She is a person within the meaning of 42 U.S.C. § 1983 and acts under color of state law as to the allegations in this complaint. Superintendent Critchfield resides in Idaho. She is sued in her official capacity only.

¹ Plaintiff Roe, through her parents, has concurrently filed a motion to proceed anonymously.

15. Defendant Idaho State Board of Education (“Board of Education”) is Idaho’s single governing body for public kindergarten through college education. Idaho Const. Art. IX § 2. The Board of Education is required to enforce state educational law, including S.B. 1100. Idaho Code § 33-107(5)(a). It also supervises and controls school districts in Idaho. *Id.* § 33-116. It is an education program receiving federal financial assistance.

16. Defendants Linda Clark, William G. Gilbert Jr., David Hill, Shawn Keough, Kurt Liebich, Cally J. Roach, and Cindy Siddoway are the individual members of the Idaho State Board of Education, who have responsibility for the general supervision of Idaho’s state educational institutions and its public school system. Under Idaho Code § 33-107, the Board of Education and its members are empowered to supervise “all entities of public education,” *id.* § 33-107(3), and to “[e]nforce the school laws of the state,” *id.* § 33-107(5)(a), including S.B. 1100. The Board of Education’s members are each persons within the meaning of 42 U.S.C. § 1983 and act under color of state law as to the allegations in this complaint. All reside in Idaho and are sued in their official capacities only. Idaho’s public school system is an education program receiving federal financial assistance.

17. Defendant Independent School District of Boise City #1 (“Boise School District”) is a public school district located in Boise, Idaho, subject to S.B. 1100’s enforcement mandate. It is an education program receiving federal financial assistance.

18. The individual members of the Boise School District’s Board of Trustees— Defendants Dave Wagers, Maria Greeley, Nancy Gregory, Elizabeth Langley, Beth Oppenheimer, and Shiva Rajbhandari, along with any person who may fill any currently vacant board seat—are responsible for governing the District in compliance with state law and rules of the State Board of Education, including S.B. 1100. Idaho Code § 33-512(13). The Board of

Trustees' members are each persons within the meaning of 42 U.S.C. § 1983 and act under color of state law as to the allegations in this complaint. The Board of Trustees' members all reside in Idaho, and they are all sued in their official capacities only. The Boise School District is an education program receiving federal financial assistance.

19. Defendant Coby Dennis is the Superintendent of the Boise School District. He is responsible for carrying out the policies of the Boise School District, recommending policies to the District's Board of Trustees, and making decisions for the District when the Board of Trustees is in recess, including Boise School District's compliance with S.B. 1100. The Superintendent shall "shall [] act as the authorized representative of the district whenever such is required." Idaho Code § 33-513(2). He is a person within the meaning of 42 U.S.C. § 1983 and acts under color of state law as to the allegations in this complaint. He resides in Idaho and is sued in his official capacity only.

FACTUAL ALLEGATIONS

I. Gender Identity and Gender Dysphoria Are Well-Established Concepts in the Medical Community.

20. Gender identity is a well-established medical and psychological term that refers to a person's fundamental, deeply felt understanding of their own gender. As the medical community has long recognized, it is a core characteristic of human identity that everyone possesses. There is also a medical consensus that gender identity is generally established at an early age, although a person's recognition of their gender identity can emerge at any time, and has significant biological roots.

21. The phrase "sex assigned at birth" refers to the sex designation recorded on person's birth certificate, generally based on the appearance of external genitalia at birth. While the majority of people possess a gender identity that matches their sex assigned at birth, that is

not the case for transgender people, who are defined as transgender because their gender identity does not match their sex assigned at birth. People whose gender identity is congruent with the sex they were assigned at birth are referred to as “cisgender” or non-transgender.

22. People who are transgender have a consistent, persistent, and insistent understanding that their sex is different from the sex they were assigned at birth. People who are cisgender have a consistent, persistent, and insistent understanding that their sex is the same as the sex they were assigned at birth.

23. There is a medical consensus that efforts to change a person’s gender identity—including for the purpose of bringing that gender identity into alignment with a person’s sex assigned at birth—are not only ineffective, but unethical, and deeply harmful. That consensus emerged after decades of harmful attempts to change transgender peoples’ identities through therapies that consistently failed—and often resulted in depression and suicide.

24. A person possesses multiple sex-related characteristics including, but not limited to, chromosomal makeup, hormones, internal and external reproductive organs, secondary sex characteristics, and gender identity. Medical experts who study human gender and sex, however, agree that gender identity is the single most important factor that determines a person’s sex, including where a person’s sex-related characteristics are not in typical alignment.

25. Discordance between one’s gender identity and sex assigned at birth can be associated with clinically significant distress, which is known as gender dysphoria. Gender dysphoria is a condition recognized by the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, 5th edition. Without adequate treatment, gender dysphoria can result in profound psychological distress, anxiety, depression, and even suicidal ideation or self-harm.

26. Treatment for gender dysphoria is governed by the internationally-recognized Standards of Care for the Health of Transgender and Gender Diverse People (“Standards of Care”), published by the World Professional Association for Transgender Health (“WPATH”) since 1980. WPATH is an international, multidisciplinary, professional association of medical providers, mental health providers, researchers, and others that promotes evidence-based care and research for transgender health. WPATH published the eighth and most recent edition of the Standards of Care in 2022. These standards are developed and continuously updated by the foremost experts in the field of transgender health based on a systematic review of the evidence-based research on transgender health. They are also recognized by other mainstream medical organizations such as the American Medical Association, the American Psychological Association, and the American Academy of Pediatrics.

27. In accordance with the Standards of Care, treatment for gender dysphoria consists of the person transitioning to living openly and being treated by others as the sex corresponding to the person’s gender identity.

28. An essential part of that treatment is social transition, in which the individual lives in accordance with their gender identity in all aspects of life. While the precise details are specific to each person, social transition typically includes adopting a new first name, using and asking others to use pronouns reflecting the individual’s gender identity, wearing clothing typically associated with that gender, and using sex-specific facilities corresponding to that gender. At school, for example, transgender boys may appear indistinguishable from boys whose gender identity aligns with their sex assigned at birth (i.e., cisgender boys), and transgender girls may appear indistinguishable from cisgender girls.

29. To be effective at alleviating gender dysphoria, it is critical that social transition is respected consistently across all aspects of a transgender individual’s life—for example, at home, in school, and at work. Failing to recognize or respect a transgender person’s gender is contrary to established medical protocols and can exacerbate the symptoms of gender dysphoria.

30. In addition to social transition, medical treatments such as gender-affirming hormone therapy and surgical care may also be undertaken to facilitate transition and alleviate dysphoria by bringing a person’s body into greater typical alignment with their gender identity.

31. Psychotherapy to reduce the harmful effects of stigma that a transgender person may have internalized regarding their identity may also be an important form of support for individuals with gender dysphoria. But it is not a substitute for social and medical transition as a means of treating gender dysphoria.

