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Appendix A

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**Pro hac vice* application pending

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

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

Plaintiffs,

v.

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

Defendants.

Case No.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

The Idaho legislature passed the Healthcare Ban, and on April 4, 2023, Governor Brad Little signed the bill into law in the name of "protecting minors." But lawmakers and the Governor ignored the extensive legislative testimony that the Healthcare Ban *harms* children. Idaho doctors testified about the damage that the Healthcare Ban would cause by limiting physicians' ability to treat patients' gender dysphoria, as well as the unavoidable, grave harm to the health and wellbeing of transgender youth if they are prohibited from receiving necessary medical care, including debilitating anxiety, severe depression, self-harm, and suicide. Transgender people testified about their painful experiences of depression and social isolation before receiving treatment for their gender dysphoria, and the marked improvement that care brought to their lives. Parents of transgender children begged legislators not to eliminate their ability to protect their children's health and wellbeing in Idaho. The Lawmakers disregarded *all* of this testimony and passed a law that interferes with loving parents' decisions about what is best for their children, and criminalizes doctors who provide medically necessary care for their patients.

The Healthcare Ban is not only harmful to the wellbeing of the minors it purports to protect; it is also unconstitutional. It violates the right to equal protection of transgender adolescents by singling out for prohibition only medical treatments that affirm a patient's gender if inconsistent with that patient's "biological sex"—thus prohibiting those treatments only for transgender minors. The law is subject to heightened scrutiny because it classifies based on sex and because classifications based on transgender status are at least quasi-suspect. The Healthcare Ban also infringes on a fundamental right—parents' right to make decisions about their children's medical care. Burdens on this right are subject to strict scrutiny. But the Healthcare Ban does not satisfy any level of constitutional scrutiny because it serves no

governmental interest whatsoever, let alone a compelling one. To the contrary, as major medical groups recognize, laws like the Healthcare Ban are a grave threat to the safety and wellbeing of minors. The Healthcare Ban is not narrowly tailored to further any government interest and is sweeping in its application, without exception. The Healthcare Ban is unconstitutional for the additional reason that it was based on negative attitudes toward and disapproval of transgender people. This was reflected in statements made by legislators who supported the law, and the fact that the Healthcare Ban is just part of a broader campaign by the Idaho Legislature targeting transgender people of all ages.

Idaho's Healthcare Ban is unconstitutional. Plaintiffs bring this action for declaratory and injunctive relief prohibiting its enforcement. The law by its own terms will not take effect until January 2024. Plaintiffs will work with Defendants' counsel and the Court to set a schedule for a preliminary injunction motion that will allow the Court to resolve that motion before the law would otherwise take effect.

JURISDICTION AND VENUE

1. This action arises in part under the United States Constitution and 42 U.S.C. § 1983.

2. This Court has subject matter jurisdiction pursuant to Article III of the United States Constitution and 28 U.S.C. §§ 1331, 1343, and 1367.

3. Plaintiffs' claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201 and 2202 and 42 U.S.C. § 1983.

4. Venue in this district is proper pursuant to 28 U.S.C. §§ 1391(b)(1) and 1391(b)(2), because one or more Defendants resides in this district and because a substantial part of the events giving rise to the claims occurred in this district, where one or more Plaintiffs reside.

5. Consistent with Dist. Idaho Loc. Civ. R. 3.1, venue is proper in the Southern Division because Plaintiffs and some Defendants legally reside in Ada County, Idaho, and because that is where the claim for relief arose.

PARTIES

I. The Minor Plaintiffs and Their Families

A. The Poe Family

6. Plaintiffs Pam Poe, Penny Poe, and Peter Poe live in Idaho. Penny and Peter are the parents of Pam. Pam is 15 years old and has lived in Idaho her whole life. She is transgender and is currently receiving medically necessary care that would be prohibited by the Healthcare Ban. The experience of Pam and her family is discussed in paragraphs 71-81 below.

B. The Doe Family

7. Plaintiffs Jane Doe, Joan Doe, and John Doe live in Idaho. Joan and John met while in college and are the parents of Jane. Jane is 16 years old and has lived in Boise her whole life. She is transgender and currently receiving medically necessary care that would be prohibited by the Healthcare Ban. The experience of Jane and her family is discussed in paragraphs 82-94 below.

II. Defendants

8. Defendant Raúl Labrador is the Attorney General of the State of Idaho. The Attorney General's offices are located at 700 W. Jefferson St. #210, Boise, Idaho. The Healthcare Ban grants Defendant Labrador authority to bring legal action to enforce the Ban, and Defendant Labrador has publicly announced that he intends to enforce the Healthcare Ban. Defendant Labrador is sued in his official capacity.

9. Defendant Jan M. Bennetts is the Prosecuting Attorney for Ada County, Idaho, where Plaintiffs reside. County Prosecutor Bennetts is named in her official capacity. County

Prosecuting Attorneys bear "primary" responsibility for enforcing the Healthcare Ban in their respective Idaho counties. *See* Idaho Code § 31-2227.

10. The individual members of the Idaho Code Commission (Defendants Jeremy Vaughn, Andrew Doman, and Jill Holinka) are sued in their official capacities and all reside in Idaho, and are designated in the caption by their titles pursuant to Federal Rule of Civil Procedure 17(d). The Code Commission'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. The Idaho Code Commission is an office of the Secretary of State established by statute. *See* Idaho Code §§ 73-201–73-221. The Commission's purpose is to keep the Idaho Code up to date by indicating changes to laws, including constitutional changes, and providing annotations, and the Commission has all power and authority necessary to accomplish that purpose. It has the specific power to keep the Idaho Code up to date, to provide annotations to the Code, and to provide references in the Code to decisions of the federal courts. *Id.* § 73-205. These Defendants are referred to in this Complaint collectively as the "Idaho Code Commission Defendants."

III. FACTUAL BACKGROUND

A. Gender Dysphoria and Its Treatment

1. Gender Identity

11. "Gender identity" is a person's internal sense of belonging to a particular gender. Everyone has a gender identity, and it is a fundamental aspect of human development for all people. No medical intervention can alter a person's gender identity.

12. People are "transgender" when their gender identity does not align with the sex assigned to them at birth. A transgender boy is a boy who was assigned a female sex at birth but

persistently, consistently, and insistently identifies as male. A transgender girl is a girl who was assigned a male sex at birth but persistently, consistently, and insistently identifies as female.

13. Some transgender people recognize this misalignment in early childhood. For others, it can become apparent with the onset of puberty and the resulting physical changes, or later into adulthood.

14. People are "cisgender" when their gender identity aligns with the sex assigned to them at birth. A cisgender boy is a boy who was assigned male at birth and persistently, consistently, and insistently identifies as male. A cisgender girl is a girl who was assigned female at birth and persistently, consistently, and insistently identifies as female.

15. Some people's gender identity does not strictly fall within the binary categories of male and female. The term non-binary is commonly used to express such a gender identity.

16. The terms "sex designated at birth" or "sex assigned at birth" are more accurate and precise than the term "biological sex" used in the Healthcare Ban, because "biological sex" falsely implies clear divisions between and uniformity within "sexes." For example, some people with intersex characteristics may have a chromosomal configuration typically associated with a male sex designation (XY) but external genitalia typically designated female (a vulva rather than a penis). For these reasons, the Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, warns practitioners that the terms "biological sex" and "biological male or female" are imprecise and should be avoided.

2. Gender Dysphoria

17. The lack of alignment between one's gender identity and their sex assigned at birth can cause significant distress, particularly during the onset of puberty, when the development of secondary sex characteristics—e.g., breasts for those assigned female at birth or

facial hair for those assigned male at birth—can widen the gap between someone's gender identity and their physical appearance.

18. "Gender dysphoria" is the clinical diagnosis for the significant distress that can result from the incongruity between one's gender identity and the sex they were designated at birth. It is codified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) (DSM-5 released in 2013, and DSM-5-TR released in 2022). To be clear, being transgender is not a medical or psychiatric condition to be cured—gender identity is innate, and no medical or psychological treatment can change it. The American Psychiatric Association has thus explained that "[t]he presence of gender variance is not the pathology." Instead, gender dysphoria results "from the distress caused by the body and mind not aligning and/or societal marginalization of gender-variant people." Laws targeting transgender people, like the one at issue here, are an example of such marginalization.

19. To be diagnosed with gender dysphoria, a patient's incongruence between their gender identity and the sex they were designated at birth must have persisted for at least six months and the dysphoria must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. Gender dysphoria is a serious medical condition. If left untreated, gender dysphoria can result in debilitating anxiety, severe depression, self-harm, and suicide. These symptoms will only worsen without treatment.

3. Treatment of Gender Dysphoria

20. The World Professional Association for Transgender Health ("WPATH") has published guidelines for the treatment of gender dysphoria since 1979, which are widely accepted in the medical community. These guidelines are now known as the Standards of Care

for the Health of Transgender and Gender Diverse People ("WPATH Standards of Care"). The current version is Standards of Care 8, published in 2022. The recommendations in WPATH's Standards of Care 8 are based on a systematic review of the evidence.

21. The WPATH Standards of Care provide guidelines for multidisciplinary care of transgender people and describe criteria for medical interventions to treat gender dysphoria, including puberty-delaying medication, hormone treatment, and surgery when medically indicated. Every major medical organization in the United States recognizes that these treatments are medically necessary for some patients in order to treat gender dysphoria, and that they are safe and effective treatments.

22. A clinical practice guideline from the Endocrine Society (the "Endocrine Society Guideline") provides protocols for the treatment of gender dysphoria similar to those outlined in the WPATH Standards of Care.

23. Doctors in Idaho and throughout the country follow both the WPATH Standards of Care and the Endocrine Society Guideline to treat people with gender dysphoria.

24. Recommendations for treatment for gender dysphoria depend on whether treatment is for a pre-pubertal child, an adolescent, or an adult. In all cases, the precise treatment recommended for gender dysphoria will depend upon each patient's individualized needs.

25. Before puberty, gender-affirming care does not include any pharmaceutical or surgical interventions. Care for a pre-pubertal child often includes supporting the child's "social transition," which refers to living consistently within one's persistently expressed gender identity (e.g., adopting a new name and pronouns and dressing in a manner that aligns with one's gender identity).

26. Under the WPATH Standards of Care and the Endocrine Society Guideline, medical interventions may become medically necessary and appropriate after transgender youth reach puberty. Both guidelines recommend that adolescent patients receive comprehensive psychological assessments prior to receiving any gender-affirming medical interventions.

27. Both Pam Poe and Jane Doe are receiving treatment in accordance with the WPATH Standards of Care and the Endocrine Society Guideline.

(a) Puberty-Delaying Treatment

28. For many transgender adolescents, going through puberty in accordance with the sex designated to them at birth can cause extreme distress. For these adolescents, puberty-delaying medications—known as gonadotropin-releasing hormone ("GnRH") antagonists—can minimize and potentially prevent gender dysphoria, as well as the permanent, unwanted physical changes that undergoing endogenous puberty would cause. Puberty-delaying treatment is safe and effective in treating gender dysphoria in adolescents.

29. Under the Endocrine Society Guideline, transgender adolescents may be eligible for puberty-delaying treatment if:

- A qualified mental health professional has confirmed that:
    - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria;
    - gender dysphoria worsened with the onset of puberty;
    - if there are any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence), those have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment; and
    - the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment.

- The adolescent:
    - has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility; and
    - has given informed consent, and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable law) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.
- And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
    - agrees with the indication for GnRH agonist treatment;
    - has confirmed that puberty has started in the adolescent; and
    - has confirmed that there are no medical contraindications to GnRH agonist treatment.

30. WPATH Standards of Care similarly provide that transgender adolescents may be eligible for puberty-delaying treatment if:

- A health care professional has confirmed that:
    - The experience of gender diversity/incongruence is marked and sustained over time;
    - That puberty has started;
    - The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed;
    - The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
- The adolescent:
    - Has been informed of possible reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.

31. Puberty-delaying treatment works by pausing a person's endogenous puberty. For transgender girls, this treatment pauses the physiological changes typical of male puberty and prevents the development of associated secondary sex characteristics like facial hair, a pronounced Adam's apple, deepening of the voice, and genital growth. For transgender boys, puberty-delaying treatment pauses the development of breasts and menstruation. The use of these interventions after the onset of puberty can eliminate or reduce the need for gender-affirming surgeries later in life, and prevent bodily changes that cannot be later corrected with surgical interventions.

32. Puberty-delaying treatment is reversible. If puberty-delaying treatment is stopped and no gender-affirming hormone therapy is provided, endogenous puberty resumes and patients undergo puberty in a timeline typical of their peers.

33. Puberty-delaying treatment does not, by itself, impair future fertility.

34. When puberty-delaying treatment is followed by gender-affirming hormone therapy, fertility may be affected. For this reason, patients and their families are counseled about fertility preservation before even beginning puberty-delaying treatment. Where preserving fertility is important to the family, treatment can be timed to minimize the risk.

35. If gender-affirming hormone therapy is provided after puberty-delaying treatment, patients then undergo puberty consistent with their gender identity on a timeline typical of their peers.

(b) Gender-Affirming Hormone Therapy

36. For some adolescents, it may be medically necessary and appropriate to treat their gender dysphoria with gender-affirming hormone therapy (testosterone for transgender boys, and testosterone suppression and estrogen for transgender girls).

37. Under the Endocrine Society Guidelines, transgender adolescents may be eligible for gender-affirming hormone therapy if:

- A qualified mental health professional has confirmed:
  - the persistence of gender dysphoria; and
  - if there are any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence), those have been addressed, such that the adolescent's environment and functioning are stable enough to start sex hormone treatment.
- The adolescent:
  - has been informed of the partly irreversible effects and side effects of treatment (including potential loss of fertility and options to preserve fertility);
  - the adolescent has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to the treatment; and
  - has given informed consent, and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable laws) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.
- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
  - agrees with the indication for sex hormone treatment; and
  - has confirmed that there are no medical contraindications to sex hormone treatment.

38. WPATH Standards of Care similarly provide that transgender adolescents may be eligible for gender-affirming hormone therapy if:

- A health care professional has confirmed that:
  - The experience of gender diversity/incongruence is marked and sustained over time;
  - That puberty has started;

- The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed;
- The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.

- The adolescent:
  - Has been informed of the possible reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.

39. Through decades of clinical experience and research, gender-affirming hormone therapy has been shown to be safe and effective at treating gender dysphoria in both adolescents and adults.

40. Adverse side effects from clinically supervised gender-affirming hormone therapy are rare.

41. While gender-affirming hormone therapy can in some circumstances affect fertility, many people receiving hormone therapy can conceive children while undergoing treatment or after discontinuing or pausing hormone therapy treatment (e.g., men who are transgender can give birth and women who are transgender can produce viable sperm). Patients and their parents are counseled about fertility preservation, and treatment can be tailored to minimize the risk.

42. Apart from the potential impact on fertility, gender-affirming hormone therapy poses the same (rare) potential risks as the use of these medications for non-transgender patients for other purposes.

(c) Gender-Affirming Surgical Interventions

43. Under the WPATH Standards of Care, surgical interventions may become medically necessary and appropriate in certain cases for transgender adolescents. Gender-

affirming surgeries are only considered for minors if they have longstanding gender dysphoria and are assessed to possess the emotional and cognitive maturity to understand the risks and benefits of the treatment.

44. Plaintiffs are not aware of any doctors in Idaho who perform any gender-affirming surgeries on minors. Elsewhere, gender-affirming surgeries for transgender minors are not common, and the vast majority are chest masculinization surgery for transgender boys.

IV. The Enactment of the Healthcare Ban

45. On March 29, 2023, the Idaho State Legislature passed the Healthcare Ban, prohibiting medical providers from providing medications or surgical treatments to minors "for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." The law defines "sex" based on "chromosomes and internal and external reproductive anatomy." H.B. 71 § 1. The specified treatments include surgeries which alter "the appearance of genitalia that differs from the child's biological sex" or "mastectom[ies]," in addition to "administering or supplying . . . [p]uberty blocking medication," "testosterone to a female," or "estrogen to a male." *Id.* A child is defined as anyone under eighteen years of age. *Id.*

46. Notably, the Healthcare Ban makes it a felony for Idaho doctors to provide these medical treatments to minors *only* when it is "for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." *Id.* The same medical treatments are not banned under the law if they are provided for any other purposes, including to affirm a minor's gender if it is *consistent* with the child's "biological sex."

47. The Healthcare Ban treats the provision of gender-affirming medical care to minors as a "crime[ ] of violence," *id.* § 2, and imposes on healthcare providers a penalty of

imprisonment up to 10 years. *Id.* § 1. This is equivalent to the prison penalty for involuntary or vehicular manslaughter. H.B. 71 § 2; Idaho Code § 18-4007. And the Ban authorizes up to $5,000 in fines in addition to imprisonment.

48. There is no exception for treatment that is necessary for the adolescent's health—regardless of their prior course of treatment, individual circumstances, or degree of distress—if the treatment's purpose is to affirm a minor's gender "inconsistent with [their] biological sex." HB 71E1 § 1, 18-1506C(4)(a).

49. The Ban expressly allows physicians to perform permanent and irreversible treatment on children with intersex conditions, including genital surgeries on newborns, despite their incapacity to assent, and despite the fact that major medical organizations like the American Academy of Family Physicians have expressly said that such surgeries on intersex infants and youth are harmful. H.B. 71 § 1.

50. In passing the law, the State Legislature ignored compelling testimony from the very people the Healthcare Ban affects. Indeed, the House Judiciary, Rules & Administration committee took the extraordinary, unprecedented step of trying to prevent people under the age of 18 from testifying, and after public outcry, ultimately passed a modified rule which made it harder for people under the age of 18 to testify. Further, the State Legislature ignored testimony from transgender adults who shared their painful experiences of depression and social isolation prior to receiving treatment for their gender dysphoria, and how their lives were improved by receiving care prohibited by the Healthcare Ban.

51. The State Legislature ignored testimony from parents of transgender children who testified to the harm that the legislation would do to their children's wellbeing, and who begged legislators not to strip them of their ability to get their children lifesaving care in their home

state. The mother of one 15-year-old transgender Idahoan testified that since her daughter began receiving hormone therapy, she witnessed her "go from being lost and unhappy to being comfortable and thriving." She added, "We know that there are risks to hormone treatments, but we also know there are risks to delaying those treatments, such as depression, suicide, and more difficulty integrating into society as adults. Parenting is hard, and there are so many risks that we have to weigh from whether or not we circumcise an infant to which vaccinations to give to when to let our teenagers date or letting them drive a car for the first time, all of which can have negative consequences. As a parent, I'm appealing to you to not take away my right to work with professionals to parent my child and help her fulfill her potential to be a healthy, productive adult." But in passing the Healthcare Ban, the legislature did just that. The State Legislature also ignored testimony from Idaho doctors about the damage that the Healthcare Ban would cause by limiting physicians' options for treating gender dysphoria, as well as the unavoidable grave harm to the health and wellbeing of transgender youth if they are prohibited from receiving necessary medical care.

52. The legislature's decision to supplant the medical judgment of Idaho physicians (and every major medical association in the nation) with its own, to subject Idaho physicians to draconian penalties for providing patients with well-accepted medical care, and to intrude on family medical decisions, is extraordinary.

53. Statements from members of the State Legislature demonstrate disapproval of transgender people. For example, the bill's first-listed sponsor, Representative Bruce Skaug, and co-sponsor Senator Ben Adams equated the provision of well-accepted treatment for gender dysphoria in adolescents with "genital mutilation" and the "wicked past [of] sterilizations." On her official Twitter account, Senator Tammy Nichols, another cosponsor, referred to identifying

as LGBTQ as an "epidemic" of which "States need to help stop the spread," and called gender-affirming medical care "Frankenstein Practices." On his official Twitter account, Senator Scott Herndon dismissed gender dysphoria as "a social mania that needs to stop."

54. This law is just the latest of a wave of recently proposed bills and laws in Idaho targeting transgender people for marginalization.

55. During the 2020 legislative session, the State Legislature passed, and the Governor signed into law, bills prohibiting transgender people from changing the gender recorded on their birth certificate, H.B. 509, 65th Leg., 2nd Sess. (Idaho 2020), and prohibiting transgender women and girls from participating in women's sports, regardless of the circumstances, H.B. 500, 65th Leg., 2nd Sess. (Idaho 2020).

56. On March 14, 2023, the State Legislature introduced H.B. 314, which would ban schools or public libraries from making material deemed inappropriate available, and which was widely understood to target books specifically discussing sexual orientation or gender identity. H.B. 314, 67th Leg., 1st Sess. (Idaho 2023). The bill passed both houses before being vetoed by Governor Little.

57. And just two weeks prior to signing the Healthcare Ban, Governor Little signed SB 1100 into law, which will ban transgender public-school students from using the bathroom that aligns with their gender identity. S.B. 1100, 67th Leg., 1st Sess. (Idaho 2023).

58. Viewed in the proper context, it is clear that the State Legislature's passage of the Healthcare Ban had nothing to do with protecting children and everything to do with expressing disapproval of, and stigmatizing, transgender people.

V. The Criminalized Treatment Is Permitted for Treating Other Conditions

59. While the Healthcare Ban prohibits the use of well-established treatments for gender dysphoria in transgender adolescents—including puberty-delaying drugs, testosterone

therapy, estrogen therapy, testosterone suppressants, and mastectomy—it permits the use of those very medications and surgeries for minors for other purposes, including to affirm the gender of cisgender minors.

60. For example, cisgender boys may be prescribed testosterone if they have not begun puberty by 14 years of age. For most of these patients, puberty would eventually initiate naturally even without testosterone. But testosterone is prescribed to avoid some of the social stigma that can come from undergoing puberty later than one's peers and failing to develop the secondary sex characteristics consistent with their gender at the same time as one's peers. Similarly, cisgender boys who are forecasted to have a post-pubertal height of 5'4" or shorter—which is roughly the average height of an American woman—may be treated with testosterone for "short stature." Idaho doctors are thus free to prescribe testosterone to cisgender boys, including to affirm cisgender boys' gender identity. But under the Healthcare Ban, they would face imprisonment for prescribing exactly the same medication to affirm a transgender boy's gender identity.

61. Likewise, cisgender girls with polycystic ovarian syndrome (a condition that can cause increased testosterone and, as a result, symptoms including facial hair) may be treated with testosterone suppressants. The same treatments that are permitted for cisgender minors—often to affirm their gender—are banned if provided to transgender minors to affirm *their* gender.

62. Puberty delaying medication is widely used to treat "central precocious puberty"—the premature initiation of puberty (before eight years of age in people assigned female at birth and before nine years of age in people assigned male). Central precocious puberty can lead to anxiety, depression, and lower academic achievement, as well as impairment of final adult height. Under the Healthcare Ban, doctors in Idaho can prescribe puberty-delaying

medications to treat children with precocious puberty, but cannot prescribe those very same medication to treat transgender adolescents with gender dysphoria..

63. Cisgender girls may be treated with estrogen for a variety of conditions, including primary ovarian insufficiency, hypogonadotropic hypogonadism (lack of hormone production due to a problem with the pituitary gland or hypothalamus), and Turner's Syndrome (a chromosomal condition that can cause a failure of ovaries to develop). Under the Healthcare Ban, doctors in Idaho can prescribe estrogen to treat cisgender girls with any of these conditions but cannot prescribe the same medication to treat transgender adolescents with gender dysphoria.

64. The Healthcare Ban also criminalizes providing mastectomy to transgender young men to treat gender dysphoria because it is "inconsistent" with their "biological sex," but cisgender boys are permitted to undergo mastectomy to ensure their bodies track their own perception of their gender. Cisgender adolescent boys can have surgery to treat gynecomastia—the proliferation of ductal or glandular breast tissue, as opposed to adipose tissue, in individuals assigned male at birth. These surgeries are commonly performed to reduce psychosocial distress, often related to the incongruence with one's gender. Therefore, a transgender boy cannot receive chest-masculinizing surgery to affirm his gender identity, but a cisgender boy can.

VI. The Healthcare Ban Will Cause Severe Harm to Transgender Adolescents

65. Withholding gender-affirming medical care from adolescents with gender dysphoria when it is medically indicated puts them at risk of extreme harm to their health and wellbeing.

66. Adolescents with untreated gender dysphoria often suffer significant distress. Many are on medications for depression and anxiety. Self-harm and suicidal ideation are exceedingly common. Indeed, suicidality among transgender young people is a crisis. One

survey found that more than half of transgender youth had seriously contemplated suicide. Studies have found that as many as 40% of transgender people have attempted suicide at some point in their lives.

67. When adolescents are able to access puberty-delaying treatment and hormone therapy—which prevent them from going through endogenous puberty and allow them to go through puberty consistent with their gender identity—their distress recedes and their mental health improves. Both clinical experience and medical studies confirm that for many young people, this treatment is transformative, helping them go from suffering to thriving.

68. If a healthcare provider is forced to deny or discontinue puberty-delaying treatment or hormone therapy due to the Healthcare Ban, it will cause patients to undergo their endogenous puberty. For a girl who is transgender, this could mean that she would experience genital growth, body hair growth, deepening of her voice, and development of a more pronounced Adam's apple. For a boy who is transgender, this could mean the initiation or resumption of a menstrual cycle and breast growth. This can result in extreme distress for adolescents with gender dysphoria. Additionally, the effects of undergoing one's endogenous puberty may not be reversible even with subsequent hormone therapy and surgery in adulthood, thus exacerbating lifelong gender dysphoria in patients who have this treatment withheld or cut off.

69. And for patients who have been relying on puberty-delaying treatment and/or hormone therapy to alleviate their gender dysphoria, being forced to stop treatment and experience the changes of endogenous puberty can be extremely distressing and have significant impact on mental health. Moreover, abruptly withdrawing hormone therapy can pose additional risks to patients. The body takes about six weeks to ramp up endogenous hormones, so a patient

will be without sufficient circulating hormones at all if their treatment is abruptly halted. This can result in depressed mood as well as debilitating hot flashes and headaches. For patients on spironolactone—a testosterone suppressant—abruptly terminating treatment can cause a patient's blood pressure to spike, increasing the risk of heart attack or stroke even for young patients.

70. Gender-affirming medical care is lifesaving treatment for many adolescents experiencing gender dysphoria. The major medical and mental health associations in the United States all support the provision of such care as safe and effective treatment. These associations include the American Academy of Pediatrics, American Medical Association, the Endocrine Society, the Pediatric Endocrine Society, the American Psychological Association, the American Psychiatric Association, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American Nurses Association, the National Association of Social Workers, and WPATH.

VII. The Impact of the Healthcare Ban on Plaintiffs

(a) The Poe Family

71. Pam Poe is a fifteen-year-old ninth grader and a lifelong Idaho resident. She has a part-time job and loves engineering, programming, and math. Pam lives with her parents and her seventeen-year old sister. Her oldest sister is nineteen years old and has moved out of the family home.

72. Pam is transgender. She is a girl with a female gender identity, but when she was born, she was designated as male.

73. Pam began to realize she was transgender around March 2021, while she was in seventh grade.

74. In August of 2021, Pam worked up the courage to tell her mom that she was transgender. Her mother reacted with acceptance and support, hugging her, thanking Pam for introducing herself, and declaring, "I love you."

75. Pam began experimenting with traditionally feminine clothing and makeup throughout eighth grade. She began living socially as a girl when she started high school in August 2022.

76. In late-2021, Pam was struggling with depression, anxiety, and self-harm, and she began seeing a counselor weekly. When counseling did not alleviate her negative feelings, Pam asked her mom to admit her to a residential treatment facility in late February 2022. She spent one week there, and she was diagnosed with gender dysphoria while in treatment.

77. Two months after leaving the treatment center, Pam began seeing a doctor who specializes in treating gender dysphoria. Pam's mom observed that when she left her first appointment having learned that puberty blockers were a possibility for her, Pam had a huge smile and seemed like the happiest she had been in almost a year.

78. After careful evaluation, thorough discussion of risks and benefits, and bloodwork, in May 2022, when Pam Poe was 14, her doctor prescribed her puberty blockers. The medication had a near-immediate positive effect on Pam. By pausing the physical changes that were causing her depression and anxiety, her mental health greatly improved.

79. In April 2023, when Pam was 15 years old, Pam's family and her doctor had a conversation about the possibility of Pam beginning hormone treatment. The doctor performed bloodwork, discussed the risks and benefits as well as options for fertility preservation, and confirmed Pam's ongoing therapy and mental health support. Pam and her parents, in close consultation with her doctor, decided that this was the appropriate treatment plan for Pam. The

family signed a consent form, and the doctor wrote Pam a prescription for hormone therapy. Pam continues to be on hormone therapy.

80. Pam and her family are afraid of the impact the Healthcare Ban will have on them if it goes into effect. Pam is scared that losing access to her medication will mean that her body will undergo unwanted, permanent changes that are inconsistent with her gender identity. Pam and her parents worry about the severe stress and anxiety associated with Pam's gender dysphoria returning if she is forced to stop gender-affirming medical care.

81. Pam has lived in her Idaho neighborhood for her entire life, and Pam's school, friends, and family are all there, as well as her parents' jobs. However, Pam's parents are not willing to sacrifice her health and wellbeing to stay if that means she can no longer receive the medical care she needs in Idaho. If the Healthcare Ban goes into effect, the Poe family is considering upending their settled lives to move out of Idaho.

(b) The Doe Family

82. Jane Doe is a 16-year-old rising senior in high school and has lived in Idaho her entire life. When she is not at school, she likes to play video games, listen to music, and go on walks. She is interested in computer science and coding, and she plans to go to college after she graduates high school.

83. Jane is transgender. She is a girl with a female gender identity, but when she was born, she was designated as male.

84. Growing up, Jane always felt more like a girl than a boy. Socially, she was a lot more comfortable playing with and associating with the girls. When teams were divided into girls and boys at recess, she felt like she belonged with the girls' team, and the girls would

usually allow her to join. When playing "make believe," she was always a girl character. Beginning at a young age, Jane expressed a desire to be a mom.

85. Before she came out as transgender, Jane's gender dysphoria negatively impacted her mental health. In 2018, as she started puberty, Jane hated the way her body was changing, and her mental health worsened. She particularly despised having her picture taken, and there are few photos of her from this time. Jane did not like *who she was* when she had to move through the world as a boy. She sometimes wished she did not even exist. She frequently secluded herself because she did not think she could be herself in social settings. Her schoolwork suffered as well.

86. Jane came out to her friends in Summer 2020, and the response was overwhelmingly positive. Her friends' support of her true self made Jane feel the happiest she had in years.

87. Jane made the brave decision to tell her parents that she was transgender in Fall 2020. Her parents were not surprised and were supportive and loving. They knew that their daughter was the same beautiful soul she had always been.

88. Around October, 2020, Jane began socially transitioning, dressing, wearing makeup, and using her new name consistent with her female gender identity.

89. In mid-October 2020, Jane saw her pediatrician, who referred her to a doctor who specializes in treating gender dysphoria. The next month, she met with that doctor and was diagnosed with gender dysphoria. Jane and her parents had multiple conversations with the doctor over time, in which the doctor provided them with information about gender dysphoria, counseled them on the risks and benefits of gender-affirming medical care, counseled them on fertility preservation, and recommended that Jane see a therapist.

90. After several months of therapy, additional visits with her doctor, and lab work, Jane Doe's doctor prescribed Jane a puberty blocker in January 2021. Knowing that the pubertal changes to her body were not going to get worse was a huge relief to Jane.

91. The family began to discuss amongst themselves the possibility of Jane starting on hormone therapy and later discussed this with the doctor. The doctor advised them again on the risks and benefits, further counseled them on fertility preservation, and conducted additional lab work. Jane had been consistent in her gender identity, and ultimately the doctor recommended hormone therapy to address her gender dysphoria. In April 2021, at age fourteen, Jane started hormone therapy at a very low dose. Her doctor has been monitoring Jane and her bloodwork since then, adjusting her medications as needed.

92. Since receiving gender-affirming medical care, Jane's mental health has significantly improved. She no longer has days where her gender dysphoria is so severe that she feels she cannot get out of bed. She experiences happiness when she looks in the mirror. She feels able to go out into the world. Her grades in school have improved as well. When Jane was preparing to go to the prom and looked at herself in the mirror, Jane's mom could see the glow of Jane's authentic gender expression.

93. The ongoing debate over HB 71 and other anti-transgender bills has been a heavy cloud over Jane and has negatively impacted her life. She feels like her home state does not recognize her humanity and is telling her she has to leave. The 2023 legislative session brought back depressive and harmful thoughts for Jane that she had not had since transitioning. The looming law has affected her school life and her grades. She recently had to take several days off of school because she was too depressed to go. When the bill passed, Jane wept in the hallway at school, and her parents had to come and take her home.

94. Jane's family is seriously considering leaving Idaho for Jane's senior year of high school to ensure that she can continue to access the medical care that has helped her so significantly. The Doe family loves living in Idaho; their community is in Idaho, and their friends are in Idaho. They do not want to leave, but they might have to in order to care for their child.

CAUSES OF ACTION

COUNT ONE

THE HEALTH CARE BAN VIOLATES THE FOURTEENTH AMENDMENT'S GUARANTEE OF EQUAL PROTECTION UNDER THE LAW (MINOR PLAINTIFFS)

95. Plaintiffs repeat and reallege each and every allegation contained in paragraphs 1 through 94 as if fully set forth herein.

96. Jane Doe and Pam Poe (the "Minor Plaintiffs") bring this Count against Defendant Labrador and Defendant Jan M. Bennetts, in their official capacities.

97. The Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, enforceable pursuant to 42 U.S.C. § 1983, protects individuals and groups from discrimination by the government.

98. The Healthcare Ban prohibits the provision of various medical treatments to minors only when the care is provided "for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." HB 71E1 § 1, 18-1506C(3). Whether or not a person can receive certain medical treatments turns on their sex and on whether the care is consistent with stereotypes associated with a person's sex assigned at birth.

99. The Healthcare Ban therefore discriminates against transgender youth, including the Minor Plaintiffs, based on their transgender status and sex, including their failure to conform to stereotypes associated with their sex assigned at birth.

100. In addition to facially discriminating based on sex and transgender status, the Ban was also passed because of its deleterious effects on transgender people, not in spite of them.

101. Discrimination based on transgender status and sex is subject to heightened scrutiny under the Equal Protection Clause and is therefore presumptively unconstitutional, placing a demanding burden of justification upon the State to provide at least an exceedingly persuasive justification for the differential treatment.

102. Transgender people have obvious, immutable, and distinguishing characteristics that define that class as a discrete group. These characteristics bear no relation to transgender people's abilities to perform in, or contribute to, society.

103. Transgender people have historically been subject to discrimination, and remain a very small minority of the American population that lacks political power.

104. Gender identity is a core, defining trait, that cannot be changed voluntarily or through medical intervention, 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.

105. Under the Healthcare Ban, the same medical treatments that are prohibited when provided to transgender adolescents to help align their bodies with their gender identity may be provided to cisgender adolescents to help align their bodies with their gender identity, or for any other purpose.

106. Under the Healthcare Ban, the Doctor Plaintiffs are prohibited from providing certain medically necessary care to their adolescent transgender patients that they are permitted to provide to their cisgender adolescent patients.

107. The Healthcare Ban does nothing to protect the health or wellbeing of minors. To the contrary, it gravely threatens the health and wellbeing of adolescents suffering from gender dysphoria by denying them access to necessary medical care that is recognized as safe and effective by every major medical association in the United States.

108. The Healthcare Ban is not substantially related to any important government interest, nor is it even rationally related to any legitimate government interest.

109. There is no rationale for the Healthcare Ban that could explain why only gender-affirming medical care—and *all* types of gender-affirming medical care—is singled out for prohibition.

110. The Healthcare Ban's targeted ban on medically necessary care for transgender youth is based on generalized fears, negative attitudes, and disapproval of transgender people that are not legitimate bases for unequal treatment under any level of scrutiny.

111. Defendants are liable for their violation of the right to equal protection under 42 U.S.C. § 1983, and the Minor Plaintiffs are entitled to a declaratory judgment that the Healthcare Ban violates the Equal Protection Clause of the Fourteenth Amendment.

COUNT TWO

THE HEALTH CARE BAN VIOLATES THE RIGHT TO PARENTAL AUTONOMY GUARANTEED BY THE FOURTEENTH AMENDMENT'S DUE PROCESS CLAUSE (PARENT PLAINTIFFS)

112. Plaintiffs repeat and reallege each and every allegation contained in paragraphs 1 through 94 as if fully set forth herein.

113. Joan Doe, John Doe, Penny Poe, and Peter Poe (the "Parent Plaintiffs") bring this Count against Defendant Labrador and Defendant Jan M. Bennett, in their official capacities.

114. The Due Process Clause of the Fourteenth Amendment of the United States Constitution, enforceable pursuant to 42 U.S.C. § 1983, protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children.

115. That fundamental right of parental autonomy includes the right of parents to seek and follow medical advice to protect the health and wellbeing of their minor children.

116. Parents' fundamental right to seek and follow medical advice is at its apogee when the parents, their minor child, and that child's doctor all agree on an appropriate course of medical treatment.

117. The Healthcare Ban's prohibition against well-accepted medical treatments for adolescents with gender dysphoria stands directly at odds with parents' fundamental right to make decisions concerning the care of their children. The Healthcare Ban barges into Idaho families' living rooms and strips Idaho parents of the right to provide medical care for their children.

118. The Healthcare Ban does nothing to protect the health or wellbeing of minors. To the contrary, it gravely threatens the health and wellbeing of adolescents with gender dysphoria by denying their parents the ability to obtain for them necessary medical care that is recognized as safe and effective by every major medical association in the United States.

119. The Healthcare Ban's prohibition against the provision of medically accepted treatments for adolescents with gender dysphoria is not narrowly tailored to serve a compelling government interest; nor is it rationally related to any legitimate government interest.

120. There is no rationale for the Healthcare Ban that could explain why only gender-affirming medical care—and *all* types of gender affirming medical care—is singled out for prohibition and the medical decision-making regarding this care is taken away from parents.

121. Defendants are liable for their violation of the right to due process under 42 U.S.C. §1983, and the Parent Plaintiffs are entitled to a declaratory judgment that the Healthcare Ban violates the Due Process Clause of the Fourteenth Amendment.

COUNT THREE

PUBLISHING THE HEALTH CARE BAN IN THE IDAHO CODE VIOLATES DUE PROCESS GUARANTEED BY THE FOURTEENTH AMENDMENT DUE TO LACK OF FAIR NOTICE

(ALL PLAINTIFFS AGAINST IDAHO CODE COMMISSION DEFENDANTS)

122. All plaintiffs bring this count against the Idaho Code Commission defendants, in their official capacities.

123. Because the Healthcare Ban is unconstitutional, if it is published in the Idaho Code, it will mislead and deceive Idahoans, including medical professionals, law enforcement, other government actors, and the general public, about the requirements of the law. The publication of HB 71's provisions in the official Idaho Code, especially without clear notice that the law is unconstitutional and unenforceable, would coerce compliance with the law despite its unconstitutionality and illegality, chill health care providers from providing necessary medical care, chill minors and their parents from seeking necessary medical care, and promote unconstitutional and illegal enforcement of the law by government actors.