II. The Exclusion of Transgender People from Facilities Consistent with Their Gender Identity Causes Well-Documented Harms.

32. In the United States, school and other public multiple-occupancy restrooms and locker rooms are often separately designated for females and males. So-called “bathroom bills” like S.B. 1100 exclude transgender people from equal access to facilities matching their gender identity. In the context of schools, such bills require that a transgender student be treated as the “sex” that corresponds with their sex assigned at birth for purposes of facilities access, even when that student’s parents, health care professionals, teachers—and often peers—all recognize that student as the sex that corresponds to their gender identity.

33. That exclusion—which is nothing short of a denial of that student’s true self—can cause a multitude of adverse mental and physical health consequences for transgender students. Those include (1) interference with the process of social transition; (2) involuntary disclosure that the student is transgender; (3) promotion of the view that there is something wrong with the

transgender student and that the transgender student does not belong in spaces used by classmates, a view that can foster additional discrimination, harassment, and even violence; (4) negative health consequences caused when transgender students try to avoid going to the restroom; and (5) impairment of the student's concentration and learning. Together, such consequences exacerbate the avoidable harms of gender dysphoria and lead to feelings of rejection, invalidation, isolation, shame, and stigmatization.

34. First, excluding transgender students from using facilities that align with their gender identity impairs and impedes a central component of the treatment for gender dysphoria—living in a manner consistent with one's gender identity in all aspects of life. Transgender people generally use restrooms consistent with their identity after completing other aspects of social transition (e.g., wearing clothing typically associated with their gender, changing their hair, and otherwise modifying their physical appearance to match their gender). Using such gender-affirming facilities is a significant part of a social transition—and an important step in treating the symptoms of gender dysphoria. Expecting or requiring transgender students to use facilities that conflict with their gender identity can interfere with their treatment and even undermine the positive effects of socially transitioning in other aspects of life. S.B. 1000 thus exacerbates the symptoms of gender dysphoria, such as depression, anxiety, and suicidal ideation, and damages a transgender person's mental and physical health.

35. Second, transgender youth are often subjected to victimization in the school environment, including bullying, physical assault, sexual assault, mistreatment, property vandalism, and other direct and indirect attacks. Forcing transgender students to use facilities discordant with their gender identity can disclose the fact that they are transgender to other students and adults who may not have otherwise known and to whom the student may not have

otherwise disclosed that fact. A transgender girl, for instance, who lives as female in all aspects of life, including school, may be forced to use the restroom designated for males, thereby revealing to others that she is transgender. This involuntary disclosure, in turn, increases the likelihood of the transgender student being targeted for harassment and mistreatment, and increases their fear of such victimization, with the attendant harms resulting from that stress.

36. Third, the many harms inflicted by excluding transgender people from the facilities matching their gender identity cannot be avoided through purported “accommodations” that relegate transgender people to using separate facilities from other students, such as a faculty, nurse, or single-user restroom. As a practical matter, these alternate facilities are often located in less accessible areas and are not always open or available. And consigning a transgender student to use of these alternate facilities ostracizes and segregates them from their fellow students: It communicates a message of disapproval to both the student and the school community that the student’s identity is not and should not be respected; that the student’s presence in a restroom facility matching their gender identity represents a threat to others; and that transgender classmates must be separated from everyone else because of who they are. Such facilities are separate and unequal in every respect.

37. Fourth, when transgender students lack equal access to facilities that match their gender identity—and are relegated to “alternate facilities” in less accessible areas—they often avoid school restrooms, even for the entire length of the school day. Such avoidance has negative consequences for the student’s health, which can include urinary tract infections and kidney infections, as well as an adverse impact on the student’s ability to concentrate and access the benefits of education. Transgender students may also limit their food or fluid intake in an

attempt to lessen their need to use the restroom, with the same ill consequences for their health and attention level.

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

III. Plaintiffs' Background

A. Rebecca Roe

39. Plaintiff Rebecca Roe is a 12-year-old girl who has attended school within Boise School District since she was in kindergarten. She will be attending seventh grade during the 2023-24 academic year at a junior high school within Boise School District.

40. Rebecca enjoys playing video games, hanging out with friends at the mall, watching anime shows, and doodling artwork. She also takes *kung fu* lessons, both for physical exercise and potential self-defense.

41. Although Rebecca is now thriving as a transgender girl, her mental health suffered in the past before she came to understand her gender identity better and received the support that she needed. Rebecca's parents became concerned about her mental well-being around the time she was in fourth grade. She exhibited signs of depression and seemed generally

“checked out.” She also began falling behind in coursework even though she otherwise generally excels academically.

42. During the summer after fourth grade, the issue of Rebecca’s gender arose in the context of a conversation with her parents regarding pride month for LGBTQ people. Rebecca’s parents wanted to reassure her that they would still love her no matter who she was. In the course of that conversation, Rebecca expressed to her parents that she did not believe that she was a boy. Rebecca’s parents were unsure of what to make of this information at the time.

43. In fifth grade, older students would sometimes pick on Rebecca, such as when they saw her by herself during recess. Overall, she struggled socially at school during fifth grade, even though she also had a tight circle of friends.

44. Motivated by concerns about Rebecca’s well-being, Rebecca’s parents began taking Rebecca to see a therapist to ensure that she received the mental health support she needed. During her therapy sessions, Rebecca expressed that she did not feel like a boy, consistent with what she had conveyed to her parents during the summer after fourth grade. The therapist also spoke with Rebecca about any distress that she felt around issues related to gender.

45. Rebecca’s gender identity is female. She has never felt typically masculine like others assigned male at birth. When she would look at her male friends, she would think to herself, “I don’t feel like this.” When she would look at her female friends, however, she would think to herself, “I feel more like that.”

46. After discussions between Rebecca, Rebecca’s therapist, and Rebecca’s parents, the family decided to give Rebecca the opportunity to “be herself” for spring break in 2021, when Rebecca was not attending school, and to express her gender in the way that felt most comfortable to her. Rebecca went shopping and chose more typically feminine clothes for

herself. In contrast to the distress associated with gender dysphoria, Rebecca felt joy and relief when her gender expression matched her gender identity. Rebecca's parents noticed the improvements in her mental health as well and that she seemed to be more confident in herself.

47. Following this experience, and particularly after the end of fifth grade, Rebecca continued the process of social transition to live in a manner consistent with her gender identity. For example, she began to use a more typically feminine name rather than a typically masculine name and asked others to use her new, female name; she dressed in clothes typically worn by girls; she adopted a more feminine hairstyle; and she started using female pronouns.

48. Rebecca's friends accepted and supported her as she undertook the process of social transition. They respected her name and pronouns. In addition, Rebecca's name was also updated in the school information system, and school staff respected her name and pronouns as well. Overall, Rebecca's experience in sixth grade was significantly better than her experience in fifth grade because she was able to live in a manner consistent with her gender identity in several respects and was generally treated by her fellow students like other girls.

49. After Rebecca began her social transition, she also began using restrooms designated for females outside of school without incident. Like other girls, she would enter the women's restroom, go into a stall and close the door behind her, use the toilet, and then wash her hands and leave. It was a routine practice that did not cause any problems for anyone, including others using the restroom at the same time as her.

50. Rebecca has not used a restroom designated for males, whether at school or outside of school, since fifth grade. Using the restrooms designated for males would feel wrong to Rebecca because she is a girl.

51. When Rebecca is in public, she is generally perceived by others as female. Thus, if she were to use the restroom designated for males, it would appear to others that a girl was using the men's restroom, something far more disruptive to social expectations than her use of the women's restroom. As part of treatment for her gender dysphoria, Rebecca also receives puberty-delaying medication, which allows transgender adolescents to avoid physical changes associated with their endogenous puberty, and can be followed by gender-affirming hormone therapy where medically appropriate, which facilitates even greater alignment between one's gender identity and body. Living in a manner consistent with her gender identity, including having access to the girls' restroom, is an important aspect of the treatment for Rebecca's gender dysphoria.

52. Prior to the start of the sixth grade school year, it was initially envisioned that Rebecca would use the nurse's restroom rather than the boys' restroom. Rebecca ultimately did not feel comfortable using the nurse's restroom, however, because it felt stigmatizing and isolating to use in comparison to her female peers, who were not limited to using only that single-stall facility. It was also in a less accessible location than the restrooms used by Rebecca's female classmates.

53. As a result, Rebecca generally avoided using the restroom at school. She limited her fluid intake and would "hold it" at school to avoid using the restroom. These measures were not only unhealthy but they were increasingly difficult to endure as the school day progressed. They also created a physical and mental distraction while Rebecca was in class, as she spent her time thinking to herself that she was "almost there" as she waited for the school day finally to end so that she could use the restroom at home.

54. Rebecca will be attending a new school in seventh grade, alongside new classmates, and she would like to fit in with her female classmates. Rebecca's parents have significant concerns about Rebecca's physical safety, mental health, and her general well-being if she is ultimately excluded from girls' facilities. As parents who love their child and want to see her thrive, they agonize that Rebecca's use of the boys' restroom, which may be unavoidable at times if she is excluded from the girls' facilities, would expose her transgender status in situations where it would otherwise remain private and leave her vulnerable to violence and targeting by other students. If Rebecca is only allowed to use either the boys' restroom or a single-stall restroom, Rebecca is also afraid that any of her classmates at her new school could find out that she is transgender, and she wishes to have control over her private information.

55. The idea that Rebecca will be excluded from using facilities designated for girls is painful and stressful to her and makes her feel unequal to other girls. It makes her feel like an outsider. Her new school is also farther from home, making it even more difficult and unhealthy for her to delay using the restroom until the end of the day. Furthermore, living in a manner consistent with her gender identity, including access to the girls' restroom, is an important aspect of the treatment for Rebecca's gender dysphoria, and at this stage in her social transition, Rebecca wishes to use the girls' restroom when she is outside the home, including at school, just like other girls.

B. SAGA

56. SAGA is a student organization for high school students at Boise High School. SAGA and its activities are led by students, and the organization meets weekly on school grounds during the school year. SAGA's goals are to provide LGBTQ+ students and their allies with support, resources, and information about events. Part of SAGA's mission is to make the

school environment a safe and welcoming place for LGBTQ+ students. S.B. 1100 inflicts serious and ongoing harm against certain of SAGA's members.

57. SAGA brings this action on behalf of its members harmed by S.B. 1100.

58. Certain transgender SAGA members, consistent with school practices pre-dating S.B. 1100, wish to use multi-occupancy facilities on school grounds, including during the 2023-24 school year, consistent with their gender identity, and inconsistent with their sex assigned at birth. That includes those with a gender support plan, approved by the school and their parents, that allows them to use multi-occupancy facilities consistent with their gender identity. These gender support plans play an important role in transgender students' mental and physical health, including their social transition. Under S.B. 1100, transgender students would have to change their facilities use on campus by either using facilities that do not correspond to their gender identity or by avoiding the use of multi-occupancy facilities altogether.

59. On their school campus, transgender SAGA members have inconsistent access to one, single-stall, gender-neutral restroom in a building separate from most classrooms. That restroom is frequently unavailable either because it is occupied or closed. It is also further from most classrooms than the multi-occupancy restrooms, making it more difficult to access during short breaks between classes.

60. Any transgender SAGA member who is prohibited from using facilities consistent with their gender identity under S.B. 1100 will be harmed by being treated differently than their classmates who can use facilities consistent with their gender identity. They will have to choose between using facilities inconsistent with their identity, causing distress and potential harassment, or avoiding facilities use, causing discomfort and potential health issues.

61. Some members will face the risk of being outed as transgender under S.B. 1100, including in situations where they would not otherwise disclose their status, by having to change their established restroom use or by being forced to use restrooms inconsistent with their identities (including the names and pronouns they use in the school community).

62. S.B. 1100 is contrary to the mission of SAGA, which exists to support all members of the LGBTQ+ community and ensure that school is a safe and welcoming environment for them. If S.B. 1100 remains in effect, SAGA will also have to spend additional time supporting students that have lost restroom access and advocating for more gender-neutral restroom options for students so they can make it through their school day. Because SAGA does not have the capacity to handle multiple projects at a time, this would interfere with its ability to complete other mission-driven student services, such as the clothing drive it has done in the past and would like to do again this year.

IV. Idaho Enacted S.B. 1100 Without Any Evidence that It Furthers Privacy or Safety.

A. Inclusive School Policies and Practices Had Been in Effect Long Before S.B. 1100.

63. For many years preceding the enactment of S.B. 1100, and at many schools across Idaho, transgender students have had the ability to access school facilities matching their gender identity pursuant to inclusive policies and practices. Collectively, these inclusive policies and practices have covered the educational experience of tens of thousands of Idaho students, cisgender and transgender alike, without causing harm.

64. Upon information and belief, at least 60 local educational agencies across Idaho, including school districts and charter schools, have adopted inclusive policies recognizing that, like other students, transgender students must have the ability to access facilities that match their gender identity.

65. Many of these policies were based on a model policy regarding sexual orientation and gender identity, Policy 3281, developed by the Idaho School Boards Association (“ISBA”) in 2015. Policy 3281 sought to foster a safe educational environment for all students regardless of gender identity, gender expression, or sexual orientation. As relevant here, Policy 3281 specified that students are allowed to use the facilities that correspond to the gender identity they consistently assert at school, and that no student would be required to use facilities that conflict with their gender identity. It also recognized that any student, whether transgender or not, with a need or desire for increased privacy could be given the option of a separate or private restroom or changing area. Since Policy 3281 was issued, a significant number of school districts adopted it or implemented practices that align with it.