124. The lack of fair notice of the unconstitutionality and unenforceability of the Healthcare Ban in the Idaho Code would violate the due process clause of the Fourteenth Amendment.

125. The Idaho Code Commission defendants are liable for their imminent violation of the right to due process under 42 U.S.C. §1983, and the Plaintiffs are entitled to declaratory judgment declaring that official publication of the provisions of HB 71, without clear notice of those provisions' unconstitutionality and unenforceability is unconstitutional, as well as injunctive relief prohibiting publication of those provisions without such clear notice.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray that this Court:

(a) Enter a judgment declaring that the Healthcare Ban violates the equal protection clause and the due process clause of the Fourteenth Amendment and is therefore unenforceable;

(b) Issue preliminary and permanent injunctions enjoining Defendants and their employees, agents, and successors in office from enforcing the Healthcare Ban;

(c) Enter a judgment declaring that official publication of the Healthcare Ban in the Idaho Code without clear notice of the law's unconstitutionality and unenforceability is unconstitutional;

(d) Issue preliminary and permanent injunctions enjoining the members of the Idaho Code Commission and their employees, agents, and successors in office from publishing the Healthcare Ban in the Idaho Code without clear notice of those provisions' unconstitutionality and unenforceability is unconstitutional;

(e) Waive the requirement for the posting of a bond as security for entry of preliminary injunctive relief;

(f) Award Plaintiffs their costs and expenses, including reasonable attorneys' fees, pursuant to 42 U.S.C. § 1988 and other applicable laws; and

(g) Grant such other relief as the Court deems just and proper.

Dated: May 31, 2023

Respectfully submitted,

AMERICAN CIVIL LIBERTIES UNION FOUNDATION

/s/ Li Nowlin-Sohl
Li Nowlin-Sohl

/s/ Leslie Cooper
Leslie Cooper

/s/ Taylor Brown
Taylor Brown

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

/s/ Alexia D. Korberg
Alexia D. Korberg

/s/ Jackson Yates
Jackson Yates

/s/ Dana L. Kennedy
Dana L. Kennedy

/s/ Jordan Orosz
Jordan Orosz

WREST COLLECTIVE

/s/ Richard Eppink
Richard Eppink

/s/ Casey Parsons
Casey Parsons

GROOMBRIDGE, WU, BAUGHMAN AND STONE LLP

/s/ Eric Alan Stone
Eric Alan Stone

/s/ Ariella C. Barel
Ariella C. Barel

LEGISLATURE OF THE STATE OF IDAHO
Sixty-seventh Legislature First Regular Session - 2023

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 71, As Amended in the Senate

BY JUDICIARY, RULES AND ADMINISTRATION COMMITTEE

AN ACT

RELATING TO THE VULNERABLE CHILD PROTECTION ACT; AMENDING CHAPTER 15, TITLE 18, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 18-1506C, IDAHO CODE, TO PROVIDE A SHORT TITLE, TO DEFINE TERMS, TO PROHIBIT CERTAIN PRACTICES UPON A CHILD, TO PROVIDE CERTAIN EXEMPTIONS, TO PROVIDE A PENALTY, AND TO PROVIDE SEVERABILITY; AMENDING SECTION 19-5307, IDAHO CODE, TO PROVIDE A CODE REFERENCE; AND PROVIDING AN EFFECTIVE DATE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Chapter 15, Title 18, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 18-1506C, Idaho Code, and to read as follows:

18-1506C. VULNERABLE CHILD PROTECTION. (1) This section shall be known and may be cited as the "Vulnerable Child Protection Act."

(2) As used in this section:

(a) "Child" means any person under eighteen (18) years of age; and

(b) "Sex" means 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.

(3) A medical provider shall not engage in any of the following practices upon a child for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex:

(a) Performing surgeries that sterilize or mutilate, or artificially construct tissue with the appearance of genitalia that differs from the child's biological sex, including castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, clitoroplasty, vaginoplasty, vulvoplasty, ovariectomy, or reconstruction of the fixed part of the urethra with or without metoidioplasty, phalloplasty, scrotoplasty, or the implantation of erection or testicular prostheses;

(b) Performing a mastectomy;

(c) Administering or supplying the following medications that induce profound morphologic changes in the genitals of a child or induce transient or permanent infertility:

(i) Puberty-blocking medication to stop or delay normal puberty;

(ii) Supraphysiological doses of testosterone to a female; or

(iii) Supraphysiological doses of estrogen to a male; or

(d) Removing any otherwise healthy or nondiseased body part or tissue.

(4) A surgical operation or medical intervention shall not be a violation of this section if the operation or intervention is:

(a) Necessary to the health of the person on whom it is performed and is performed by a person licensed in the place of its performance as a medical practitioner, except that a surgical operation or medical intervention is never necessary to the health of the child on whom it is performed if it is for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex;

(b) For the treatment of any infection, injury, disease, or disorder that has been caused or exacerbated by the performance of gender transition procedures, whether or not the procedures were performed in accordance with state and federal law; or

(c) Performed in accordance with the good faith medical decision of a parent or guardian of a child born with a medically verifiable genetic disorder of sex development, including:

(i) A child with external biological sex characteristics that are ambiguous and irresolvable, such as a child born having 46, XX chromosomes with virilization, 46, XY chromosomes with undervirilization, or with both ovarian and testicular tissue; or

(ii) When a physician has otherwise diagnosed a disorder of sexual development in which the physician has determined through genetic testing that the child does not have the normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a male or female.

(5) Any medical professional convicted of a violation of this section shall be guilty of a felony and shall be imprisoned in the state prison for a term of not more than ten (10) years.

(6) The provisions of this act are hereby declared to be severable, and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this section.

SECTION 2. That Section 19-5307, Idaho Code, be, and the same is hereby amended to read as follows:

19-5307. FINES IN CASES OF CRIMES OF VIOLENCE. (1) Irrespective of any penalties set forth under state law, and in addition thereto, the court, at the time of sentencing or such later date as deemed necessary by the court, may impose a fine not to exceed five thousand dollars ($5,000) against any defendant found guilty of any felony listed in subsections (2) and (3) of this section.

The fine shall operate as a civil judgment against the defendant and shall be entered on behalf of the victim named in the indictment or information, or the family of the victim in cases of homicide or crimes against children, and shall not be subject to any distribution otherwise required in section 19-4705, Idaho Code. The clerk of the district court may collect the fine in the same manner as other fines imposed in criminal cases are collected and shall remit any money collected in payment of the fine to the victim named in the indictment or information or to the family of the victim in a case of homicide or crimes against minor children, provided that none of the provisions of this section shall be construed as modifying the provisions of chapter 6, title 11, Idaho Code, chapter 10, title 55, Idaho Code, or

section 72-802, Idaho Code. A fine created under this section shall be a separate written order in addition to any other sentence the court may impose.

The fine contemplated in this section shall be ordered solely as a punitive measure against the defendant and shall not be based upon any requirement of showing of need by the victim. The fine shall not be used as a substitute for an order of restitution as contemplated in section 19-5304, Idaho Code, nor shall such an order of restitution or order of compensation entered in accordance with section 72-1018, Idaho Code, be offset by the entry of such fine.

A defendant may appeal a fine created under this section in the same manner as any other aspect of a sentence imposed by the court. The imposition of a fine created under this section shall not preclude the victim from seeking any other legal remedy; provided that in any civil action brought by or on behalf of the victim, the defendant shall be entitled to offset the amount of any fine imposed pursuant to this section against any award of punitive damages.

(2) The felonies for which a fine created under this section may be imposed are those described in:

Section 18-805, Idaho Code (Aggravated arson);
Section 18-905, Idaho Code (Aggravated assault);
Section 18-907, Idaho Code (Aggravated battery);
Section 18-909, Idaho Code (Assault with intent to commit a serious felony);
Section 18-911, Idaho Code (Battery with intent to commit a serious felony);
Section 18-913, Idaho Code (Felonious administration of drugs);
Section 18-918, Idaho Code (Felony domestic violence);
Section 18-923, Idaho Code (Attempted strangulation);
Section 18-1501, Idaho Code (Felony injury to children);
Section 18-1506, Idaho Code (Sexual abuse of a child under the age of sixteen);
Section 18-1506A, Idaho Code (Ritualized abuse of a child);
Section 18-1506B, Idaho Code (Female genital mutilation of a child);
Section 18-1506C, Idaho Code (Vulnerable child protection);
Section 18-1507, Idaho Code (Sexual exploitation of a child);
Section 18-1508, Idaho Code (Lewd conduct with a child under the age of sixteen);
Section 18-1508A, Idaho Code (Sexual battery of a minor child sixteen or seventeen years of age);
Section 18-4001, Idaho Code (Murder);
Section 18-4006, Idaho Code (Felony manslaughter);
Section 18-4014, Idaho Code (Administering poison with intent to kill);
Section 18-4015, Idaho Code (Assault with intent to murder);
Section 18-4502, Idaho Code (First degree kidnapping);
Section 18-5001, Idaho Code (Mayhem);
Section 18-5501, Idaho Code (Poisoning food, medicine or wells);
Section 18-6101, Idaho Code (Rape);
Section 18-6501, Idaho Code (Robbery).

(3) Notwithstanding the provisions of section 18-306(4) and (5), Idaho Code, the fine created under this section may also be imposed up to five thousand dollars ($5,000) for attempts of the felonies described in:
Section 18-4001, Idaho Code (Murder);
Section 18-6101, Idaho Code (Rape).

SECTION 3. This act shall be in full force and effect on and after January 1, 2024.

Appendix B

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, et al.**,**

Plaintiffs,

v.

RAÚL LABRADOR, et al.,

Defendants.

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

STIPULATION RE: BRIEFING SCHEDULE AND PAGE LIMIT ON MOTIONS

The parties, by and through their counsel of record, hereby stipulate and agree as follows:

1. Plaintiffs plan to file a motion for a preliminary injunction imminently. Plaintiffs' motion will seek an order prohibiting Defendants from enforcing a newly enacted law, House Bill 71. Plaintiffs seek to have the motion decided before the law goes into effect on January 1, 2024.
2. Defendants plan to file responses opposing the motion for a preliminary injunction.
3. Due to the importance of the issues raised and anticipated reliance on multiple expert declarations, the Parties request leave of the Court to file overlength briefs and propose that: Plaintiffs be allowed up to 30 pages for a brief in support of their motion for a preliminary injunction; Defendants have at least 30 pages for their responses; and Plaintiffs be allowed at least 15 pages for their replies in support of their motion. The Parties reserve their rights to request additional pages for responsive briefing at the appropriate time.
4. Furthermore, in order to ensure that the Parties have adequate time to address the issues in their responses, the Parties request additional time beyond the standard time provided in Local Civil Rule 7.1 to respond and propose a briefing schedule as follows:
    a. Defendants shall have 45 days to respond to the Plaintiff's motion for a preliminary injunction.
    b. Plaintiffs shall have 30 days to file their replies in support of their motion.
5. Pursuant to Local Civil Rules 6.1 and 7.1, the parties request that the Court approve this request for additional pages and stipulated briefing schedule.

DATED: July 18, 2023

AMERICAN CIVIL LIBERTIES UNION FOUNDATION

By: __/s/ Li Nowlin-Sohl_____
LI NOWLIN-SOHL
Counsel for Plaintiffs

DATED: July 18, 2023

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

By: __/s/ Lincoln Wilson_____
LINCOLN WILSON
Chief of Civil Litigation and Constitutional Defense
Counsel for Defendants Raúl Labrador and the Individual Members of the Idaho Code Commission

DATED: July 14, 2023

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Ada County Prosecuting Attorney

By: ___/s/ Dayton Reed_____
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Ada County Prosecuting Attorney's Office
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Appendix C

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, by and through her parents and next friends, et al.

Plaintiffs,

v.

RAÚL LABRADOR, in his official capacity as Attorney General of the State of Idaho, et al.

Defendants.

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

COMBINED MEMORANDUM OF LAW IN OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION AND IN SUPPORT OF MOTION TO DISMISS

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INTRODUCTION

Idaho's Vulnerable Child Protection Act regulates specific medical treatments for a specific psychiatric diagnosis in a specific age group. In particular, it prohibits the use of medical interventions (like puberty blockers and cross-sex hormones) and surgical interventions (like mastectomies and penectomies) as a treatment for gender dysphoria in minors. The Act permits the use of mental health therapy to treat gender dysphoria in minors. And the Act permits adults to obtain any intervention.

The reason for prohibiting these interventions for minors is clear: The interventions provide no proven benefit, impose lifelong and irreversible harm, and carry significant unknown risks. The harms include not only near-certain sterilization and lack of sexual function, but also increased chances of heart disease, stroke, blood clots, breast and uterine cancer, liver dysfunction, hypertension, and osteoporosis. The unknowns include a complete lack of evidence regarding long-term outcomes for the current patient population and *total* uncertainty regarding the neurological and cognitive effects resulting from the suppression of healthy puberty in adolescents. No benefit from these interventions has been reported in any reliable study. And not a single systematic review—the highest form of medical evidence—has ever demonstrated reduced death by suicide from these interventions.

Governments around the globe have taken note. Specifically, public health authorities in Europe have acknowledged that the risks associated with these interventions outweigh any demonstrated benefits. Several states in the U.S. have likewise acknowledged the danger of these interventions and corresponding lack of proven benefit and prohibited the practice of this experimental medicine on minors.

Two federal courts of appeals have concluded that such commonsense regulations are likely constitutional. The Eleventh Circuit Court of Appeals recently vacated a preliminary injunction against Alabama's law protecting minors from these interventions. And the Sixth Circuit Court of Appeals stayed preliminary injunctions against similar laws in both Tennessee and Kentucky.

The reasoning of those decisions shows why Idaho's Vulnerable Child Protection Act is likewise constitutional. Specifically, the Act is not subject to heightened scrutiny merely because it acknowledges biological differences that must be considered in the medical context. The Act is not subject to heightened scrutiny absent some showing of invidious discrimination—which cannot be made here. Lastly, the Parent Plaintiffs' claims fail because parents do not have a substantive Due Process right to obtain for their children puberty blockers, cross-sex hormones, and surgeries that are prohibited by state law. One cannot conclude that these interventions are "deeply rooted in our Nation's history."

Moreover, even if the Act were subject to heightened scrutiny, it easily passes. The Act serves the compelling government interest of protecting minors from harmful and unproven medical interventions. And a prohibition on those interventions is necessary to adequately serve that compelling interest because almost nothing is known about the long-term consequences associated with them. In addition, the existence of detransitioners—those who have transitioned but later come to identify with their sex—offers living proof that, as Plaintiffs' experts conceded, providers cannot know who has a "true" need for these interventions ahead of time.

Finally, even if Plaintiffs are entitled to injunctive relief, they have offered no justification for either statewide relief or an injunction against the Act in all its applications. Therefore, if the Court enters an injunction, it should limit the scope of that injunction to Plaintiffs and their providers.

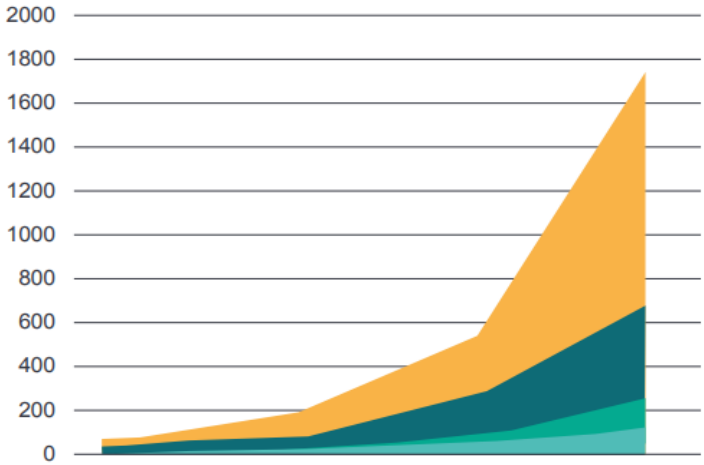
BACKGROUND

I. Gender dysphoria is a psychiatric diagnosis.

There are two human sexes—male and female. Malone Decl. ("Malone") ¶ 59. An individual's sex is an objective and biological fact that cannot be changed. *Id.*; Weiss Decl. ("Weiss")¶ 34. Distinct from "sex," an individual's "gender identity" is his or her personal sense of being male or female. *See* Malone ¶ 62. Individuals "identify as transgender" when their sex is different from their gender identity. *Karnoski v. Trump*, 926 F.3d 1180, 1187 n.1 (9th Cir. 2019). "Gender dysphoria," in contrast, is a specific psychiatric diagnosis defined by diagnostic criteria set out in the *Diagnostic and Statistical Manual of Mental Disorders* 5-TR ("DSM-5"). Cantor Decl. ("Cantor") ¶ 109. Although its definitions vary slightly for children, adolescents, and adults, all cases are characterized by a strong and lasting desire to be the opposite sex and "clinically significant" distress that impairs the individual's ability to function in daily life. *Id.*

In the last decade, the number of minors diagnosed with gender dysphoria has exploded. Cantor ¶ 64; Malone ¶ 15. This explosion has disproportionately affected adolescent natal females. Malone ¶ 16. The following chart displays the number of minors, distinguished by sex, referred to the UK's Gender Identity Services clinic between 2009 and 2016:

Figure 1: Sex ratio in children and adolescents referred to GIDS in the UK (2009-16)



	2009	2010	2011	2012	2013	2014	2015	2016
Adolescents F	15	48*	78*	141*	221*	314*	689*	1071*
Adolescents M	24	44*	41	77*	120*	185*	293*	426*
Children F	2	7	12	17	22	36	77*	138*
Children M	10	19	29	30	31	55*	103*	131

AFAB = assigned female at birth; AMAB = assigned male at birth

***Indicates** $p<.05$ which shows a significant increase of referrals compared to the previous year

Source: de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018).[32]

The Cass Review, Independent Review of Gender Identity Services for Children and Young People: Interim Report at 33 (Feb. 2022), *available at* http://tinyurl.com/5s56653n.

Health authorities in the UK, Sweden, and Finland have noted this phenomenon is "unexplained," with this group of "later-presenting birth-registered female teenagers" now the "current predominant cohort" of minors with gender dysphoria. Cantor ¶¶ 64-65. Some researchers posit that "social contagion," meaning the "well-established psychological concept defined as the spread of behaviors, attitude and affect through crowds and other types of social aggregates from one member to another," may be a "factor in both the rise of new cases and the demographic shift

towards females." Malone ¶¶ 16-17. Others have noted the correlation between this increase and social media. Cantor ¶¶ 287-89.

II. "Transitioning" minors inflicts irreversible harms and unknown risk.

Psychotherapy is an accepted approach to treating gender dysphoria. Cantor ¶¶ 16, 290. Advocates of so-called "gender-affirming care," however, also endorse medically and surgically "transitioning" as a treatment for minors with gender dysphoria. These interventions cause known harms and carry unknown risks.

A. Taking cross-sex hormones before puberty causes sterility.

The protocol for *medical* interventions to treat gender dysphoria calls for the suppression of an adolescent's natural puberty. As Plaintiffs explain, under the guidelines from the World Professional Association for Transgender Health (WPATH) and the Endocrine Society, providers prescribe GnRH agonists (puberty blockers) to suppress an adolescent's natural puberty. Dkt. 32-1 at 4. This suppression allegedly prevents the distress associated with going through natural puberty when the adolescents' gender identity is not consistent with their sex. *See id.*

Next, as Plaintiffs also explain, providers prescribe cross-sex hormones. *See id.*This means that natal females take testosterone, and natal males take estrogen. *Id.* Adolescents who are prescribed cross-sex hormones for this purpose "will require continuing treatment with cross-sex hormones for life." Cantor ¶ 224.

It is a near certainty that treatment in accordance with either the WPATH or Endocrine Society Guidelines will result in sterility. It is essentially indisputable that taking cross-sex hormones without first going through puberty will sterilize a person. Cantor ¶ 205; Malone ¶ 118; Weiss ¶ 116. Relatedly, these individuals may never be

able to achieve an orgasm. Cantor ¶ 208; Weiss ¶ 115. Even for those who begin such treatment at a later stage of puberty, "no studies at all have been done" regarding "when, … or with what probability either males or females can achieve healthy fertility if they later regret their transition" and cease treatment. Cantor ¶ 206. "Infertility is frequent in those females treated with testosterone even if not given puberty blockers." Weiss ¶ 134. And the "hormonal and surgical treatment pathway" will sterilize a person. Malone ¶ 19.

There are no established fertility options for minors who undergo medical transition. For minors who take cross-sex hormones without going through puberty, "no viable fertility preservation options exist." Cantor ¶ 205. The "fertility options" for natal females who have been exposed to cross-sex hormones are so uncertain "that mouse studies are being done to try to understand how to mitigate the harm." Weiss ¶ 135. In addition, when natal females undergo a so-called "gender-affirming mastectomy," Connelly Decl. ¶ 26, "it is functionally irreversible" and "breast-feeding a child will never be possible." Cantor ¶ 207.

B. The neurological effects of suppressing puberty are unknown.

Pubertal hormones "drive important stages of neural development." Cantor ¶ 209. As UK health authorities have put it, a "further concern" regarding pubertal suppression "is that adolescent sex hormone surges may trigger the opening of a critical period for experience-dependent rewiring of neural circuits underlying executive function," meaning "maturation of the part of the brain concerned with planning, decision making and judgment." *Id.* (quotations omitted).

"To date, there has been very limited research on the short-, medium- or longer-term impact of puberty blockers on neurocognitive development." *Id.* (quotations omitted). Given this lack of knowledge, many "have expressed concern that blocking the process of puberty during its natural time could have a negative and potentially permanent impact on brain development." Cantor ¶ 212.

C. Puberty blockers and cross-sex hormones cause other harms.

In addition to near-certain infertility, medicalized transition causes additional harms. These harms include "increased risks of heart disease, stroke, blood clots, breast and uterine cancer, liver dysfunction, hypertension, and osteoporosis." Malone ¶ 24; *see also* Cantor ¶¶ 214-225; Weiss ¶¶ 133, 136-49.

III. No reliable science evidence justifies medical transition for minors.

Because the "fundamental objective of medicine is to enhance an individual's health and well-being," a medical intervention is justified only when its probable benefits outweigh its probable risks. Malone ¶ 40. Systematic reviews of the evidence—including those by European health authorities—have concluded that the evidence does not show the benefits of medically or surgically "transitioning" minors outweigh the risks. European health authorities concluded that the experience of "detransitioners" casts doubt on the safety and efficacy of these treatments.

A. Medical ethics require benefits outweigh the risks.

Any particular medical treatment cannot simply be labeled "safe." Cantor ¶ 70. Instead, a medical treatment is appropriate only when the probable benefits outweigh the probable risks associated with the treatment. Cantor ¶ 71. Under this risk-benefit analysis, serious risks associated with a particular treatment cannot be

justified "without evidence of correspondingly greater benefit." Cantor ¶ 52. Therefore, no medical intervention that carries risks should be used unless there is "a higher degree of certainty regarding its benefits." Malone ¶ 40. Given the significant irreversible risks—including sterility—of medically and surgically transitioning minors, these interventions cannot be justified unless there is a high degree of certainty regarding their benefits. *Id.* ¶¶ 40-42.

B. European Authorities find benefits do not outweigh the risks.

Several European countries have concluded that the demonstrated benefits do not clearly outweigh the risks. *Id.* ¶¶ 124-30. In particular, health authorities in Sweden and the U.K. have engaged in systematic reviews of the evidence surrounding these treatments. Cantor ¶¶ 78-85. This means the health authorities engaged in "a comprehensive analysis of the entire body of evidence" surrounding the "transition" of minors, rather than focused on "individual research studies alone." Malone ¶ 27. The point of the systematic review is to "minimiz[e] opportunities for bias in gathering and evaluating research evidence." Cantor ¶ 40. A systematic review is the highest form of medical evidence. *Id.*

Every systematic review of medically and surgically transitioning minors shows a "low" or "very-low" degree of certainty in mental-health improvement. Malone ¶ 28. No systematic review has ever demonstrated reduced death by suicide resulting from these treatments. *Id.* After Swedish health authorities conducted their systematic review, they concluded that the "risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits." Cantor ¶ 28 (quotations omitted). UK health authorities have

said "it is an unanswered question whether the evidence for the use and safety of [puberty blockers] is strong enough as judged by reasonable clinical standards." *Id.* ¶ 19 (quotations omitted). Health authorities and researchers in Finland, Norway, France, and Denmark have expressed similar caution. *Id.* ¶¶ 21-24, 29-33; Malone ¶ 129. Meanwhile, in the United States, the FDA has not approved the use of puberty blockers or cross-sex hormones as a treatment for gender dysphoria. *L.W. v. Skrmetti*, 73 F.4th 408, 418 (6th Cir. 2023) (noting "the FDA is not prepared to put its credibility and careful testing protocols behind the use" of these drugs for this purpose).

C. Detransitioners cast significant doubt on Plaintiffs' claims.

With the rise of minors being diagnosed with gender dysphoria has come the rise of "detransitioners"—those who have previously undergone some form of "gender-affirming" treatment but later come to identify with their natal sex. Malone ¶ 12. At least two recent studies suggest the medical detransition rate among youth who underwent gender transitions in recent years may be as high as 30%—and that is only within a few years of beginning transition. *Id.* ¶ 34. A study based on a highly reliable dataset from the U.S. military healthcare system similarly showed that nearly 30% of youth who commenced medical transition discontinued it within the first four years. *Id.* ¶ 35. The existence of detransitioners has been part of the basis for caution throughout the world. Cantor ¶ 29 (citing Press Release, Academie Nationale de Medecine of France, Medicine and gender transidentity in children and adolescents, February 25, 2022); Malone ¶ 129 (citing Status Article, *Health services for children and young people with gender dysphoria,* Ugeskr Læger 2023; 185: V11220740 (July 3, 2023)). The unexplained fact of those who transitioned as minors and later came

to identify with their natal sex casts doubt on the entire practice of "youth transgender medicine."

IV. Idaho enacts the Vulnerable Child Protection Act.

This past spring, Idaho passed a law to protect children and adolescents from the dangers of these unproven medical and surgical interventions. The Vulnerable Child Protection Act (the Act) makes it a crime to perform particular surgical or medical interventions on minors "for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." *See* Idaho Code § 18-1506(c)(3). The Act will go into effect on January 1, 2024.

Plaintiffs filed this lawsuit in May. *See* Dkt. 1. The Plaintiffs are two minors and their respective parents. *Id.* ¶¶ 6-7. They allege they are currently receiving care that will be prohibited by the Act in January. *Id.* Plaintiffs filed this motion for a preliminary injunction in July. *See* Dkt. 32.

STANDARD OF DECISION

A motion to dismiss under Rule 12(b)(6) may seek dismissal based on "the lack of a cognizable legal theory or the absence of sufficient facts alleged under a cognizable legal theory." *Godecke v. Kinetic Concepts, Inc.*, 937 F.3d 1201, 1208 (9th Cir. 2019). "A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of the equities tips in his favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7,

20 (2008). And a court cannot grant a preliminary injunction if it lacks subject matter jurisdiction. *See Ex parte McCardle*, 74 U.S. 506, 514.

ARGUMENT

I. The Court lacks subject matter jurisdiction.

At the outset, Plaintiffs' claims against the Attorney General and the members of the Idaho Code Commission fail for lack of subject matter jurisdiction. These Defendants have Eleventh Amendment immunity, and the *Ex parte Young* exception applies only if they are "clothed with some duty in regard to the enforcement of the laws of the state, and ... threaten and are about to commence proceedings ... to enforce against parties affected [by] an unconstitutional act." *Ex parte Young*, 209 U.S. 123, 155–56 (1908). And proving a justiciable controversy in the pre-enforcement context also requires a threat: for standing, "whether the prosecuting authorities have communicated a specific warning or threat to initiate proceedings," *Twitter, Inc. v. Paxton*, 56 F.4th 1170, 1174 (9th Cir. 2022), and for ripeness, a "specific and credible threat of adverse action." *Lopez v. Candaele*, 630 F.3d 775, 781 (9th Cir. 2010).

Plaintiffs do not meet these standards as to the Attorney General and the Code Commission Defendants. As the Attorney General has recently explained, he lacks authority to enforce Idaho criminal law absent a referral by county prosecutors, and Plaintiffs do not allege that any such referral has occurred, much less that the Attorney General has made any threat of enforcement.[1] *See* Formal Att'y Gen. Op. 23-1;

[1] The Attorney General recognizes that the Court has recently rejected this argument but he asserts it here to preserve his immunity defense. *Planned Parenthood v. Labrador*, ___ F.Supp.3d ____, 2023 WL 4864962, at *7 (D. Idaho July 31, 2023).

Idaho Code § 31-2227; Idaho Code § 31-2604;*Newman v. Lance*, 922 P.2d 395, 399 (Idaho 1996); *State v. Summer*, 76 P.3d 963, 968 (Idaho 2003). And there is even less of a connection to the members of the Idaho Code Commission, which has *no* enforcement authority of any kind, nor do Plaintiffs allege otherwise. The mere act of publication of the code is not enforcement, and it has no nexus to Plaintiffs' purported harm. Dkt. 1 ¶ 123. In fact, the only claim they assert against the members of the Code Commission—that the law is void for vagueness—is not even one on which they seek a preliminary injunction. *See* Dkt. 1, Count III.

II. Plaintiffs fail to demonstrate a likelihood of success on the merits.

Plaintiffs fail to demonstrate a likelihood of success on the merits—the "most important" preliminary-injunction factor—for several reasons. *California v. Azar*, 911 F.3d 558, 575 (9th Cir. 2018) (quotations omitted). First, the Act is not subject to heightened scrutiny because it does not discriminate on the basis of either sex or transgender status. Second, even if the Act were subject to heightened scrutiny, it is constitutional given the compelling interest served by the Act and the fact that the treatments at issue offer no proven benefit, impose numerous long-term irreversible harms, and carry risks that are completely unknown.

A. The Act does not discriminate by sex or transgender status.

1. The Act does not discriminate based on sex.

Under the Equal Protection Clause, sex discrimination is a "preference to members of either sex over members of the other." *Reed v. Reed*, 404 U.S. 71, 76 (1971). The Act clearly does not violate this constitutional principle because it applies to both males and females the same. Instead, as the Eleventh Circuit held with

respect to a similar law, the Act "is best understood as a law that targets specific medical interventions for minors, not one that classifies on the basis of any suspect characteristic under the Equal Protection Clause." *Eknes-Tucker v. Gov. of Ala.*, No. 22-11707, --- F.4th---, 2023 WL 5344981, at *15 (11th Cir. Aug. 21, 2023).

Moreover, a statute regulating *medical procedures* does not trigger heightened scrutiny when it acknowledges sex-based distinctions. As the Supreme Court recently explained, "[t]he regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny" absent a showing of "'invidious discrimination against members of one sex or the other.'" *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2245–46 (2022) (quoting *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974)). "In *Geduldig*, the Supreme Court stated that a classification based on pregnancy is not per se a classification based on sex, even though 'it is true that only women can become pregnant.'" *Hecox v. Little*, Nos. 20-35813, 20-35815, ___ F.4th ____, 2023 WL 5283127, at *11 (9th Cir. Aug. 17, 2023) (quoting *Geduldig*, 417 U.S. at 496 n.20). Here, the Act regulates two *separate* "medical procedure[s] that only one sex can undergo," *id.*, because a natal female "cannot transition through use of estrogen" and a natal male "cannot transition through use of testosterone," *L.W.*, 73 F.4th at 419. The Act does not trigger heightened scrutiny simply because it acknowledges these biological distinctions.

It is true the Act "mentions the word 'sex.'" *Id.* But as the Sixth Circuit recently asked with respect to a similar law, "how could it not?" *Id.* "That is the point of the existing hormone treatments—to help a minor transition from one gender to another." *Id.* Thus, the Act "refers to sex only because the medical procedures that it

regulates—puberty blockers and cross-sex hormones as a treatment for gender dysphoria—are themselves sex-based." *Eknes-Tucker*, 2023 WL 5344981 at *16.

Plaintiffs' sex-stereotyping argument fails for a similar reason. Dkt. 32-1 at 14–15. First, "[p]hysical differences between men and women are . . . enduring." *United States v. Virginia*, 518 U.S. 515, 533 (1996). They are "not a stereotype." *Tuan Anh Nguyen v. INS*, 533 U.S. 53, 68 (2001). And this enduring biological reality explains *why* the "regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny." *Dobbs*, 142 S. Ct. at 2245–46.

Second, the diagnosis of gender dysphoria turns *expressly* on sex stereotypes. For example, the criteria for pre-pubertal children asks whether the child has shown a preference "for the toys, games, or activities *stereotypically* used or engaged in by the other gender." Dkt. 32-6 ¶ 18 (emphasis added). For boys, it asks if the child rejected "*typically masculine* toys, games, and activities" and demonstrated an "avoidance of rough-and-tumble play." *Id.* (emphasis added). For girls, it asks whether the child rejected "*typically feminine* toys, games, and activities." *Id.* (emphasis added). Thus, the Act "targets certain medical interventions for minors meant to treat the condition of gender dysphoria," which is expressly diagnosed based on gender stereotypes. *Eknes-Tucker*, 2023 WL 5344981 at *17. But the Act *itself* "does not further any particular gender stereotype." *Id.* Instead, it simply regulates particular interventions for a *diagnosis* that turns on gender stereotypes. *Id.*

Third, Plaintiffs' examples of medical procedures that, they say, demonstrate sex-based discrimination only undermine their argument. Specifically, Plaintiffs highlight treatments for gynecomastia in natal males and polycystic ovarian

syndrome (PCOS) in natal females. *See* Dkt. 32-1 at 15. But neither gynecomastia nor PCOS are *psychological* disorders. As Plaintiff's own expert admitted, gynecomastia is "diagnosed clinically by physical exam" and "does not turn on the presence or lack thereof of psychological distress." Connelly Dep. ("Ex. A") 247:6-8, 14-17. Similarly, Plaintiffs' expert admitted that the diagnosis for PCOS "is not dependent o[n] psychological distress." Ex. A 248:1-6. Thus, treatments for gynecomastia and PCOS do not "affirm" the gender of a patient to treat psychological distress; rather, they treat *physical* conditions. In contrast, and also as Plaintiffs' expert admitted, the purpose of prescribing puberty blockers and cross-sex hormones is to treat the *psychological* condition of gender dysphoria. Ex. A 70:12-25. Plaintiffs provide no example of a treatment permitted in Idaho that "affirms" the gender of a natal male as male or a natal female as female to treat *psychological distress*. Therefore, permitting treatments for gynecomastia and PCOS does not reflect any sort of sex-based discrimination in the Act's regulation of medical interventions as a treatment for gender dysphoria in minors.

2. The Act does not discriminate based on transgender status.

The Ninth Circuit has "held that heightened scrutiny applies to laws that discriminate on the basis of transgender status" because transgender persons are a "'quasi-suspect class.'" *Hecox*, 2023 WL 5283127 at *11. While Defendants dispute that holding and reserve their right to challenge it *en banc* or before the Supreme Court, even if it were correct, it would not apply here based on the testimony of Plaintiffs' own experts. That is because the Act regulates medical and surgical treatments for a particular psychiatric diagnosis—gender dysphoria—that Plaintiffs' experts say

is not the same as transgender status. Brady Dep. (Ex. B") 71:12-14 (individual can be "transgender without having gender dysphoria"). Regulating treatment for a psychiatric diagnosis does not classify based on identity.

First, Ninth Circuit precedent does *not* establish that regulation of treatments for gender dysphoria constitute discrimination based on transgender status. To be sure, a law may not be drafted with "seemingly neutral criteria that are so closely associated with the disfavored group that discrimination on the basis of such criteria is, constructively, facial discrimination against the disfavored group." *Hecox*, 2023 WL 5283127 at *10 (cleaned up). But the Ninth Circuit has expressly reserved the question whether the regulation of "gender dysphoria" is so "closely correlated with being transgender" that a regulation related to gender dysphoria "constitutes discrimination against transgender persons." *Karnoski,* 926 F.3d at 1201 n.18; *see also Doe v. Snyder*, 28 F.4th 103, 114 (9th Cir. 2022) (treating as an open question whether "disallowing gender reassignment surgery should be treated as discriminating against transgender persons").

Second, even if transgender identity were equivalent to having gender dysphoria, that still does not suggest heightened scrutiny applies to the regulation of *specific treatments* for gender dysphoria. It does not trigger heightened scrutiny to "restrict[] a specific course of medical treatment that, by the nature of things, only gender nonconforming individuals may receive." *Eknes-Tucker*, 2023 WL 5344981 at *17. As the Ninth Circuit explained in *Hecox*, if "a classification based on pregnancy is not per se a classification based on sex, even though it is true that only women can become pregnant." *Hecox*, 2023 WL 5283127 at *11 (cleaned up). For the same reasons, then, a

classification based on a gender dysphoria is not per se a classification based on transgender status *even if* only transgender persons can be diagnosed with gender dysphoria. Therefore, just as the regulation of a procedure that only one *sex* can undergo "does not trigger heightened constitutional scrutiny" absent proof of invidious discrimination against members of one sex, *Dobbs*, 142 S. Ct. at 2245–46, so too "the regulation of a course of treatment that only gender nonconforming individuals undergo would not trigger heightened scrutiny unless the regulation were a pretext for invidious discrimination against such individuals." *Eknes-Tucker*, 2023 WL 5344981 at *17. And as explained in more detail below, there is no plausible basis to conclude that the Act is a mere pretext for invidious discrimination. In sum, the Act does not discriminate by sex or transgender status, and heightened scrutiny does not apply.

B. Parents have no right to experimental and harmful treatments.

Hidden away in the Due Process Clause, the Parent Plaintiffs purport to have discovered a constitutional right to obtain puberty blockers, cross-sex hormones, and gender-transition surgeries for their children. But their analysis falls well short of the Supreme Court's requirements for a substantive Due Process right. That test requires that the right is "fundamental" or "deeply rooted in this Nation's history and tradition." *Washington v. Glucksberg*, 521 U.S. 702, 720–21 (1997). "But the use of these medications in general—let alone for children—almost certainly is not 'deeply rooted' in our nation's history." *Eknes-Tucker* 2023 WL 5344981 at *10. The "earliest-recorded uses of puberty blocking medication and cross-sex hormone treatment for purposes of treating the discordance between an individual's biological sex and sense of gender identity did not occur until well into the twentieth century." *Id.*

In light of this history, the Parent Plaintiffs seek to raise the level of generality for the right they are asserting. They primarily rely on principles discussed in the Supreme Court's decision in *Parham v. J.R.*, 442 U.S. 584, 602 (1979), regarding the right of parents to make medical decisions for their children. *See* Dkt. 32-1 at 23. But because courts seek to "exercise the utmost care whenever" they "are asked to break new ground in th[e] field" of substantive Due Process, they require "a careful description of the asserted fundamental liberty interest." *Glucksberg*, 521 U.S. at 721. And "*Parham* does not at all suggest that parents have a fundamental right to direct a particular medical treatment for their child that is prohibited by state law." *Eknes-Tucker*, 2023 WL 5344981 at *12.

Indeed, there is not even a "historical recognition of a fundamental right of *adults* to obtain the medications at issue for themselves." *Id.* at *13 n.18. Therefore, "it would make little sense for adults to have a *parental* right to obtain these medications for their children but not a *personal* right to obtain the same medications for themselves." *Id.* It would make little sense to find a parental right to a pharmacological treatment that the FDA has not even approved to treat gender dysphoria. *L.W.*, 73 F.4th at 418. This perhaps explains why the United States does not endorse this argument. *See* Dkt. 45 at 1 n.2. And the cases Plaintiffs cite "applying the fundamental parental right in the context of medical decision-making do not establish that parents have a derivative fundamental right to obtain a particular medical treatment for their children as long as a critical mass of medical professionals approve." *Eknes-Tucker*, 2023 WL 5344981 at *13; *see also L.W.*, 73 F.4th at 417-18 (citing *Abigail All. for Better Access to Dev. Drugs v. von Eschenbach*, 495 F.3d 695, 703 (D.C. Cir. 2007)

(en banc)). Thus, Plaintiffs "have not shown that a right to new medical treatments" such as these "is deeply rooted in our history and traditions and thus beyond the democratic process to regulate." *L.W.* 73 F.4th at 417.

C. The Act satisfies any level of scrutiny.

The Act, "like other health and welfare laws, is entitled to a strong presumption of validity." *Dobbs*, 142 S. Ct. at 2284. And "[j]udicial deference is especially appropriate where 'medical and scientific uncertainty' exists." *L.W.*, 73 F.4th at 417 (quoting *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007)). Because the Act does not trigger heightened scrutiny for reasons already explained, it is subject only to rational-basis review, which "is a paradigm of judicial restraint." *Raidoo v. Moylan*, 75 F.4th 1115, 1121 (9th Cir. 2023) (quotations omitted). And the Act clearly satisfies that standard, which "is highly deferential to the government" and asks only whether "some conceivable legitimate purpose could have supported it." *Id.*

Nevertheless, the Act satisfies any level of scrutiny that might be applied. Even if strict scrutiny applies, the Act survives, since States "have a compelling interest in protecting children from drugs, particularly those for which there is uncertainty regarding benefits, recent surges in use, and irreversible effects." *Eknes-Tucker*, 2023 WL 5344981 at *13. And the unknown long-term effects of these treatments, when combined with the impossibility of identifying who will persist in their identity as transgender, underscores that the Act's ban is necessary to *adequately* serve the compelling interest of protecting children and adolescents.

Here, the seriousness of the unknowns is staggering. For example, Plaintiffs' expert Dr. Connelly forthrightly admitted that she does not "think there's enough

data to draw conclusions about adverse effects on brain development in patients treated with medical interventions." Ex. A 208:5-8. In addition, Dr. Connelly also admitted she is not aware of a single study suggesting that natal females who transition during adolescence will be able to achieve pregnancy. Ex. A 253:16-20. And even from a clinical perspective, Dr. Connelly has no idea what the long-term outcomes are for her patients because over 90% of them move to different providers by the time they are 22 years old. Ex. A 66:8-13. And her clinic does not even attempt to contact them. Ex. A 67:23-25. To her knowledge, not a single one of her patients who has received medical interventions has ever conceived a child. Ex. A 258:25-259:2.

Moreover, the unexplained existence of detransitioners and those who regret their transition also justifies the need for a ban. Critically, as Plaintiffs' expert Dr. Connelly admitted, it is not possible to identify those who will detransition ahead of time. Ex. A 84:21-23; *see also id.* 271:15-22 (agreeing that it would "be unrealistic to predict or eliminate" gender-related regret "that results from a change in gender identity"). Plaintiffs' experts generally treat the existence of detransitioners as an inconvenient fact to be minimized—stating that there has been a "'weaponization of information on regret,'" Ex. A 269:3-15, or that regret "'has been woefully politicized.'" Ex. B. 190:17-25. But no amount of downplaying the tragic stories of detransitioners can undermine the fact that they are living proof of the lack of evidence to justify using these interventions on minors.

Because the Act satisfies strict scrutiny, it necessarily satisfies intermediate scrutiny. That standard asks whether the Act "serves important governmental objectives" and the alleged "'discriminatory means employed are substantially related to

the achievement of those objectives.'" *Hecox*, 2023 WL 5283127 at *13 (quoting *Virginia*, 518 U.S. at 516). Here, the State of Idaho clearly "has an 'exceedingly persuasive justification' for regulating these drugs" and surgeries given the "potentially uncertain risks," the "uncertainty about how to tell which patients need these interventions for this purpose and which don't." *Eknes-Tucker*, 2023 WL 5344981 at *21 (Brasher, J., concurring). Thus, "even if [Idaho's] statute triggered intermediate scrutiny, it would likely survive that heightened scrutiny." *Id.*

Plaintiffs assert that the Act would fail even rational-basis review. Specifically, both Plaintiffs and the United States assert that the Legislature enacted the Act out of animus. But "[o]n the few occasions where" the Supreme Court has held that a law fails rational basis, the "common thread has been that the laws at issue lack *any* purpose other than a bare . . . desire to harm a politically unpopular group." *Trump v. Hawaii*, 138 S. Ct. 2392, 2420 (2018) (cleaned up) (emphasis added). Given the state of scientific evidence regarding these treatments, it is impossible to suggest that the Act lacks *any* purpose other than a bare desire to harm transgender persons. As Swedish health authorities have concluded, the "risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits." Cantor ¶ 28 (citing Swedish Socialstyrelsen Support 2022 at 10-12). The law clearly has a rational basis.

In support of their animus argument, Plaintiffs and the United States cite two statements from Senator Tammy Nichols. But of course, "[s]tray remarks of individual legislators are among the weakest evidence of legislative intent." *Tingley v. Ferguson*, 47 F.4th 1055, 1087 (9th Cir. 2022). Indeed, the evidence of legislative intent

demonstrates beyond doubt that Idaho legislators were motivated by their concern regarding the lack of benefit and the harm associated with these treatments: The United States itself acknowledges that Idaho legislators deem these treatments "dangerous," "experimental, irreversible, and medically unnecessary." Dkt. 45 at 16, 17 n.38 (quotations omitted). Moreover, "[e]ven when an argument about legislative motive is backed by statements made by legislators who voted for a law," courts should be reluctant "to attribute those motives to the legislative body as a whole." *Dobbs*, 142 S. Ct. at 2256. "What motivates one legislator to make a speech about a statute is not necessarily what motivates scores of others to enact it." *Id.*

In any event, the statements that Plaintiffs and the United States highlight are far from probative. For one, they came *after* the law was enacted. Moreover, Plaintiffs' assertion that Senator Nichols's support for this law was motivated by animus is belied by the public record. Before the bill was passed, Senator Nichols noted that the Act addressed a "very sensitive topic." Senate Chamber Session Day 78 (Mar. 27, 2023)(https://tinyurl.com/3ebfbknt) 3:08:23-3:08:24. Specifically, she highlighted that many children diagnosed with gender dysphoria may have other underlying mental health conditions that should be treated with therapy rather than medical intervention. *See id.* 3:08:45-3:12:10. Senator Nichols also discussed the experience of a transgender individual who came to Idaho to describe the adverse effects the individual suffered as a result of these treatments. *See id.* 3:12:15- 3:12:32. The Senator's thoughtful consideration of this "sensitive topic" is not a desire to harm transgender individuals.

In a footnote, the United States cites certain statements from Senator Ben Adams and Representative Bruce Skaug relating to a child's mental state and gender dysphoria. Dkt. 45 at 19, n.45. The United States says these statements demonstrate animus because they "did not refer to or cite any medical or scientific support." *Id.* But this argument ignores the testimony offered at the hearings on these bills—namely, that providing medical interventions to affirm a child or adolescent's gender identity, rather than mental health therapy to treat the gender dysphoria, is harmful, not helpful. *See, e.g.*, Testimony of Dr. Roger Hiatt, February 7, 2023, House Judiciary, Rules & Administration Hearing, 24:07-24:21 (https://tinyurl.com/59jt7376)("Efforts to medicalize a psychiatric disorder robs otherwise healthy children of the opportunity to rediscover their innate biology and instead doom them to a lifetime as medical patients in pursuit of an impossible dream."). As noted by one individual who had transitioned as an adult and, after many complications, is transitioning back, children with gender dysphoria "need help, they need mental care help, not gender-affirming help." February 7, 2023, House Judiciary, Rules & Administration Hearing, 18:15-18:20. In sum, given the compelling interest served by the Act and the fact that the long-term outcomes and harms are completely unknown, the Act satisfies any level of scrutiny.

D. Plaintiffs' experts' opinions are unreliable.

As set forth above, the totality of the scientific literature shows that the risks of the procedures banned by the Act far outweigh their benefits. And Plaintiffs' experts opinions to the contrary are unreliable. Although the Rules of Evidence do not technically apply at the preliminary injunction stage, the serious defects in Plaintiffs'

experts' methodologies would preclude them from satisfying the reliability requirements of Rule 702. This absence of reliable scientific proof too is a reason Plaintiffs cannot show they are likely to succeed on the merits.

First, Plaintiffs' experts show a shocking lack of familiarity with the medical evidence surrounding these interventions. "[S]ound scientific methodology requires that a scientist consider all of the scientific evidence when making causation determinations," *In re Zoloft*, 26 F. Supp. 3d 449, 463 (E.D. Penn. 2014), and "expert testimony that 'cherry-picks' relevant data" should be excluded. *EEOC v. Freeman*, 778 F.3d 463, 469 (4th Cir. 2015) (Agee, J., concurring) (collecting cases); *In re Lipitor*, 892 F.3d 624, 634 (4th Cir. 2018); *Rink v. Cheminova, Inc.*, 400 F.3d 1286, 1293 n.7 (11th Cir. 2005). But not only did Dr. Brady not consider contrary evidence, she has never even read a *single* publication from any European health authority regarding the treatment for gender dysphoria. Ex. B. 203:4-7. Indeed, at her deposition, she could not recall *ever* reading a research publication that disagreed with her conclusions. Ex. B. 133:13–18. Nor had she ever read a systematic review relating to the treatment of gender dysphoria. Ex. B. 137:5–10. Dr. Connelly, for her part, said she had read one systematic review but could not "remember the title of it." Ex. A 118:11–15. Neither of them cited these reviews in their declarations. It is frankly "alarming" that Plaintiffs' experts engaged in this "biased reliance on favorable sources" while ignoring systematic reviews by European medical authorities that "could not be more relevant" to their opinions. *Daniels-Feasel v. Forest Pharms., Inc.*, 2021 WL 4037820, at *12 (S.D.N.Y. Sept. 3, 2021), *aff'd*, 2023 WL 4837521 (2d Cir. July 28, 2023).

Second, Dr. Connelly and Dr. Brady either misunderstand or overstate the conclusions that can be drawn from the studies they cite. At her deposition, Dr. Brady could not recall whether *any* study of medical and surgical interventions, including those she cites, controlled for whether the participants were receiving mental-health therapy. Ex. B. 49:6-12. Where, as here, a critical question is whether the more intrusive interventions of medical and surgical interventions are necessary given the less intrusive option of mental-health therapy, the failure to control for mental-health therapy is a confounding variable that forecloses any reliable conclusion. Cantor ¶¶ 179-81; *see* Ex. B. (161:4-11) (agreeing that, all else being equal, providers should "prefer the less invasive procedure"). Relatedly, in her declaration, Dr. Brady asserts there are "no scientific studies demonstrating that non-medical treatments alone" are effective in the treatment of gender dysphoria. Brady Decl. ¶ 41. But not "only do such studies exist, Dr. Brady cited one herself in her declaration." Cantor ¶ 290 (highlighting Dr. Brady's reliance on the Costa study, which found that "psychotherapy" was "effective in improving mental health"). With respect to Dr. Connelly's opinion, when Swedish researchers conducted a systematic review, they "excluded due to high risk of bias" many of the studies that Dr. Connelly cites as her leading authorities. *Compare* Cantor Table 1 at 33-34 (noting exclusion by Swedish researchers of Achille, Allen, de Vries, and López de Lara studies), *with* Connelly Decl. ¶ 32 n.7 (relying on those same studies).

Third, it is no answer for Dr. Connelly and Dr. Brady to say they are relying on their clinical experience. Ex. A 288:6-16; Ex. B. 141:11-19. In "evidence-based medicine, opinion based on clinical experience" is "the *least* reliable source of medical

knowledge." Cantor ¶ 54. Compared to other forms of evidence, "non-systematic recollections of unstructured clinical experiences with" individuals "in an uncontrolled setting" is "the most subject to bias." *Id.* Indeed, it was reliance on this anecdotal evidence that led to development of evidence-based medicine. *See id.* Thus, an expert who grounds an opinion in clinical experience must "explain how his experience leads to the conclusion reached, why his experience is a sufficient basis for the opinion, and how his experience is reliably applied to the facts." *United States v. Wilson*, 484 F.3d 267, 274 (4th Cir. 2007). Plaintiffs' experts make "no attempt to do this," *In re Lipitor*, 185 F. Supp. 3d 786, 806 (D.S.C. 2016), and their opinions are little more than "unscientific speculation offered by a genuine scientist." *Rosen v. Ciba-Geigy Corp.*, 78 F.3d 316, 318 (7th Cir. 1996).

The distinction between clinical expertise and reported data is perhaps most stark with respect to Dr. Connelly's testimony. In her declaration, she states that her clinic sees "dramatic improvements" when patients "begin gender-affirming medical care" as measured by the anxiety-screening tool GAD-7 and the depression-screening tool PHQ-9. Connelly Decl. ¶ 31. But in an article published with data from her clinic that measured anxiety and depression using the GAD-7 and PHQ-9, the data showed that, between first and second visits at the clinic, the average scores indicating both anxiety and depression *increased* for patients on cross-sex hormones and *decreased* for patients who were *not* on cross-sex hormones. Ex. A 189:23-190:13; 191:8-23. In other words, the published data shows precisely *the opposite* of what Dr. Connelly reports seeing in her declaration. And even if these recorded changes were not statistically significant, that fact in and of itself refutes Dr. Connelly's claim of seeing

"dramatic improvement" at her clinic when patients "begin gender-affirming medical care." Connelly Decl. ¶ 31. Plaintiffs' experts' reliance on their unsupported clinical judgment is all the more troubling because their "opinion runs contrary to the published literature" in systematic reviews, which they fail to even cite. *In re Lipitor*, 185 F. Supp. 3d at 806.

III. Plaintiffs have not met the remaining preliminary-injunction factors.

Although likelihood of success on the merits "is the most important factor" when analyzing a request for injunctive relief, *California v. Azar*, 911 F.3d at 575 (quotations omitted), Plaintiffs invoke the Ninth Circuit precedent that "serious questions going to the merits" are sufficient to obtain an injunction when "the balance of hardships tips sharply towards the plaintiff." *See* Dkt. 32-1 11 (citing *Roman v. Wolf*, 977 F.3d 935, 941 (9th Cir. 2020)). But even accounting for this standard, Plaintiffs have still failed to show they are entitled to a preliminary injunction.

Idaho "will suffer irreparable harm from its inability to enforce the will of its legislature, to further the public-health considerations undergirding the law, and to avoid irreversible health risks to its children." *L.W.*, 73 F.4th at 421; *see also Latta v. Otter*, 771 F.3d 496, 500 (9th Cir. 2014) (noting authority for the proposition "that 'a state suffers irreparable injury whenever an enactment of its people or their representatives is enjoined'" (quoting *Coal. for Econ. Equity v. Wilson*, 122 F.3d 718, 719 (9th Cir. 1997))). Moreover, as catalogued above, Plaintiffs have failed to provide evidence showing that the benefits of these treatments outweigh the harms associated with them. Indeed, the *entire point* of the Act is to *prevent* irreparable harm to children and adolescents from these specific interventions. Idaho acknowledges that

Plaintiffs disagree about how best to treat gender dysphoria in minors, but Idaho's "elected representatives made these precise cost-benefit decisions" in adopting the Act. *L.W.*, 73 F.4th at 421. Finally, timing does not favor Plaintiffs because the Act does not go into effect until January 1, 2024. That provides Plaintiffs time to draw down their medication, which "'lessens the harm' to minors 'who wish to continue receiving treatment.'" *Doe 1 v. Thornbury*, 75 F.4th 655, 657 (6th Cir. 2023) (per curiam) (quoting *L.W.*, 73 F.4th at 421).

"When the government is a party," the balance of equities and public-interest "factors merge." *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014). Here, Idaho's "interests in applying the law to its residents and in being permitted to protect its children from health risks weigh heavily in favor of the State at this juncture." *L.W.*, 73 F.4th at 421–22. If the Act is enjoined, untold numbers of children in Idaho will face lasting harm and irreversible damage to their bodies. Plaintiffs have not shown they are entitled to an injunction imposing that harm to the public.

IV. The scope of Plaintiffs' requested relief is inappropriate.

Even if this Court concludes that Plaintiffs are entitled to injunctive relief, Plaintiffs have failed to demonstrate that the scope of relief they request is appropriate. As an initial matter, Plaintiffs' remedial argument seemingly conflates two distinct questions—whether Plaintiffs are entitled to a *statewide* injunction and whether Plaintiffs are entitled to an injunction against enforcement of the statute in *all*

applications. This conflation is ultimately irrelevant, however, because Plaintiffs have failed to demonstrate an entitlement to either form of relief.

With respect to the question of statewide relief, an "injunction must be narrowly tailored to remedy the specific harm shown." *East Bay Sanctuary Covenant v. Barr*, 934 F.3d 1026, 1029 (9th Cir. 2019) (quotations omitted). Plaintiffs would be entitled to an injunction throughout the State of Idaho only if "such breadth was necessary to remedy" Plaintiffs' "harm." *Id.* To obtain an injunction of that scope, Plaintiffs' request must be "supported by the record as it stands." *Id.* at 1028. The relief they seek is access to particular medical interventions, which could be provided by an injunction prohibiting enforcement of the Act against Plaintiffs and their providers. And the two premises of their request for that relief are flawed.

First, Plaintiffs speculate that providers would not know who the Plaintiffs are. Dkt. 32-1 at 28. But Plaintiffs provide no support for this speculation, and the Court's grant of leave for *them* to proceed anonymously cannot be used to leverage relief for non-parties. Moreover, the injunction runs against *Defendants*, and the Court could enter a protective order disclosing the identity of Plaintiffs and their Providers to ensure Defendants comply, so a statewide injunction is not "necessary." Second, Plaintiffs worry that "the institutions where" providers "work may implement policies prohibiting" the relevant care. Dkt. 32-1 at 28. But institutions may *already* prohibit the relevant care, which has nothing to do with any injunctive relief from this Court. Plaintiffs' speculative assertions are not "supported by the record" and come woefully short of showing a statewide injunction is "necessary to remedy" Plaintiffs' harm. *East Bay Sanctuary Covenant*, 934 F.3d at 1028–29.

With respect to whether Plaintiffs are entitled to facial, as opposed to as-applied relief, "litigants mounting a facial challenge to a statute normally must establish that *no set of circumstances* exists under which the statute would be valid." *United States v. Hansen*, 143 S. Ct. 1932, 1939 (2023) (cleaned up). Plaintiffs do not argue the Act is unconstitutional in *every* circumstance. Nor could they, since the substance of their constitutional claims turn entirely on WPATH and Endocrine Society guidelines. Even the guidelines that Plaintiffs champion impose limitations on gender-affirming medical and surgical interventions. *See* Dkt. 32-1 at 3–5.

Thus, even under Plaintiffs' theory, the Legislature may clearly regulate the provision of interventions not in accordance with those guidelines. This regulation would include prohibiting the provision of any medical or surgical interventions to any child before puberty, Dkt. 32-1 at 3; providing any interventions to individuals who are not formally diagnosed with gender dysphoria under the DSM-V, *id.*; or providing interventions when an individual's co-occuring mental-health issues may interfere with diagnostic clarity or the ability to provide informed consent, *id.* at 4–5. And the concern that providers may not strictly follow the guidelines is not merely hypothetical: Plaintiffs' own expert stated that, in her opinion, "there may be extenuating circumstances" where "different care may be provided that may not be included in the guidelines." Ex. A 103:25–104:14. Plaintiffs are entitled to neither statewide relief nor an injunction against the Act in all applications.

CONCLUSION

The Court should deny an injunction and dismiss the Complaint.

DATED: September 5, 2023.

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

By: /s/ *Lincoln D. Wilson*
LINCOLN DAVIS WILSON
Chief, Civil Litigation and
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on September 5, 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

PAM POE, by and through her parents and next friends, Penny and Peter Poe, et al.

Plaintiffs,

v.

RAÚL LABRADOR, in his official capacity as Attorney General of the State of Idaho, et al.

Defendants.

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

EMERGENCY MOTION TO STAY INJUNCTION PENDING APPEAL

Defendant Raúl Labrador hereby moves the Court to stay the preliminary injunction previously entered by it on December 26, 2023. *See* Dkt. 78; *see also* F.R.C.P. 62(d); Fed. R. App. P. 8(a)(1). This motion is supported by the memorandum in support of the motion, filed herewith.

DATED: January 3, 2024.

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

By: */s/ James E. M. Craig*
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on January 3, 2024, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which caused the same to be served by electronic service upon all counsel of record.

/s/ James E. M. Craig
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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

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

Plaintiffs,

v.

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

Defendants.

Case No. 1:23-cv-00269

PLAINTIFFS' BRIEF IN SUPPORT OF MOTION TO PROCEED UNDER PSEUDONYMS

Introduction

Plaintiffs are transgender youth and their parents. They bring this action to protect their right to obtain necessary gender-affirming medical care, by challenging the constitutionality of H.B. 71, which prohibits the provision of gender-affirming medical care to transgender youth and which Governor Little signed into law on April 4, 2023. Plaintiffs move here for permission to proceed under pseudonyms in this case. They do so because of the history of violence and harassment towards transgender people and those who support them, and the heightened publicity and scorn often directed at plaintiffs in litigation such as this. H.B. 71 bans certain healthcare for minors. No child should have to publicly identify themselves to challenge that law.

Plaintiffs therefore respectfully request that the Court allow Plaintiffs Pam Poe and Jane Doe, both minor children, and their parents and next friends, Plaintiffs Penny and Peter Poe and Joan and John Doe, to proceed under pseudonyms to protect their privacy and ensure their safety. Parties may preserve their anonymity in judicial proceedings "in special circumstances when the party's need for anonymity outweighs prejudice to the opposing party and the public's interest in knowing the party's identity." *Does I thru XXIII v. Advanced Textile Corp.*, 214 F.3d 1058, 1068–69 (9th Cir. 2000). This Court has previously granted such a motion under very similar circumstances, recognizing the potential harm from revealing the identities of a minor plaintiff and her parents challenging a law targeting transgender girls and women. *See generally* Order on Plaintiffs' Motion for Minor and Her Next Friends to Proceed Under Pseudonyms (Dkt. 9), *Hecox v. Little*, No. 1:20-cv-00184-DCN. Dkt. 48 at 2–3 (June 12, 2020). Plaintiffs ask that the Court do so here as well.

Argument

A. Plaintiffs Should Be Permitted to Proceed Under Pseudonym To Protect the Privacy of the Minor Plaintiffs.

The Federal Rules require protecting the identities of minors in court filings by using their initials rather than their full names. *See* Fed. R. Civ. P. 5.2(a)(3). In addition, courts routinely allow minors to proceed under pseudonym, recognizing the "heightened protection" appropriate for minor plaintiffs. *See, e.g., Doe v. Porter*, 370 F.3d 558, 561 (6th Cir. 2004); *see also Doe v. Stegall*, 653 F.2d 180, 186 (5th Cir. 1981) (noting the "special vulnerability" of minor plaintiffs). And courts always have "discretion to allow parties to use pseudonyms in the unusual case when nondisclosure of the party's identity is necessary . . . to protect a person from harassment, injury, ridicule or personal embarrassment." *D.T. v. Armstrong*, Case No. 1:17-cv-00248-EJL, 2017 WL 2636519, at *1 (D. Idaho June 16, 2017) (quoting *Advanced Textile Corp.*, 214 F.3d at 1068–69) (internal quotations omitted).

Pam Poe and Jane Doe are minors. Poe Decl. ¶ 3; Doe Decl. ¶ 3. Both seek to proceed under pseudonym in order to adequately protect their privacy. Poe Decl. ¶ 8; Doe Decl. ¶ 8. Appearing by their initials is insufficient to protect their privacy because the complaint discloses details that, when combined with their initials, would reveal their identities. *Id*.

For example, the complaint discloses that Pam Poe is a transgender fifteen-year-old girl, and it discloses her hobbies, interests, and unique experiences. Compl. ¶¶ 71–81. Likewise, the complaint discloses that Jane Doe is a transgender sixteen-year-old girl, and it discloses her hobbies, academic interests, and unique experiences. Compl. ¶¶ 82–94. This information plus their initials would be sufficient to reveal these minor plaintiffs' identities to anyone motivated to uncover their identities and do them harm. Poe Decl. ¶ 8; Doe Decl. ¶ 8. The only way to

protect their identities while placing relevant facts before the Court is to allow them to proceed under pseudonym.

Likewise, both Pam Poe's and Jane Doe's next friends and parents should be allowed to proceed anonymously. Each minor Plaintiff shares the same last name as her parents. Poe Decl. ¶ 8; Doe Decl. ¶ 8. Revealing their parents' names would effectively identify the minors' names. *Id*. This Court can, and should, protect against this breach of the minor Plaintiffs' privacy. *See Stegall*, 653 F.2d at 186; *Porter*, 370 F.3d at 561.

B. Plaintiffs Should Be Permitted to Proceed Under Pseudonym to Protect Them from Harm.

Concealing Pam Poe and Jane Doe's identities is a sufficient goal in its own right, given that they are minors, and this is a case about their healthcare. But there is a separate, independently sufficient reason to permit pseudonymous litigation here: Publication of any of the Plaintiffs' identities would put them in harm's way. The Ninth Circuit has recognized the importance of allowing plaintiffs to proceed under pseudonym "when identification creates a risk of retaliatory physical or mental harm" and "the need for anonymity outweighs prejudice to the opposing party and the public's interest in knowing the party's identity." *Advanced Textile*, 214 F. 3d at 1068. Further, courts have recognized that threats of harassment and violence especially favor anonymity. See *Doe v. New Ritz, Inc.*, Case No. WDQ-14-2367, 2015 WL 4389699 at *2, n.12 (D. Md. July 14, 2015) (citing *Doe v. Stegall*, 653 F.2d at 186). All criteria for anonymity are satisfied here.

First, all Plaintiffs face a serious risk of retaliatory physical or mental harm if their identities are revealed. The subject matter of the complaint is one of highly contentious, highly public debate and scrutiny. The Idaho legislature has passed several bills in recent years limiting the rights of transgender people, including H.B. 500, which prohibits transgender female athletes

from participating in women's sports,[1] S.B. 1100 which prohibits transgender individuals from using the bathroom consistent with their gender identities,[2] and H.B. 71, which Plaintiffs challenge here. As similar laws have passed in other states throughout the country, the topic of banning gender-affirming medical care for minors has garnered national debate and attention.[3] By challenging a statewide law that has received such widespread media attention, Plaintiffs, including minor children, are at risk of harassment and harm. This is evidenced by the derogatory and harassing statements made in response to the ACLU's public Twitter post about the impact of H.B. 71 on transgender youth in Idaho.[4]

This is not specific to Idaho, to be clear. Transgender people, and non-transgender people who support the transgender community, are often targets of violence. Courts have recognized as much. "[T]here exist numerous documented instances of those targeted for violence based on their . . . gender identity." *Whitaker ex rel. Whitaker v. Kenosha Unified Sch.*

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[1] *See, e.g.*, Madison Hardy, *Transgender athletes bill passes senate committee; will be amended by full senate Monday*, Idaho County Free Press (Mar. 14, 2020), https://www.idahocountyfreepress.com/news/transgenderathletes-bill-passes-senate-committee-will-be-amended-by-full-senatemonday/article_986cb92c-6596-11ea-90ad-1b1d2c5c15c4.html; Talya Minsberg, *'Boys Are Boys and Girls Are Girls': Idaho Is First State to Bar Some Transgender Athletes*, N.Y. Times (Apr. 1, 2020), https://www.nytimes.com/2020/04/01/sports/transgender-idaho-ban-sports.html.

[2] *See* Sydney Kashiwagi, *Idaho governor signs bill that restricts transgender students' bathroom use in schools*, CNN (Mar. 25, 2023), https://www.cnn.com/2023/03/25/politics/idaho-bathroom-bill-brad-little-transgender-youth/index.html

[3] *See, e.g.*, Francesca Paris, *Bans on Transition Care for Young People Spread Across the U.S.*, N.Y. Times (Apr. 17, 2023), https://www.nytimes.com/2023/04/15/upshot/bans-transgender-teenagers.html#:~:text=Ten%20states%20in%20the%20past,surgery%20for%20people%20under%2018; Geoff Mulvihill, *Conflict over transgender rights simmers across the US*, AP News (Apr. 28, 2023), https://apnews.com/article/lgbtq-laws-states-gender-affirming-zephyr-fc2528326823c8232cb0aaa7ece0beab.

[4] ACLU (@ACLU), Twitter (Apr. 30, 2023, 12:21 P.M.) https://twitter.com/ACLU/status/1652709652608565252?cxt=HHwWiIC-iYarze8tAAAA

Dist. No. 1 Bd. of Educ., 858 F.3d 1034, 1051 (7th Cir. 2017) ("There is no denying that transgender individuals face discrimination, harassment, and violence because of their gender identity."); *see also In re E.P.L.*, 26 Misc. 3d 336, 338 (N.Y. Sup. Ct. 2009). This violence often extends to family members and others who support transgender people, including those who treat them.[5]

Plaintiffs are concerned for their safety, in terms of discrimination, harassment, and property damage. Poe Decl. ¶ 8; Doe Decl. ¶ 8. Sadly, those concerns are well founded and reasonable.

On the other hand, there is no risk of prejudice to the opposing parties in this matter from allowing Plaintiffs to proceed pseudonymously. The Plaintiffs are willing to provide their

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[5] *See, e.g.*, Anna Orso, *Philadelphia man dies by suicide after video goes viral of him defending relationship with trans girlfriend, friends say*, Philadelphia Inquirer (Aug. 22, 2019), https://www.inquirer.com/news/maurice-willoughby-died-by-suicide-after-viral-video-defending-transgender-girlfriend-20190822.html (describing death by suicide of cisgender man who was harassed for being in a relationship with a transgender woman); Barbara Findlay, *Acting Queerly: Lawyering for Trans People in Trans/Forming Feminisms: Trans-Feminist Voices Speak Out*, 145, 150–51 (Krista Scott-Dixon, ed.) (2006) (describing social ostracism of cisgender attorney who represented transgender woman); *Brandon Teena's Killers: 25 Years Later*, Forensic Files Now (Apr. 12, 2019), https://forensicfilesnow.com/index.php/2019/04/12/brandon-teenas-killers-25-years-later/comment-page-1/ (describing murder of transgender man, cisgender woman in a relationship with the transgender man, and a cisgender man who was staying with them); Michael Rowe, *Remembering Pfc. Barry Winchell on the 10th Anniversary of His Murder*, HuffPost (Dec. 6, 2017), https://www.huffpost.com/entry/taps-for-barry-winchell-r_b_226004 (describing murder of a cisgender man for being in a relationship with a transgender woman); Emily McCombs, *Christian, Conservative And Parenting A Transgender Child in Texas*, HuffPost (Mar. 2, 2017, 5:19 PM), https://www.huffpost.com/entry/kimberly-and-kai-shappley-transgenderchild-bathroom-rights_n_58b5b5b6e4b060480e0c4393 (describing family and friends of cisgender woman rejecting her after she began support her transgender daughter); Megan Messerly, *Health care access for trans youth is crumbling — and not just in red states*, Politico (Apr. 23, 2023), https://www.politico.com/news/2023/04/23/docs-who-treat-trans-youth-under-attack-00093322 (describing death threats, harassment, fears of litigation, and lack of support from institutions that undermines providers' ability to provide care to transgender individuals).

identities to the Defendants in discovery pursuant to a confidentiality order. Their application here is merely to avoid *public* disclosure. Thus, allowing Plaintiffs to file under a pseudonym will not prejudice the opposing parties in investigating the claims or presenting a defense. Furthermore, pseudonyms will not "'obstruct public scrutiny of the important issues in this case.'" *Doe v. Kamehameha Schools/Bernice Pauahi Bishop Estate*, 596 F.3d 1036, 1043 (9th Cir. 2020) (quoting *Advanced Textile*, 214 F.3d at 1072); *see also Armstrong*, 2017 WL 2636519 at *2 (noting that anonymity may actually further public interest in disclosure, since it may lead to fuller disclosure of sensitive information the plaintiff would otherwise not put forward). The facts presented are sufficient to provide the public information about the case without disclosing Plaintiffs' names and identities.

Conclusion

That Pam Poe and Jane Doe are minors, the nature of the private information at issue, the history of violence and harm to the transgender community and those who defend and associate with them, and the contentious nature of this dispute all support anonymity in this case. Granting this motion will not prejudice the Defendants or the public. For the foregoing reasons, the motion to proceed under pseudonym should be granted.

Dated: May 31, 2023

Respectfully submitted,

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Appendix F

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, *by and through her parents and next friends, Penny and Peter Poe*; **PENNY POE**; **PETER POE**, *et al.*,

v.

Plaintiffs,

RAÚL LABRADOR, *in his official capacity as Attorney General of Idaho, et al.*,

Defendants.

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

DECLARATION OF PENNY POE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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DECLARATION OF PENNY POE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Penny Poe, hereby declare as follow:

1. I offer this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth herein, and could and would testify competently to these facts if called as a witness. I am a Plaintiff in this Action, and call myself "Penny Poe." I am the parent and next friend of my minor child, Pam Poe, who is also a Plaintiff. My husband, "Peter Poe," is the father of Pam Poe and is also a Plaintiff.

2. My husband and I reside in Meridian, Idaho, with our daughter Pam and her sibling. We have an adult daughter who also lives in Idaho. We are all lifelong Idahoans. We have lived in Meridian for the last fifteen years and before that, we resided in Boise.

3. I work as a data coordinator for an Idaho agency. My husband is employed in the operations division of a warehouse.

4. Our daughter, Pam Poe, is fifteen years old.

5. Pam is a girl.

6. Pam is transgender.

7. Pam first told me that she was transgender in August 2021. My husband and I were hosting family one evening at our home. I received a text from Pam telling me that she was nonbinary, that her name was now "Pam," and the pronouns she would like to use. I realized it was a big moment for her and that she likely had a lot of fear. I can admit that in the moment I felt overwhelmed when I first read the text. Having so many family members over and not being able to go and comfort Pam in the moment made it harder. I texted her back and told her that I loved her and that we would talk more in the morning. I eventually told my husband late in the evening about what Pam had texted me.

8. The next morning, after much of my family had left, I went to Pam's room. I sat next to her on the floor, gave her a big hug, and just told her repeatedly how much I loved her. I asked her who else she had told, who does not know, and who she wanted to avoid knowing at that time.

9. As parents, there was not a question in our minds about supporting our daughter, but when she first told me, I did not know anything about being nonbinary or transgender, or what it would look like to support her. I just knew I wanted the best for her, and I wanted her to be happy and healthy. It took me some time to learn through self-education. I also learned a lot from Pam and her healthcare providers, as we have embarked on this journey.

10. Although I sensed that telling me was a huge relief for Pam, I saw her struggling with her mental health in late 2021. She was depressed and anxious, but most concerning was that Pam was having thoughts of self-harm and was actually engaging in self-harm. I believe that this behavior was being driven by the overwhelming emotions that she had been and was continuing to deal with, including what we later learned was gender dysphoria. It scared us a lot, as a family. I never want to lose my daughter.

11. We quickly got her into weekly counseling, so that she would have a professional to talk to and another person to receive support from. Despite the counseling, Pam continued to have severe mental health issues and thoughts of self-harm, and she was engaging in self-injurious behavior. Thankfully, around the last week in February 2022, Pam was brave enough to come to me and tell me how severe her symptoms were and she said that she needed more support. As a family we decided that Pam would benefit from inpatient residential treatment. That way we would know she was safe, in the care of trained professionals around the clock, and she could get the care we all agreed she needed.

12. Pam spent one week at the inpatient residential treatment facility. She was diagnosed with gender dysphoria, depression, and anxiety by one of her treating providers at the facility.

13. My husband and I immediately started seeking out providers who had experience in treating gender dysphoria. It took longer than we would have liked because of waiting lists, but Pam was finally able to start seeing a doctor who specialized in treating gender dysphoria about two months later, around May 2022.

14. During the first visit, my husband and I were both there with Pam. We learned a lot during that appointment. Pam's doctor went through a long questionnaire with Pam. In evaluating Pam and discussing treatment options for gender dysphoria, he considered that she was already seeing a mental health professional, had already been diagnosed with gender dysphoria, and that we had received a referral for treatment following her time in inpatient residential treatment. He also drew blood to perform lab work to establish where Pam was in terms of her puberty. The doctor discussed the risks of puberty blocking medication, the expected results from treatment, and potential effects on Pam's fertility if she were to later receive estrogen therapy.

15. I will never forget the huge smile on Pam's face after we left that first appointment. She looked the happiest I had seen her in over a year. While it was still very early in the process, I had such a huge sense of relief. I knew we were on the right track. I was happy that we knew why Pam was experiencing the feelings she was, and that we had a doctor who could provide the treatment and support that she needed.

16. Pam's doctor prescribed puberty blockers and she began taking them in June 2022. Pam was 14 years old at the time. The change in Pam was almost overnight. Her mental health

improved significantly just knowing that the changes that were happening to her body, which had been causing her such severe distress, were no longer going to happen or progress.

17. For the next year, Pam was a different person. She started feeling more confident and happier without having to experience the distress that male puberty caused for her. We told more and more people that her name was now Pam and that she used female pronouns. She was herself, happy, and thriving. She saw her doctor regularly for check-ins and lab work, to monitor the effectiveness and dosage of the puberty blockers, and to make sure she was happy and otherwise healthy. When Pam started high school in August 2022, she went to school as Pam because it was important for her to start these next four years living authentically. Everything at school has been great for Pam regarding her being transgender. She was treated as the girl that she is from day one.

18. In April 2023, when Pam was 15 years old, we raised with her doctor the possibility of beginning estrogen therapy as the next step in treatment for her gender dysphoria. Again, after careful consideration, evaluation by her doctor, discussion with her doctor of the potential risks and benefits of estrogen therapy and fertility preservation, and talks as a family, Pam, her father and I, along with her doctor, agreed that estrogen therapy was an appropriate medical treatment for her gender dysphoria. We signed the informed consent paperwork and her doctor prescribed her estrogen therapy. She has now been on estrogen therapy since April 2023

19. Pam's mental health has continued to improve with treatment, as she continues to develop into the person she knows herself to be. As parents, my husband and I could honestly not be happier. We have our child back and she is flourishing. She is a wonderful, talented, and beautiful young woman, who we are so proud of.