66. An increasing number of school districts nationwide, including those in Idaho, adopted inclusive policies and practices like Policy 3281 after the U.S. Department of Education took various actions, beginning around 2010 and including a 2015 “Dear Colleague” letter from its Office of Civil Rights, that confirmed the obligation of schools to treat transgender students equally under federal law.

67. Some Idaho districts have also adopted inclusive policies or practices without necessarily adopting Policy 3281 itself. For example, since at least 2016 if not earlier, transgender students in Boise School District have been able to work with their parents and school staff to develop a written gender support plan. The plan addresses topics such as student safety, the name and gender marker to be used in the student’s school records, and the student’s use of school restrooms and locker rooms. Thus, a transgender boy, for example, is able to have a gender support plan, signed by school staff, confirming his use of the boys’ facilities at school.

68. In 2016, Boise School District issued a public statement explaining that, “under federal civil law, the District is required to provide access to public facilities consistent with the student’s gender identity.” It further explained that, for purposes of facilities use, “Gender identity is not a fluid concept. A student may not choose to identify as male one day and a female the next. School districts elsewhere that have implemented these policies require that the gender identification be both persistent and consistent over time.” The District’s statement also recognized that there was nothing mutually exclusive between providing transgender students with access to facilities consistent with their gender identity, on the one hand, and “continu[ing] to provide safe and supportive school environments for all students, including transgender students,” on the other hand.

69. Despite the widespread adoption of inclusive policies and practices in Idaho over the last several years, there has been no evidence that such policies have caused any of the purported harms the Legislature lists in its “findings” as supposed justification for S.B. 1100. *See* 33-6601(4)² (finding that “[r]equiring students to share restrooms and changing facilities with members of the opposite biological sex generates potential embarrassment, shame, and psychological injury to students, as well as increasing the likelihood of sexual assault, molestation, rape, voyeurism, and exhibitionism”).

70. The experiences of other jurisdictions are in accord. For example, the District of Columbia Public Schools have provided transgender students with access to restroom and locker room facilities consistent with their gender identity since 2006 and implemented the practice

² Citations to S.B. 1100 (referenced as 33-6601 to 33-607) are to Idaho Code, Title 33 Education, Chapter 66 [67] Protecting the Privacy and Safety of Students in Public Schools.

through an official policy in 2015. No school has reported any incident in which a cisgender student has been harmed because of the policy.

71. In another example, the State of California enacted legislation in 2013 confirming that students have the right to use restrooms and other facilities based on their gender identity. The Los Angeles Unified School District, the second largest public school district in the country, has had a similar policy in place even longer. Millions of students have attended school under these inclusive policies, and there is no evidence that providing transgender students with this access has harmed any students.

72. Similarly, schools in countless other jurisdictions—including in Arizona, Delaware, Florida, Illinois, Kentucky, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Washington, and Wisconsin—have successfully implemented inclusive policies and practices, without evidence of harm to students.

B. In 2023, After Years of Inclusive Policies, the Idaho Legislature Proposed S.B. 1100.

73. Like numerous other Idaho school districts, on January 10, 2023, Caldwell School District in central Idaho considered adopting an inclusive restroom policy. The meeting abruptly ended, however, after Senator Chris Trakel, who attended the school board meeting and orchestrated opposition to the policy, asserted that the policy would risk children’s “moral health.” When the board chair attempted to speak, Senator Trakel raised his voice, asserting that “he had the floor” at the local school board meeting. Protesters then disrupted the meeting by yelling threats at board members, and district officials had to abruptly adjourn.

74. Other state officials also weighed in on the situation in Caldwell later that month. Idaho Attorney General Raul Labrador, who had recently assumed office, took to Twitter to

interject his view in opposition to Caldwell School District’s potential adoption of an inclusive policy recognizing transgender students’ equal right to access facilities matching their gender identity, insisting that he needed to defend Idaho children. He publicly attacked ISBA, a non-profit organization founded in 1942 to serve school boards and members throughout Idaho, for “peddling” Policy 3281, through a January 25, 2023 letter that he also posted to Twitter. He specifically targeted transgender girls, whom he referred to as “biological boys,” and dismissed transgender students’ “gender—along with potential gender dysphoria” as “choices.”

75. In a January 30, 2023 letter, ISBA responded to the Attorney General that all of ISBA’s model policies are drafted in-house and go through an intensive legal review process. It confirmed that its model policies are not based on any special interest group or entity, and that any legal questions about its policies are referred to outside legal counsel whose lawyers practice education law and represent education clients throughout the state. It explained that “Current interpretation of Title IX – and likewise for Title VII – does protect discrimination on the basis of sex to include a person’s gender identity and sexual orientation.”

76. ISBA also confirmed that “in places where these policies have been adopted and operating for many years, there have been no reported incidents of unlawful behavior.” It explained that its policies “assist school communities address practical issues that arise in their schools on a daily basis and require a clear, uniform and workable solution.”

77. On the heels of the situation in Caldwell, State Superintendent of Public Instruction Debbie Critchfield also wrote a letter dated January 19, 2023, to Senator Cindy Carlson to provide clarification and context regarding gender-related policies that address student facilities in public schools. Senator Carlson responded that Superintendent Critchfield’s office should take action to prevent enforcement of policies that protect transgender students’ use

of facilities consistent with their gender identity, on the grounds that they were purportedly inconsistent with existing state law. Senator Carlson closed her letter by declaring that “[w]e need to send the message” about kids not being “indoctrinate[d]” with “this garbage.”

C. Legislative Proceedings Identify No Evidence That S.B. 1100 Protects Any Student from Being Harmed in Any Respect.

78. On February 13, 2023, Senator Ben Adams introduced S.B. 1100 in the Idaho Senate. Short-titled “Protecting the Privacy and Safety of Students in Public Schools,” the law was widely referred to as the “Idaho bathroom bill.” While S.B. 1100 has multiple provisions, as detailed further below, its central provision is a statewide ban that excludes transgender students from school restrooms and other facilities consistent with their gender identity.

79. S.B. 1100 was drafted by the Idaho Family Policy Center, an organization that advocates for public policy based on “biblical truths in sexuality and gender.” Supporters of S.B. 1100 expressed their disapproval of transgender people. For example, Senator Trakel testified: “The Idaho Republican Party recognizes that children are a heritage of the Lord. We believe biological gender to be an essential characteristic of a child’s identity and purpose . . . We strongly oppose any person, entity, or policy that attempts to confuse minors regarding their bio[logical] gender.” Another supporter testified at the Education Committee that “God made men and women . . . and eventually men and women made men’s and women’s bathrooms for men and women,” and that “[W]e either have part A or part B. Let’s keep it simple.”