20. Like any person these days who watches or reads the news, we started seeing the legislation banning gender-affirming medical care popping up all over the country. I do not think we ever thought it would come to Idaho. When the H.B. 71 legislation was introduced in the Idaho legislature, we were terrified. After everything that we had been through with Pam, including the fear of losing our daughter before we were able to get her the care that she needed, we just could not believe that Pam was now at risk of being taken off her medication. It was inconceivable that we, as her parents, and in consultation with her doctor, had no say in the decision.

21. Around the time H.B. 71 was being debated, my husband and I noticed that Pam's mental health seemed to be negatively impacted. When the legislation passed, Pam was visibly devastated. As were we. Gender-affirming medical care saved our daughter. Now, we live every day knowing that in a few short months, Pam may no longer be able to receive the care she needs anywhere in Idaho, our home.

22. The stress and fear have impacted our entire family. We are lifelong Idahoans. We never imagined a time when we would leave Idaho, and especially not during the middle of Pam's high school years. This is where our home is, our community, our lives, our family, our friends, our jobs, our children's schools, and their friends. We do not want to uproot our lives, but Pam's health, safety, and ability to access the healthcare she needs is and has to be a top priority. We are terrified of the potential consequences on Pam's health if her medical care is banned, because we do not even have to guess what will happen to her mental health and to her body, because we have been through it. The thought of my child going back to feeling like she does not want to live or wants to hurt herself is just something I cannot even think about.

23. My husband and I would never put her through that because we would be forcing her to live as someone she is not and placing her in danger because of the effects on her mental

health. We have explored the possibility of regularly traveling to another state for care, and the time, logistics, and costs would be very difficult for our family. If we had to move, it would mean giving up our jobs, our home, our financial security, disrupting our two youngest children's educations and lives, and leaving everything we have ever known behind. Both of these options would result in significant hardship on everyone in our family, but these are our only options if H.B. 71 goes into effect.

24. H.B. 71 will be devastating for our family. We ask the Court please not to let H.B. 71 take effect.

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

Executed in Idaho, on this 18th day of July, 2023.

Penny Poe

Penny Poe

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IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

PAM POE, *by and through her parents and next friends, Penny and Peter Poe*; **PENNY POE**; **PETER POE**, *et al.*,

v.

Plaintiffs,

RAÚL LABRADOR, *in his official capacity as Attorney General of Idaho, et al.*,

Defendants.

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

DECLARATION OF PAM POE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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DECLARATION OF PAM POE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Pam Poe, hereby declare as follows:

1. I am a fifteen-year-old transgender girl, living with my mom, dad, and sibling in Meridian, Idaho. I am a Plaintiff in this lawsuit and call myself "Pam Poe." Our counsel have explained to me and my family what a preliminary injunction is, and we eagerly join the other Plaintiffs in seeking an injunction. Our lawyers have helped me prepare this Declaration, but the story below is mine. I have personal knowledge of the facts I explain below, and I would testify to them if called as a witness.

2. I have lived in Meridian, Idaho my entire life. I will be a sophomore in high school beginning in August 2023. I am interested in engineering, programming, and math. During the summer, I have a part-time job. This year is my second year working there.

3. While I am a girl, I was designated male at birth. Growing up, I always felt different, like I was not really a boy, but I did not know how to describe those feelings. I also did not know how to describe the mental and emotional distress I began experiencing as I got older because I knew that my gender was wrong. I know that I am a girl, not a boy. I just want to live and be treated like any other girl.

4. Around the time I was in 7th grade, as I began to experience puberty, I noticed how heavily I was struggling with depression, anxiety, and thoughts of self-harm. I started engaging in acts of self-injury. I did not really understand why exactly, but I was in a very dark place. During that time, there were times I felt like I did not want to exist anymore because I was so unhappy with what was happening to my body, feeling trapped and not like myself, and because people saw me as a boy and addressed me as one.

5. Eventually, these feelings became so overwhelming that I finally told my mom what I was feeling in August 2021.

6. I remember that moment clearly. We had a bunch of family over at the house, but I was feeling uncomfortable with myself, so I stayed in my room for most of the evening. As it got late that night, I realized that I could not wait any longer. I had to tell my mom my truth. I had been wanting to tell her for so long, but I was scared. I decided to text her and come out. I told her that I was non-binary (I was still exploring my gender identity and knew I was not a boy, but did not yet understand that I am a girl), that I wanted to be called "Pam," and that I wanted people to use different pronouns in referring to me. I was not sure how or if she was going to respond, because it was so late and she was entertaining family. But she did respond. She used my new name and told me that she loved me, and that we would talk about it in the morning, when things were quieter and we would have more privacy.

7. The next morning my mom came into my room. She sat by me on the floor and hugged me. She told me that she loved me. It was very emotional, but I was so happy that she accepted me. Because we still had family in town and some staying with us, we also talked about who knew, who did not know, and who we should avoid finding out for now. My mom was already trying to protect me, and that also made me feel very happy, safe, and loved.

8. I continued to try to understand my gender identity and who I am. Not long after coming out, I told my parents I was more comfortable with she/her pronouns. I knew I didn't feel like a boy and was coming to realize I didn't have to force a masculine presence on myself. I was still exploring whether nonbinary, transgender, or no gender felt like the right label for how I was feeling. I stopped trying to be the boy that society told me to be, and I focused on presenting my true self.

9. My parents found a counselor, who I started seeing weekly. He diagnosed me with depression. Even with counseling, I continued to struggle. Due to puberty, my body was still changing in ways that were making me feel miserable, because with every change, I became more and more physically a boy, and I just knew that was not who I was.

10. One day in early 2022, I sent my mom a text at 2am because I did not want to wake her, asking for admission to hospitalized care. I told her that I did not want to be alive anymore. It was hard to describe to her how I was feeling at the time. I decided that an inpatient stay at a residential treatment facility would help me and provide me with greater support. With my parents' support, I entered residential treatment at the end of February 2022 and stayed there for one week. During my time in inpatient treatment, I opened up more to one of the providers I was seeing about my gender identity and the distress, depression, and anxiety around my body. That provider diagnosed me with gender dysphoria, in addition to my depression and anxiety.

11. Before, when I thought about the possibility of being diagnosed with gender dysphoria, I had assumed it would be something negative and that I would feel shame about the diagnosis. However, when I received the diagnosis, I felt relief and validation. I felt like I had permission to stop fighting my identity and pretending to be someone I wasn't. My body and its developments were causing me severe dysphoria, because I was unable to be seen by others as a girl, or even a feminine human being

12. After I left the residential treatment facility, I was referred to a doctor who is an expert in treating gender dysphoria. Unfortunately, the next available appointment was not until a few weeks later, in May 2022.

13. At the appointment, my doctor evaluated me, talked with my parents and me about the possibility of me being treated with puberty blockers, and discussed with us the benefits of

treatment and the risks. I also had blood drawn to figure out where my body was, in terms of puberty. I remember leaving that first appointment with a huge smile and feeling just overwhelmed with relief . Learning that puberty blockers were possible and that they would stop the changes happening to my body took a huge weight off my shoulders and helped my mental health.

14. At my next visit with the doctor, after again discussing everything we discussed at the first meeting, my parents and I, along with the doctor, decided that puberty blockers were the right treatment for me. I began puberty blockers in June 2022. I just felt so happy and relieved because I knew that it was going to stop what was happening to me. My mental health started to improve and only continued to improve over the next few months.

15. A counselor had been recommended to us as someone with experience caring for people with gender dysphoria, and after several months on the waitlist, I began therapy with her in July 2022.

16. With my parents' support, I had begun socially transitioning after coming out to them. I started wearing more feminine clothing, wearing makeup, and dying my hair and growing it out. Making these changes made me feel more like myself. Seeing that that my family saw me, accepted me, and treated me as who I really am also made me feel more like myself.

17. Being able to be myself, because of the puberty blockers and socially transitioning, I became more confident. I was already out to my close friends and family, and I realized I was ready to reintroduce myself, my real self, to other people in my life. When I started high school in August 2022, I entered as a girl and have been treated as a girl since day one.

18. Socially transitioning helped me feel like I wasn't hiding when I was in public. I felt more confident that people were seeing *me*, not the masculine role I was assigned. It didn't alleviate all of my distress though. I still constantly worried about people seeing certain parts of

me that are not in line with my gender identity and expression. Puberty blockers paused more changes to my body that did not align with my gender identity, and I was still having a lot of gender dysphoria about the ways my body didn't align with my gender identity.

19. In April 2023, after being on puberty blockers for almost a year, my parents and I had a conversation with my doctor about starting estrogen therapy. My doctor performed more bloodwork, talked to us about the potential risks and benefits of estrogen therapy, discussed options for fertility preservation, and confirmed my ongoing therapy and mental health support. My parents and I, in talking with my doctor, decided that estrogen therapy was the best and appropriate treatment for my gender dysphoria. I started treatment and I have been on estrogen ever since. Just like with the puberty blockers, the estrogen therapy has made such a difference in my life. My mental health is the best it has ever been. I am feeling more confident, happy, and excited that I am developing as a girl.

20. Before I began gender-affirming medical treatment, I was in a very dark place. I struggled so hard, with anxiety, depression, hiding away by myself, thoughts of self-harm, and even harming myself to cope with it all. The changes because of male puberty were making me miserable and causing all of those bad symptoms. I could not see a future for myself and did not want to exist. Gender-affirming medical care saved my life. When I think back to that time, it makes me sad. I know it really scared my parents. It scared me too. I did not want to die, I just wanted to be myself, my true self. I am so glad that I told my parents about what I was struggling with. I wish I had told them sooner.

21. It is hard for me to find the words to explain the difference in my life now that I am receiving gender-affirming medical care and living as the girl that I know I am. I am happy and confident. I am excited about the future I see for myself.

22. That is also why I am incredibly anxious and scared about H.B. 71. My entire family is very scared. If H.B. 71 becomes law, I would have to stop receiving the medical treatment that has saved me. I have already lived through the extreme mental health symptoms of not receiving treatment and I never want to experience that again. I cannot go back to that.

23. If H.B. 71 becomes law, my parents have talked about moving out of Idaho when my sister graduates from high school next year. We also talked about traveling to get care, but that would be a significant financial burden for my family. If we move, I will leave the only home I have ever known, my close community of friends, and my healthcare providers, who I trust, who have supported me, and who have changed my life for the better. I do not want to leave. I want to stay in Idaho, in my home, and continue receiving the healthcare I need. Please, please do not let this law take effect.

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

Executed in Idaho, on this 18th day of July, 2023

Pam Poe

Pam Poe

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IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

PAM POE, *by and through her parents and next friends, Penny and Peter Poe*; **PENNY POE**; **PETER POE**, *et al.*,

v.

Plaintiffs,

RAÚL LABRADOR, *in his official capacity as Attorney General of Idaho*, *et al.*,

Defendants.

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

DECLARATION OF JANE DOE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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Attorneys for Plaintiffs

DECLARATION OF JANE DOE IN SUPPORT OF
PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Jane Doe, hereby declare as follows:

1. I am a Plaintiff in this action, and refer to myself here as "Jane Doe." I make this Declaration in support of my and the other Plaintiffs' Motion for a Preliminary Injunction. My lawyers have helped me prepare this Declaration because I am not a lawyer and I have no experience with Declarations. The facts I describe below are about my own experience, however. I have personal knowledge of them, and would testify competently to them if called as a witness.

2. I am a sixteen-year old girl. I live with my mom, dad, and siblings in Boise, Idaho, where I have lived my entire life. This fall, I will be a high school senior. After high school, I plan to attend college. I am in interested in majors related to computer coding, cybersecurity, or videogame development.

3. I am transgender. I have a female gender identity, but I was designated as male at birth.

4. I have gender dysphoria, and was diagnosed with gender dysphoria by my doctor in November 2020.

5. For as long as I can remember, I knew that something felt off about my being a boy. I have always naturally related to other girls, felt the most like myself around other girls, and had similar interests as other girls. When I was younger, I did not have the words to express my feelings related to my gender identity or being transgender. But I knew it even before I knew the words for it.

6. In school, when we would be divided into girls' teams and boys' teams, I always wanted to be and felt like I belonged on the girls' team. When I would play "make believe" with my friends, I was always a girl character. When I would play video games, I would almost always

choose a girl avatar. My mom and dad have told me that when I was little and my mom was pregnant with my younger sibling, I would lay down and place a doll on my stomach and tell them that I wanted to be a mom.

7. While I always felt like I was not a boy, it was difficult and scary for me to address these feelings. That distress became severe with puberty. I now understand this to be gender dysphoria. But I never tried to tell my parents about my feelings when I was young, out of my own fear of rejection from friends and the community.

8. I did not meet a transgender person, or at least someone I knew was transgender, until I was about 10 years old and met a transgender woman who was friends with my parents. My parents explained to me that their friend was transgender, that she had been born a boy but was a woman on the inside, and was now living her life as a woman. It was like hearing them describe my own life to me. Before that, I did not know that transitioning was even possible. I was immediately excited about the possibility that I could do the same one day.

9. In 2018, my body started changing as I entered puberty. It became increasingly devastating to me, and my mental health began to deteriorate. The changes to my body made me look like a boy. I remember that I would often refuse to allow my photograph to be taken during that time because of the pain it caused me seeing myself as someone I was not. I could not hide all of the physical changes, and I would often self-isolate and avoid social settings. I wanted to be social, but the pain of being perceived as a boy and seeing myself with male features was too much to bear. I also began to suffer academically at school because I could not focus on my schoolwork due to the severe mental health issues my gender dysphoria was causing me. There were times that I simply just did not want to exist because the physical changes to my body were trapping me in an existence that was not me and caused me so much pain, on a constant basis.

10. In June 2020, my gender dysphoria had intensified so badly that I needed to tell someone. I told one friend in July and then a couple more in September. In late September 2020, I finally found the courage to tell my parents that I am transgender, that I am a girl, that I was suffering, and that I needed help. My parents did not hesitate. They told me they loved me, they would support me in anything, and they just wanted me to be happy and healthy.

11. With my parents' support, I began socially transitioning in October 2020. I began going by a female first name and using feminine pronouns. I wore a feminine hairstyle and I started wearing girls' clothes. I told my mom I wanted to wear makeup and, as part of all of the ways in which she supported me when I asked for her help, she taught me about makeup and how to apply it. All of this helped my gender dysphoria, but I was still experiencing male puberty, which was causing significant physical changes to my body that I could not hide or cover up with makeup or clothes. And I knew that some of these unwanted changes would be permanent. My gender dysphoria was still causing me significant pain.

12. In mid-October 2020, my parents and I had a visit with my pediatrician to discuss what I was experiencing. My pediatrician referred me to a doctor who specializes in the treatment of gender dysphoria. My parents also found a therapist for me.

13. We had our first visit with the doctor in November 2020. The doctor examined me, asked me about my experience regarding my gender over the years, took blood for tests, and talked to me about the options for treating gender dysphoria based on my age, the risks and benefits of treatment, and things we could do to preserve my ability to have children.

14. After several months of therapy, an additional visit with the doctor, and much discussion with my parents, we decided to start on puberty blockers. I began receiving that treatment in January 2021.

15. The puberty blockers stopped any new changes from happening to my body and prevented my gender dysphoria from getting worse. Knowing that further changes would not happen was a big relief to me and improved my mental health.

16. After a few successful months on puberty blockers, we began talking about starting gender-affirming estrogen therapy. I spoke to my parents about it and during one of our visits with my doctor, he talked to my parents and me about the risks and benefits of estrogen therapy and fertility preservation, and he drew more blood for tests. Eventually, my parents and I agreed that gender-affirming estrogen therapy was appropriate for me. The doctor agreed. In April 2021, at the age of 14, I began a low dose of gender-affirming estrogen therapy.

17. Since April 2021, I see my doctor regularly for lab work, so that he can make sure I remain healthy and so he can check my hormone levels and change my estrogen dosage if needed to remain in target ranges for my age.

18. Estrogen has been amazing. It has changed my body in more feminine ways that I am so happy with. Seeing these bodily changes has helped my gender dysphoria a lot, and I feel like my body more accurately reflects who I am.

19. With the help of my parents, I began legally transitioning in 2023. My parents and I first obtained a court-ordered name change in Idaho. We then had my Idaho birth certificate corrected with my new legal name and we corrected the gender marker, changing it from male to female. My parents also helped me update my information with the United States Social Security Office and helped me obtain a United States passport with my new legal name and a female gender marker.

20. My parents and I also spoke to the administrators at my school, who were great about everything. They readily corrected my name and gender marker in my digital school records,

so that my teachers and any substitute teachers would not use the wrong name for me or the wrong pronouns and gender. This is really important to me, and I am so glad that the administrators at my school are supportive of me.

21. Being able to medically transition and see myself, and be seen by others, as the girl I am absolutely saved my life. Before I told my parents I was transgender and about the feelings of my gender dysphoria, I was not me. I was isolating myself, depressed, anxious, and I felt trapped and scared almost daily. I could not see a future for myself and did not want to exist. I am so grateful that when I told my parents about what I was experiencing, they listened to me, trusted me, and took me to providers who could give me the gender-affirming health care that I needed to be who I am.

22. My whole life has turned around. I am confident in who I am. My academics have improved. My mental health has improved substantially. I no longer feel the need to isolate, and I can live my life more fully and authentically. I am excited about what comes next in my life and everything I hope to do in the future.

23. Now all of that is at risk because of H.B. 71 and I am really scared. My parents and siblings are scared, and the others who love and care about me are scared, too. The anxiety from H.B. 71 and the possibility of my healthcare being taken away and having to go back to life as it was before I began receiving gender-affirming medical care is very stressful and harmful to my mental health. It caused me to miss a lot of school while the law was being debated. As a result, my grades suffered last semester.

24. If H.B. 71 becomes law, I would no longer be able to receive the estrogen therapy that I have been on for over two years that treats my gender dysphoria. I fear what would happen

to my mental, emotional, and physical health if my medication is cut off because of H.B. 71 and I have to resume male puberty. I have already lived that pain.

25. My parents have talked to my siblings and me about trying to find care for me out of state or selling our house and leaving Idaho—the only home I've ever known—because of H.B. 71. I don't know if we can find care out of state or what it would look like to have to regularly travel for healthcare. Having to move would mean losing my friends, my family, my home, my community, my school, and everything that I have always known. It would mean the same for my parents and siblings. My oldest sibling is starting college in Idaho in the fall. I worry about what impact moving will have on him, his college plans, and our relationship. I do not want to move to a different state far away from him. I do not want any of this. I just want to stay in Idaho, my home, and continue receiving the healthcare I have been receiving that has made the life I am now living possible. But if H.B. 71 goes into effect, my family understands that this healthcare is so central to my wellbeing that we will likely have no other choice but to move out of Idaho.

26. I ask that the Court please help me. Please do not let my healthcare be taken away.

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

Executed in Idaho, on this 18th day of July, 2023

Jane Doe

Jane Doe

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IN THE UNITED STATES DISTRICT COURT
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PAM POE, *by and through her parents and next friends, Penny and Peter Poe*; **PENNY POE**; **PETER POE**, *et al.*,

v.

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RAÚL LABRADOR, *in his official capacity as Attorney General of Idaho*, *et al.*,

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

DECLARATION OF JOAN DOE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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DECLARATION OF JOAN DOE IN SUPPORT OF
PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Joan Doe, hereby declare as follow:

I offer this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth herein and could and would testify competently to these facts if called as a witness.

1. I am a Plaintiff in this action, and refer to myself here as "Joan Doe." I am the mother and next friend of Plaintiff Jane Doe, my minor child. Plaintiff John Doe is my husband, and Jane Doe's father. I make this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this Declaration and would testify completely to these facts if called to do so.

2. My husband and I, with our three children, have resided in Boise for seventeen years. I work part-time at an elementary school. My husband is an engineering director at a technology company.

3. Our daughter Jane Doe is sixteen years old, is a girl, and is transgender.

4. My husband and I love Jane unconditionally, exactly as we do our other two children. As parents, we have always done what we know and believe to be best for her, to ensure that she is happy and healthy. That is all we have ever wanted for all of our children.

5. Jane was assigned the sex male at birth, and we gave her a traditionally male name. Around September 2020, when she was 14 years old, Jane told my husband and me that she is transgender. She told us that she had known she was a girl for much longer, but that she had been afraid to tell us and unsure how to do so. But she told us that she could not put off telling us any

longer because she was in so much pain because of changes that were happening to her body. Like any mother whose child tells them that they are in pain, this broke my heart more than I could ever express. No mother ever wants their child to be in any kind of pain, let alone to struggle in silence.

6. My husband and I have friends who are transgender, and we felt we understood at some level what it means to be transgender and how difficult it can be in this world. And like any parents confronting something new with their child, we had concerns because we just did not know how to get Jane the right help. Our main concern was and continues to be Jane's health and happiness.

7. As a child, Jane had naturally gravitated towards things considered to be for little girls. For example, when Jane played video games, which she enjoys, she would always choose to be a female character. Jane would also often choose clothes in the girls' section of the store.

8. Before Jane told us she is transgender, I saw her struggle immensely with her mental health, especially as puberty started. At the time, I was not sure what was causing it, but I saw her withdrawing and closing off from her normal self. In retrospect, I realize this was stemming from her gender dysphoria.

9. After Jane told us what was going on and that she is transgender, we immediately wanted to educate ourselves and to get her help. We first took her to her long-time pediatrician. We explained to the pediatrician what Jane had told us, and Jane herself explained how she felt and what she was experiencing. While our pediatrician had no personal experience treating gender dysphoria, and therefore referred us to someone with expertise in the area, I will never forget what she said to Jane that day: "from the moment you were born my job has been to make sure you're healthy and happy, and this doesn't change anything." It meant so much to us that she knew instinctually to support us and to do so overtly.

10. With our pediatrician's help, we found a therapist with experience working with transgender patients and made appointments for Jane, and we found a doctor who had experience caring for youth with gender dysphoria. We reached out and set up an appointment.

11. While we waited for the appointment, Jane began to socially transition and we educated ourselves about that. She chose her new name, and she started styling her hair more femininely and wearing makeup.

12. We noticed some improvements in Jane's mental health and confidence, just from calling her by her chosen name and pronouns, supporting her in dressing and grooming herself how she wanted, and in finally being free to live as herself. But she remained distressed about the changes that puberty was bringing to her body.

13. When the time finally came for Jane's first appointment with the doctor in November 2020, she was very excited. During that appointment, several things happened. We provided Jane's past medical history, which was quite limited because she had never had any medical issues. The doctor evaluated her, asking her a lot of questions about her experiences, understanding of herself, and mental health history. Separately, he and I talked about what I had seen with regard to Jane's gender identity, experiences, and mental health. He also requested contact information for Jane's primary care doctor and therapist. Next, he went over the treatment options for gender dysphoria, such as puberty blockers, and later, potentially gender-affirming estrogen therapy. He explained what to expect regarding timelines, and risks associated with each type of treatment, and he also did bloodwork.

14. After the first appointment with her doctor, Jane continued seeing her therapist, which went really well. She also continued to see her doctor during this time so he could see how she was progressing in therapy, and to continue to discuss the potential risks and benefits of

treatment and to discuss fertility preservation options should she proceed with gender affirming medical care.

15. During this time, we also continued to discuss everything we were learning with Jane, privately as a family. Jane still struggled with the changes that were happening to her body as male puberty continued, and she was hopeful knowing that she had options and a competent doctor who could provide the care she needed. But she wanted the process to move faster.

16. In January, 2021, with the support of her therapist and doctor, as a family we decided that Jane would start puberty blockers. I know that this was a huge relief for Jane. Even though the effects were not immediate, just knowing that she was finally getting the care to stop the changes to her body that were causing her so much pain really impacted her mental health in a positive way. I was just so happy to see her happy and getting what she needed to be herself.

17. In April 2021, Jane was nearly 15 and there were no doubts about the stability of Jane's female gender identity, so in consultation with Jane's doctor and after again discussing what to expect from estrogen therapy, the potential risks and benefits, and fertility preservation options, we all agreed that it was appropriate for Jane to start estrogen therapy for the continued treatment of her gender dysphoria.

18. Jane remains on estrogen therapy for the treatment of her gender dysphoria, under the care and supervision of her doctor.

19. Gender-affirming medical care has changed Jane's life, and the life of our family, for the better. She has never been happier. She has never been more herself. As a parent, to see where she started, in so much pain, in comparison to where she is today, a vibrant, happy, outgoing, beautiful young woman, has been lifechanging for me and my family as well. Her mental health

has significantly improved. Her grades in school have improved. And this is all because she was able to access the healthcare that she needed.

20. As a family, when we first heard about H.B. 71, we were naturally concerned and confused. We have seen how beneficial gender affirming medical care had been for Jane.

21. Leading up to H.B. 71 being passed, my husband and I witnessed Jane's mental health begin to decline, out of anxiety about what was happening in the state legislature and out of fear of having to stop gender-affirming medical care. Her mental health deteriorated to a state that we had not seen since before she came out to us and began treatment. It terrified all of us. Jane's anxiety around potentially losing care intensified to such debilitating levels that her grades began to slip again. She started missing school because her anxiety was so bad that she could not get out of bed or leave her room. She was scared to go outside. I was heartbroken to see my child, this beautiful flower that had blossomed so much and was finally thriving, start to wither away.

22. On the day H.B. 71 passed into law, Jane was so emotionally devastated that my husband and I had to pick her up from school and bring her home for the day.

23. This is the medical care that we want for our child. This is the medical care for which we sought out experienced, competent providers for. My husband, Jane's siblings, and I, are all so scared about what will happen to Jane if she is forced to stop treatment. We do not know what to do. We have thought about trying to find care in another state, but do not know if we can make it work with out-of-state providers, insurance, time off for travel, and the additional financial burden. My husband and I are also seriously considering uprooting our lives and our

children's lives by leaving Idaho, so that Jane can continue to receive the gender-affirming medical care she needs.

24. We do not want to leave Idaho. Jane does not want to leave Idaho. Her siblings do not want to leave Idaho. They have lived here their entire lives. This is where we have built our lives, it is our community, it is where they go to school, and it is where our friends and family are. I love my job and care deeply about the students that I work with. The reality that I might have to quit my job because of H.B. 71 makes me incredibly sad.

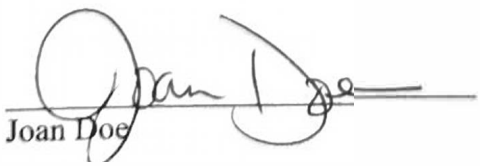
25. Our oldest child committed to attending Boise State University before any of this happened, because he wanted to remain close to us and we wanted to be close to him.

26. As each day passes, our fear grows and we are still grappling with what we must do if H.B. 71 goes into effect in a few months. Jane's health is our priority, and we know that we have done what is best for her. The fear and uncertainty is affecting all of us, and threatens to upend all of our lives. All that we want is for Jane to be able to continue receiving the care that we agree she needs, her providers agree that she needs, and that we have seen, firsthand, as necessary for our daughter to thrive.

27. But as parents who have seen what it means when their child is not receiving care, we understand how serious Jane's gender dysphoria is, and how harmful it would be if her treatment is cut off and all her progress is lost.

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

Executed in Idaho, on this 18th day of July, 2023.



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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

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

Plaintiffs,

v.

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

Defendants.

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

EXPERT DECLARATION OF CHRISTINE BRADY, PhD

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*Admitted *pro hac vice*

Attorneys for Plaintiffs

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

1. I am over 18 years of age and competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. The opinions expressed herein are my own and do not necessarily express the views or opinions of my employer.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinions.

4. In preparing this declaration, I reviewed Idaho State Legislature House Bill 71 (hereafter "Ban"). My opinions contained in this declaration are based on my training as a psychologist; my clinical experience as a pediatric psychologist, including my experience treating youth and young adults up to age 23 with gender dysphoria; my knowledge of peer reviewed research relevant to the treatment of gender dysphoria; my knowledge of the clinical best practice guidelines set forth by professional organizations for the treatment of gender dysphoria including the World Professional Association for Transgender Health ("WPATH") Standards of Care for the Health of Transgender and Gender Diverse People Version 8 ("SOC 8"), Endocrine Society's the Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline ("Endocrine Society Guideline"), and the American Psychological Association ("APA") Guidelines for Psychological Practice With Transgender and Gender Nonconforming People.

BACKGROUND AND QUALIFICATIONS

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

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

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

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

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

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

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

11. I am being compensated at an hourly rate of $250 per hour for preparation of expert declarations and reports, and $400 per hour for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

EXPERT OPINIONS

A. Gender Identity

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

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

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

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

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

B. Diagnosing Gender Dysphoria

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

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

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[1] Jack L. Turban et al., *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, 77 JAMA PSYCHIATRY 68, 69 (2019).
[2] *Id*. at 68.
[3] AMERICAN PSYCHOLOGICAL ASSOCIATION, APA RESOLUTION ON GENDER IDENTITY CHANGE EFFORTS 1-2 (2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf; AMERICAN MEDICAL ASSOCIATION & GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, SEXUAL ORIENTATION AND GENDER IDENTITY CHANGE EFFORTS (SO-CALLED "CONVERSION THERAPY") 4 (2022), https://www.ama-assn.org/system/files/conversion-therapy-issue-brief.pdf; American Academy of Child & Adolescent Psychiatry, *Conversion Therapy Policy Statement* (Feb. 2018), https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

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

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

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

1. A strong desire to be of the other gender or insistence that one is the other gender (or some alternative gender different from one's assigned gender).

2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire, or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

3. A strong preference for cross-gender roles in make-believe play or fantasy play.

4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.

5. A strong preference for playmates of the other gender.

6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, game and activities.

7. A strong dislike of one's sexual anatomy.

8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

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

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

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

1. A marked incongruence between one's experienced/expressed gender and primary or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

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

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

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

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

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[4] *See, e.g.*, Madeleine S.C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual Outcome of Gender-Dysphoric Children*, 47 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1413, 1413-23 (2008) (investigating which childhood measures of gender behavior related to "desistance").
[5] Kristina R. Olson et. al., *Gender Identity 5 Years After Social Transition*, 150 PEDIATRICS 1, 3 (2022).
[6] Tessa Brik et al., *Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*, 49 ARCHIVES SEXUAL BEHAV. 2611, 2615 (2020).
[7] Jack L. Turban et al., *Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis*, 8 LGBT HEALTH 273, 273-80 (2021).

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

C. The Treatment of Gender Dysphoria

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

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

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

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

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

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

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

[9] N. Henderson et al., *The Impact of Gender Identity Clinic Waiting Times on the Mental Health of Transitioning Individuals*, 65 EUR. PSYCHIATRY S851 (2022)
[10] E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH S1 (2022).
[11] *Id.* at S3.
[12] *Id.*

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

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

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

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

[13] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (2017).
[14] American Psychological Association, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, AM. PSYCH. 832 (2015).
[15] *Id.* at 832-33.

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

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

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

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

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

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

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

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

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

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

D. Efficacy of Medical Treatment for Gender Dysphoria

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

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

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

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

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

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

E. Harm to Transgender Youth if Care is Restricted

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

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

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

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

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

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

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

Executed on: 7/19/2023

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

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

Plaintiffs,

v.

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

Defendants.

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

EXPERT DECLARATION OF KARA CONNELLY, MD

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Attorneys for Plaintiffs

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

1. I am over 18 years of age and competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinions.

4. In preparing this declaration, I reviewed Idaho State Legislature House Bill 71 (hereinafter, "Ban"). My opinions contained in this declaration are based on my training as a pediatric endocrinologist; my clinical experience as a pediatric endocrinologist, including my experience treating youth and young adults with hormonal therapies for a variety of conditions, including gender dysphoria; my knowledge of peer-reviewed research relevant to the treatment of gender dysphoria and other medical conditions for which hormonal therapies are provided; and my knowledge of the clinical practice guidelines for the treatment of gender dysphoria set forth by professional organizations including the World Professional Association for Transgender Health ("WPATH") and the Endocrine Society, as well as clinical practice guidelines for the treatment of a wide range of conditions within the field of endocrinology.

5. I am being compensated at a rate of $350 per hour for the time I spend on this case. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

6. In the past four years, I have not given expert testimony at trial or deposition in any cases.

I. BACKGROUND AND QUALIFICATIONS

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

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

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

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

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

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

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

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

II. TREATMENT PROTOCOLS FOR GENDER DYSPHORIA

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,

d. the adolescent has sufficient emotional capacity and maturity to give informed consent to this (reversible) treatment,

2. And the adolescent:

a. has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,

b. has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment:

a. agrees with the indication for GnRH agonist treatment,

b. has confirmed that puberty has started in the adolescent, and

c. has confirmed that there are no medical contraindications to GnRH agonist treatment.[4]

[4] Endocrine Society Guideline at 3878.

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

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

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

a. agrees with the indication for sex hormone treatment, and

b. has confirmed that there are no medical contraindications to sex hormone treatment.[5]

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

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

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

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

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[5] *Id.*

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

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

III. GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS IS EFFECTIVE

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

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

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

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

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

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

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

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

IV. GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS IS SAFE

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

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

[8] Turban, J.L., et al. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS ONE* 17(1):e0261039.
[9] *See, e.g.*, van Leerdam, T.R., Zajac, J.D., & Cheung, A.S. (2023). The Effect of Gender-Affirming Hormones on Gender Dysphoria, Quality of Life, and Psychological Functioning in Transgender Individuals: A Systematic Review, *Transgender Health*. 8(1); Colizzi, M., Costa, R., & Todarello., O. (2014). Transsexual patients' psychiatric comorbidity and positive effect of cross-sex hormonal treatment on mental health: results from a longitudinal study. *Psychoneuroendocrinology*. 39:65–73.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[12] Rosenfeld, L. (2002). Insulin: discovery and controversy. *Clin Chem.* 48:2270–2288.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Executed on: _7/14/2023_

Kara Connelly MD

Kara Connelly, MD

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

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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

PAM POE, by and through her parents and next friends, Penny and Peter Poe; **PENNY POE**; **PETER POE**; **JANE DOE**, by and through her parents and next friends, Joan and John Doe; **JOAN DOE**; **JOHN DOE**, *Plaintiffs*, v. **RAÚL LABRADOR**, in his official capacity as Attorney General of the State of Idaho; **JAN M. BENNETTS**, in her official capacity as County Prosecuting Attorney for Ada, Idaho; and the **INDIVIDUAL MEMBERS OF THE IDAHO CODE COMMISSION**, in their official capacities, *Defendants*.	Case No. 1:23-cv-00269-CWD

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Attorneys for Plaintiffs

I, JACK TURBAN, MD, MHS hereby declare as follows:

1. I have been retained by counsel for Plaintiffs as an expert witness in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated herein.

3. In preparing this declaration, I reviewed the State's combined memorandum of law in opposition to motion for preliminary injunction and in support of motion to dismiss and the expert declarations by Drs. James Cantor and Daniel Weiss. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or other developments in my area of expertise.

BACKGROUND AND QUALIFICATIONS

4. My curriculum vitae is attached as Exhibit A to this declaration. I am currently an Assistant Professor of Child & Adolescent Psychiatry at the University of California, San Francisco (UCSF) School of Medicine, where I am also Affiliate Faculty at the Philip R. Lee Institute for Health Policy Studies. As a member of the faculty at UCSF, I serve as director of the Gender Psychiatry Program in the Division of Child & Adolescent Psychiatry. I also serve as an attending psychiatrist in the adult LGBT psychiatry clinic and in the eating disorders program. In my career, I have cared for at least 100 adolescents with gender dysphoria. In addition to my clinical work, I conduct research focusing on the determinants of mental health among transgender youth and teach medical students, psychology trainees, psychiatry residents, and child and adolescent psychiatry fellows.

5. I received my undergraduate degree in neuroscience from Harvard College. I received both my MD and Master of Health Science (MHS) degrees from Yale University School

of Medicine. I completed residency training in general psychiatry in the combined Massachusetts General Hospital / McLean Hospital residency training program (Harvard Medical School) and fellowship training in child and adolescent psychiatry at Stanford University. I am board certified in psychiatry by The American Board of Psychiatry and Neurology.

6. My research focuses on the mental health of transgender youth and youth experiencing gender dysphoria. While at Yale, I was awarded the Ferris Prize for my thesis entitled "Evolving Treatment Paradigms for Transgender Youth." In 2017, I received the United States Preventative Health Services Award for Excellence in Public Health based on my work related to the mental health of transgender youth. I have lectured on the mental health of transgender youth at Yale School of Medicine, UCSF, Stanford University, and The Massachusetts General Hospital (a teaching hospital of Harvard Medical School). I have given invited grand rounds presentations at academic institutions around the country and have presented nationally and internationally on topics related to the mental health of transgender people and people experiencing gender dysphoria.

7. I have served as a manuscript reviewer for numerous professional publications, including *The Journal of The American Medical Association (JAMA)*, *JAMA Pediatrics*, *JAMA Psychiatry*, *The Journal of The American Academy of Child & Adolescent Psychiatry*, *Pediatrics*, *The Journal of Adolescent Health*, and *The American Journal of Public Health*. I received commendation as a top peer reviewer from *Annals of Internal Medicine*, the academic journal of the American College of Physicians. I am an academic editor for the journal *PLoS One* and a contributing editor for *The Journal of The American Academy of Child & Adolescent Psychiatry.* I have served as lead author for textbook chapters on the mental health of transgender youth, including for *Lewis's Child & Adolescent Psychiatry: A Comprehensive Textbook* and the textbook

of The International Academy for Child & Adolescent Psychiatry and Allied Professionals. I am co-editor of the textbook *Pediatric Gender Identity: Gender-Affirming Care for Transgender and Gender Diverse Youth.*

8. I have published extensively on the topic of transgender youth, including nine articles in peer-reviewed journals within the past two years.

9. In the last four years, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Brandt et al. v. Rutledge, et al*., No. 21-CV-450 (D. Ark.) (deposition and trial testimony); *K.C. v. Medical Licensing Board of Indiana*, No. 1:23-cv-00595-JPH-KMB (S.D. Ind.) (deposition).

10. I am being compensated at an hourly rate of $400 per hour for preparation of expert declarations and reports and time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

THERE IS NO BASIS FOR THE STATE'S EXPERTS' ASSERTIONS THAT THERE IS NO RELIABLE RESEARCH SHOWING THE EFFICACY AND EFFECTIVENESS OF GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS

11. There are over a dozen studies evaluating the efficacy and effectiveness[1] of puberty blockers and gender-affirming hormones for the treatment of adolescents with gender dysphoria.[2]

[1] Efficacy refers to studies looking at an intervention under "ideal circumstances" (*e.g.*, in a research clinic), whereas effectiveness studies look at the impact of an intervention under "real world" conditions (*i.e.*, in the general community practice setting).

[2] Such studies include: De Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*, *8*(8), 2276-2283; De Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, *134*(4), 696-704; Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *The Journal of Sexual Medicine*, *12*(11), 2206-2214; Allen, L. R., Watson, L.