80. In passing S.B. 1100, the Idaho Senate identified no reported incidents in Idaho of transgender people committing acts of violence in public restrooms. Instead, they resorted to speculation. For example, Senator Trakel hypothesized that the bill would prevent “some small child” from otherwise being “molested or raped in the bathroom.” To the contrary, opponents of S.B. 1100 explained that privacy and safety justifications were affirmatively disproven by the

many years that transgender students had been using facilities matching their gender identity. Even legislators supporting S.B. 1100 conceded that they were not aware of any documented case of a transgender person committing violence against a non-transgender person in a restroom.

81. The Senate also ignored testimony of youth who would be harmed by the law, including through the stigmatizing effect of being relegated, at best, to single-occupancy facilities away from their peers if available. A transgender student explained that the bill would further marginalize transgender students, perpetuate harmful mythologies that associate transgender people with sexual deviance, and isolate the transgender community.

82. Instead, although the Legislature would ultimately justify S.B. 1100 based on purported findings about protecting the privacy and safety of students, the actual legislative history included only unfounded speculation, contradicted by all the available evidence.

83. The bill emerged from committee with a “do pass” recommendation on a 6-2 vote. On March 9, 2013, S.B. 1100 passed the full Senate on a 28-7 vote. There was no meaningful debate on the floor.

84. Proceedings in the House had a similar tenor as proceedings in the Senate. Supporters of S.B. 1100 reprised unsubstantiated views that allowing transgender people to use facilities aligning with their gender identity would lead to “predators” entering restrooms. Opposing the bill, Representative Holli Woodings commented that “it’s not my understanding that there’s been any documented cases of trans person violence on non-trans people?” with which Representative Edward Hill, who supported S.B. 1100, agreed.

85. On March 16, 2023, S.B. 1100 passed the full House on 59-10-1 vote, sponsored by Representative Hill. There was no debate.

86. Governor Brad Little then signed S.B. 1100 on March 22, 2023. With scant legislative deliberation, it took just over one month from the bill’s introduction to its signing.

87. During the same session, the Legislature also enacted other anti-LGBTQ laws, including a criminal prohibition against providing transgender youth with medically necessary gender-affirming healthcare.

D. S.B. 1100’s Provisions and Purported Justifications

88. S.B. 1100, a copy of which is attached as Exhibit 1, defines “sex” as the “immutable biological and physiological characteristics, specifically the chromosomes and internal and external reproductive anatomy, genetically determined at conception and generally recognizable at birth, that define an individual as male or female.” 33-6602(3).

89. In other words, under S.B. 1100’s definition of sex, a transgender person is a member of the “sex” that is the opposite of their gender identity. But that definition ignores the scientific and medical consensus that recognizes that gender identity is the critical determinant of sex where gender identity diverges from an individual’s sex assigned at birth. Indeed, the Legislature’s definition of sex was constructed in order to deny transgender people recognition of their gender.

90. Based on its definition of “sex,” S.B. 1100 requires that every public school multiple-occupancy restroom or changing facility must be designated for use by male persons only or female persons only, and used only by members of that “sex,” and prohibits any person from entering these facilities unless they are of the designated “sex.” 33-6603(1). S.B. 1100 also mandates that public schools must “ensure that all restrooms and changing facilities provide its users with privacy from members of the opposite sex.” 33-6603(2).

91. In addition to imposing a statewide mandate, S.B. 1100 also creates a private right of action that places a “bounty” on the heads of transgender students and encourages peers to search them out. Any student who encounters someone of the “opposite sex” in covered facilities may obtain statutory damages of at least \$5,000, in addition to damages for any harm purportedly experienced, and attorneys’ fees for the school’s non-compliance with the terms of S.B. 1100. 33-6606. By creating this right of action, the Legislature sent a clear message: A cisgender student sharing a restroom with a transgender student—even for a brief moment—should receive thousands of dollars as a reward for reporting that they were in the vicinity of a transgender person using facilities consistent with their gender identity.

92. Although S.B. 1100 lays out various exemptions where its provisions do not apply—notwithstanding the law’s assumption that access to sex-designated facilities by members of the “opposite sex” causes harm—none of these exemptions provide transgender students with equal access to facilities matching their gender identity as compared to their cisgender peers. One of these exemptions permits coaching staff and personnel to enter otherwise prohibited facilities specifically during athletic events—which legislative proceedings indicated was to facilitate a halftime “pep talk”—notwithstanding purported concerns about privacy.

93. Similarly, while S.B. 1100 requires that schools provide purported “reasonable accommodations” to anyone who provides a written request detailing that they are “unwilling or unable” to use the multi-occupancy facilities designated for the person’s “sex,” it makes clear that this does not include access to facilities “designated for use by members of the opposite sex while persons of the opposite sex are present or could be present.” 33-6605. When transgender people are relegated to alternate “accommodations,” they are often inferior to the facilities used by others, located in less accessible locations, and stigmatizing for them to use.

94. While S.B. 1100 targets transgender students, its provisions also apply to other transgender people as well, such as school staff or a student’s siblings or parents who are transgender and may need to use school facilities while on campus.

95. Additionally, S.B. 1100 provides that for any school-sponsored events with overnight lodging, no person may share sleeping quarters, a restroom, or a changing facility with a person of the “opposite sex” unless they are members of the same family. 33-6603(4). Thus, for example, if four students generally stay in one hotel room for a school trip, a transgender student may be forced to stay in a room without any other students, causing them to feel isolated and stigmatized and depriving them of the same social bonding that other students experience.

96. S.B. 1100 was enacted on a foundation of imagined fears and stereotypes that transgender people are predators from whom children must be shielded—rather than a recognition that transgender people are friends, neighbors, relatives, and members of the community entitled to equal dignity and respect.

97. These impermissible motivations are reflected in S.B. 1100 itself. While couched in terms of “privacy and safety,” lawmakers targeted transgender students, and their use of facilities matching their gender identity, as purportedly “increasing the likelihood of sexual assault, molestation, rape, voyeurism, and exhibitionism” and causing “potential embarrassment, shame, and psychological injury to students.” 33-6601(2-5).

98. These purported justifications are baseless and unsupported. There is no evidence to substantiate that transgender people who use facilities associated with their gender identity are more likely to harm others compared to their non-transgender peers.

99. There is also no evidence to substantiate that inclusive policies or practices cause cisgender people to pretend to be transgender and thereby engage in misconduct that would not

otherwise occur. Such misconduct is already directly barred by other prohibitions, and nothing about an inclusive policy alters that reality. In stark contrast, it is transgender people who are more likely to be harassed, mistreated, or assaulted in facilities, particularly where they are forced to use facilities inconsistent with their gender identity.

100. In addition, transgender people using facilities consistent with their gender identity does not intrude on others' reasonable expectations of privacy in those facilities. The Legislature failed to identify any evidence to support this claim during legislative proceedings, even though inclusive policies and practices have existed in many Idaho schools for years. For example, there is no evidence indicating that transgender people are any more likely to unnecessarily expose themselves to others than non-transgender people. To the contrary, transgender people often take steps to avoid drawing unnecessary attention to themselves and thereby reduce the risk of harassment.