These studies can be roughly delineated into two categories: uncontrolled longitudinal studies and controlled cross-sectional studies. Uncontrolled longitudinal studies (*e.g.*, Chen et al. *New England Journal of Medicine* 2023[3] and deVries et al. *Journal of Sexual Medicine* 2011[4]) have examined mental health before and after gender-affirming medical interventions and found that mental health is improved after treatment. Controlled cross-sectional studies (*e.g.*, van der Miesen

B., Egan, A. M., & Moser, C. N. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology*, *7*(3), 302-311; Kaltiala, R., Heino, E., Työläjärvi, M., & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry*, *74*(3), 213-219; de Lara, D. L., Rodríguez, O. P., Flores, I. C., Masa, J. L. P., Campos-Muñoz, L., Hernández, M. C., & Amador, J. T. R. (2020). Psychosocial assessment in transgender adolescents. *Anales de Pediatría (English Edition), 93*(1), 41-48; van der Miesen, A. I., Steensma, T. D., de Vries, A. L., Bos, H., & Popma, A. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health*, *66*(6), 699-704; Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. *Pediatrics*, *145*(4), e20193006; Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, *145*(2), e20191725; Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2021). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. *Journal of Adolescent Health*, *70*(4), 643-649; Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, *17*(1), e0261039; Tordoff, D. M., Wanta, J. W., Collin, A., Stephney, C., Inwards-Breland, D. J., Ahrens, K. (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Network Open*, *5*(2), e220978; Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A. C., & Olson-Kennedy, J. (2023). Psychosocial functioning in transgender youth after 2 years of hormones. *New England Journal of Medicine*, *388*(3), 240-250.

[3] Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A.C., & Olson-Kennedy, J. (2023). Psychosocial functioning in transgender youth after 2 years of hormones. *New England Journal of Medicine*, *388*(3), 240-250.

[4] De Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*, *8*(8), 2276-2283.

et al. *Journal of Adolescent Health*[5] and Turban et al. *PLoS One*[6]) have compared those who accessed gender-affirming medical care to those who desired but did not access this treatment and found that those who accessed treatment had better mental health outcomes. These two types of study designs offer complementary information that make experts in this field confident regarding the mental health benefits of these treatments. These studies are additionally supplemented by decades of clinical experience from experts around the world who care for adolescents with gender dysphoria.

12. The State's experts devote many pages to quarreling with individual studies' methodologies. All studies in medicine have strengths and weaknesses, and one must examine the body of literature as a whole to draw conclusions. Examining the body of literature regarding gender-affirming medical care for adolescent gender dysphoria as a whole provides a rich scientific perspective, linking these treatments to clear mental health benefits.

13. The State's experts often discuss the concept of "confounding" variables—the notion that certain *other variables* that are related to gender-affirming care and mental health outcomes may be the true reason for observed mental health benefits. The question of "confounding effect" has been examined in several ways. For instance, a 2022 paper from my research group that assessed the relationship between treatment with gender-affirming medical interventions and improved mental health statistically adjusted for a range of potentially confounding variables including age, gender identity, sex assigned at birth, sexual orientation,

[5] van der Miesen, A. I., Steensma, T. D., de Vries, A. L., Bos, H., & Popma, A. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health*, *66*(6), 699-704.

[6] Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, *17*(1), e0261039

race/ethnicity, level of family support for gender identity, relationship status, level of education, employment status, household income, having ever received pubertal suppression, having ever been exposed to gender identity conversion efforts, and having experienced any harassment based on gender identity in school.[7] Even after adjusting for these potential confounding factors, the study found that treatment with gender-affirming medical care during adolescence was associated with lower odds of adverse mental health outcomes.

14. A potential confounder that the State's experts raise in particular is whether or not participants received supportive psychotherapy in addition to gender-affirming medical care. Of note, there is no evidence-based psychotherapy that treats gender dysphoria itself, so such therapy is generally aimed at supporting the patient in general with their mental health. Some studies assessing gender-affirming medical care in adolescents have taken psychotherapy into account and found that benefits seen were not explained by the psychotherapy. Costa et al.[8] examined two cohorts of adolescents with gender dysphoria. Both cohorts received six months of supportive psychotherapy for the initial six months of the study. For the next twelve months, one group continued to receive supportive psychotherapy alone (the "delayed eligible" group), while the other received supportive psychotherapy *and* pubertal suppression (the "immediately eligible" group). The delayed eligible group had statistically significant improvement in global functioning after six months of psychotherapy alone. Of note, this supportive psychotherapy was aimed at improving mental health generally, not gender dysphoria specifically. The delayed eligible group

[7] Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, *17*(1), e0261039.

[8] Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *The Journal of Sexual Medicine*, *12*(11), 2206-2214.

likely had worse mental health at baseline and thus was more likely to have their mental health improve with therapy. The "immediately eligible" group, which was deemed eligible for puberty blockers likely in part because their other mental health conditions besides gender dysphoria were reasonably well-controlled, did not see an improvement with therapy over these first six months. For the next twelve months of the study, the delayed eligible group that continued to receive psychotherapy alone saw no further improvement in their mental health. However, the immediately eligible group that received pubertal suppression in addition to psychotherapy saw statistically significant improvement in their global mental health functioning. This shows that pubertal suppression alleviated psychological distress that supportive psychotherapy alone could not—presumably gender dysphoria-related distress, given the mechanism of the medication. A study by Tordoff et al. similarly examined psychotherapy as a potentially confounding variable and their results showed that mental health improvements seen were not from psychotherapy alone.[9] Another study by Achille et al. [10] ran regression analyses in order to separate out the impacts of gender-affirming medical interventions from the impact of counseling and psychiatric medications. Though the sample size made it statistically difficult to detect differences, pubertal suppression was associated with better scores on the Center for Epidemiology Studies Depression Scale for participants assigned male at birth, which was a statistically significant finding.[11]

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[9] Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open*, *5*(2), e220978.

[10] Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. *International Journal of Pediatric Endocrinology*, *2020*(8). doi: 10.1186/s13633-020-00078-2.

[11] It is important to note that in statistics, a statistically significant finding tells you that a finding is likely to represent a true effect and the finding was not due to random chance. In contrast, the lack of a statistically significant finding does not tell you one way or another if there is an effect. I would caution against over-interpreting non-statistically significant findings. Lack of a

15. As discussed above, Dr. Cantor is likely correct (Cantor, ¶ 196) that the pubertal suppression plus therapy group in Costa was different from the therapy alone group in that the latter group had other mental health concerns. However, this would mean that this group would be even more likely to respond well to psychotherapy than the therapy plus pubertal suppression group—as the study found in the first six months of psychotherapy alone; the pubertal suppression plus therapy had improvement over the latter course of the study when pubertal suppression was added, whereas the therapy alone group did not.[12] Again, this speaks to the mental health benefits of pubertal suppression for gender dysphoria, separate from the impact of supportive psychotherapy.

16. Of note, Dr. Cantor asserts that Carmichael et al. 2021[13] supersedes the results of Costa et al. 2015 because "neither group actually had experienced any significant improvement at all." (Cantor, ¶196). He failed to recognize that the Carmichael study did find that global functioning scores improved; however, for reasons not clearly outlined in the Carmichael study,

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statistically significant finding does not mean that no effect exists; it simply means the analysis in question does not tell the researchers one way or another if an effect exists.

[12] Dr. Cantor also references a letter to the editor about the Costa study that mentions the "dropout" rate being high (Cantor, ¶ 196). However, the dropout rate is nearly identical in the two groups, and there is no clear reason to think that the dropout rates would have thus impacted the results. If one had seen, for instance, that the dropout rate was much higher in the pubertal suppression group, one may think that people were leaving the study due to adverse effects of treatment; however, this was not seen in the study—the dropout rates were nearly identical in both groups. Biggs, M. (2019). A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, *16*(12), 2043.

[13] Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., Viner, R. M. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One*, *16*(2), e0243894.

the authors did not run statistical analyses on this measure, as they did in the Costa 2015 publication.[14]

17. Dr. Cantor raises the possibility that the studies finding benefits of gender-affirming medical care for adolescents reflect reverse causation (*i.e.,* the notion that improved mental health causes one to access gender-affirming medical care rather than the reverse, that gender-affirming medical care leads to better mental health). (*See* Cantor, ¶ 61). This issue has been examined in the literature. For example, in a recent major publication in *The New England Journal of Medicine*, Chen et al. used a technique called parallel process modeling and found that improvements in mental health tracked along with improvements in appearance congruence over time (a measure of the degree to which study participants' bodies aligned with their gender identities), suggesting that gender-affirming medical care was the cause of the improvements in mental health, and arguing against the notion of reverse causation.[15]

18. The State's experts spend a great deal of time focusing on the lack of randomized controlled trial ("RCT") studies in this area. First, controlled cross-sectional studies and uncontrolled longitudinal cohort studies are well-accepted in medical research and often relied upon in medicine. It is true that randomized controlled trials provide valuable information and strong evidence of causation that other studies do not. But such studies are not always feasible or ethical in medicine, and many treatments are provided without the benefit of randomized

[14] The discussion in the Carmichael study goes on to say, "Participant experience of treatment as reported in interviews was positive for the majority, particularly relating to feeling happier, feeling more comfortable, better relationships with family and peers and positive changes in gender role" and that their lack of statistically significant findings for other measures that were statistically analyzed "may relate simply to sample size."

[15] Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A.C., & Olson-Kennedy, J. (2023). Psychosocial functioning in transgender youth after 2 years of hormones. *New England Journal of Medicine*, *388*(3), 240-250.

controlled trials. Randomized controlled trials are not feasible in the realm of gender-affirming medical care for adolescent gender dysphoria in particular. Because of the existing body of literature linking gender-affirming medical care to improved mental health outcomes for adolescents with gender dysphoria, it would be extraordinarily difficult to recruit people to participate in studies, knowing they could be randomized to receive no treatment. Particularly for vulnerable and pediatric populations, is not considered ethical to randomize patients to placebo treatments when there is substantial evidence that active treatment confers important benefits. Thus, a randomized controlled trial of gender-affirming medical care for adolescent gender dysphoria would be unlikely to be approved by an Institutional Review Board (IRB), the ethical boards at universities that decide if research is allowed to proceed). [16]

19. The State's experts also claim that data based on self-report and surveys are not valid or reliable evidence. Their claims represent a broad misunderstanding of psychiatry. Clinical psychiatry and clinical psychiatric research almost always involve patient reports of their symptoms. Because psychiatric conditions (*e.g.*, generalized anxiety disorder, major depressive disorder, schizophrenia, obsessive compulsive disorder, and gender dysphoria, among many others) do not have laboratory tests, diagnosis is made largely based on patient reports of their symptoms. At times these may be supplemented by reports from parents and clinician observations, particularly for establishing a diagnosis; however, they are not considered standard

[16] Of note, an RCT was recently conducted in Australia among adults with gender dysphoria to examine the impact of testosterone therapy. Nolan, B. J., Zwickl, S., Locke, P., Zajac, J. D., & Cheung, A. S. (2023). Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinization: A Randomized Clinical Trial. *JAMA Network Open*, *6*(9), e2331919. The RCT found that those randomized to immediate testosterone therapy had better mental health outcomes than those randomized to the clinic's regular waitlist. Given that they are a vulnerable group that generally warrants stricter protection under IRB review, it is unlikely that such an RCT would be approved for minors.

or necessary in clinical trials that track symptoms over time or compare the mental health of those receiving treatment to those not receiving treatment. The studies cited in this declaration utilize commonly used and validated self-report psychometric measures including the Kessler-6 measure of past-month severe psychological distress,[17] Beck Depression Inventory II,[18] and self-report measures from the National Institutes of Health Toolbox Emotion Battery.[19] These self-report instruments are standard in psychiatric research.

20. Survey methodologies are widely used in psychiatric research. Of note, the State's experts repeatedly cite survey research in their own reports (*e.g.,* Littman 2018,[20] Diaz 2023,[21] Littman 2021[22]). It is worth highlighting that there exist both high-quality and low-quality survey

[17] Kessler, R. C., Green, J. G., Gruber, M. J., Sampson, N. A., Bromet, E., Cuitan, M., Furukawa, T.A., Gureje, O., Hinkov, H., Hu, C., Lara, C., Lee, S., Mneimneh, Z., Myer, L., Oakley-Browne, M., Posada-Villa, J., Sagar, R., Viana, M. C., & Zaslavsky, A. M. (2010). Screening for serious mental illness in the general population with the K6 screening scale: results from the WHO World Mental Health (WMH) survey initiative. *International Journal of Methods in Psychiatric Research*, *19*(S1), 4-22.

[18] Beck, A. T., Steer, R. A., & Brown, G. (1996). Beck depression inventory–II. *Psychological Assessment*.

[19] Slotkin, J., Nowinski, C., Hays, R., Beaumont, J., Griffith, J., Magasi, S., & Gershon, R. (2012). NIH Toolbox scoring and interpretation guide. *Washington (DC): National Institutes of Health*, 6-7.

[20] Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, *13*(8), e0202330.

[21] Diaz, S. & Bailey, J. M. (2023). Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. *Archives of Sexual Behavior*, *52*(3), 1031-1043. This article was later retracted by the journal. Diaz, S. & Bailey, J. M. (2023). Retraction Note: Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. *Archives of Sexual Behavior*, doi: 10.1007/s10508-023-02635-1.

[22] Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior*, *50*(8), 3353-3369.

methodologies. For example, Littman 2018 has been criticized for asking leading questions to a group that is ideologically focused, making it easy for participants to bias results and analyses.[23] In contrast, the 2015 US Transgender Survey had over 180 questions across 32 sections.[24] If participants were to attempt to bias the results in a certain direction, they would have needed to answer questions at distant parts of the survey in a particular fashion, based on what study design they believed researchers would use. Our group's analyses also utilized regression analyses that adjusted for a range of potentially confounding variables, further adding to the complexity of the analyses. Of note, the analysis plans for our group's studies were designed only after the 2015 USTS was already administered.

21. The State's experts' opinions concerning the evidence related to gender-affirming medical care and its impact on suicidality demonstrate a lack of understanding of suicidality research. Dr. Weiss and Dr. Cantor focus on a lack of data showing elevated rates of completed suicides among youth with gender dysphoria, at least as compared to youth with other mental health disorders. (Weiss, ¶ 89; Cantor, ¶¶ 147–53). It is true that there is a paucity of literature in this regard. Such research is often conducted by examination of death records, and because gender identity is rarely recorded on such records, this research has been difficult to conduct. However, there have been studies showing lower odds of suicidal ideation among those who receive treatment.[25] The suggestion that there is not really an elevated risk of suicide because the data we

[23] Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, *13*(8), e0202330; Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, *14*(3), e0214157.

[24] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

[25] See for example Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, *145*(2), e20191725 in the realm of cross-sectional studies and Allen, L. R., Watson, L. B., Egan, A. M., & Moser, C. N.

have is about suicidal ideation and not completed suicides demonstrates a profound lack of understanding of suicidality. Moreover, suicidal ideation is an indicator of severe psychological distress, rising to the level of the individual not wanting to live. Whether or not it ultimately results in a completed suicide, suicidal ideation is a serious negative outcome to be prevented. Reducing suicidal ideation is an important goal of mental health treatment, and it is vital for patients to have access to interventions that that reduce suicidal ideation.

22. The State's experts highlight that rates of suicidality are elevated among transgender people after gender-affirming care and Dr. Weiss even suggests that gender-affirming medical care "may increase the risk of suicide." (Weiss, ¶ 90). For example, he highlights a study by Dhejne et al. published in 2011[26] that found that those who had gender-affirming surgery had a 19-fold increased odds of suicidality when compared to the general population. Such statistics are not evidence that gender-affirming care is ineffective or that it increases suicide risk. The discussion from that very study explains:

> "It is therefore important to note that the current study is only informative with respect to transsexual persons health after sex reassignment; no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism. In other words, the results should not be interpreted such as sex reassignment *per se* increases morbidity and mortality. Things might have been even worse without sex reassignment. As an analogy, similar studies have found increased somatic morbidity, suicide rate, and overall mortality for patients treated for bipolar disorder and schizophrenia. This is important information, but it does not follow that mood stabilizing treatment or antipsychotic treatment is the culprit."

(2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology*, *7*(3), 302-311 in the realm of longitudinal studies.

[26] Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS One*, *6*(2), e16885.

In other words, though gender-affirming care improves mental health, it does not eliminate other factors like societal experiences of transphobia that adversely impact mental health. To evaluate if gender-affirming medical care is helpful to mental health using a control group, the control group would need to be transgender people who desired but did not access the treatment, not the general population. Almazan & Keuroghlian used that appropriate control group in a study published in *JAMA Surgery* in 2021[27] and found that access to gender-affirming surgery was associated with lower odds of past-year suicidal ideation. They further conducted post-hoc analyses that argued against the possibility of reverse causation (*i.e.,* they showed that people who received surgery had better mental health after the treatment, rather than having better mental health at baseline prior to having the surgery).

THE STATE'S EXPERTS' CLAIM THAT IDAHO'S BAN ON GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENT GENDER DYSPHORIA IS CONSISTENT WITH INTERNATIONAL CONSENSUS IS NOT ACCURATE

23. The State's experts rely on reports from some European countries and imply that Idaho's ban on gender-affirming medical care is in line with "international consensus." (*See* for example Cantor, ¶¶ 17-33).[28] This is not accurate. *None* of these countries have banned—let alone

[27] Almazan, A. N., & Keuroghlian, A. S. (2021). Association between gender-affirming surgeries and mental health outcomes. *JAMA Surgery*, *156*(7), 611-618.

[28] For example, Cass, H. (2022, February). The Cass Review: Independent review of gender identity services for children and young people Interim report. National Health Service (NHS), UK (England); COHERE Finland (Council for Choices in Health Care in Finland) (2020, June 16). Medical treatment methods for dysphoria associated with variations in gender identity in minors—Summary of a recommendation. [Translated], *available at* https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474 (Finland); Swedish Socialstyrelsen. (2022, February 22). Uppdaterade rekommendationer för hormonbehandling vid könsdysfori hos unga. [Updated recommendations for hormone therapy for gender dysphoria in young people.], *available at* https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdateraderekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/ (Sweden); Swedish Socialstyrelsen. (2022, December). Care of children and adolescents with gender dysphoria. Summary of national guidelines, *available at*

criminalized—gender-affirming medical care for adolescents with gender dysphoria as Idaho does. Rather, the government health authorities in the select countries referenced have made changes to the way in which gender-affirming care is being delivered (*e.g.,* moving care to research settings where more data can be collected).[29] Rather than put it in line with "international consensus," Idaho's ban on gender-affirming medical care for adolescent gender dysphoria puts the law squarely outside of mainstream medical views and policies around the world.

24. The State's experts focus on the European reports' assessment of the body of research on gender-affirming care for minors. Of note, most of these reports were not peer-reviewed and were published by government entities.[30] These types of government reports are not the types of research that experts rely upon when forming conclusions about research. Moreover, they do not include all of the relevant literature. The State's experts attempt to bolster the importance of these reports by calling them "systematic reviews." But all a "systematic review" means is that the authors of the reports pre-defined the search terms they used when conducting literature reviews in various databases.[31] Merely pre-defining search terms does not guarantee that

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https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf (Sweden); French Academy of Medicine. (2022) Medicine and gender transidentity in children and adolescents, *available at* https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en.

[29] Contrary to the suggestion of Dr. Weiss (¶ 168), that gender services for minors have been shut down in the U.K., the National Health Service replaced a centralized clinic with several regional clinics.

[30] The one exception is that the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) published its systematic review in the journal *Acta Paediatrica*, a Swedish medical journal that appears to be peer-reviewed. *See* Ludvigsson, J. F., Adolfsson, J., Höistad, M., Rydelius, P.-A., Kriström, B., & Landén, M. (2023). A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. *Acta Paediatrica.* doi: 10.1111/apa.16791.

[31] Harvard Countway Library. Systematic Reviews and Meta Analysis Q&A. Accessed: October 1, 2023, *available at* https://guides.library.harvard.edu/meta-analysis/GettingStarted.

the systematic review will identify the full body of relevant literature,[32] nor does it tell you anything about the reliability of the review authors' description and analysis of the literature. The primary advantage to a systematic review would be its potential (though no guarantee) to identify research publications that had not previously been identified in this discussion. The reports cited by the State's experts did not identify any such new research reports that affect my conclusions about the research.

THE STATE'S EXPERTS HAVE INAPPROPRIATELY APPLIED RESEARCH ON PREPUBERTAL CHILDREN TO TRANSGENDER ADOLESCENTS IN CLAIMING THAT THERE IS A HIGH LIKELIHOOD OF "DESISTANCE" AMONG ADOLESCENTS WITH GENDER DYSPHORIA

25. Dr. Cantor inappropriately uses studies of young prepubertal children to imply that adolescents who are candidates for gender-affirming medical care are likely to desist if not provided with gender-affirming care. (Cantor, ¶115). Though the terms "children" and "adolescents" are sometimes used synonymously in common parlance, these terms have specific and distinct meanings in the context of child and adolescent psychiatric research. In this field, "child" and "children" refer to minors who have not yet reached the earliest stages of puberty (*i.e.*, Tanner 2). The terms "adolescent" and "adolescents" refer to minors who have begun puberty. Studies of prepubertal children (who are not candidates for gender-affirming medical interventions under *any* existing clinical guidelines) cannot be conflated with studies of adolescents (who,

[32] This is the case with a Cochrane review abstract from 2020 cited by Defendants' experts regarding gender-affirming hormone therapy among transgender women (Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz, S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *Cochrane Database of Systematic Reviews*, *2020*(11), CD013138). The Cochrane review did not identify several cohort studies examining gender-affirming medical care for adolescent gender dysphoria, likely due to its search methodology, and because it only examined studies published prior to 2019.

depending on several factors, *may* be candidates for various forms of gender-affirming medical interventions).

26. This distinction is vital in the realm of "desistence" studies (*i.e.*, studies that aim to assess how many young people who identify as transgender will later identify as cisgender). The suggestion by Dr. Cantor that a majority of transgender minors affected by the Idaho law will come to identify with their assigned sex at birth inappropriately relies on studies of gender diverse *prepubertal* children, which have, in the past, shown that many of these children will not grow up to be transgender. These studies do not apply to transgender minors who have reached puberty (*i.e.*, "adolescents").[33] Once a transgender youth begins puberty, it is extremely rare for them to later identify as cisgender.[34] The notion that puberty will generally result in transgender people coming to identify as cisgender is also clearly not true given the fact that there are over 1 million transgender adults in the U.S.[35] and the vast majority of older cohorts were unable to access pubertal suppression.[36]

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[33] Dr. Cantor suggests that the desistance studies are not irrelevant to adolescents because they do not specify at what developmental stage the reported desistance occurred. (Cantor, ¶119). But those studies say nothing about whether desistance is common among adolescents with gender incongruence.

[34] See Turban, J.L., de Vries, A.L.C., & Zucker, K. (2018). Gender Incongruence & Gender Dysphoria. In Martin A., Bloch M.H., & Volkmar F.R. (Editors): *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook, Fifth Edition*. Philadelphia: Wolters Kluwer. This textbook chapter provides comment from the directors of two of the oldest and most established gender clinics in the world.

[35] Flores, A. R., Herman, J., Gates, G. J., & Brown, T. N. (2016). *How many adults identify as transgender in the United States?* (Vol. 13). Los Angeles, CA: Williams Institute.

[36] See, for example, Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, *145*(2), e20191725, which found that only 2.5% of those who desired pubertal suppression for gender dysphoria were able to access it.

27. Any study regarding prepubertal children and their likelihood of ultimately identifying as transgender should not be used to assess the interventions targeted by the Idaho law, namely, pubertal suppression, gender-affirming hormones, and gender-affirming surgery, since none of these interventions are provided to prepubertal patients under current medical guidelines.[37]

28. Further, the utility of "desistence" studies even for predicting the future gender identity of prepubertal children is not appropriate due to their reliance on an outdated diagnosis of "gender identity disorder in children," which did not require a child to identify as a sex different than their sex assigned at birth. This diagnosis likely captured many cisgender "tomboys" or cisgender boys with feminine interests like dresses or dolls who never identified as transgender to begin with and, thus, unsurprisingly did not identify as transgender when followed up with later in life. In fact, an analysis of the so-called "desistence" studies found that, when asked their gender identity, 90% of the children with "gender identity disorder" in these studies reported an answer that aligned with their sex assigned at birth.[38] In contrast, the diagnosis of "gender dysphoria in children" requires one to not merely have gender atypical interests and behaviors; one must identify as a gender different than one's sex assigned at birth. This is a vital distinction. While the diagnostic category of "gender identity disorder" would capture many cisgender children, the diagnostic category of "gender dysphoria" from the DSM-5, by definition, does not. [39]

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[37] Hembree, W.C., Cohen-Kettenis, P.T., Gooren, L., *et al*. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinology & Metabolism*, 102(11), 3869-3903.

[38] Olson, K. R. (2016). Prepubescent Transgender Children: What We Do and Do Not Know. *Journal of the American Academy of Child and Adolescent Psychiatry*, *55*(3), 155-156.

[39] For more information on the limits of "desistence studies" see Olson, K.R. (2016). Prepubescent Transgender Children: What We Do and Do Not Know. *Journal of the American Academy of Child & Adolescent Psychiatry*, 3(55), 155-156.

THE STATE'S EXPERTS' ASSERTION THAT GENDER AFFIRMING CARE CAUSES PERSISTENCE OF GENDER INCONGRUENCE IS NOT SUPPORTED BY EVIDENCE

29. The State's experts suggest that gender affirming care, including social transition, causes the persistence of gender incongruence among youth. Despite Dr. Cantor spending a considerable portion of his declaration on the importance of differentiating correlation from causation, he does not apply that to the findings that social transition is correlated with "persistence." He outlines data showing that youth who socially transition are more likely to continue to identify as transgender later in life (*i.e.,* correlation). But this correlation could be due to two possibilities: (1) social transition could influence a child's gender identity, making them identify more strongly as transgender and thus more likely to persist, or (2) children who go on to socially transition identified more strongly as transgender than those who did not *prior* to social transition, and thus their pre-transition gender incongruence lead to the social transition in the first place.

30. Research by Rae et al. has shown that the second possibility is far more likely to be what is occurring.[40] Rae et al.'s 2019 study showed that gender identification is not significantly different before and after a social transition, but that those who ultimately underwent a social transition had a greater degree of gender incongruence *prior to social transition*.[41] The study made clear that this correlation—between pre-pubertal social transition and transgender identity—is because those who undergo a pre-pubertal social transition had stronger discordance between

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

[41] Note that in most studies, a lack of a statistically significant finding is not informative. This study used sophisticated Bayesian statistics to show that gender identification was not different before and after a social transition. Such a finding of something not being different is, under these methods, reliable.

their sex assigned at birth and their gender identity to begin with, and that social transition itself does not appear to increase gender discordance.

31. The State's experts also point to studies showing that the overwhelming majority of transgender adolescents who start pubertal suppression go on to future additional gender-affirming medical interventions, suggesting that pubertal suppression causes continued gender incongruence. (*E.g.*, Weiss, ¶119, referring to a "conveyer belt of 'gender transition'"). It is another logical fallacy to infer that a study showing that the majority of adolescents on puberty blockers proceeding on to future gender-affirming medical interventions is evidence that the treatment causes persistence; rather, it is just as possible, and in my opinion more likely, that, given the comprehensive biopsychosocial mental health assessment that is done prior to starting gender-affirming medical interventions under current guidelines, the adolescents who started pubertal suppression were those who were, through medical and mental health screening, determined, prior to starting pubertal suppression, to have a low likelihood of future desistence in their transgender identity.

THE STATE'S EXPERTS' SUGGESTION THAT PATIENTS SEEK GENDER-AFFIRMING MEDICAL CARE BECAUSE OF SOCIAL INFLUENCE IS WITHOUT BASIS

32. The State's experts claim that social influence is responsible for adolescents seeking gender-affirming medical care and is a cause of "rapid-onset gender dysphoria". (Cantor ¶ 136; Weiss ¶¶ 35, 106.)

33. As an initial matter, Defendants' experts fail to note that "rapid-onset gender dysphoria" is not a recognized mental health condition.[42] The term "rapid-onset gender dysphoria"

[42] Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, *14*(3), e0214157.

entered the literature in 2018 through a publication by Dr. Lisa Littman, discussed briefly above.[43] Soon after the initial publication of Dr. Littman's article, a correction was published.[44] The correction noted, "Rapid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis at this time. This report did not collect any data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon."[45] The correction goes on to say "the term should not be used in any way to imply that it explains the experiences of all gender dysphoric youth . . . ." The American Psychological Association has highlighted that, due to the lack of empiric basis, "rapid-onset gender dysphoria" should not be used in assessment or clinical treatment contexts.[46] Despite this, the State's experts cite the 2018 Littman article to make unsubstantiated claims about adolescents with gender dysphoria.

34. The Littman study was an anonymous online survey of the parents of transgender youth, recruited from websites where this notion of "social contagion" leading to transgender identity is popular. The anonymous survey participants were asked what they thought was the

[43] Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, *13*(8), e0202330.

[44] Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, *14*(3), e0214157.

[45] A recent study by Bauer et al. in *The Journal of Pediatrics* examined some of the associations that would be consistent with the existence of "rapid-onset gender dysphoria" and concluded that their results "did not support the rapid onset gender dysphoria hypothesis." Bauer, G. R., Lawson, M. L., Metzger, D. L., & Trans Youth CAN! Research Team. (2022). Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"?. *Journal of Pediatrics*, *2022*(243), 224-227. Two recent publications from our group similarly did not support the notion: Turban, J. L., Dolotina, B., King, D., & Keuroghlian, A. S. (2022). Sex assigned at birth ratio among transgender and gender diverse adolescents in the United States. *Pediatrics*, *150*(3), e2022056567 and Turban, J. L., Dolotina, B., Freitag, T. M., King, D., & Keuroghlian, A. S. (2023). Age of Realization and Disclosure of Gender Identity Among Transgender Adults. *Journal of Adolescent Health*, *72*(6), 852-859.

[46] American Psychological Association et al. CAAPS Position Statement on Rapid Onset Gender Dysphoria (ROGD). Available at: https://www.caaps.co/rogd-statement. Accessed: October 1, 2023.

etiology of their children's transgender identity. Some of these parents believed that their children became transgender as a result of watching transgender-related content on websites like *YouTube* and having LGBTQ friends. The alternative interpretation, and in my opinion more likely interpretation, is that these youth sought out transgender-related media and LGBTQ friends because they wanted to find other people who understood their experiences and could offer support. The parent respondents also noted that, from their perspective, their children became transgender "all of a sudden," hence the term "rapid-onset." Once again, the problem here is that the study did not interview the adolescents themselves, nor their healthcare providers. It is common for transgender (as with gay, lesbian and bisexual) children and adolescents to conceal their identity from their parents for long periods of time. In a recent study from our research group, transgender people who first understood their gender identity in childhood waited a median 14 years before sharing this with another person.[47] In my experience working with transgender youth and adults, the reasons for this tend to be out of fear of negative repercussions (rejection, being kicked out of the house, or even physical assault) were their parents to find out that they are transgender. Children often learn to conceal their gender non-conforming behaviors and transgender identity early, particularly if their parents have strong negative reactions to them exhibiting gender non-confirming behavior.

35. The State's experts point to the increase in referrals to gender clinics, particular among birth-assigned females, over time as a point of concern. (*E.g.*, Cantor, ¶17, ¶25; Weiss ¶179). The increase in referrals has coincided with increased visibility of transgender people, including transgender men, in society and greater awareness of gender dysphoria and access to

[47] Turban, J. L., Dolotina, B., Freitag, T. M., King, D., & Keuroghlian, A. S. (2023). Age of Realization and Disclosure of Gender Identity Among Transgender Adults. *Journal of Adolescent Health*, *72*(6), 852-859.

medical care to treat it. In the past, people thought of gender dysphoria as something that primarily impacted birth-assigned males. This likely led to many cases of gender dysphoria among birth-assigned females being overlooked by families or undiagnosed or "missed" by doctors. In recent years, literacy regarding gender dysphoria among birth-assigned females has increased among physicians. As fewer birth-assigned females go undiagnosed, the sex ratio in gender clinics has shifted away from predominantly birth-assigned males. This is similar to a pattern that has been seen in autism spectrum disorder. For example, a large study found that with increasing awareness that autism spectrum disorder can impact birth-assigned females as well as birth-assigned males, the sex ratio shifted more toward birth-assigned females, from 5.1:1 (birth-assigned males to females) to 3.1:1.[48] The same study saw the sex ratio for the related diagnosis of Asperger's syndrome similarly shift from 8.4:1 to 3.0:1. Whereas parents and pediatricians in the past may have had limited literacy regarding gender diversity in adolescents, today more Americans, as well as people abroad, have greater understanding of the experiences of transgender youth. This fact has undoubtedly increased the number of parents bringing their adolescents to gender clinics for evaluation and pediatricians referring patients to gender clinics. Additionally, insurance coverage of gender-affirming medical interventions has improved drastically, meaning that more families are able to afford care, which results in an increase in referrals for evaluation.

36. Of note, not all adolescents who present at gender clinics ultimately go on to receive gender-affirming medical interventions.[49] In fact, in a large study from a Netherlands gender

[48] Jensen, C. M., Steinhausen, H. C., & Lauritsen, M. B. (2014). Time trends over 16 years in incidence-rates of autism spectrum disorders across the lifespan based on nationwide Danish register data. *Journal of Autism and Developmental Disorders*, *44*(8), 1808-1818.

[49] Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M. B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels, B. P. C., & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study

clinic, the percentage of patients who presented for evaluation who actually started any kind of gender-affirming treatment has decreased over time.[50] The authors of that study note:

> "[T]his finding may be explained by the fact that in the past it was harder to find information about [gender dysphoria] and its treatment, and only people with extreme types of [gender dysphoria] managed to visit our gender identity clinic for treatment. Currently, owing to media attention and the internet, it is easier to access information about our gender identity clinic, making the threshold lower to search for help."

This shows that while more people may be coming in for evaluation, the criteria for diagnosis and treatment remain stringent and a smaller percentage of patients are actually being diagnosed with gender dysphoria and referred on for medical treatment.

THE STATE'S EXPERTS ASSERTIONS OF HIGH RATES OF TRANSITION REGRET ARE UNSUPPORTED BY THE EVIDENCE

37. The State's experts suggest that a large number of adolescents who undergo gender-affirming medical care go on to regret treatment; however, this is not supported by extant evidence. In 2018, Amsterdam's VUMC Center of Expertise on Gender Dysphoria published the rates of regret among their cohort of 6,793 transgender patients who had undergone gender-affirming medical and surgical interventions.[51] Among transgender women with gender dysphoria who underwent gender-affirming surgery, 0.6% experienced regret. Among transgender men with

(1972–2015): trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, *15*(4), 582-590.

[50] Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M. B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels, B. P. C., & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, *15*(4), 582-590.

[51] Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M. B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels, B. P. C., & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, *15*(4), 582-590.

gender dysphoria who underwent gender-affirming surgery, 0.3% experienced regret. Several of those who experienced regret were classified as having "social regret" rather than "true regret," defined in the study as still identifying as transgender but deciding to reverse their gender-affirming surgery due to factors like "the loss of relatives [being] a large sacrifice." The study also reported that only 1.9% of adolescents who started pubertal suppression did not choose to go onto gender-affirming hormones. In a second study of 143 transgender adolescents who started pubertal suppression, 5 (3.5%) decided not to proceed with further gender-affirming medical treatments.[52] One of these adolescents noted that pubertal suppression helped them to better understand their gender identity, and they ultimately identified with their sex assigned at birth. One birth-assigned female had ongoing chest dysphoria but chose to live with a female gender expression regardless, though was dreading further breast development and menstruation. One stopped due to unspecified "psychosocial reasons" but continued to identify as transgender. One identified as gender non-binary and felt they no longer needed treatment. One came to identify with his sex assigned at birth. There was no indication that any of these adolescents *regretted* pubertal suppression; rather, this study shows that the treatment served its goal of allowing adolescents more time to better understand their gender identity before being assessed for additional treatment.

38. The State's experts cite some studies discussing rates of discontinuing gender-affirming medical interventions. For example, Dr. Weiss cites findings from a study by Roberts et al. published in 2022 that "[a]mong those who had started hormonal intervention before age eighteen, 26% discontinued treatment. Among all the natal females in this follow up study, 36%

[52] Brik, T., Vrouenraets, L. J., de Vries, M. C., & Hannema, S. E. (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. *Archives of Sexual Behavior*, 49(7), 2611-2618.

discontinued treatment."[53] (Weiss, ¶159). It is essential to note that discontinuation of a medication does not necessarily indicate regret. This study examined only rates of discontinuation, not *reasons* for discontinuation. Reasons for discontinuing can include satisfaction with degree of physical gender congruence already attained, social stress related to transphobia, or financial reasons like loss of insurance. As the paper notes, in citing our 2021 publication in the journal *LGBT Health*, "many individuals who report [stopping] gender-affirming hormones [report] subsequently restarting treatment or the intention to restart treatment."

39. Dr. Weiss also failed to mention that the Roberts study found that discontinuation rates were lower among those who started gender-affirming medical care as minors when compared to those who started as adults, likely due to the comprehensive psychosocial mental health evaluations conducted prior to initiating care. The publication's discussion section notes, "Regardless of the reason for the higher hormone continuation rate among TGD youth, this finding provides support for the idea that TGD individuals below the age of legal majority, with the assistance of their parents or legal guardians and health care providers, can provide meaningful informed assent for gender-affirming hormones and do not appear to be at a higher risk of future discontinuation of gender-affirming hormones because of their young age alone."

40. The State, on page nine of its combined memorandum of law in opposition to motion for preliminary injunction and in support of motion to dismiss, asserts that a paper by Hall et al. shows that "the medical detransition rate among youth who underwent gender transitions in recent years may be as high as 30% . . ." The cited paper shows no such thing. First, this was a study of adults, not youth. Second, the study did not find a detransition rate of 30%. The paper

[53] Roberts, C. M., Klein, D. A., Adirim, T. A., Schvey, N. A., Hisle-Gorman, E. (2022). Continuation of Gender-affirming Hormones among Transgender Adolescents and Adults. *Journal of Clinical Endocrinology & Metabolism*, *107*(9) e3937-e3943.

notes, "twelve cases (12/175, 6.9%) were agreed by all authors to meet the case definition for detransitioning. Regret was specifically documented in two cases [1.1%]"[54] Also of note in this study is that the authors did not record reasons for detransition (defined in this study as going back to presenting as one's sex assigned at birth). The State also cites a press release from the French Academy of Medicine, which, though it states there is an "increasing number of transgender young adults wishing to "detransition," provides no detransition rate, nor any citation that shows this is true.[55] One of the few citations the press release does provide is to the 2018 Littman paper I discuss above.[56]

41. In a peer-reviewed manuscript that was named Best Clinical Perspectives Manuscript of the year by *The Journal of The American Academy of Child & Adolescent Psychiatry*, Dr. Alex Keuroghlian and I created a framework for understanding transgender adolescent patients who discontinue gender-affirming medical interventions.[57] We explained that this may be due to external factors (*e.g.*, pressure from family, societal rejection, harassment by peers) or internal factors (*e.g.*, a change in the understanding of one's gender identity). We highlighted that discontinuation of gender-affirming medical interventions does not always coincide with a change in understanding of one's gender identity or with transition-related regret.

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[54] Hall, R., Mitchell, L., & Sachdeva, J. (2021). Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: retrospective case-note review. *BJPsych Open*, *7*(6), e184.

[55] French Academy of Medicine. (2022) Medicine and gender transidentity in children and adolescents, *available at* https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en.

[56] The French Academy of Medicine press release itself recommends, "in the event of a persistent desire for transition, a careful decision about medical treatment with hormone blockers or hormones of the opposite sex within the framework of multi-disciplinary consultation meetings."

[57] Turban, J. L., & Keuroghlian, A. S. (2018). Dynamic gender presentations: understanding transition and" de-transition" among transgender youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, *57*(7), 451-453.

Our team later published a study highlighting that a substantial number of currently identified transgender people (13.1%) have "de-transitioned"[58] at some point in their life, with the majority (82.5%) citing external factors like family rejection, societal stigma, or harassment.[59] Given that these people *currently* identify as transgender, it highlights that many people who "de-transition" choose to transition again in the future. This harkens to the history of the "ex-gay" movement in which many gay and lesbian individuals reported that they were "cured" of their homosexuality, only to later reveal that they were still gay but felt pressured by their communities to say for many years that they were not.

42. The State's experts cite two papers discussing the experiences of some individuals who detransitioned, one by Littman and one by Vandenbussche.[60] (Weiss, ¶157). Neither of these papers provide information on the prevalence of detransition or, specifically. the rate of detransition among those who initiate gender-affirming medical care during adolescence. In fact, the introduction of the Littman article states that the paper is not "designed to assess the prevalence of detransition as an outcome of transition." In addition, in the Littman study, 34% of the participants reported that gender-affirming care was "a necessary part of [their] journey." And

[58] This study defined "de-transition" as an affirmative answer to the following: "Have you ever de-transitioned? In other words, have you ever gone back to living as your sex assigned at birth, at least for a while?"

[59] Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health,* 8(4), 273-280.

[60] Littman L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior*, 50(8), 3353–3369; Vandenbussche, E. (2021). Detransition-related needs and support: A cross-sectional online survey. *Journal of Homosexuality*, 69(9), 1602-1620. Of note, of the 237 individuals in the Vandenbussche study, only 25% had medically transitioned as minors and many did not medically transition at all.

among this group of people who de-transitioned, most reported that undergoing gender-affirming medical care was in some way helpful.

43. Dr. Weiss cites Reddit in his attempt to claim there is evidence that rates of detransition and regret among those initiating gender-affirming medical care are high. (Weiss, ¶156). He notes that one Reddit group called r/detrains has over 49,000 members. However, there is no indication that all or even many of the 49,000 members of that group have detransitioned, even if that term is broadly defined. In fact, in reading r/detrans, one will find posts expressing concern that the group has been dominated by members who have not actually detransitioned but rather by "people who are wanting to prey on their vulnerability and use them as political pawns."[61]

44. There are undoubtedly some people who start gender-affirming medical interventions and later stop them. A small minority of these appear to regret the treatment, though differentiating regret related to transphobia from regret related to the treatment itself can be difficult to disentangle. But as I reviewed above, all existing research suggests that regret following gender-affirming medical interventions is rare. As with all medical interventions, gender-affirming medical interventions cannot claim a 100% success rate. However, for the vast majority of adolescents, these interventions improve mental health. Accordingly, it is dangerous to take this option away from families and physicians.

THERE IS NO EVIDENCE-BASED PSYCHOTHERAPY TO TREAT GENDER DYSPHORIA

45. The State's experts suggest that psychotherapy can provide relief for gender dysphoria in lieu of gender-affirming medical care. While psychotherapy can be very helpful for

[61] Post by a member of the Reddit group r/detrans, available at: https://www.reddit.com/r/honesttransgender/comments/k6fidf/rdetrans_is_just_an_antitrans_sub_now/?utm_source=share&utm_medium=web2x&context=3. Accessed: October 1, 2023.

adolescents with gender dysphoria to help explore their gender identity and address comorbid conditions like depression and anxiety, there are no evidence-based psychotherapy protocols that effectively treat gender dysphoria itself.

46. In the past, some clinicians have described psychotherapeutic strategies to attempt to lead youth with gender dysphoria to identify with their sex assigned at birth.[62] Such practices, often referred to as "gender identity conversion efforts", have subsequently been linked to adverse mental health outcomes, including suicide attempts, particularly when people are exposed to them as children.[63] In addition to being harmful, there is no peer-reviewed research to suggest that these gender identity conversion efforts are successful in changing a person from transgender to cisgender.[64]

47. While the State's experts repeatedly criticize the extensive body of research linking gender-affirming medical care to improved mental health outcomes for adolescent gender dysphoria, they do not provide evidence to support their implication that gender dysphoria can be treated with psychotherapy alone.

48. Dr. Weiss asserts that "exploratory, non-judgmental psychotherapy can alleviative suffering in patients with 'gender dysphoria' and may help them accept their natal sex." (Weiss,

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[62] Meyer-Bahlburg, H.F. (2002). Gender Identity Disorder in Young Boys: A Parent-and Peer-Based Treatment Protocol. *Clinical Child Psychology and Psychiatry*, *7*(3), 360-376.

[63] Turban, J.L., Beckwith, N., Reisner, S.L., & Keuroghlian, A.S. (2020). Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. *JAMA Psychiatry*, *77*(1), 68-76.

[64] Gender identity conversion efforts have therefore been labelled unethical by major medical organizations including The American Medical Association and The American Academy of Child & Adolescent Psychiatry. American Medical Association. (2017). Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations. H-160.991. *Available at* https://policysearch.ama-assn.org/policyfinder/detail/gender%20identity?uri=%2FAMADoc%2FHOD.xml-0-805.xml; The American Academy of Child & Adolescent Psychiatry. (2018). Conversion Therapy. *Available at* https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

¶40). Exploratory psychotherapy can be helpful for adolescent patients who are unsure of their gender identity to come to understand it. Dr. Weiss appears to be suggesting that such therapy can help transgender people become cisgender. The sources he cites to support this do no such thing. The first is a letter to the editor that provides no data or evidence to support the assertion.[65] The second is a description of twelve adolescent patients who underwent the psychosocial assessment that is required prior to initiating gender-affirming medical care for adolescent gender dysphoria and ultimately did not pursue gender-affirming medical care.[66] This case series is not evidence that psychotherapy is effective in promoting identification with one's sex assigned at birth, but rather, that the psychosocial evaluation is effective in identifying appropriate candidates for gender-affirming medical care.[67]

CONCLUSION

49. In summary, the declarations from the State's experts do not provide justification for banning gender-affirming medical care for adolescents with gender dysphoria. The scientific evidence that I outlined above shows the benefits of the proscribed care. This research is consistent with the decades of clinical experience from around the world—including my own—of improved mental health outcomes from these interventions. None of the European countries the State's experts cite have banned care. The research the State's experts cite on "desistance" among prepubertal children has no bearing on adolescents with gender dysphoria, and there is no scientific

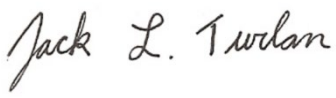
[65] D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, *50*(1), 7-16.

[66] Churcher Clarke, A., & Spiliadis, A. (2019). 'Taking the lid off the box': The value of extended clinical assessment for adolescents presenting with gender identity difficulties. *Clinical Child Psychology and Psychiatry*, *24*(2), 338-352.

[67] Incidentally, it is surprising to see Dr. Weiss rely on this study at all as throughout the remainder of his declaration, he dismisses research that lacks high GRADE-level data.

support for their assertions that providing gender-affirming medical care causes "persistence" of gender incongruence. Nor is there any evidence supporting the State's experts' claims that youth are seeking gender-affirming medical care due to peer and social media influence, or that those who receive care are likely to come to regret it. Finally, there are no evidence-based alternatives for treating gender dysphoria. While the State's experts critique the literature regarding the benefits of gender-affirming medical care, they offer no studies supporting an alternative treatment. The Idaho ban would leave physicians, adolescents, and their parents without any evidence-based treatments for adolescent gender dysphoria, a condition that can cause immense suffering.

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



Executed on: October 13, 2023 JACK L. TURBAN, MD, MHS

Exhibit A

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ACADEMIC APPOINTMENTS

University of California, San Francsisco School of Medicine San Francisco, CA. September 2022-Present
Assistant Professor of Child & Adolescent Psychiatry and Affiliate Faculty in the Philip R. Lee Institute for Health Policy Studies. Responsibilities include serving as director of the gender psychiatry program, and as an attending psychiatrist in the adult gender and sexual minority clinic, and in the eating disorders clinic, as well as research focusing on the determinants of mental health among transgender and gender diverse youth and the teaching of medical students, residents, and fellows.

EDUCATION & TRAINING

Stanford University School of Medicine Palo Alto, CA July 2020-June 2022
Fellow in Child & Adolescent Psychiatry. Fellow in child and adolescent psychiatry. Research focused on pediatric gender identity and LGBTQ mental health. Served as administrative chief fellow 2021-2022.

Massachusetts General Hospital & McLean Hospital Boston, MA July 2017 – May 2020
Integrated Adult, Child, & Adolescent Psychiatry Resident. Resident physician in the integrated adult, child, and adolescent psychiatry program. Research focused on pediatric gender identity and LGBT mental health.

Yale School of Medicine New Haven, CT. August 2012- May 2017
Doctor of Medicine & Master of Health Science with honors. Clinical rotations included inpatient pediatrics, inpatient child psychiatry, inpatient adolescent psychiatry, residential adolescent psychiatry, psychiatric consult liaison service, clinical neuromodulation, neurology clinics, and neurosurgery. Completed award-winning masters' thesis as a Howard Hughes Medical Institute (HHMI) medical research fellow on evolving treatment paradigms for transgender youth.
Clerkship Grades: All Honors
USMLE: Step 1 (252), Step 2 (256)

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

RESEARCH EXPERIENCE

The Fenway Institute Boston, MA 2017-Present
Post-doctoral Research Fellow. Currently using data from the National Transgender Discrimination Survey to determine the adult mental health correlates of recalled childhood experiences including exposure to conversion therapy and access to gender-affirming hormonal interventions. PIs: Timothy Wilens, Alex Keuroghlian, & Sari Reisner

Stanford Division of Child & Adolescent Psychiatry Palo Alto, CA 2020-2022
Post-doctoral Resaerch Fellow. Estabished the Stanford Evaluation of Gender Affirmation (SEGA) study, which examines the impact of gender-affirming medical and surgical interventions on the mental health of transgender and gender diverse youth. Mentors: Dr. David Hong & Dr. Tandy Aye

McLean Institute for Technology in Psychiatry Belmont, MA. 2017-2020
Post-doctoral Research Fellow. Conducted cross-sectional studies that examine the associations between geosocial "hook-up apps," internalizing psychopathology, and compulsive sexual behavior. Utilizing the TestMyBrain platform. PI: Laura Germine

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Yale Program for Research on Impulsivity & Impulse Control Disorders New Haven, CT 2016-2019
Pre-doctoral Research Fellow. Conducted a studies of US military veterans who had recently returned from deployment, studying rates and comorbidities of those veterans who exhibit compulsive sexual behavior facilitated by social media. PI: Marc Potenza MD/PhD

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

Yale Department of Dermatology New Haven, CT 2015-2016
HHMI Medical Research Fellow. Studied the potential molecular mediators of Langerhans Cell-mediated UVB-induced epidermal carcinogenesis. Techniques included transgenic mouse models of chronic UV exposure, epidermal sheet preparations, immunohistochemistry, confocal microscopy, flow cytometry, Bioplex analysis, quantitative PCR and tissue culture. PI: Michael Girardi MD

Yale Department Laboratory Medicine New Haven, CT 2012-2014
Pre-doctoral Research Fellow. Employed mass spectrometry to compare metabolite profiles of recurrent tumor versus radiation-induced necrosis following Gamma Knife Radiosurgery for brain metastases, working to identify novel biomarkers for non-invasive imaging techniques. PI: Tore Eid MD/PhD

Yale Department of Neurosurgery New Haven, CT 2012-2012
Pre-doctoral Research Fellow. Developed a database of patients who received gamma knife radiosurgery or whole brain radiation for the treatment of brain metastases. This database is designed to evaluate the relative risks of radiation-induced necrosis following these two treatment modalities. PI: Veronica Chiang MD

Eaton-Peabody Laboratory Cambridge, MA 2009-2011
Undergraduate Rearch Fellow. Worked at the Massachusetts Eye and Ear Infirmary laboratory, studying stem cells of the inner ear and working toward cochlear hair cell regeneration. PI: Albert Edge PhD

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

LEADERSHIP

UCSF Child & Adolescent Psychiatry Grand Rounds Committee San Francisco, CA. 2023-Present
Member. Works with with committee to select and work with grand rounds speakers for the weekly child and adolescent psychiatry grand rounds series.

UCSF Child & Adolescent Psychaitry Fellowship Selection Committee San Francisco, CA 2022-Present
Member. Conducts interviews for applications to the UCSF child and adolescent psychiatry fellowship training program, sits on selection committee, works on recruitment efforts.

The Upswing Fund 2020-Present
Scientific Advisory Board. Member of the scientific advisory board of a $15M charitable fund to support adolescent minority mental health during the COVID19 pandemic. Funded by Melinda Gates's Panorama Global.

Stanford Medicine Diversity Cabinet LGBTQ+ / Sexual and Gender Minority Subcommittee 2021-2022
Member. Working to improve Stanford School of Medicine in all aspects relevant to sexual and gender minorities including curriculum, clinical care, and employee support.

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Stanford Pediatric Gender Journal Club 2021-2022
Founder. Organizing a monthly journal club focusing on the latest research relevant to the care of transgender and gender diverse youth.

MGH Psychiatry Gender Lab Meetings Boston, MA 2019-2020
Founder. Established monthly lab meetings for those in the MGH psychiatry department to discuss ongoing research regarding transgender mental health.

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

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

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

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

VOLUNTEER WORK & ADVOCACY

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

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

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

Harvard College Admissions New Haven, CT 2012-2020
Interviewer. Interviewing students from the Boston area for admission to Harvard College.

SELECTED PEER REVIEWED PUBLICATIONS: ORIGINAL RESEARCH

Turban J.L., Dolotina B., Freitag T.M., King D., Keuroghlian A.S. Age of realization of transgender identity and mental health outcomes among transgender and gender diverse adults: examining the "rapid onset gender dysphoria" hypothesis. *Journal of Adolescent Health*. [In Press]

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Turban J.L., Dolotina B., King D., Keuroghlian A.S. (2022) Sex assigned at birth ratio among transgender and gender diverse adolescents in the United States. *Pediatrics*. [Accepted]

Turban J.L., King D., Kobe J., Reisner S.L., Keuroghlian A.S. (2022) Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS ONE*, 17(1): e0261039.

Passell E., Rutter L.A., **Turban J.L.**, Scheuer L., Wright N., Germine L. (2021) Generalized Anxiety Disorder Symptoms are Higher Among Same- and Both-Sex Attracted Individuals in a Large, International Sample. *Sexuality Research and Social Policy*. [ePub ahead of print]

Lewis, J. M., Monico, P. F., Mirza, F. N., Xu, S., Yumeen, S., **Turban, J. L.**, Galan A., & Girardi, M. (2021). Chronic UV radiation–induced RORγt+ IL-22–producing lymphoid cells are associated with mutant KC clonal expansion. *Proceedings of the National Academy of Sciences*, 118(37).

Turban J.L., King, D., Li, J.L., Keuroghian, A.S. (2021) Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes. *Journal of Adolescent Health*. 69(6), 991-998.

Turban J.L., Loo, S. S., Almazan, A. N., Keuroghlian, A.S. (2021) Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health*. 8(4), 273-280.

Turban, J. L., Passell E, Scheer L, Germine L. (2020) Use of Geosocial Networking Applications Is Associated With Compulsive Sexual Behavior Disorder in an Online Sample. *The Journal of Sexual Medicine*. 17(8), 1574-1578.

Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, *145*(2), e20191725.

Turban, J. L., Shirk, S. D., Potenza, M. N., Hoff, R. A., & Kraus, S. W. (2020). Posting Sexually Explicit Images or Videos of Oneself Online Is Associated With Impulsivity and Hypersexuality but Not Measures of Psychopathology in a Sample of US Veterans. *The Journal of Sexual Medicine*, *17*(1), 163-167.

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

Acosta, W., Qayyum, Z., **Turban, J. L.**, & van Schalkwyk, G. I. (2019). Identify, engage, understand: Supporting transgender youth in an inpatient psychiatric hospital. *Psychiatric Quarterly*, 90(3), 601-612.

Turban, J. L., King, D., Reisner, S. L., & Keuroghlian, A. S. (2019). Psychological Attempts to Change a Person's Gender Identity from Transgender to Cisgender: Estimated Prevalence Across US States, 2015. *American Journal of Public Health*, 109(10), 1452-1454.

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

Turban, J. L., Potenza, M. N., Hoff, R. A., Martino, S., & Kraus, S. W. (2017). Psychiatric disorders, suicidal ideation, and sexually transmitted infections among post-deployment veterans who utilize digital social media for sexual partner seeking. *Addictive Behaviors*, 66, 96-100.

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Turban J. L.*, Lu, A. Y*., Damisah, E. C., Li, J., Alomari, A. K., Eid, T., ... & Chiang, V. L. (2017). Novel biomarker identification using metabolomic profiling to differentiate radiation necrosis and recurrent tumor following Gamma Knife radiosurgery. *Journal of Neurosurgery*, 127(2), 388-396.

Kempfle, J. S., **Turban, J. L.,** & Edge, A. S. (2016). Sox2 in the differentiation of cochlear progenitor cells. *Scientific Reports*, 6, 23293.

SELECTED PEER REVIEWED PUBLICATIONS: COMMENTARY, REVIEWS, & PERSPECTIVES

Lerario, M. P., Rosendale, N., Waugh, J. L., Turban, J., & Maschi, T. (2023). Functional Neurological Disorder Among Sexual and Gender Minority People. *Neurologic Clinics*. [In Press]

Chen A, Cohen I.G., Kraschel K., **Turban J.L.**. Legal & Ethical Perspectives on Criminalization of Standard of Care Medical Practices. *Cell Reports Medicine*.

Turban J.L., Brady C., & Olson-Kennedy J. Understanding & Supporting Patients with Dynamic Desires for Gender-affirming Medical Interventions. *JAMA Network Open*.

Dolotina B. **& Turban J.L.** "Phantom Networks" Prevent Children & Adolescents from Obtaining the Mental Health Care They Need. *Health Affairs*. 41(7).

Turban J.L., Kamceva M, Keuroghlian A.S. Pharmacologic Considerations for Transgender and Gender Diverse People. *JAMA Psychiatry*. 79(6): 629-630.

Dolotina B. & **Turban J.L.**. (2022) A multipronged, evidence-based approach to improving mental health among transgender and gender diverse youth. *JAMA Network Open*. 5(2): e220926.

Turban J.L., Almazan A.N., Reisner S.L., Keuroghlian A.S. (2022) The importance of non-probability samples in minority health research: lessons learned from studies of transgender and gender diverse mental health. *Transgender Health*. [ePub ahead of print]

Turban J.L., Kraschel K.L., Cohen, G.C. (2021) Legislation to Criminalize Gender-affirming Medical Care for Transgender Youth. *JAMA*. 325(22), 2251-2252.

Liu M., **Turban J.L.**, Mayer K.H. (2021) The US Supreme Court and Sexual and Gender Minority Health. *American Journal of Public Health*. 111(7), 1220-1222.

Suto, D.J., Macapagal, K., **Turban, J.L.** (2021) Geosocial Networking Application Use Among Sexual Minority Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*. 60(4), 429-431.

Turban, J. L., Keuroghlian, A. S., & Mayer, K. H. (2020) Sexual Health in the SARS-CoV-2 Era. *Annals of Internal Medicine*. 173(5), 387-389.

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

Malta, M., LeGrand, S., **Turban, J.L.**, Poteat, T., & Whetten, K. (2020). Gender-congruent government identification is crucial for gender affirmation. *The Lancet Public Health*. 5(4), e178-e179.

Turban J.L. (2019). Medical Training in the Closet. *The New England Journal of Medicine*, *381*(14), 1305.

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Turban, J. L., & Keuroghlian, A. S. (2018). Dynamic gender presentations: understanding transition and" de-transition" among transgender youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, 57(7), 451-453.

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

Turban, J. L. (2018). Potentially Reversible Social Deficits Among Transgender Youth. *Journal of Autism and Developmental Disorders*, 48(12), 4007-4009.

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

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

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

Turban, J., Ferraiolo, T., Martin, A., & Olezeski, C. (2017). Ten things transgender and gender nonconforming youth want their doctors to know. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(4), 275-277.

Turban, J. L. (2017). Transgender Youth: The Building Evidence Base for Early Social Transition. *Journal of the American Academy of Child and Adolescent Psychiatry*, 56(2), 101.

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

TEXTBOOKS AND TEXTBOOK CHAPTERS

Forcier, M., Van Schalkwyk, G., **Turban, J. L.** (Editors). Pediatric Gender Identity: Gender-affirming Care for Transgender & Gender Diverse Youth. Springer Nature, 2020.

Challa M., Scott C., **Turban J.L.** Epidemiology of Pediatric Gender Identity. In Forcier, M., Van Schalkwyk, G., **Turban, J. L.** (Editors). Pediatric Gender Identity: Gender-affirming Care for Transgender & Gender Diverse Youth. Springer Nature, 2020.

Turban J.L., Shadianloo S. Transgender & Gender Non-conforming Youth. In Rey, J.M. (Editor): IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva. International Association of Child and Adolescent Psychiatry and Allied Professionals, 2018.

Turban, J. L., DeVries, A.L.C., Zucker, K. Gender Incongruence & Gender Dysphoria. In Martin A., Bloch M.H., Volkmar F.R. (Editors): Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook, Fifth Edition. Philadelphia: Wolters Kluwer 2018.

INVITED GRAND ROUNDS PRESENTATIONS

Turban JL. Transgender Youth Mental Health. Maudsley Hospital / Kings College London Grand Rounds, 2023.

Turban JL. Resaerch Updates: Supporting the Mental Health of Transgneder and Gender Diverse Youth. Department of Behavioral Health, Wake Forest School of Medicine / Atrium Health, 2023.

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Turban JL. Supporting the Mental Health of Transgender and Gender Diverse Youth. Child & Adolescent Psychiatry Grand Rounds, Long Island Jewish Medical Center / Zucker Hillside, 2023.

Turban JL. Suicidality in Sexual and Gender Minority Youth. Psychiatry Grand Rounds, Boston Children's Hospital, 2023.

Turban JL. Opinion Writing to Promote Public Health & Evidence-Based Public Policy. Medical Education Grand Rounds, The University of Vermont Larner College of Medicine, 2022.

Turban JL. Research Updates: Supporting the Mental Health of Transgender & Gener Diverse Youth. Division of Child & Adolescent Psychiatry Grand Rounds, Stanford University School of Medicine, 2022.

Turban JL. Supporting Transgender & Gender Diverse Youth: Research Updates & Treatment Paradigms. Department of Psychiatry Grand Rounds, University of Nebraska Medical Center, 2022.

Turban JL. Supporting the Mental Health of Transgener & Gender Diverse Youth. Department of Pediatrics, Division of Behavioral Health Grand Rounds, University of Utah, 2022.

Turban JL. Gender Diverse Youth: Treatment Paradigms & Research Updates. Psychiatry Grand Rounds, Thomas Jefferson University, 2021.

Turban JL. Supporting Gender Diverse Youth Throughout Development. Child Psychiatry Grand Rounds, Georgetown, 2021.

Turban JL. Understanding Pediatric Gender Identity through Childhood and Adolescence. Grand Rounds, Institute of Living, 2021.

Turban JL. Evolving treatment paradigms for transgender youth. Pediatric Grand Rounds, Albany Medical Center, 2021.

Turban JL. Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, McLean Hospital (Harvard Medical School), 2021.

Turban JL. Einstein Psychiatry Grand Rounds: Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, Einstein Medical Center, 2021.

Turban JL. COVID19 and Pediatric Mental Health. Pediatrics Grand Rounds, Stanford University School of Medicine, 2021.

Turban JL. Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, Beth Israel Deaconess Medical Center (Harvard Medical School), 2020.

ADDITIONAL INVITED PRESENTATIONS

Turban JL. Suicide Prevention for LGBTQ+ Youth. *National Institues of Health*, Bethesda, 2023.

Turban JL. NAMI LGBTQ+ Mental Health Roundtable Discussion. *National Alliance on Mental Illness*, San Francisco, 2023.

Turban JL. Supporting the Mental Health of Transgender & Gender Diverse Youth. *United Nations NGO Committee on Mental Health*, United Nations, 2023.

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Turban JL & Spetz J. How to Give Expert Testimony. *UCSF Philip R. Lee Institute for Health Policy Studies Impacting Policy Series*, San Francisco, 2023.

Turban JL. The Research on Gender-affirming Care for Transgender Youth. *AusPATH Research Seminar*. Sydney, 2023.

Turban JL. Building a Career in Sexual & Gender Minority Health Research. *National Institutes of Health*, Bethesda, 2022.

Turban JL. Research Updates: Gender-affirming Care for Transgender Youth. MUSC LGBTQ+ Health Equity Summit, Medical University of South Carolina, 2022.

Turban JL. Keynote: Supporting The Mental Health of Transgender & Gender Diverse Youth. Edythe Kurz Educational Institute Conference, Westchester, 2022.

Turban JL, Peters B, Olson-Kennedy J. Gender-Affirming Care: Through a Medical, Surgical, and Mental Health Lens. Critical Issues in Child & Adolescent Mental Health Conference, San Diego, 2022.

Turban JL. Improving Mental Health Outcomes for Transgender and Gender Diverse (TGD) Youth Through Gender-affirming Care. National LGBTQIA+ Health Education Center, The Fenway Institute, 2022.

Turban JL. Combatting anti-trans legislation through science, data, and writing. State of Queer Mental Health Conference by The Mental Health Association of San Francisco, Online, 2021.

Turban JL. Updates on LGBTQ Mental Health. Annual Psychiatric Times World CME Conference, Online, 2021.

Turban JL. Imbasciani LGBTQ Health Equity Lecture: Evolving Treatment Paradigms for Transgender and Gender Diverse Youth. University of Vermont Larner College of Medicine, Burlington, 2021.

Turban JL. The Emergence of Gender-affirming Care for Transgender & Gender Diverse Youth, United Nations NGO Committee on Mental Health, Oral Presentation, Online, 2021.

Turban JL. Keynote – Transgender & Gender Diverse Youth: Research Updates. Stony Brook Transgender Health Conference, Online, 2021.

Turban JL. Opinion Writing on Sensitive Topics. Harvard Media & Medicine Course, Live Lecture, Online, 2021.

Turban JL. Gender affirming care for transgender and gender diverse youth: what we know and what we don't. University of Texas Pride Health Institute, Oral Presentation, Online, 2020.

Turban JL. Q&A on Transgender Youth Mental Health. PEOPLE in Healthcare at University of Toledo, Oral Presentation, Online, 2020.

Turban JL, Pagato S, Gold J, Broglie J, Naidoo U, Alvarado A. Innovation of Student Mental Health during COVID19. Panel to the People, Oral Presentation, Online, 2020.

Turban JL, Belkin B, Vito J, Campos K, Scasta D, Ahuja A, Harris S. Discussion on Abomination: Homosexuality and the Ex-Gay Movement. Panelist, The Association of LGBTQ+ Psychiatrists Virtual Session, Oral Presentation, Online, 2020.

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Turban JL. Is Grindr affecting gay men's mental health? Oral Presentation, UCLA & AETC Coping with Hope, Online, Oral Presentation, 2020.

Turban JL, Hall TM, Goldenberg D, Hellman R. Gay Sexuality and Dating. Moderator, The Association of LGBTQ+ Psychiatrists Virtual Session, Oral Presentation, Online, 2020.

CONFERENCE PRESENTATIONS & ABSTRACTS

Turban JL, Calhoun A, Gold, J. Mission-Based Media Collaborative Work Concerning "Controversial" Topics in Psychiatry. Annual Meeting of The American Psychiatric Association, Oral Presentation, San Francisco, 2023.

Turban JL, Ahuja A. Autogynephilia: Historical Context, Clarifications, and Controversy. Annual Meeting of The American Psychiatric Association, Oral Presentation, San Francisco, 2023. [Cancelled]

Turban JL. A Systematic Approach for Understanding Gender Identity Evolution. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Oral Presentation, Toronto, 2022.

Turban JL. Transgender Youth: Evolving Gender Identities and "Detransition." Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Toronto, 2022.

Turban JL. From The New York Times to Hollywood: Communicating With the Public Through Opinion Writing, Publishing, Social Media, and Consulting for Film and TV, Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Toronto, 2022.

Turban JL. Writing for the Lay Press to Combat Misinformation Regarding Pediatric Mental Health, Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Oral Presentation, Toronto, 2022.

Turban JL. COVID-19 and Psychosexual Dynamics, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Oral Presentation, Toronto, 2022.

Dolotina B, **Turban JL**, King D, Keuroghlian AS. Age of Realization of Gender Identity and Mental Health Outcomes among Transgender Adults: Evaluating the "Rapid Onset Gender Dysphoria" Hypothesis, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Poster, Toronto, 2022.

Turban JL. Sex ratio among transgender adolescents in the United States. World Professional Association for Transgender Health Scientific Symposium, Oral Presentation, Montreal, 2022.

Turban JL. Access To Gender-Affirming Hormones During Adolescence And Mental Health Outcomes Among Transgender Adults. World Professional Association for Transgender Health Scientific Symposium, Oral Presentation, Montreal, 2022.

Turban JL, Gold J, Hartselle S, Yen J. From The New York Times to the Big Screen: Communicating With the Public Through Opinion Writing, Publishing, Social Media, and Consulting for Film and TV. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Online, 2021.

Turban JL. Creating Change through Opinion Writing in Child & Adolescent Psychiatry. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Oral Presentation, Online, 2021.

Turban JL, Giedinghagen A, Janssen A, Myint M, Daniolos P. Transgender Youth: Understanding "De-transition," Non-linear Gender Trajectories, and Dynamic Gender Identities. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Online, 2021.

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Turban JL. A framework for understanding dynamic gender identities through internal and external factors. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2021.

Turban JL, Geosocial networking application use among birth-assigned male adolescents. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2021.

Turban JL. LGBTQ Families and the US Supreme Court. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentations, Online, 2021.

Turban JL, King D, Kobe J, Reisner SL, Keuroghlian AS. Access to Gender-affirming Hormones during Adolescence and Mental Health Outcomes among Transgender Adults. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Poster, Online, 2021.

Turban JL. Gender Identity Conversion Efforts: Quantitative Perspectives. Annual Meeting of The American Psychiatric Association, Oral Presentation, Online, 2021.

Turban JL. For Worse: Negative Aspects of Social Media for LGBT Youth. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2020.

Turban JL. Hookup App Use among Gay and Bisexual Males: Sexual Risk and Associated Psychopathology. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Online, 2020.

Turban JL. Communicating with the Public: From The New York Times to The Big Screen. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Online, 2020.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TEACHING PRESENTATIONS

Advanced Topics in Pediatric Gender Care. Stanford Child & Adolescent Psychiatry Fellowship Didactics, 2023.
Opinion Writing About The "Politically Sensitive" and Personal. Harvard Medical School Master of Science in Media, Medicine, and Health Degree Program, 2022.
Gender-affirming Care for Transgender & Gender Diverse Youth, Zuckerberg San Francisco General Hospital Adolescent Psychology Internship Didactics, 2022.

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Supporting Transgender & Gender Diverse Youth. UCSF Trauma Recovery Center Didactics, 2022.
Developmental Psychopathology, Psychotherapy & Psychopharmacology Course: Pediatric Gender. Stanford University School of Medicine Child & Adolescent Psychiatry Fellowship Didactics, 2021.
Supporting Gender Diverse Youth Through Various Stages of Development. Univeristy of California San Francisco Child & Adolescent Psychiatry Fellowship Didactics, 2021.
Treatment of Transgender and Gender Diverse Youth. Stanford University School of Medicine Psychiatry Residency Didactic, 2021.
Caring for Transgender and Gender Diverse Youth. University of California San Diego General Psychiatry Residency Resident Rounds, 2021.
Opinion Writing 101. Stanford Pediatrics Residency Program, 2021.
Psychotherapeitic Considerations for Transgender Youth. Stanford PsyD Child Psychotherapy Course, 2021.
Transgender Youth: Treatment Paradigms and Research Updates. Children's Health Council DBT Program Lecture Series, 2021.
Gender-affirming Care for Patients with Primary Psychotic Disorders. McLean Psychotic Disorders Division Seminar Series, 2019.
Gender-affirming Care for Transgender Elders. McLean Geriatric Psychiatry Seminar Series, 2019.
Writing about Gender & Sexuality (Guest Lecture), Course: Sexual Outcasts & Uncommon Desires, Emerson College, 2019
Gender-affirming Care for Transgender and Gender Diverse Patients on Inpatient Psychiatric Units, MGH Inpatient Psychiatry Seminar Series, 2019.
Transgender & Gender Non-conforming Youth, MGH/McLean Adult Residency program, 2018.
Writing about Gender Identity for the Lay Audience (Guest Lecture), Course: Kids These Days, Emerson Journalism Program, 2017
International Approaches to the Treatment of Gender Incongruence, VU Medical Center, Amsterdam, 2017
Time to Talk About It: Physician Depression and Suicide, Yale Clerkship Didactics, 2017
Medical Management of Adolescent Gender Dysphoria. Yale Pediatrics Clerkship, 2015-2016
Medical Management of Children and Adolescents with Gender Dysphoria, Yale Pediatrics Residency Didactics, 2016
Reflective Writing Workshop Leader. Yale Surgery Clerkship, 2015-2016
Langerhans Cell Facilitation of Photocarcinogenesis. Yale Department of Dermatology Research Forum, 2016
Panel: Treating Transgender & Gender Non-conforming Patients in the Emergency Setting. Yale Emergency Medicine Clerkship, 2016
Panel: Challenges to the Learning Climate: Difficult Patients, Harassment, and Mistreatment. Yale Pre-Clinical Orientation, 2016
Panel: Personal Behavior and Professionalism, Introduction to the Profession, 2016

RESEARCH SUPPORT

Current Funding:
Sorensen Foundation Fellowship, $287,000 (2021-2023)
The Impact of Gender-affirming Medical and Surgical Interventions on Psychopathology and Implicit Gender Incongruence among Transgender Adolescents
Role: Principal Investigator

UCSF Population Health Equity Scholars Grant, $20,000 (2023-2024)
Systematic content analysis of federal appellate court rulings regarding the constitutionality of bans on gender identity and sexual orientation conversion efforts
Role: Principal Investigator

Completed Funding:
Stanford Department of Psychiatry and Behavioral Sciences Trainee Innovator Grant, $5,000 (2020-2021)

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Examining the impact of gender identity conversion therapy bans on suicidality among transgender and gender diverse people in the U.S.: a difference-in-differences analysis
Role: Principal Investigator

American Academy of Child & Adolescent Psychiatry Pilot Research Award, $15,000 (2019-2020)
Childhood and Adolescent Experiences with Gender-related Medical Care and Adult Mental Health Outcomes: Analysis of the 2015 U.S. Transgender Survey
Role: Principal Investigator

AWARDS & HONORS

Top Peer Review Service, *Annals of Internal Medicine* (2022)
Stanford Child & Adolescent Psychiatry Chief Fellow (2021-2022)
Wasserman Award for Advocacy in Children's Mental Health (2021)
Top Manuscript of The Year - *Pediatrics* (2020)
American Psychiatric Association Child & Adolescent Psychiatry Fellowship (2019-2021)
Ted Stern Scholarship and Travel Award (2019)
Editor's Pick for Best Clinical Perspectives Manuscript – *Journal of The American Academy of Child & Adolescent Psychatry* (2018)
SciShortform Project: Best Shortform Science Writing, Columns & Op-Eds (2018)
Ted Stern Scholarship and Travel Award (2018)
Medaris Grant (2018)
Editor's Pick for Best Clinical Perspectives Manuscript – *Journal of The American Academy of Child & Adolescent Psychatry* (2017)
United States Preventative Health Services Award for Excellence in Public Health (2017)
NBC Pride 30 Innovator (2017)
Ferris Thesis Prize, Yale School of Medicine (2017)
Parker Prize, Yale School of Medicine (2017)
Howard Hughes Medical Institute Medical Research Fellowship (2015-2016)
American Academy of Child and Adolescent Psychiatry Life Members Mentorship Grant (2016)
Student Scholarship, Gender Conference East (2016)
Farr Award for Excellence in Research (2016)
Yale Office of International Medical Education Grant, Buenos Aires, Argentina (2016)
Yale Office of International Medical Education Grant, VU Medical Center, The Netherlands (2016)
Yale Summer Research Grant (2012)
AIG International Scholar, Harvard College (2007-2011)
Harvard International Study Grant, Alicante, Spain (2008)
David Rockefeller International Study Grant, Shanghai, China (2009)

PROFESSIONAL MEMBERSHIPS & COMMITTEES

American Psychiatric Association, Member
American Academy of Child & Adolescent Psychiatry, Member
American Psychiatry Association, Council on Communications
American Academy of Child & Adolescent Psychiatry, Media Committee
American Academy of Child & Adolescent Psychiatry, Chair of Subcomittee on Interfacing with the Media
World Professional Association for Transgrender Health, Member
US Professional Association for Transgender Health, Member
US Professional Association for Transgender Health, Research Committee
Athlete Ally, Affiliate Scholar
Psychiatric Times, Editorial Board

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ACADEMIC JOURNAL SERVICE & AD HOC PEER REVIEW

PLoS One, Academic Editor
JAACAP, Contributing Editor
JAMA, Peer Reviewer
JAMA Pediatrics, Peer Reviewer
JAMA Psychiatry, Peer Reviewer
JAMA Network Open, Peer Reviewer
Annals of Internal Medicine, Peer Reviewer
Pediatrics, Peer Reviewer
Journal of the American Academy of Child & Adolescent Psychiatry, Peer Reviewer
JAACAP Open, Peer Reviewer
Journal of Child Psychology and Psychiatry, Peer Reviewer
Journal of Adolescent Health, Peer Reviewer
Academic Psychiatry, Peer Reviewer
Journal of Autism and Developmental Disorders, Peer Reviewer
American Journal of Public Health, Peer Reviewer
Perspectives on Psychological Science, Peer Reviewer
Transgender Health, Peer Reviewer
Journal of Clinical Medicine, Peer Reviewer
Brain Sciences, Peer Reviewer
Social Science & Medicine, Peer Reviewer
Sexual Health, Peer Reviewer
Women, Peer Reviewer

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

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

Plaintiffs,

v.

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

Defendants.

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

EXPERT REBUTTAL DECLARATION OF CHRISTINE BRADY, PhD

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Attorneys for Plaintiffs

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

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated herein.

3. My background and credentials are outlined in my initial declaration.

4. I reviewed the declarations of Drs. Cantor and Weiss. There are many assertions made in those declarations that I do not believe are supported by evidence. I do not attempt to address all of them here but, instead, respond to some of the central arguments made in those declarations. I reserve the right to supplement my opinions, if necessary, as the case proceeds.