101. Merely sharing the same physical space as transgender people does not infringe upon the privacy of cisgender people. There are also measures that can be undertaken to increase privacy for anyone desiring additional privacy, transgender or not, without excluding transgender people from facilities matching their gender identity.

CAUSES OF ACTION

COUNT I

Violation of Equal Protection

U.S. Const. Amend. XIV

(Against Defendants Critchfield, Clark, Gilbert Jr., Hill, Keough, Liebich, Roach, Siddoway,

Dennis, Wagers, Greeley, Gregory, Langley, Oppenheimer, and Rajbhandari)

102. Plaintiffs reallege and incorporate by reference the allegations above as though fully set forth herein.

103. Plaintiffs state this cause of action against Defendants in their official capacities for purposes of seeking declaratory and injunctive relief, and challenging S.B. 1100 facially and as applied.

104. The Fourteenth Amendment to the United States Constitution, enforceable pursuant to 42 U.S.C. § 1983, provides that no State shall “deny to any person within its jurisdiction the equal protection of the laws.” U.S. Const. amend. XIV, § 1. Defendants are all governmental actors and/or employees acting under color of state law for purposes of 42 U.S.C. § 1983 and the Fourteenth Amendment.

105. S.B. 1100 facially and intentionally discriminates against transgender people like Plaintiffs based on sex-related considerations. Discrimination based on sex includes but is not limited to discrimination based on gender nonconformity, gender identity, transgender status, gender transition, and nonconformity to sex-based stereotypes.

106. S.B. 1100 engages in sex-based classification by limiting access to school restrooms and other facilities based on sex assigned at birth, even where such facilities are inconsistent with an individual’s gender identity. S.B. 1100 also discriminates against transgender people based on sex by imposing harmful differential treatment on those who fail to conform to the stereotypes associated with their sex assigned at birth. The assumption that someone’s gender identity will and should align with their sex assigned at birth is a sex-based stereotype. S.B. 1100 discriminates against individuals who fail to conform to this stereotype—which the medical community has long understood is not true for all individuals. For example, although S.B. 1100 denies Plaintiff Rebecca Roe access to girls’ restrooms because her female

gender identity does not conform to her sex assigned at birth, a cisgender peer whose female identity does conform to her sex assigned at birth can use girls' restrooms.

107. Under the Equal Protection Clause of the Fourteenth Amendment, discrimination based on sex is presumptively unconstitutional and subject to heightened scrutiny.

108. S.B. 1100 facially and intentionally discriminates against transgender people like Plaintiffs based on transgender status. S.B. 1100 classifies based on transgender status by prohibiting transgender people from using school restrooms and other facilities that align with their gender identity, while permitting cisgender students to use school restrooms and other facilities that align with their gender identity. In other words, it treats people differently solely based on whether their assigned sex at birth aligns with their gender identity: if it does, they may use the facilities that correspond to their sex; if it does not, they may not. That is discrimination on the basis of transgender status.

109. Under the Equal Protection Clause of the Fourteenth Amendment, any discrimination based on transgender status is presumptively unconstitutional and subject to heightened scrutiny. *Karnoski v. Trump*, 926 F.3d 1180, 1200 (9th Cir. 2019). Government discrimination against transgender people bears all the indicia of a classification requiring heightened scrutiny by the courts.

a. Transgender people have long been victims of extreme discrimination across the country, including in Idaho, and continue to suffer such discrimination to this day.

b. Transgender status and gender identity bear no relation to one's ability to contribute to society.

c. Transgender people are politically vulnerable to attack and lack sufficient power to adequately protect their rights through the legislative process. Transgender people have

been unable, in large measure, to secure explicit federal, state, and local protections to protect themselves against discrimination, and they have been and continue to be regularly targeted by anti-transgender legislation, regulations, bills, and other government action.

d. Gender identity is a core, defining trait, and is so fundamental to one's identity and conscience that a person cannot be required to abandon it as a condition of equal treatment. Gender identity is also generally fixed at an early age and cannot be voluntarily changed. Thus, transgender status is immutable.

110. S.B. 1100 treats transgender people differently and worse than cisgender people who are similarly situated. Under S.B. 1100, cisgender people are able to access restrooms and other sex-specific facilities consistent with their gender identity, but transgender people are banned from restrooms and other sex-specific facilities consistent with their gender identity.

111. S.B. 1100 deprives transgender people such as Plaintiffs of their right to equal protection by branding them as less worthy than their cisgender peers.

112. S.B. 1100's discrimination against transgender people based on sex and transgender status fails every level of scrutiny. It is not substantially related to an important government interest. It is not even rationally related to any legitimate government interest. Schools across the nation, and in Idaho, regularly allow transgender students to use restrooms that align with their gender identity without causing increased safety or privacy problems for any students.

113. Far from advancing any interest in safety or privacy, S.B. 1100 endangers the safety, privacy, and well-being of transgender people. For example, if a transgender girl were forced to use the boys' restroom, she would be exposed to a heightened risk of harassment and assault by students who believe that she should not be in the boys' restroom, even though that is

the facility aligned with her “sex” as defined by S.B. 1100. Alternatively, forcing transgender students to only use single-occupancy or other “reasonable accommodation” facilities will stigmatize them as “others,” similarly exposing them to a heightened risk of harassment and assault and jeopardizing their psychological health.

114. In enacting S.B. 1100, the Legislature disguised conclusory allegations rooted in bias and misunderstanding as “legislative findings” that lack any factual support. But rather than advancing any legitimate governmental interest, S.B. 1100’s requirement that transgender students use facilities incongruent with their gender identity communicates the State’s disapproval of their gender identity, which the Constitution and federal law protect.

115. For example, the Legislature deemed every student to have a “natural right to privacy in the bathroom,” but that right to privacy cannot create—and has been held not to by the Ninth Circuit—any right on the part of cisgender students not to share a restroom with transgender individuals. *Parents for Privacy*, 949 F.3d at 1228.

COUNT II

Violation of Title IX

20 U.S.C. § 1681

(Against Defendants Idaho Board of Education and Boise School District)

116. Plaintiffs reallege and incorporate by reference the allegations above as though fully set forth herein.

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

research, occupational training, or other education program or activity operated by a recipient” of federal funding. 34 C.F.R. § 106.31; 7 C.F.R. § 15a.400; 45 C.F.R. § 86.31.

118. Under Title IX, discrimination “on the basis of sex” encompasses discrimination based on gender nonconformity, gender identity, transgender status, gender transition, and nonconformity to sex-based stereotypes.