DR. WEISS'S ASSERTION THAT GENDER DYSPHORIA IS A SYMPTOM OF OTHER MENTAL HEALTH DISORDERS IS UNSUPPORTED BY EVIDENCE

5. Dr. Weiss misunderstands gender dysphoria to be a symptom of other mental health issues such as trauma, abuse and depression (as opposed to a separate diagnosis), and claims that if those other issues are addressed, that will resolve the gender dysphoria. Declaration of Daniel Weiss (Dkt. 56-3) ("Weiss Decl.") ¶ 21; Ex. B to the Declaration of Ritchie Eppink, Daniel Weiss Deposition Transcript ("Weiss Dep.") 213:1-215:8. By using quotation marks when referring to gender dysphoria (but not any other diagnoses), Dr. Weiss apparently disagrees with the DSM's recognition of gender dysphoria as a psychiatric diagnosis. His views are completely at odds with how gender dysphoria is understood by those working within the mental health field, including Dr. Cantor, who agrees that gender dysphoria is a mental health condition that should be treated. Declaration of James Cantor (Dkt. 56-4) ("Cantor Decl.") ¶109. Indeed, gender dysphoria (and precursor diagnoses such as "gender identity disorder") has been included in the DSM as a diagnosis since the publication of the DSM-III in 1980. Gender dysphoria, like all mental health conditions, can co-occur with other diagnosed conditions but

that does not mean that in those cases, gender dysphoria is a symptom of other conditions. Moreover, not all people with gender dysphoria have the other mental health conditions mentioned by Dr. Weiss. I have treated a number of adolescents with gender dysphoria who do not meet criteria for any other DSM diagnosis and have no history of trauma or abuse.

DEFENDANTS' EXPERTS' STATED CONCERNS ABOUT GENDER-AFFIRMING CARE ARE BASED ON A MISUNDERSTANDING OF HOW SUCH CARE IS PROVIDED IN ACCORDANCE WITH THE WPATH SOC

6. The State's experts assert a number of concerns about the treatment of adolescents with gender dysphoria that are premised on a profound misunderstanding of how care is provided in accordance with the recommendations of the World Professional Association for Transgender Health's Standards of Care for Transgender and Gender Diverse People ("WPATH SOC"). Specifically, they assert concerns regarding automatic acceptance of reported transgender identity, the misdiagnosis of gender dysphoria, and social influences causing adolescents to present at gender clinics. All of these stated concerns ignore or misunderstand the comprehensive psychosocial evaluation, which is a core recommendation of the WPATH SOC prior to considering any medical interventions for adolescents.

7. Dr. Cantor suggests that gender affirming healthcare providers support "transition-on-demand". Cantor Decl. ¶ 125. He seems to be asserting that when patients present to gender clinics, if they say they are transgender, doctors fail to engage in exploration of the patient's gender identity and other comorbidities. *See* Cantor Decl. p. 111 (heading) (suggesting doctors "assum[e] literal accuracy of self-report"). This is simply untrue. Under the WPATH SOC, a comprehensive psychosocial assessment is a critical component of care prior to considering medical interventions. WPATH SOC, p. S59-S61. And that includes not only assessing whether the patient meets the criteria for gender dysphoria, but also assessing other mental health issues affecting the patient. *Id.*, p. S62-S63. Additionally, information is obtained

not *just* from the youth but also from their parents. *Id.*, p. S60. This is not only to increase the reliability of the clinical data obtained, but to more fully understand the history of the child's experience related to their gender and any other mental health issues.

8. The State's experts also suggest that adolescents may be misdiagnosed with gender dysphoria when they have other mental health conditions that need to be addressed.[1] Again, this overlooks the comprehensive psychosocial evaluation that is provided prior to considering medical interventions. Differential diagnosis is a part of the process and alternative or additional mental health conditions may be identified. In my own clinical experience, I've had a number of patients who have presented expressing issues related to their gender identity where, after evaluation and exploration, it became clear that the patient did not have gender dysphoria and there were other issues that required attention and treatment. In other cases, patients have gender dysphoria in addition to other mental health issues that need to be addressed. It is not unique to gender dysphoria that individuals can carry multiple mental health

[1] Dr. Cantor suggests a specific concern about gender dysphoria diagnoses being misdiagnosed as borderline personality disorder (BPD). Cantor Decl. ¶ 160. He highlighted two of nine criteria of BPD that he believes could be diagnostically confused with gender dysphoria, starting with "recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior" and "identity disturbance: markedly and persistently unstable self-image or sense of self." While suicidal thoughts and self-harm behaviors are diagnostic criteria for many mental health disorders including various forms of depression, bipolar disorder, schizophrenia, anxiety and PTSD, they are not part of the diagnostic criteria for gender dysphoria and the presence of those symptoms would not impact or influence the diagnosis of gender dysphoria. As for the "identity disturbance" criterion, as stated in the diagnostic criteria for BPD, the identity must be "persistently unstable." In the case of gender dysphoria, symptoms must be stably present for a duration of at least six months and in most cases presenting to our Gender Clinic, have been stable for several years. Goldhammer and colleagues (2019) examined the relationship between BPD and gender dysphoria and concluded that "gender minority identity is rarely a sign of identity diffusion." Hilary Goldhammer et al., *Distinguishing and Addressing Gender Minority Stress and Borderline Personality Symptoms*, 27 HARV REV PSYCHIATRY 317-325, 323 (2019). Finally, in order to be diagnosed with BPD, an individual must display 5 or more of the nine criteria. Having these two symptoms alone would not meet criteria for BPD and completely different symptoms must be had in order to be diagnosed with gender dysphoria.

diagnoses. And the suggestion by the State's experts that a gender dysphoria diagnosis and treatment with gender-affirming medication means that any other mental health conditions a patient has will not be addressed, *see* Cantor Decl. ¶¶ 158, 237, is without basis. I provide psychotherapy for comorbidities to many patients who are receiving puberty blockers or hormone therapy, and this is common in gender clinics across the country.

9. The State's experts assert that many adolescents present for care at gender clinics because they are influenced by social media and their peers. Cantor Decl. ¶ 136; Weiss Decl. ¶ 30. It is hard to imagine this happening given that in my clinical experience, most patients have experienced gender incongruity and dysphoria for several years prior to presenting to clinic. In any case, should social influence lead someone to present to a medical provider asserting a transgender identity and seek gender-affirming medical care, like all patients they would receive a comprehensive psychosocial evaluation prior to considering any medical interventions, which would examine the history of their gender identity and possible external drivers of identity. I am confident that such evaluations would identify peer and social media influence if that were a factor and no medical interventions would be provided if the patient did not meet the criteria for gender dysphoria.

THE STATE'S EXPERTS INAPPROPRIATELY RELY ON THE DESISTANCE STUDIES OF PREPUBERTAL CHILDREN TO SUPPORT BANNING GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS WITH GENDER DYSPHORIA

10. The State presents data on pre-pubertal gender nonconforming children to suggest that most youth affected by the Idaho law will "cease to want to be the other gender." Cantor Decl. ¶ 116. There are several reasons why such a conclusion cannot be made from this data. First, the studies included in Dr. Cantor's meta-analysis date from 1972 – 2021 (with all but 1 of the 11 studies done during prior to the DSM-5). Cantor Decl. Table 2, pp. 50-51. As outlined in my opening declaration, prior to DSM-5, the diagnostic criteria did not require that a child

identify with a different sex – in other words, a child could be diagnosed with the precursor diagnosis of gender identity disorder solely on the basis of gender atypical behavior. As Dr. Cantor acknowledges in his report, many of the studies were not limited to transgender children, but rather included gay, uncertain, and crossdressing children; several of the studies—as indicated by their titles—assessed "effeminate behavior in boys". *Id*. Therefore, the studies do not provide data on desistance of children who have gender dysphoria.

11. Second, the studies looked only at prepubertal children and say nothing about the likelihood of desistance among adolescents—youth who have started puberty, who Dr. Cantor recognizes are less likely to desist. Cantor Decl. ¶ 245 (desistance less likely to occur after age 12). It is important to note that medical interventions are not offered to pre-pubertal youth. Thus, the rates of desistance among prepubertal children would not support an argument to prohibit medical care for adolescents.

DR. CANTOR'S OPINION THAT GENDER-AFFIRMING MEDICAL CARE SHOULD BE POSTPONED UNTIL ADULTHOOD WOULD RESULT IN SERIOUS SUFFERING

12. Dr. Cantor states "Accepting that gender identity can change, even if only *involuntarily*, calls for the very policy Dr. Brady rejects: Hold off medicalization until adulthood." Cantor Decl. ¶ 267. As an initial matter, Dr. Cantor overstates the likelihood of gender identity changing among adolescents—the group affected by the Idaho law—by relying inappropriately on the desistance studies of prepubertal children. In my clinical experience, while I have had patients who, over time, use different gender diverse identity labels for themselves, e.g., shifting from identifying as transgender female to non-binary, shifts from gender diverse to cisgender have been extremely rare (6 out of over 900 patients). The fact that there may be some adolescents who have a shift in their gender identity to cisgender is not a basis to withhold treatment from those who need and would benefit from it. The fact that a

patient's gender identity changed to cisgender does not equate with regretting treatment or negative consequences of treatment. That was my clinical experience with my two patients who shifted to a cisgender identity after having received pubertal suppression. And research shows that people whose gender identity evolved to cisgender have nonetheless found that the treatment helpful for them at the time.[2] Moreover, almost all if not all medical treatments have some patients who ultimately regret receiving them, but that is not a reason to deny treatment to those who need and benefit from it.

13. The State's experts suggest that gender dysphoria can be treated with psychotherapy alone. *See, e.g.*, Weiss Dep. 186:10-187:2. While psychotherapy can be important to treat comorbidities—which is something I do regularly with patients—it does not address the distress of gender dysphoria. For my patients who have had to delay accessing medical treatment (e.g., because their parents did not consent to treatment), their gender dysphoria was not alleviated despite regular therapy and often their mental health severely decompensated until they were able to begin medical treatment.

14. Dr. Cantor suggests that a study by Costa (2015) demonstrates the effectiveness of psychotherapy alone, and that I misinterpreted the findings of that study. Cantor Decl. ¶ 290; *see* R. Costa et al, Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria, 12 J. SEXUAL MEDICINE 2206-2214 (2015). That is not so. Costa found that psychosocial support alone for 6 months significantly improved psychosocial functioning in a group of adolescents with GD who were deemed "delayed eligible" for puberty blockers, but then no further significant improvements were observed (plateau) over the next 12

[2] *See*, *e.g.*, Lisa Littman, *Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners*. 50 ARCHIVES SEXUAL BEHAV.3353-3369, 3363 (2021).

months of psychological support and their psychosocial functioning scores continue to be lower than those of healthy peers. *Id.* at 2211. In contrast, for adolescents with GD who were deemed "immediately eligible" for blockers, 6 months of psychosocial support alone did not significantly improve their psychosocial functioning but after 12 months of pubertal suppression, their psychosocial functioning significantly improved and their scores matched those of healthy peers. *Id.* The "delayed eligible" group included those individuals who needed more time to make a decision or where "clinicians needed more time to make the decision of starting GnRHa because of possible comorbid psychiatric problems and/or psychological difficulties." *Id.* at 2208-09.This study unsurprisingly reaffirms that psychological support can be helpful to improve psychosocial functioning, particularly in individuals with other psychiatric issues. *Id.* at 2212. It also shows that pubertal suppression provided benefits that did not come with psychotherapy alone. *Id.* at 2212-13. Also, of note, the delayed eligible group all elected to receive pubertal blockers on average 6 months after the study concluded. *Id*. at 2209.

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

Executed on: 10/13/2023

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

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

Plaintiffs,

v.

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

Defendants.

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

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1. I am submitting this rebuttal declaration to respond to some of the assertions made by Defendants and their experts. While the Defendants' expert declarations are filled with many statements that I believe are not supported by evidence, I do not attempt to address all of them but rather focus on some of the issues that seem most pertinent.

DEFENDANTS AND THEIR EXPERTS' ASSERTIONS ABOUT RISKS OF GENDER-AFFIRMING MEDICAL CARE

Asserted risks of puberty blockers

2. Defendants' experts, *see*, *e.g.* Weiss ¶ 123. suggest that puberty blockers may negatively impact cognitive development. These medications have been used for decades for youth with central precocious puberty without any observed or measured negative impact on cognitive development. Wojniusz S et *al.* Cognitive, Emotional, and Psychosocial Functioning of Girls Treated with Pharmacological Puberty Blockage for Idiopathic Central Precocious Puberty. Front Psychol. 2016.

3. Defendants' experts' suggestion that the impact on cognitive development might be different with puberty blockers used for gender dysphoria compared to central precocious puberty is based on the mistaken assumption that youth treated with puberty blockers for gender dysphoria are left in a prolonged hypogonadal state. In practice, the timing of discontinuing pubertal suppression for patients who have been treated with puberty blockers for gender dysphoria is typically at ages when many of their peers are also starting puberty. Many youth begin puberty at age 13, 14 or even older. In the field of pediatric endocrinology there are no concerns about brain development in patients related to the age of pubertal onset. When delayed puberty is treated, the goals are to induce development of secondary sex characteristics or growth acceleration; concern about cognitive development is not a reason treatment is considered. Harrington H and Palmert MR. An Approach to the Patient With Delayed Puberty, *The Journal of Clinical Endocrinology & Metabolism*, Volume 107, Issue 6, June 2022, Pages 1739–1750. In my general endocrine clinic, many cisgender youth present after age 14, and not uncommonly at age 16 or 17, for evaluation of absent or delayed puberty. I have not had any concerns about cognition in these patients.

4. In addition, cognitive development during adolescence is a complex process relying on a number of different mechanisms, including the psychosocial environment. Chronic stress, particularly during adolescence, can impact cognitive development. Eiland L, Romeo RD. Stress and the developing adolescent brain. Neuroscience. 2013 Sep 26;249:162-71. Gender diverse youth who are denied the option of puberty blockers and thus are forced to undergo development of secondary sex characteristics can experience significant stress; the contribution of this to cognitive development cannot be ignored.

5. Defendants' experts also raise the risk of a negative impact on bone health with the use of puberty blockers. *See* Weiss ¶ 112. There is a risk of reduced bone density growth related to the use of puberty blockers, as I indicated in my opening declaration, whether used to treat gender dysphoria or central precocious puberty. This is something that is discussed with families prior to initiating treatment. Pubertal suppression can delay the peak accrual of bone mineralization that occurs during puberty. Research shows that bone mineral density increases when blockers are stopped and puberty resumes endogenously or with gender affirming hormone therapy. Schagen SEE, et *al*. Bone Development in Transgender Adolescents Treated With GnRH Analogues and Subsequent Gender-Affirming Hormones. J Clin Endocrinol Metab. 2020 Dec 1;105(12):e4252–63.; Vlot MC et *al*. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. Bone. 2017 Feb;95:11-19.

6. Defendants' expert Dr. Weiss points to a risk of idiopathic intracranial hypertension (IIH) for youth prescribed puberty blockers as a reason not to treat gender dysphoria with this medication. *See* Weiss ¶ 113. This is in relation to a warning issued by the Federal Drug Administration (FDA) in 2022 based on postmarketing surveillance data. This warning was based on 6 cases of IIH in youth treated with puberty blockers, 5 of whom were being treated for central precocious puberty and 1 treated for gender dysphoria. The nature of the postmarketing surveillance data collection did not allow for calculation of incidence. A recently published registry-based cohort study out of Sweden reported that of the 410 individuals with gender dysphoria treated with puberty blockers over the 10-year study period, no cases of IIH were identified. Karamanis G et *al.* Incidence of Idiopathic Intracranial Hypertension in Individuals With Gonadotropin-Releasing

Hormone Analogue Treatment for Gender Dysphoria in Sweden. JAMA Pediatr. 2023 Jul 1;177(7):726-727. I am not aware of any pediatric endocrinology practices that have ceased treatment with puberty blockers for central precocious puberty or any other condition based on this warning.

Asserted health risks of hormone therapy

7. The defendants' experts bring up concerns about health risks resulting from hormone therapy, such as heart disease, stroke, blood clots, and liver dysfunction. *See*, *e.g*. Weiss ¶¶ 133-149. However, these risks are the same when estrogen and testosterone are used to treat gender dysphoria as when they are used to treat delayed puberty or hypogonadism in cisgender adolescents. In other words, these risks for transgender girls receiving estrogen therapy are the same as these risks for cisgender girls receiving estrogen therapy, and these risks for transgender boys receiving testosterone therapy are the same as these risks for cisgender boys receiving testosterone therapy.[1] For cisgender or transgender youth receiving such treatments, it is important to monitor hormone levels to make sure they are in the appropriate range to avoid these adverse health consequences. These risks are well-managed (for cisgender and transgender patients) when care is provided and monitored by a physician. In my clinical experience with over 500 cisgender and gender diverse patients receiving hormone therapy, I have had no patients experience blood clots, heart disease, stroke or liver dysfunction. One patient taking testosterone developed higher red blood cell counts but these normalized with reduction in the testosterone dose.

8. One of the defendants' experts also makes the claim that testosterone therapy in birth-assigned females increases the risk of breast cancer; however, the references used, Weiss ¶ 139, are not represented accurately in the declaration. These studies report that

[1] Additionally, given that hormone prescribing protocols in published guidelines by the Endocrine Society simulate natural endogenous puberty, the health risk profile for transgender boys receiving testosterone therapy becomes more in line with that for cisgender boys who go through endogenous puberty, which means, for example, higher risks of heart attack than cisgender girls. Similarly, the health risk profile for transgender girls receiving estrogen therapy becomes more in line with that for cisgender girls who go through endogenous puberty, which means, for example, higher risks of breast cancer than cisgender boys.

transgender women treated with estrogen have a higher rate of breast cancer than cisgender men, but lower rate than cisgender women, and that transgender men treated with testosterone have a lower rate of breast cancer than cisgender women but a higher rate than cisgender men. Berliere M et *al*. Effects of Hormones on Breast Development and Breast Cancer Risk in Transgender Women. Cancers (Basel). 2022 Dec 30;15(1):245; Corso G et *al*. Risk and incidence of breast cancer in transgender individuals: a systematic review and meta-analysis. Eur J Cancer Prev. 2023 May 1;32(3):207-214. These findings are not surprising given that estrogen causes the development of breast tissue and cisgender men have very little breast tissue.

Asserted risks to fertility

9. Defendants' experts discuss the potential impact on fertility of gender-affirming medical care. While, as I discussed in my opening declaration, some treatments can impair fertility and this is thoroughly discussed with patients and their families, along with fertility preservation options, this outcome is not certain. There are many reports of transgender men who, after taking and stopping testosterone, are able to conceive children, with or without fertility treatment. Light AD et *al*. Transgender men who experienced pregnancy after female-to-male gender transitioning. Obstet Gynecol. 2014 Dec;124(6):1120-1127; Light AD et *al*. Family planning and contraception use in transgender men. Contraception. 2018 Oct;98(4):266-269; Stroumsa D et *al*. The Power and Limits of Classification - A 32-Year-Old Man with Abdominal Pain. N Engl J Med. 2019 May 16;380(20):1885-1888.[2] For this reason, in our informed consent process, we inform trans males that testosterone is not an effective contraception and they could become pregnant. Treatment can be tailored to minimize the risk to fertility where that is important to the family; for example, allowing some puberty to occur in transgender girls prior to starting puberty blockers so that they are able to preserve sperm, or temporarily stopping testosterone in transgender males to preserve eggs or try to get pregnant.

[2] Defendants suggest that the fact that I am not aware of any of my patients having conceived a child means they were unable to do so. Defs' brief. ¶ 20. My patients transition their care to adult medical providers by their early 20's, before they would be ready to start having families.

Asserted risk to sexual response

10. Dr. Cantor suggests that gender-affirming medical care will lead to "lifetime lack of orgasm and sexual function." *See* Cantor ¶ 208. In actuality, sexual satisfaction is impacted by a multitude of factors, including psychological well-being. Studies have shown that as psychological well-being improves steadily during gender affirming treatment, so does sexual satisfaction. Young transgender adults who started their gender affirming care during adolescence had more sexual activity and satisfaction compared with individuals not accessing gender affirming care until adulthood. Bungener SL et *al.* Sexual Experiences of Young Transgender Persons During and After Gender-Affirmative Treatment. Pediatrics. 2020 Dec;146(6):e20191411. One study of transgender women having undergone vaginoplasty after pubertal suppression in adolescence reported that most were able to achieve orgasm. Bouman MB et *al*. Patient-Reported Esthetic and Functional Outcomes of Primary Total Laparoscopic Intestinal Vaginoplasty in Transgender Women With Penoscrotal Hypoplasia. J Sex Med. 2016 Sep;13(9):1438-1444. Another study found no difference between transgender women who were treated with puberty blockers early in puberty versus late in puberty in their ability to orgasm after gender affirming genital surgery. van der Meulen I et *al.* The Effect of Puberty Suppression on Sexual Functioning in Transwomen after Gender Affirmative Surgery, *The Journal of Sexual Medicine*, Volume 20, Issue Supplement_4, July 2023.

11. In my clinical experience with patients, gender affirming medical care improves sexual function and experiences due to the positive effect of physical effects on alignment with gender identity. Transgender men treated with testosterone do not experience any negative effects on sexual function, aside from possible vaginal dryness. Transgender women treated with estrogen can have diminished ability to achieve and sustain erections (which may be a desired effect), but treatment can be tailored to avoid that if desired.

Assertions regarding regret and detransition

12. Defendants and their experts devote significant time to suggesting that it is common for patients treated with gender-affirming medical care to detransition and regret treatment. There is no evidence to support this. One study of a large sample demonstrated that less

than 2% of people who transition ever detransition due to a shift in gender identity. Turban JL et *al*. Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. LGBT Health. 2021 May-Jun;8(4):273-280. Regret related to gender-affirming hormone use is rare. Wiepjes CM et *al*. The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets. J Sex Med. 2018 Apr;15(4):582-590. In my experience with hundreds of patients with gender dysphoria who have received puberty blockers and/or gender-affirming hormones, a number of patients have discontinued hormones because they were satisfied and happy with the physical changes they had experienced and did not feel the need to continue treatment. These patients did not come to identify with their sex assigned at birth or regret treatment. I am aware of just two patients who, after undergoing gender affirming medical care, have said they had a shift in their gender identity to their birth-assigned sex and neither have any regrets about their treatment.

13. Defendants' assertion, Defs' brief, ¶ 30, that I view detransitioners as "an inconvenient fact to be minimized" cannot be further from the truth. Defendants are aware of (and presented to me at my deposition) a paper I co-authored that details a multidisciplinary approach to adult patients who expressed desire to reverse their gender affirming surgery (0.3% in our institution). The study aimed to better understand factors impacting patient's experiences to aid in the development of protocols to support them. Patients in my clinic are all counseled about the possibility that their experience regarding their gender may shift and change and we encourage them to come to us for support if that occurs.

14. The possibility of regretting medical decisions is part of medicine. A review of the body of research on this topic found that the mean rate of medical decision regret across studies was 16.5%. Perez, MMB, *et al*. Extent and Predictors of Decision Regret About Health Care Decisions: A Systematic Review. Medical Decision Making. Aug. 2016:777. A review of the research on regret in the context of surgeries found that across studies the average rate of regret was 14.4%. Wilson, A, *et al*. Regret in Surgical Decision Making: A Systematic Review of Patient and Physician Perspectives. World J. Surgery (2017) 41L1454-1465.

DEFENDANTS AND THEIR EXPERTS' ASSERTIONS REGARDING THE EFFICACY OF GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS

15. Defendants and their experts assert that there is a lack of evidence of efficacy of gender-affirming medical care. First, they suggest that the research evidence we have demonstrating efficacy is not valuable because it is "low quality". The defendants are referring to the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to rating quality of evidence. This approach includes four levels of evidence quality, and is largely dependent on the type and methods of investigation. As such, observational studies including cross-sectional studies with comparison groups and longitudinal cohort studies—the types of studies done on gender-affirming medical care— are generally rated lower quality than randomized controlled clinical trials. Observational studies are critical to medical research and informing the practice of medicine, and the label of "low quality" under GRADE does not mean that the evidence is unreliable or of poor quality. Indeed, one recent study found that only 12% of health care interventions are supported by "high quality" evidence as defined by the GRADE standard, and more than half are supported by "low quality" or "very low quality" evidence. Howick J et *al*. Most healthcare interventions tested in Cochrane Reviews are not effective according to high quality evidence: a systematic review and meta-analysis. J Clin Epidemiol. 2022 Aug;148:160-169.

16. As I discussed in my opening declaration, Connelly ¶ 56, randomized controlled trials are not always feasible due to ethical concerns and methodological limitations. Ashley F et *al,* Randomized-controlled trials are methodologically inappropriate in adolescent transgender healthcare, Int J Trans Health. Well-designed observational studies are necessary and valuable, and can provide reliable evidence, sometimes more reliable than randomized controlled trials. This is not limited to research pertaining to gender affirming medical care.

17. Also as discussed in my opening declaration, in my clinical experience, I've seen the profoundly beneficial impact of gender affirming medical care on my patients. Defendants assert, Defs' brief, at 26-27, that my statement that gender affirming medical care improves depression and anxiety in patients is contradicted by a study published by my clinical team. Cantu AL et *al*. Changes in Anxiety and Depression from Intake to

First Follow-Up Among Transgender Youth in a Pediatric Endocrinology Clinic. Transgend Health. 2020 Sep 2;5(3):196-200. This study looked at depression and anxiety screener data at the first follow up visit, which was typically just a few months after initiating hormone therapy (follow-up visits are recommended at 3-4 months after initial visit.[3] We know from patients that physical changes occur very slowly, and often, patients do not notice physical differences until 3 to 6 months after initiating treatment; thus, we were not surprised that the improvements in depression and anxiety were not detected at the three month point. Over time, as patients see their bodies begin to match their gender, we consistently see significant improvement in patient mental health. In addition to seeing improvement in GAD-7 and PHQ-9 scores measuring anxiety and depression, we see reduction or elimination in suicidal ideation, improved family functioning and social relationships, and improved school engagement and performance. We get this information from the patients as well as their parents, who are often surprised to see such dramatic changes in their children's lives and well-being.

18. Defendants and their experts assert that clinical experience is not reliable evidence and appear to suggest that it should be disregarded. *See* Cantor ¶¶ 284 et seq. Yet Dr. Cantor seems to acknowledge that such evidence may be useful, as it "might be the only option available" if there aren't systematic cohort studies available. While we would ideally always have more and stronger research to support all medical practices, as clinicians we must rely on the best evidence available to guide clinical care. Clinical practice guidelines like those of the Endocrine Society and the WPATH Standards of Care make recommendations based on the best evidence that exists. In all areas of medicine, sometimes treatment recommendations are made based on expert opinion from clinical experience. Gender affirming medical care for adolescents is supported by multiple cohort and retrospective studies; however, the experience of clinicians is also valuable.

19. Defendants and their experts suggest that lack of FDA approval of puberty blockers, testosterone, and estradiol for the treatment of gender dysphoria supports their position that these treatments are not effective. My opening declaration discusses the wide-spread

[3] Our study was intended to continue to follow-up at additional time points, however our clinical operations shifted dramatically after this paper's publication due to the COVID-19 pandemic. We plan to collect more long-term data on the patients included in that study.

use of medications off-label (without FDA approval for a particular indication). The defendants' suggestion that lack of FDA approval for an indication means the FDA does not support that use[4] is erroneous. The lack of FDA approval does not mean disapproval of these medications for this indication; it says nothing at all about the FDA's views of the treatment. That is because the FDA does not opine on the safety or efficacy of a treatment for a particular indication unless a pharmaceutical company applies for approval for that indication. Making an application may not be financially reasonable or feasible if the treatment has already been approved for other conditions because, as the FDA states, "once the FDA approves a drug, healthcare providers generally may prescribe the drug for an unapproved use when they judge that it is medically appropriate for their patient." (https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label).

DEFENDANTS AND THEIR EXPERTS' ASSERTIONS REGARDING WPATH'S GUIDELINES REGARDING GENDER-AFFIRMING SURGERIES

20. Defendants' experts suggest that the fact that the WPATH Standards of Care 8 does not include a minimum age for genital surgery is equivalent to WPATH endorsing such surgeries at any age. *See* Cantor ¶ 249. This claim disregards the strong cautionary language included in the WPATH SOC 8 about assessing the patient's emotional and cognitive maturity to make each treatment decision and guidance about how to make that assessment. *See* WPATH SOC 8at S61-62. The age at which an individual has the maturity and cognitive ability to develop realistic expectations for surgical outcomes and understand long-term consequences varies greatly from person to person, and is elucidated in the comprehensive mental health evaluation that is required prior to consideration of any surgical interventions.

[4] See Defs' brief,at 9 (stating that "the FDA is not prepared to put its credibility and careful testing protocols behind the use" of puberty blockers, estrogen and testosterone to treat gender dysphoria).

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

Executed on October 13, 2023.

Kara Connelly MD

Kara Connelly, MD

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

Pam POE, et al.,

Plaintiffs,

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

Raúl LABRADOR, et al.,

Defendants.
_____/

Expert Report of

James M. Cantor, PhD

Table of Contents

I. Credentials and Qualifications

A. Education and professional background

1. I am a sexual behavior scientist, with an internationally recognized record studying the development of human sexualities, and an expert in research methodology of sexuality. My curriculum vitae is attached as Appendix 1 to this report. My publication record includes both biological and non-biological influences on sexuality, ranging from pre-natal brain development, through adulthood, to senescence. The primary, but not exclusive, focus of my own research studies has been the development of atypical sexualities. In addition to the studies I myself have conducted, I am regularly consulted to evaluate the research methods, analyses, and proposals from sexual behavior scientists throughout the world. The methodologies I am qualified to assess span the neurochemical and neuroanatomic level, individual behavioral level, and social and interpersonal levels.

2. I am trained as a clinical psychologist and neuroscientist, and I am the author of over 50 peer-reviewed articles in my field, spanning the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities collectively referred to as *paraphilias*. Although I have studied many atypical sexualities, the most impactful of my work has been MRI and other biological studies of the origins of pedophilia. That work has revolutionized several aspects of the sex offender field, both with regard to the treatment of offenders and to the prevention of sexual abuse of children. In 2022, I received the Distinguished Contribution Award from the Association for the Treatment and Prevention of Sexual Abuse in recognition of my research and its integration into public policy. My efforts in this regard have been the subject of several documentary films.

3. Over my academic career, my posts have included Senior Scientist and Psychologist

at the Centre for Addiction and Mental Health (CAMH), and Head of Research for CAMH's Sexual Behaviour Clinic. I was on the Faculty of Medicine of the University of Toronto for 15 years and have served as Editor-in-Chief of the peer reviewed journal, *Sexual Abuse*. That journal is one of the top-impact, peer-reviewed journals in sexual behavior science and is the official journal of the Association for the Treatment and Prevention of Sexual Abuse. In that appointment, I was charged to be the final arbiter for impartially deciding which contributions from other scientists in my field merited publication. I believe that appointment indicates not only my extensive experience evaluating scientific claims and methods, but also the faith put in me by the other scientists in my field. I have also served on the Editorial Boards of *The Journal of Sex Research*, the *Archives of Sexual Behavior*, and *Journal of Sexual Aggression*. I am currently the Director of the Toronto Sexuality Centre in Canada. Thus, although I cannot speak for other scientists, I regularly interact with and am routinely exposed to the views and opinions of most of the scientists active in our field today, within the United States and throughout the world.

4. For my education and training, I received my Bachelor of Science degree from Rensselaer Polytechnic Institute, where I studied mathematics, physics, and computer science. I received my Master of Arts degree in psychology from Boston University, where I studied neuropsychology. I earned my doctoral degree in psychology from McGill University, which included successfully defending my doctoral dissertation studying the effects of psychiatric medication and neurochemical changes on sexual behavior, and included a clinical internship assessing and treating people with a wide range of sexual and gender identity issues.

5. I have a decades-long, international, and award-winning history of advocacy for destigmatizing people with atypical sexualities. While still a trainee in psychology, I founded the

American Psychological Association's (APA) Committee for Lesbian, Gay, and Bisexual Graduate Students. Subsequently, I have served as the Chair for the Committee on Science Issues for APA's Division for the Psychology of Sexual Orientation and Gender Diversity and was appointed to its Task Force on Transgender Issues. Throughout my career, my writings and public statements have consistently supported rights for transgender populations and the application of science to help policy-makers best meet their diverse needs. Because my professional background also includes neurobiological research on the development of other atypical sexualities, I have become recognized as an international leader also in the destigmatizing of the broader range of human sexuality patterns.

6. I am highly experienced in the application of sex research to forensic proceedings: I have served as the Head of Research for the Law and Mental Health Program of the University of Toronto's psychiatric teaching hospital, the Centre for Addiction and Mental Health, where I was appointed to the Faculty of Medicine.

7. I have served as an expert witness in 21 cases in the past four years, as listed on my *curriculum vitae*. These cases included criminal, civil, and custody proceedings, preliminary injunction and Frye hearings, as well as trials. I have testified in courts in Canada and throughout the U.S., including Alabama, Arizona, Florida, Illinois, Indiana, Kansas, Kentucky, Massachusetts, New York, Texas, Utah, and West Virginia. I have provided expert testimony concerning the nature and origins of atypical sexualities, as well as concerning gender dysphoria and gender identity in children.

8. For my work in this case, I am being compensated at the hourly rate of $400 per hour. My compensation does not change based on the conclusions and opinions that I provide here or later in this case or on the outcome of this lawsuit.

B. Clinical expertise vs. scientific expertise

9. In clinical science, there are two kinds of expertise: Clinicians' expertise regards applying general principles to the care of an individual patient and the unique features of that case. A scientist's expertise is the reverse, accumulating information about many individual cases and identifying the generalizable principles that may be applied to all cases. Thus, different types of decisions may require different kinds of experts, such that questions about whether a specific patient represents an exception to the general rule might be better posed to a physician's expertise, whereas questions about establishing the general rules themselves might be better posed to a scientist's.

10. In legal matters, the most familiar situation pertains to whether a given clinician correctly employed relevant clinical standards. Often, it is other clinicians who practice in that field who will be best equipped to speak to that question. When it is the clinical standards that are themselves in question, however, it is the experts in the assessment of scientific studies who are the relevant experts.

C. The professional standard to evaluate treatment models is to rely on objective assessors, not treatment model users in a conflict of interest with its results.

11. I describe in a later section the well-recognized procedures for conducting reviews of literature in medical and scientific fields to evaluate the strength of evidence for particular procedures or treatments. Importantly, the standard procedure is for such evaluations to be conducted by objective assessors with expertise in the science of assessment, and not by those with an investment in the procedure being assessed. Because the people engaged in providing clinical services are necessarily in a conflict of interest when claiming that their services are effective, formal evaluations of evidence are routinely conducted by those *without* direct

professional involvement and thus without financial or other personal interest in whether services are deemed to be safe or effective. This routine practice standard is exemplified by all of the only three systematic, comprehensive research reviews that have been conducted concerning the safety and efficacy of puberty blockers and cross-sex hormones as treatments for gender dysphoria in children.

12. In 2020, England's National Health Service (NHS) commissioned a major review of the use of puberty blockers and cross-sex hormones in children and young people and appointed prominent pediatrician Dr. Hilary Cass to lead that review, explicating that "Given the increasingly evident polarization among clinical professionals, Dr. Cass was asked to chair the group as a senior clinician with *no prior involvement* or fixed views in this area." (Cass 2022 at 35, italics added.) Dr. Cass's committee in turn commissioned formal systematic reviews of evidence from the England National Institute for Health & Care Excellence (NICE), a government entity of England's Department of Health and Social Care, established to provide guidance to health care policy, such as by conducting systematic reviews of clinical research, but without direct involvement in providing treatment to gender dysphoric individuals. (https://www.nice.org.uk/.) Similarly, the Finnish health care council commissioned its systematic review to an external firm, Summaryx Oy. (Pasternack 2019.) Summaryx Oy is a "social enterprise" (a Finnish organization analogous to a non-profit think-tank) that conducts systematic research reviews and other analyses for supporting that nation's medical and social systems. Its reviews are conducted by assessment professionals, not by clinicians providing services. (www.summaryx.eu/en/.) The systematic review by Sweden's National Board of Health and Welfare (NBHW) included four experts. (SBU Scoping Review 2019.) In addition to their own research fields, they provided clinical services in areas adjacent to but apart from gender

dysphoric children, such as physical disorders of sexual development (Dr. Berit Kriström) or gender dysphoria in adults (Dr. Mikael Landén).

13. My own most-cited peer-reviewed paper relating to gender dysphoria in minors illustrates the expertise in the evaluation of scientific evidence that I have and am recognized for. That is, that paper provided not clinical advice or a clinical study, but rather a review and interpretation of the available evidence concerning desistance in children who suffer from gender dysphoria, as well as of evidence (and lack of evidence) concerning the safety and efficacy of medical transition to treat gender dysphoria in minors. (Cantor 2019.)

14. My extensive background in the assessment of sexuality research and in the development of human sexuality places me in exactly the position of objectivity and freedom from conflict-of-interest required by the universal standards of medical research science.

15. I do not offer opinions about the best public policy. Multiple jurisdictions have attempted multiple different means of implementing that science into various public policies. Although I accept as an axiom that good public policy must be consistent with the scientific evidence, science cannot objectively assess societal values and priorities. Therefore, my opinions summarize and assess the science on which public policy is based, but I can offer no opinion regarding which public policy mechanisms would be best in light of that science.

II. Multiple international health care systems that had initially expanded medicalized transition to include minors have reversed that policy, as research on safety and effectiveness accumulated, in a growing international trend against the medicalized transition of minors.

16. Medicalized interventions for minors originated in European clinics (most prominently in the Netherlands and Sweden), and these precedents (and in particular the so-called "Dutch Protocol") are frequently cited by American clinicians. However, growing concerns about safety together with the continuing absence of reliable evidence of benefit even after more than 20 years of experience have led respected and far-from "conservative" European health care ministries to step back and discourage or even cease providing medicalized transition of minors, other than in exceptional and carefully limited circumstances, such as within registered and approved research trials. Instead, these authorities now endorse psychotherapy as the treatment of choice for minors, with medical interventions representing a method of last resort, if permitted at all. These range from medical advisories to outright bans on the medical transition of minors. I provide details concerning these policy changes below, and provide additional details regarding the underlying systematic reviews in Sections V and VI below.

A. England

17. The National Health Service (NHS) of England centralized gender counselling and transitioning services into a single clinic, the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust. Between 2008 and 2018, the number of referrals to the clinic had increased by a factor of 40, leading to a government inquiry into the causes. (Rayner 2018.) The GIDS was repeatedly accused of approving and endorsing medical transition in minors without adequate justification, including by 35 members of the GIDS own staff, who resigned by 2019. (BBC News 2021; Donnelly 2019). An ex-governor and psychotherapist of the Trust who resigned, Marcus Evans, said staff feared being called

transphobic, which was impacting their objectivity in their work. (Doward 2019).