119. Conduct specifically prohibited under Title IX includes, *inter alia*, treating one person differently from another in determining whether such person satisfies any requirement or condition for the provision of aid, benefits, or services; providing different aid, benefits, or services in a different manner; denying any person any such aid, benefit, or service; or otherwise subjecting any person to separate or different rules of behavior, sanctions, or other treatment. 34 C.F.R. § 106.31; 7 C.F.R. § 15a.31; 45 C.F.R. § 86.31.

120. The public schools that Plaintiffs attend are education programs receiving federal financial assistance. This means the schools, including the academic, extracurricular, and other educational opportunities provided, are subject to Title IX’s prohibitions on sex- and gender-based discrimination against any student.

121. By prohibiting transgender people like Plaintiffs from using the same restrooms and other facilities that their cisgender peers are allowed to use, Defendants have and continue to exclude Plaintiffs from participation in, deny them the benefits of, and subject them to discrimination in education programs and activities at their respective schools “on the basis of sex.” This violates Plaintiffs’ rights under Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681. For example, Defendants violate Rebecca Roe’s rights under Title IX by barring her from using the same girls’ restrooms that every other girl is allowed to use and relegating her to separate restroom facilities.

122. Defendants' violation of Plaintiffs' Title IX rights has caused injury and damage as a result, for which they seek nominal damages of \$1 (only as to their Title IX claim).

COUNT III

Violation of Right to Privacy

U.S. Const. Amend. XIV

(Against Defendants Critchfield, Clark, Gilbert Jr., Hill, Keough, Liebich, Roach, Siddoway, Dennis, Wagers, Greeley, Gregory, Langley, Oppenheimer, and Rajbhandari)

123. Plaintiffs reallege and incorporate by reference the allegations above as though fully set forth herein.

124. Plaintiffs state this cause of action against Defendants in their official capacities for purposes of seeking declaratory and injunctive relief, and challenging Idaho's S.B. 1100 facially and as applied.

125. The Due Process Clause of the Fourteenth Amendment to the United States Constitution, enforceable pursuant to 42 U.S.C. § 1983, provides that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. Defendants are all governmental actors and/or employees acting under color of state law for purposes of 42 U.S.C. § 1983 and the Fourteenth Amendment.

126. The substantive protections of the Due Process Clause, as well as other constitutional provisions, give rise to a right to privacy, protecting information that is highly personal and intimate, which includes information that could lead to bodily harm upon disclosure. Government infringement of these protections requires courts to apply strict scrutiny to such government action.

127. The involuntary disclosure of a person's transgender status violates that person's fundamental right to privacy. The fact that a person is transgender constitutes highly personal and intimate information. A reasonable person would find the involuntary disclosure of one's transgender status to be deeply intrusive.

128. The involuntary disclosure of one's transgender status can also cause significant harm, including placing one's personal safety and bodily integrity at risk. This harm burdens and interferes with the ability of transgender persons to live in a manner consistent with their gender identity in all aspects of life, including where doing so is medically necessary.

129. S.B. 1100 violates the fundamental right to privacy of transgender people, including Plaintiff Rebecca Roe and members of Plaintiff SAGA, by causing the involuntary disclosure of their transgender status and by depriving them of significant control over the circumstances around such disclosure.

130. There are no adequate safeguards to prevent the harms of the involuntary disclosure of one's transgender status caused by S.B. 1100. For example, once other students learn of the fact that a student is transgender, nothing prevents those students from disclosing that information to others.

131. There is no compelling, important, or even legitimate interest in the government causing transgender people such as Rebecca Roe to disclose their transgender status involuntarily any time they need to use school facilities. There is also no public policy interest that is served by causing transgender people to disclose their transgender status to third parties where they would not otherwise do so.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray that proper process issue and be served upon Defendants, requiring them to answer the Complaint within the time prescribed by law and further Plaintiffs request an order and judgment:

132. Declaring that the provisions of and enforcement by Defendants of Idaho S.B. 1100 as discussed above, including the exclusion of transgender people like Plaintiffs from covered facilities or quarters consistent with their gender identity, violate their rights under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution;

133. Declaring that the provisions of and enforcement by Defendants of Idaho S.B. 1100 as discussed above, including the exclusion of transgender people like Plaintiffs from covered facilities consistent with their gender identity, violate their rights under the Due Process Clause of the Fourteenth Amendment to the United States Constitution;

134. Declaring that the provisions of and enforcement by Defendants Board of Education and Boise School District of S.B. 1100 as discussed above, including the exclusion of transgender people like Plaintiffs from covered facilities or quarters, consistent with their gender identity, violate their rights under Title IX;

135. Declaring that Idaho S.B. 1100 is void and of no force or effect;

136. Preliminarily and permanently enjoining enforcement by Defendants of Idaho S.B. 1100 as discussed above, including the exclusion of transgender people like Plaintiffs from covered facilities or quarters, consistent with their gender identity;

137. Waiving the requirement for the posting of a bond as security for entry of temporary or preliminary injunctive relief;

138. Awarding nominal damages of \$1 for violation of Title IX only as well as Plaintiffs' costs, expenses, and reasonable attorneys' fees pursuant to 42 U.S.C. § 1988 and other applicable laws; and

139. Awarding such other relief as the Court deems just and proper.

140. The declaratory and injunctive relief requested in this action is sought against each Defendant; against each Defendant's officers, employees, and agents; and against all persons acting in active concert or participation with any Defendant, or under any Defendant's supervision, direction, or control.

Dated: July 6, 2023

Katherine M. Forster
Robyn K. Bacon
J. Max Rosen
Nicholas R. Sidney
Paul Martin
Avery P. Hitchcock
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Respectfully Submitted,

/s/ Samuel L. Linnet
Samuel L. Linnet
ALTURAS LAW GROUP, PLLC

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LAMBDA LEGAL DEFENSE & EDUCATION FUND

Exhibit 1

LEGISLATURE OF THE STATE OF IDAHO
Sixty-seventh Legislature First Regular Session - 2023

IN THE SENATE

SENATE BILL NO. 1100, As Amended

BY EDUCATION COMMITTEE

AN ACT

1 RELATING TO PROTECTING THE PRIVACY AND SAFETY OF STUDENTS IN PUBLIC SCHOOLS;
2 AMENDING TITLE 33, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 66, TITLE
3 33, IDAHO CODE, TO PROVIDE LEGISLATIVE FINDINGS, TO DEFINE TERMS, TO ES-
4 TABLISH PROVISIONS REGARDING SCHOOL RESTROOMS, TO PROVIDE EXEMPTIONS,
5 TO PROVIDE FOR REASONABLE ACCOMMODATION IN CERTAIN INSTANCES, TO PRO-
6 VIDE FOR A CIVIL CAUSE OF ACTION, AND TO PROVIDE FOR PREEMPTION; PROVID-
7 ING SEVERABILITY; AND DECLARING AN EMERGENCY AND PROVIDING AN EFFECTIVE
8 DATE.
9

10 Be It Enacted by the Legislature of the State of Idaho:

11 SECTION 1. That Title 33, Idaho Code, be, and the same is hereby amended
12 by the addition thereto of a NEW CHAPTER, to be known and designated as Chap-
13 ter 66, Title 33, Idaho Code, and to read as follows:

14 CHAPTER 66

15 PROTECTING THE PRIVACY AND SAFETY OF STUDENTS IN PUBLIC SCHOOLS

16 33-6601. LEGISLATIVE FINDINGS. The legislature finds that:

- 17 (1) There are real and inherent physical differences between men and
18 women;
- 19 (2) Every person has a natural right to privacy and safety in restrooms
20 and changing facilities where such person might be in a partial or full state
21 of undress in the presence of others;
- 22 (3) This natural right especially applies to students using public
23 school restrooms and changing facilities where student privacy and safety is
24 essential to providing a safe learning environment for all students;
- 25 (4) Requiring students to share restrooms and changing facilities with
26 members of the opposite biological sex generates potential embarrassment,
27 shame, and psychological injury to students, as well as increasing the like-
28 lihood of sexual assault, molestation, rape, voyeurism, and exhibitionism;
- 29 (5) Providing separate public school restrooms and changing facilities
30 for the different biological sexes is a long-standing and widespread prac-
31 tice protected by federal law, state law, and case law;
- 32 (6) Federal legislative action, federal executive action, and fed-
33 eral court judgments that prevent public schools from maintaining separate
34 restrooms and changing facilities for different biological sexes are in-
35 consistent with the United States constitution and violate the privacy and
36 safety rights of students; and
- 37 (7) A statewide policy ensuring separate school restrooms and chang-
38 ing facilities on the basis of biological sex is substantially related to the
39 important governmental interest in protecting the privacy and safety of all
40 students.

1 33-6602. DEFINITIONS. For the purposes of this chapter:

2 (1) "Changing facility" means a facility in which a person may be in a
3 state of undress in the presence of others, including a locker room, changing
4 room, or shower room.

5 (2) "Public school" means any public school teaching K-12 students
6 within an Idaho school district or charter school.

7 (3) "Sex" means the immutable biological and physiological character-
8 istics, specifically the chromosomes and internal and external reproductive
9 anatomy, genetically determined at conception and generally recognizable at
10 birth, that define an individual as male or female.

11 33-6603. SCHOOL RESTROOMS. (1) Every public school restroom or chang-
12 ing facility accessible by multiple persons at the same time must be:

13 (a) Designated for use by male persons only or female persons only; and

14 (b) Used only by members of that sex.

15 (2) No person shall enter a multi-occupancy restroom or changing facil-
16 ity that is designated for one sex unless such person is a member of that sex.
17 The public school with authority over the building shall ensure that all re-
18 strooms and changing facilities provide its users with privacy from members
19 of the opposite sex.

20 (3) In any other public school setting where a person may be in a state
21 of undress in the presence of others, school personnel must provide separate
22 and private areas designated for use by persons based on their sex, and no
23 person may enter these private areas unless such person is a member of the
24 designated sex.

25 (4) During any school authorized activity or event where persons share
26 overnight lodging, school personnel must provide separate sleeping quar-
27 ters for members of each sex. No person shall share sleeping quarters, a
28 restroom, or a changing facility with a person of the opposite sex, unless
29 the persons are members of the same family.

30 33-6604. EXEMPTIONS. This chapter shall not apply:

31 (1) To single-occupancy restrooms and changing facilities or restrooms
32 and changing facilities that are conspicuously designated for unisex or fam-
33 ily use;

34 (2) To restrooms and changing facilities that have been temporarily
35 designated for use by that person's biological sex;

36 (3) To a person of one sex who uses a single-sex facility designated for
37 the opposite sex, if such single-sex facility is the only facility reason-
38 ably available at the time of the person's use of the facility;

39 (4) To a person employed to clean, maintain, or inspect a restroom or
40 single-sex facility;

41 (5) To a person who enters a restroom or facility to render medical as-
42 sistance;

43 (6) To a person who is in need of assistance and, for the purposes
44 of receiving that assistance, is accompanied by a family member, a legal
45 guardian, or the person's designee who is a member of the designated sex for
46 the single-sex restroom or changing facility;

47 (7) To coaching staff and personnel during athletic events; or

1 (8) During an ongoing natural disaster or emergency, or when necessary
2 to prevent a serious threat to good order or student safety.

3 33-6605. REASONABLE ACCOMMODATION. (1) A public school shall provide
4 a reasonable accommodation to a student who:

5 (a) For any reason, is unwilling or unable to use a multi-occupancy re-
6 stroom or changing facility designated for the person's sex and located
7 within a public school building, or multi-occupancy sleeping quarters
8 while attending a public school-sponsored activity; and

9 (b) Provides a written request for reasonable accommodation to the pub-
10 lic school.

11 (2) A reasonable accommodation does not include access to a restroom,
12 changing facility, or sleeping quarter that is designated for use by members
13 of the opposite sex while persons of the opposite sex are present or could be
14 present.

15 33-6606. CIVIL CAUSE OF ACTION. (1) Any student who, while accessing a
16 public school restroom, changing facility, or sleeping quarters designated
17 for use by the student's sex, encounters a person of the opposite sex has a
18 private cause of action against the school if:

19 (a) The school gave that person permission to use facilities of the op-
20 posite sex; or

21 (b) The school failed to take reasonable steps to prohibit that person
22 from using facilities of the opposite sex.

23 (2) Any civil action arising under this chapter must be commenced
24 within four (4) years after the cause of action has occurred.

25 (3) Any student who prevails in an action brought under this chapter may
26 recover from the defendant public school five thousand dollars (\$5,000) for
27 each instance that the student encountered a person of the opposite sex while
28 accessing a public school restroom, changing facility, or sleeping quarters
29 designated for use by aggrieved student's sex. The student may also recover
30 monetary damages from the defendant public school for all psychological,
31 emotional, and physical harm suffered.

32 (4) Any student who prevails in action brought under this chapter is en-
33 titled to recover reasonable attorney's fees and costs from the defendant
34 public school.

35 (5) Nothing in this chapter limits other remedies at law or equity
36 available to the aggrieved student against the school.

37 33-6607. PREEMPTION. This chapter preempts any law, regulation, pol-
38 icy, or decree enacted or adopted by any city, county, municipality, or other
39 political subdivision within the state that purports to permit or require
40 public schools to allow persons to use facilities designated for the other
41 sex.

42 SECTION 2. SEVERABILITY. The provisions of this act are hereby declared
43 to be severable and if any provision of this act or the application of such
44 provision to any person or circumstance is declared invalid for any reason,
45 such declaration shall not affect the validity of the remaining portions of
46 this act.

1 SECTION 3. An emergency existing therefor, which emergency is hereby
2 declared to exist, this act shall be in full force and effect on and after
3 July 1, 2023.