18. In 2020, a former patient of the GIDS, Keira Bell, brought a lawsuit alleging that the GIDS practices with respect to prescribing puberty blockers for minors were unproven and potentially harmful in ways that meant that it was impossible for minors to give meaningful informed consent. After taking extensive expert evidence, the trial court concluded that puberty blockers might have "potentially irreversible" and "life-changing" effects on a young person (*Bell v. Tavistock*, [2020] EWHC 3274 (Admin), ¶148, 151), that there was "very limited evidence as to its efficacy" (¶134) such that "it is right to call the treatment experimental" (¶148), and that use of puberty blockers almost always led to use of cross-sex hormones that "may well lead to a loss of fertility" (¶¶ 137-138). While an appeals court later concluded that the trial court had exceeded the proper role of the court in making factual findings on these questions, the appeals court acknowledged that "Medical opinion is far from unanimous about the wisdom of embarking on treatment before adulthood. The question raises not only clinical medical issues but also moral and ethical issues, all of which are the subject of intense professional and public debate." (Bell v. Tavistock 2021 at ¶3.)

19. Perhaps prompted by the Keira Bell litigation, also in 2020 the English National Health Service ("NHS") commissioned the thorough independent review of the use of puberty blockers and cross-sex hormones to be chaired by Dr. Cass that I have described above. After an extensive process that included obtaining the systematic reviews of all published studies bearing on safety or efficacy of these hormonal interventions in minors as well as "extensive" listening sessions with clinicians, patients, and families, in February 2022 Dr. Cass issued an extensive "Interim Report" summarizing the state of the relevant medical science and in particular highlighting the presence of serious but unstudied risks and the lack of strong evidence of

efficacy. I will quote specific items from Dr. Cass's Report as relevant to specific topics below. At a high level, Dr. Cass concluded that to date there has been "very limited research on the sexual, cognitive, or broader developmental outcomes" from the use of puberty blockers for gender dysphoria (Cass 2022 at 19), that it is an unanswered question "whether the evidence for the use and safety of [puberty blockers] is strong enough as judged by reasonable clinical standards" (at 37), and that "the available evidence was not strong enough to form the basis of a policy position" with regard to use of both puberty blockers and cross-sex hormones in minors (at 35).

20. Following issuance of Dr. Cass's Interim Report, the National Health Service of England (NHS England) published a consultation document concerning a proposed revised service specification under which "NHS England will only commission [puberty blockers] in the context of a formal research protocol." (NHS Interim Service Specification at 12.) As of June 9, 2023, the NHS England announced its implementation of its previously interim policy. They reasserted "there is not enough evidence to support their safety or clinical effectiveness as a routinely available treatment." and that it will limit the use puberty-blockers to formal clinical trials. (Ghorayshi 2023; Moss & Parry 2023).

B. Finland

21. In Finland, minors were made eligible for medicalized transition in 2011 by that country's health care service, the Council for Choices in Health Care in Finland (COHERE). Assessments of mental health and preparedness were centralized by law into two research clinics, Helsinki University Central Hospital and Tampere University Hospital.

22. In 2019, the Service Selection Council (Palko) of the Finnish Ministry of Social Affairs and Health commissioned a systematic review of the effectiveness and safety of

medicalized transition (Pasternack 2019), and in 2020, Finnish researchers published an analysis of the outcomes of adolescents diagnosed with gender dysphoria and receiving cross-sex hormone treatment in Finland's Tampere University Hospital. (Kaltiala 2020.) Despite the purpose of medical transition being to improve mental health, the study showed:

> Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development. (Kaltiala 2020 at 213.)

They concluded that the youth who were functioning well after transition were those who were already functioning well before transition, and those who were functioning poorly before transition continued to function poorly after transition.

23. Importantly, the results of this study exemplify why correlations reported from surveys cannot be interpreted as evidence of causality. Mental health assessment would exclude the most poorly functioning youth from among those permitted to transition, but transition itself did not improve the functioning of those who were permitted to transition.

24. Consistent with the results of the independent evidence review by Summaryx Oy and analysis of the ethical issues involved, Finland's health care service ended the surgical transition of minors, ruling in 2020 that "Surgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors." (COHERE Summary 2020.) The review of the research concluded that "[N]o conclusions can be drawn on the stability of gender identity during the period of disorder caused by a psychiatric illness with symptoms that hamper development." (COHERE Summary 2020.) COHERE also greatly restricted access to puberty-blocking and cross-sex hormonal treatments, explicating that they may be considered for minors "only if it can be ascertained that their identity as the other sex is of a permanent nature and causes severe dysphoria," and only "if the need for it continues *after* [any] other psychiatric

symptoms have *ceased* and adolescent development is progressing normally." (COHERE Summary 2020, italics added.) They restricted the procedures to their centralized research clinics. The council was explicit in noting the lack of research needed for decision-making, "There is also a need for more information on the disadvantages of procedures and on people who regret them." (COHERE Summary 2020.) In light of the special developmental and ethical considerations surrounding minors, COHERE recommended that "no decisions should be made that can permanently alter a still-maturing minor's mental and physical development." (COHERE Recommendation 2020 at 7.)

C. Sweden

25. Sweden's national health care policy regarding trans issues has developed quite similarly to that of the UK. Already in place 20 years ago, Swedish health care policy permitted otherwise eligible minors to receive puberty-blockers beginning at age 14 and cross-sex hormones at age 16. At that time, only small numbers of minors sought medical transition services. An explosion of referrals ensued in 2013–2014. Sweden's Board of Health and Welfare ("Socialstyrelsen") reported that, in 2018, the number of diagnoses of gender dysphoria was 15 times higher than 2008 among girls ages 13–17. (Swedish Socialstyrelsen Support 2022 at 15.)

26. Sweden has long been very accepting with regard to sexual and gender diversity. In 2018, a law was proposed to lower the age of eligibility for surgical care from age 18 to 15, remove the requirement for parental consent, and lower the legal age for change of gender to age 12. A series of cases of regret and suicide following medical transition were reported in the Swedish media. (Orange 2020.) In 2019, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) therefore initiated its own systematic review of the research. The SBU released English-language results first as a summary and then

published as a peer reviewed article. (Ludvigsson et al., 2023.) Like the UK, the Swedish investigation employed standardized review methods to ensure the encapsulation of all the relevant evidence and came to the same conclusions: "This systematic review of almost 10 000 screened abstracts suggests that long-term effects of hormone therapy on psychosocial and somatic health are unknown, except that GnRHa treatment seems to delay bone maturation and gain in bone mineral density." (Ludvigsson 2023 at 12.) They emphasized, "The absence of long-term studies is worrying because many individuals start treatment as minors (<18 years) and CSHT is lifelong." (Ludvigsson 2023 at 10.) Regarding the full set of studies, "No randomised controlled trials were found, but we could identify 24 relevant observational studies. However, these were limited by methodological weaknesses, for instance lack of or inappropriate control group, lack of intra-individual analyses, high attrition rates that precluded conclusion to be drawn." (Ludvigsson 2023 at 9–10.)

27. In 2021, the leading Swedish pediatric gender clinic, at the Karolinska Institute, issued a new policy statement in which it stated that the Swedish evidence review "showed a lack of evidence for both the long-term consequences of the treatments, and the reasons for the large influx of patients in recent years." (Karolinska 2021.) The Karolinska Institute further stated that "These treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis." In a dramatic reversal of its policy, the Institute announced that "In light of the above, and based on the precautionary principle, which should always be applied, it has been decided that hormonal treatments (i.e., puberty blocking and cross-sex hormones) will not be initiated in gender dysphoric patients under the age of 16." Further, the Karolinska clinic announced that patients ages 16–18 would receive such treatments *only* within research settings

(clinical trials monitored by the appropriate Swedish research ethics board). (Karolinska 2021.)

28. In 2022, the Swedish National Board of Health and Welfare published a major new national policy document concerning "Support, investigation and hormone therapy in gender incongruence in children and youth," including an English-language summary. (Swedish Socialstyrelsen Support 2022.) The National Board of Health noted "the continued lack of reliable scientific evidence concerning the efficacy and the safety of both [puberty blockers and cross-sex hormones]," and concluded (based on the commissioned evidence reviews) that "the evidence on treatment efficacy and safety is still insufficient and inconclusive for all reported outcomes. Further, it is not possible to determine how common it is for adolescents who undergo gender-affirming treatment to later change their perception of their gender identity or interrupt an ongoing treatment." As a result, the Board of Health concluded that, "[f]or adolescents with gender incongruence, the . . . risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits." (Swedish Socialstyrelsen Support 2022 at 10-12.) Accordingly, the Swedish Board of Health and Welfare "recommends restraint when it comes to hormone treatment." (Swedish Socialstyrelsen Updated Recommendations 2/22/22.)

D. France

29. While medical authorities in France have not issued any actual restriction, in 2022, the Académie Nationale de Médecine of France issued a strongly worded statement, citing the Swedish ban on hormone treatments:

> [A] great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause…such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause." (Académie Nationale de Médecine 2022.)

For hormones, the Académie concluded "the greatest reserve is required in their use," and for surgical treatments, "[T]heir irreversible nature must be emphasized." The Académie warned "the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to 'detransition'." Rather than medical interventions, it advised health care providers "to extend as much as possible the psychological support phase." The Académie reviewed and emphasized the evidence indicating the very large and very sudden increase in youth requesting medical transition. It attributed the change, not to society now being more accepting of sexual diversity, but to social media, "underlining the addictive character of excessive consultation of social networks which is both harmful to the psychological development of young people and responsible, for a very important part, of the growing sense of gender incongruence." (Académie Nationale de Médecine 2022.)

E. Norway

30. In 2022, Norway's Healthcare Investigation Board (Ukom) began a review of that country's guidelines for the medicalized transition of minors. (Block, Norway's Guidance, 2023.) In 2023, it released its report, which concluded that the evidence for the use of puberty blockers and cross-sex hormone treatments in youth was insufficient, and acknowledged the international recognition of the dearth of evidence of safety and effectiveness. The report deemed medicalized transition to be experimental. (Ukom 2023, Summary and Section 11.) The report faulted the existing Norwegian guidelines, published in 2020, for concentrating on "equality and rights" while "deviating from the requirements for the development of knowledge-based guidelines." (Ukom 2023, Summary.)

31. The Norwegian report concluded that "The knowledge base, especially research-based knowledge for gender-affirming treatment (hormonal and surgical), is insufficient and the

long-term effects are little known" and that "This applies particularly to the teenage population, which accounts for a large part of the increase in referrals to the specialist health service in the last decade." (Ukom 2023, Summary and Section 7.)

32. In an interview about the report with the *British Medical Journal,* the Ukom Medical Director, Stine Marit Moen, said, "We're concerned that there may be undertreatment, overtreatment, and the wrong treatment" and added:

> We've seen a marked increase in referrals to specialised healthcare services in Norway for teenagers, as seen in many other western countries, and nobody knows the reason. The stability of the gender dysphoria of these teenagers is not known, and the evidence of long term effects of gender affirming treatments for this young population is insufficient. (Block, Norway's Guidance, 2023.)

33. Ukom noted that referrals to its national treatment service increased by a factor of eight between 2007 and 2018, and that this increase was largely from young biological females. Seventy-five percent of the referrals to its National Treatment Service had other co-morbid psychiatric diagnoses, including not only depression and anxiety but also autism spectrum disorders, ADHD, and Tourette's Syndrome. (Ukom 2023, Summary and Section 7.)

F. Assertions by U.S. organizations and officials that there is 'no debate' over medicalized transition are false.

34. The international consensus is clearly demonstrated by the multiple recent analyses, statements, and policy decisions from the health care service systems around the world. These include England's National Health Service, which noted the "Scarce and inconclusive evidence to support clinical decision making [which] has led to a lack of clinical consensus on what the best model of care for children and young people experiencing gender incongruence and dysphoria should be." (NHS 2022 at 5.)

35. As these several recent national policy reviews, statements, and recommendations make very clear, there is a great deal of doubt and debate among the sophisticated international

medical and mental health community as to whether the administration of puberty blockers and cross-sex hormones to children and young people is the best clinical practice, and as to whether these treatments have been shown to be safe and effective. Indeed, the lack of scientifically reliable data concerning safety and efficacy highlighted by the systematic evidence reviews commissioned by the English National Health Service, by the Swedish National Board of Health and Welfare, and by the Finnish Council for Choices in Health Care in Finland have caused those national health authorities and others to move sharply away from approving puberty blockers, cross-sex hormones, or surgery for minors.

36. In this report, I explain the evidence and lack of evidence behind that doubt, that debate, and the emerging international consensus of caution reflected in the several recent European policy statements or changes.

37. I note that the plaintiffs' experts have excluded all mention of the international reversals of policy, suggesting a consensus that does not exist. In fact, practices at U.S. gender clinics and statements by U.S. advocacy voices increasingly represent an outlier view, failing to update policy despite the mounting evidence.

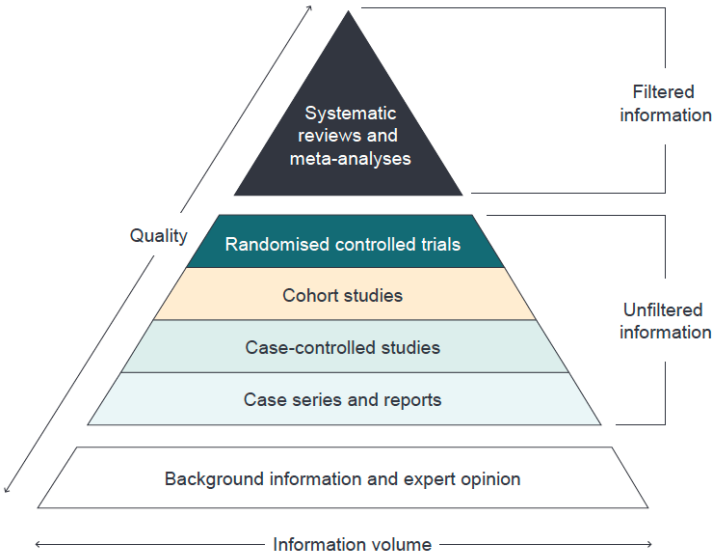
III. Clinical research has a standard Pyramid of Evidence that summarizes the relative strength of potential sources of information.

38. The widely accepted starting point in evidence-based medicine is the recognition that clinical experiences and recollections of individual practitioners (often called "expert opinion" or "clinical anecdote") do not and cannot provide a reliable, scientific basis for treatment decisions. Rather, in evidence-based medicine, clinical decision-making is based on objectively demonstrated evidence of outcomes from the treatment options. An essential first step in evidence-based medicine is identifying the relevant findings from among the immense flood of clinical journal articles published each year. Those studies and the evidence they report are then assessed according to the strength offered by the research methods used in each study. The research methods used in a study determine its reliability and generalizability, meaning the confidence one may have that using the same treatment again will have the same result again on other people. In this section, I explain the well-accepted criteria for evaluating the evidentiary value of clinical studies.

A. Clinical research comprises a standard *Pyramid of Evidence*, wherein studies from higher levels of evidence outrank even more numerous studies from lower levels of research.

39. The accepted hierarchy of reliability for assessing clinical outcomes research is routinely represented as a "Pyramid of Evidence" (Figure 1). Scientific questions are not resolved by the number of studies coming to one versus another conclusion. Studies representing higher levels of evidence outrank studies from lower levels. Even large numbers of lower-level studies cannot overcome a study representing a higher level of evidence. Indeed, because lower-level studies are generally faster and less expensive to conduct, it is typical for them to outnumber higher level studies. This is the property meant to be reflected by the pyramid's shape, which is larger at the base and smaller at the apex.

Figure 1: Pyramid of Standards of Evidence



Source: Cass, H. (2022, February). *The Cass Review: Independent review of gender identity services for children and young people Interim report.* National Health Service (NHS), UK. Available from https://cass.independent-review.uk/publications/interim-report/, citing OpenMD, retrieved from https://openmd.com/guide/levels-of-evidence.

B. The highest level of evidence for safety and effectiveness research is the systematic review of clinical experiments.

40. The most reliable and conclusive method of determining what is actually known or not known with respect to a particular treatment is the *systematic review.* Systematic reviews employ standardized procedures to assess comprehensively all available evidence on an issue, minimizing opportunities for bias in gathering and evaluating research evidence. As described by Dr. Gordon Guyatt, the internationally recognized pioneer in medical research who invented the term *evidence-based medicine,* "A fundamental principle to the hierarchy of evidence [is] that optimal clinical decision making requires systematic summaries of the best available evidence." (Guyatt 2015 at xxvi.)

1. Systematic reviews prevent the 'cherry-picking' of studies that favor a particular result.

41. Because systematic reviews are designed to prevent researchers from including only the studies they favor and other biases, systematic reviews are the routine starting point for developing clinical practice guidelines. (Moher 2009.) The methods of a systematic review include:

- Define the scope, including the "PICO": Population/Patient, Intervention, Comparison/Control, and Outcome(s);
- Select and disclose the keywords used to search the (massive) available clinical research database(s) for potentially relevant articles, identify the databases they were applied to, and the date(s) of the searches, including any subsequent updates;
- Select and disclose the inclusion/exclusion criteria to be used to filter the "hits" from the keyword searches to identify research studies to be included in the detailed review;
- Review abstracts to select the final set of studies, using at least two independent reviewers to allow for measuring inter-rater reliability on the criteria;
- Code each study's results impacting the research question(s), disclosing the list of all studies and the results coded from each;
- Evaluate the reliability of the results [risk of bias] of each included study, applying uniform criteria across them all.

42. As detailed in Section V, several systematic reviews have been conducted of the outcomes of medicalized transition of gender in minors. Their conclusions are highly consistent with each other. Much of the expert testimony offered by plaintiffs' experts, however, depends on levels of evidence far lower on the pyramid of evidence (e.g., "expert opinion") or beneath the pyramid entirely (e.g., survey studies) while ignoring the thorough, high-quality systematic reviews available in the research literature. Doing so is in direct conflict with foundational principles of evidence-based medicine.

2. Systematic reviews prevent biased assessment of individual studies by uniformly applying standard criteria to each study reviewed. The most widely used criteria set is "GRADE."

43. In order to produce unbiased assessment of the studies within the systematic review, all the studies must be evaluated using the same evaluation criteria. Without such criteria, assessments can become influenced by researchers who, intentionally or not, hold the evaluative bar higher or lower for studies according to whether the studies' conclusions support or challenge that researcher's perspective. Several such systems have been developed. The most widely used system is the "Grading of Recommendations, Assessment, Development and Evaluations" (GRADE). (Goldet & Howick 2013.) In the GRADE system, studies' findings are downgraded for:

- Risk of bias:[1]
    - Lack of clearly randomized allocation sequence,
    - Lack of blinding,
    - Lack of allocation concealment,
    - Failure to adhere to intention-to-treat analysis,
    - Trial is cut short,
    - Large losses to follow-up;
- Inconsistency;
- Indirectness of evidence;
- Imprecision; and
- Publication bias (when studies with 'negative' findings remain unpublished).

Studies' ratings are upgraded if their findings identify:

- A large effect of the treatment;
- A dose-response relationship (the size of the effect has a systematic association with the dose of the treatment given); or
- That all plausible biases only *reduce* the apparent effect of the treatment (necessarily making the estimated effect sizes conservative estimates).

[1] In science, including in the GRADE system, the term "bias" refers to any external influence leading to a systematic over- or underreporting of the outcome being measured. That is, in this context "bias" is not used in the sociopolitical sense of personal values.

44. GRADE assessments yield a four-point score representing the certainty that a reported treatment effect is true. These certainty scores are (GRADE Handbook, Section 5):

Certainty	Meaning
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect.
Very Low	We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect.

C. The highest level experimental study of clinical safety and effectiveness is the Randomized Controlled Trial (RCT). RCTs can demonstrate that a given treatment causes (rather than only correlates with) a given outcome.

45. Randomized Controlled Trials are the gold standard method of assessing the effects caused by an experimental treatment. The great scientific weight of RCTs follows from the randomization: People do not pick which research group they are in—a treatment group or a control group. Without random group assignment, it is not possible to identify which, if any, changes are due to the treatment itself or to the factors that led to who did and did not receive treatment.

46. Levels of evidence lower than RCTs are unable to distinguish when changes are caused by the experimental treatment, or by factors that can mimic treatment effects, such as 'regression to the mean' and the placebo effect.

47. In the absence of evidence that X causes Y, it is a scientific error to use language indicating there is causal relationship. In the absence of evidence of causality, it is scientifically unsupportable to describe a correlation with terms such as: increases, improves, benefits, elevates, leads to, alters, influences, results in, is effective for, causes, changes, contributes to,

yields, impacts, decreases, harms, and depresses. Scientifically valid terms for correlations include: relates to, is associated with, predicts, and varies with.

48. I note that the plaintiffs' experts repeatedly misrepresent studies using causal language to describe studies that are unable to demonstrate causality. Such language incorrectly asserts that the evidence is stronger than it actually is.

1. RCTs, but not lower levels of evidence, overcome biases representing 'regression to the mean' and other factors that can mimic clinical improvement.

49. 'Regression to the mean' arises when researching issues, such as mood, depression, or levels of emotional distress that typically fluctuate over time. People are more likely to seek out treatment during low points rather than high points in their emotional lives. Thus, when tracking emotional states over time, the average of a group of people in a treatment group may often show an increase; however, without an untreated control group to which to compare them, researchers cannot know whether the group average would have increased anyway, with only the passage of time.

50. Blinding or masking participants in an RCT from which group they are in has been described as a preferred strategy since the 1950s, in order to exclude the possibility that a person's expectations of change caused any changes observed (the "placebo effect"). In practice, however, it has often made little or no significant difference. For example, a study using very high quality methods—meta-analysis of meta-analysis research—has revealed no statistical difference in the sizes of the effects detected by blinded/placebo-controlled studies from non-blinded/non-placebo-controlled studies of depression. (Moustgaard 2019.) That is, the pre-/post-treatment differences found in placebo groups are not as attributable to participants' expectations of improvement as they are to expectable regression to the mean. (Hengartner 2020.)

2. When a 'no treatment control group' is untenable, RCTs use an 'active comparator' group instead.

51. It is not always possible to compare a group receiving a treatment to a group receiving only an inactive procedure, such as a placebo treatment or no treatment at all. In such situations, the standard, ethical, clinical research method is to compare two active treatments with each other.

52. The systematic reviews from England explicitly called for 'active comparator' studies to test whether medicalized transition of minors shows mental health benefits superior to those obtained from psychotherapy. (NICE 2020a at 40; NICE 2020b at 47.) Risk:benefit analysis cannot justify the greater risks associated with medicalization without evidence of correspondingly greater benefit.

D. Cohort studies are the highest level of evidence about medicalized transition currently available.

53. The highest-level study of medicalized transition of minors conducted thus far are cohort studies: gathering a sample of individuals who chose to undergo treatment and tracking them over time. Cohort studies are able to answer some questions that lower-level studies cannot, such as whether a high-functioning group improved over time versus having been composed of people who were already high-functioning. Cohort studies are, however, unable to demonstrate causality, to identify how much of any change was due to regression to the mean, or to detect any placebo effects.

E. Expert opinion represents the least reliable evidence.

54. As Figure 1 illustrates, in evidence-based medicine, opinion based on clinical experience is identified as the *least* reliable source of medical knowledge. Among other reasons, this is because non-systematic recollections of unstructured clinical experiences with self-

selected clientele in an uncontrolled setting is the most subject to bias. Indeed, mere "clinical experience" was long the basis of most medical and mental health clinical decisions, and it was precisely the scientific and clinical inadequacy of this type of "knowledge" that led to the development and widespread acceptance of the importance of evidence-based medicine. As Dr. Guyatt has written, "EBM places the unsystematic observations of individual clinicians lowest on the hierarchy," both because EBM "requires awareness of the best available evidence," and because "clinicians fall prey to muddled clinical reasoning and to neglect or misunderstanding of research findings." (Guyatt 2015 at 10, 15.)

F. Surveys and cross-sectional studies cannot demonstrate treatment effectiveness.

55. Surveys represent observational research rather than experimental research. (In science, experiments are studies involving a manipulation, not merely observation, by the researcher.) Surveys and cross-sectional studies can provide only correlational data and cannot demonstrate causality. (See Section IV below). It is not possible for a survey to yield evidence that a treatment is effective. No number of surveys can test a treatment, advancing it from 'experimental' to 'established' status.

56. Survey studies do not even appear on the *pyramid of evidence.* In accordance with the routine standards, systematic reviews of treatment studies exclude surveys.

57. I note that the plaintiffs' experts' reports rely largely on survey studies. The misplaced emphasis on surveys, open to whoever wanted to fill them out, masks how much the plaintiff's experts are merely parroting the claims of these youth.

IV. Methodological defects limit or negate the evidentiary value of many studies of treatments for gender dysphoria in minors.

A. In science, to be valid, a claim must be objective, testable, and falsifiable.

58. In behavioral science, people's self-reports do not represent objective evidence. It is when emotional and other pressures are strongest that the distinction between and need for objective over subjective evidence is greatest. Surveys do not represent objective evidence. This is especially true of non-random surveys and polls, recruited through online social networks of the like-minded.

B. Correlation does not imply causation.

59. Studies representing lower levels of evidence are often used because they are faster and less expensive than studies representing higher levels. A disadvantage, however, is that they are often limited to identifying which features are *associated* with which other features, but they cannot show which ones are *causing* which. It is a standard property of statistical science that when a study reports a correlation, there are necessarily three possible explanations. Assuming the correlation actually exists (rather than represents a statistical fluke or bias), it is possible that X causes Y, that Y causes X, or that there is some other variable, Z, that causes both X and Y. (More than one of these can be true at the same time.) To be complete, a research analysis of a correlation must explore all three possibilities.

60. For example, assuming a correlation between treatment of gender dysphoria in minors and mental health actually exists (rather than is a fluke): (1) It is *possible* that treatment causes improvement in mental health. (2) Yet, it is also possible that having good mental health is (part of) what enabled transition to occur in the first place. That is, because of gate-keeping procedures in the clinical studies, those with the poorest mental health are typically not permitted to transition, causing the higher mental health scores to be sorted into the transitioned group.

(See Section IV.E on *Selection Bias*.) (3) It is also possible that a third factor, such as wealth or socioeconomic status, causes both the higher likelihood of transitioning (by being better able to afford it) and the likelihood of mental health (such as by avoiding the stresses of poverty or affording psychotherapy).

61. This principle of scientific evidence is why surveys do not (cannot) represent evidence of treatment effectiveness: Surveys are limited to correlations. (See Section III.F. on *Surveys*.)

C. When two or more treatments are provided at the same time, one cannot know which treatment caused observed changes (i.e., 'confounding').

62. Confounding is a well-known issue in clinical research design. As detailed in the present report, it applies throughout treatment studies of gender dysphoria. Patients who undergo medical transition procedures in research clinics routinely undergo mental health treatment (psychotherapy) at the same time. Without explicit procedures to distinguish them, it cannot be known which treatment produced which outcome (or in what proportions). Indeed, that mental health improvement came from mental health treatment is a more parsimonious (and therefore, scientifically superior) conclusion than is medicalized treatment causing mental health improvement.

D. Extrapolation to dissimilar populations and dissimilar conditions.

63. The purpose of clinical science is to establish from a finite sample of study participants information about the effectiveness and safety, or other variables, of a treatment that can be generalized to other people. Such extrapolation is only scientifically justified with populations matched on all relevant variables. The identification of those variables can itself be a complicated question, but when an experimental sample differs from another group on variables already known to be related, extrapolation cannot be assumed but must be demonstrated directly

and explicitly.

64. Each of the systematic reviews from the UK, Sweden, and Finland emphasized that the recently observed, greatly increased numbers of youth coming to clinical attention are a population different in important respects from the subjects of often-cited research studies. Conclusions from studies of adult-onset gender dysphoria and from childhood-onset gender dysphoria cannot be assumed to apply to the current patient populations of adolescent-onset gender dysphoria. The Cass Report correctly advised:

> It is also important to note that any data that are available do not relate to the current predominant cohort of later-presenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people may not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group. (Cass 2022 at 36.)

The report also indicated:

> [I]t is important that it is not assumed that outcomes for, and side effects in, children treated for precocious puberty will necessarily be the same in children or young people with gender dysphoria. (Cass 2022 at 63.)

65. Finland's review repeated the observation of greatly (20 times) increased numbers, an entirely different demographic of cases, and increased proportions of psychiatric co-morbidities. (Finnish Palko Preparation Memo at 4-6.) The Swedish review highlighted "the uncertainty that follows from the yet unexplained increase in the number of care seekers, an increase particularly large among adolescents registered as females at birth." (Swedish Socialstyrelsen Support 2022 at 11.)

66. It is well known that males and females differ dramatically in the incidence of many mental health conditions and in their responses to treatments for mental health conditions. Thus, research from male-to-female transitioners (the predominant population until recent years) cannot be extrapolated to female-to-male transitioners (the predominant population presenting at clinics today). Outcomes from patients who experienced clear pre-pubertal childhood gender

dysphoria cannot be extrapolated to patients who first manifest diagnosable gender dysphoria well into puberty. Outcomes from clinics employing rigorous and openly reported gate-keeping procedures cannot be extrapolated to clinics or clinicians employing only minimal or perfunctory assessments without external review. Developmental trajectories and outcomes from before the social media era cannot be assumed to apply to those of the current era or the future. Research from youth with formal diagnoses and attending clinics cannot be extrapolated to self-identifying youth and those responding to surveys advertised on social media sites.

67. Further, treatment of gender dysphoria in children and adolescents presents novel-use cases very dissimilar to the contexts in which puberty blockers and cross-sex hormones have previously been studied. Whereas use of puberty blockers to treat precocious puberty *avoids* the medical risks caused by undergoing puberty growth before the body is ready (thus outweighing other risks), use of blockers to treat gender dysphoria in patients already at their natural puberty pushes them *away* from the mean age of the healthy population. Instead of avoiding an objective problem, one is created: Among other things, patients become subject to the issues and risks associated with being late-bloomers, *very* late-bloomers. This transforms the risk:benefit balance, where the offsetting benefit is primarily (however validly) cosmetic.

68. Similarly, administering testosterone to an adult male to treat testosterone deficiency addresses both a different condition and a different population than administration of that same drug to an adolescent female to treat gender dysphoria; the benefits and harms observed in the first case cannot be extrapolated to the second.

E. Mental health assessment used for gate-keeping medicalized transition establishes a *selection bias,* creating a statistical illusion of mental health improvement among the selected.

69. Importantly, clinics are expected to conduct mental health assessments of applicants

seeking medicalized transition, disqualifying from medical services patients with poor mental health. (The adequacy of the assessment procedures of specific clinics and clinicians remains under debate, however.) Such gate-keeping—which was also part of the original "Dutch Protocol" studies—can lead to misinterpretation of data unless care is explicitly taken. A side-effect of excluding those with significant mental health issues from medical transition is that when a researcher compares the average mental health of the gender dysphoric individuals first presenting to a clinic with the average mental health of those who completed medical transition, then the post-transition group would show better mental health—but only because of the *selection bias*, (Larzelere 2004; Tripepi 2010) even when the transition had no effect at all.

V. Systematic reviews of safety and effectiveness have been conducted by the health care ministries/departments of several governments. They *unanimously* concluded the evidence on medicalized transition in minors to be of poor quality.

A. Understanding safety and efficacy.

70. Plaintiffs' experts assert that use of puberty blockers and cross-sex hormones on adolescents is "safe." This claim is unsupported by any substantial scientific evidence, depreciates widely recognized risks of serious harm to minors so medicalized, and ignores both the many unknowns and the growing international doubts about their use.

71. At the outset, it is important to understand the meaning of "safety" in the clinical context. The criteria for assessing safety involve two independent components, and discussion of the safety of hormonal interventions on the natural development of children requires consideration of both of them. The term *safety* in the clinical context represents a "risk:benefit ratio," not an absolute statement that can be extrapolated across applications. In clinical research, assessing safety requires simultaneous consideration of both components of the risk:benefit ratio. That is, treatments are not deemed simply "safe" or "unsafe," as the plaintiffs' experts repeatedly use those words. These dual components are reflected in FDA regulation:

> There is reasonable assurance that a device is safe when it can be determined, based upon valid scientific evidence, that *the probable benefits* to health from use of the device for its intended uses and conditions of use, when accompanied by adequate directions and warnings against unsafe use, outweigh *any probable risks*. (Code of Federal Regulations Title 21 Sec. 860.7, italics added.)

72. Thus, for example, as I explain in further detail below, because the Endocrine Society did not undertake (or rely on) any systematic review of the efficacy of hormonal interventions to relieve gender dysphoria in minors (i.e., their benefits), and WPATH did not undertake (or rely on) any systematic review of the safety of hormonal interventions in minors (i.e., their risks), neither gathered the evidence necessary to assess the risk:benefit ratio of medicalized transition

in minors.

73. In fact, as I also review below, after conducting systematic reviews, the English, Finnish, and Swedish national health care institutions all concluded that there is insufficient evidence to determine that hormonal interventions as treatments for gender dysphoria in minors are safe. Reasons for these consistent conclusions include lack of research, insufficient research quality among the existing investigations, and insufficient investigation of long-term safety.

74. To understand the uniform conclusions of these national health care bodies, it is important to understand that—at least where there is *prima facie* reason to be concerned that certain harms may result—when the research has not been done, the absence of evidence cannot be taken as evidence of the absence of such harms. "We don't know" does not permit the conclusion "It is safe." Plaintiffs' experts and many advocates in the field of transgender medicine make this error.

B. The McMaster University systematic review of systematic reviews.

75. McMaster University is recognized as a center of expertise in the performance of methodologically sound systematic reviews. In 2022, authors associated with that McMaster University team (Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch) conducted a systematic review, "Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence," spanning all the available systematic reviews in this area, including their methodological strength, the evidence they cited, and the conclusions they reached. (Brignardello-Petersen & Wiercioch 2022.) Applying carefully disclosed criteria and methods, they identified on-point systematic reviews, and graded the methodological quality of each on-point review as high, moderate, low, or critically low. With regard to systematic reviews relating to the effects of puberty blockers or cross-sex hormones, the authors included in their

analysis all reviews that achieved at least a "low" rating of methodological quality, while excluding those rated as "very low." No systematic reviews earned a "high" methodological rating, except a review performed by the highly respected Cochrane Library of the effects of cross-sex hormones on transitioning natal males (Haupt 2020), but that most careful review in turn found *no* published studies on this topic of sufficient methodological soundness to satisfy its inclusion criteria and thus merit review. After this careful review of the data and analysis contained in available systematic reviews, the McMaster authors concluded:

> Due to important limitations in the body of evidence, there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people with gender dysphoria. This evidence alone is not sufficient to support whether using or not using these treatments. (Brignardello-Petersen & Wiercioch 2022 at 5.)

C. The quality of the systematic reviews from governmental bodies and professional associations.

76. To ensure consideration of all available evidence, I compiled into a single table all the cohort studies of safety and effectiveness included by any of the systematic reviews from the international health care systems and (although they were incomplete) by the U.S.-based clinical associations issuing guidelines or standards. I discuss their specific findings in the following sections.

77. New studies continue to be conducted and published. I have identified two additional studies that were published after these reviews were released, but that meet their inclusion criteria: Tordoff, *et al.,* 2022, and Chen, *et al.,* 2023. The findings from both these studies are consistent with those already included and are noted here for completeness.

Table 1. Cohort studies of effectiveness and safety of puberty-blockers and cross-sex hormones in minors.

	Finland (2019)	NICE (2020a,b)	Sweden (2022)	E.S. (2017)	AAP (2018)	Baker (2021) (WPATH)
Effectiveness GnRHa	Costa et al, 2015 de Vries et al, 2011	Costa et al, 2015 de Vries et al, 2011	Becker-Hebly et al, 2020 Carmichael et al, 2021 Costa et al, 2015 *** Hisle-Gorman et al, 2021			de Vries et al, 2011
Effectiveness Sex Hormones	de Vries et al, 2014*	Achille et al, 2020 Allen et al, 2019 Kaltiala et al, 2020 Lopez de Lara et al, 2020	*** *** Cantu et al, 2020* de Vries et al, 2014* ***			Achille et al, 2020 de Vries et al, 2014* López de Lara et al, 2020
Safety (Bones) GnRHa		Brik et al, 2020 Joseph et al, 2019 Khatchadourian et al, 2014 Klink et al, 2015 Vlot et al, 2017	Joseph et al, 2019 Klink et al, 2015 Navabi et al, 2021 Schagen et al, 2020 Stoffers et al, 2019 Vlot et al, 2017 Lee et al, 2020 van der Loos et al, 2021			
Safety (Bloods) GnRHa		Klaver et al, 2020 Schagen et al, 2016	Klaver et al, 2018 Klaver et al, 2020 Nokoff et al, 2020 Perl et al, 2020 Schagen et al, 2016 Schulmeister et al, 2021			
Safety (Bones) Sex Hormones	****	Khatchadourian et al, 2014 Klaver et al, 2020 Klink et al, 2015 Kuper et al, 2020 Stoffers et al, 2019 Vlot et al, 2017		Klink et al, 2015		
Safety (Bloods) Sex Hormones			Jarin, 2017 Mullins et al, 2021 Tack et al, 2016			

*Included both puberty-blockers and cross-sex hormones.
**The Endocrine Society review included bone/skeletal health, but did not explicate whether the scope included minors.
***Sweden explicitly excluded due to high risk of bias: Achille, *et al.,* (2020), Allen, *et al.* (2019), de Vries, *et al.,* (2011), and López de Lara, *et al.,* (2020).
****The Finnish review adopted the Endocrine Society review, but did not indicate whether minors were included.

D. United Kingdom

78. The National Health Service (NHS) of the United Kingdom conducted an independent review of its services for minors with gender dysphoria. (Cass 2022.) Included in that process were two systematic, comprehensive reviews of the research literature, conducted by England's National Institute for Health Care Excellence (NICE) in 2020. One regarded the efficacy, safety, and cost-effectiveness of Gonadotrophin-Releasing Hormone (GnRH) analogs (or "puberty blockers") in minors. (NICE 2020a.) The other regarded the efficacy, safety, and cost-effectiveness of cross-sex hormones, or "gender-affirming hormones," in minors. (NICE 2020b.) (Only efficacy and safety are relevant to the present report.)

79. The puberty-blocker review was tasked with reviewing the research on two relevant questions. For one:

> *In children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?* (NICE 2020a at 4.)

Clinical effectiveness of puberty-blockers was composed of three factors deemed "critical outcomes": impact on gender dysphoria, impact on mental health, and impact on quality of life. The second question addressed in the review was:

> *In children and adolescents with gender dysphoria, what is the short-term and long-term safety of GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?* (NICE 2020a at 6.)

Puberty-blocker safety was assessed as its effect on three categories of health: bone density, cognitive development or functioning, and "other."

80. The second review, for cross-sex hormone treatment, was tasked with the corresponding questions. For one:

> *In children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?* (NICE 2020b at 4.)

The critical outcomes were again deemed to be impact on gender dysphoria, on mental health, and on quality of life. The impact on mental health was composed of indicators of depression, anxiety, and suicidality and self-injury. The second question was:

> *In children and adolescents with gender dysphoria, what is the short-term and long-term safety of gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?* (NICE 2020b at 7.)

Cross-sex hormone treatment safety was assessed as its effect on bone density and on "clinical parameters," which included insulin, cholesterol, and blood pressure levels.

81. These two reviews included a systematic consolidation of all the research evidence, following established procedures for preventing the "cherry-picking" or selective citation favoring or down-playing any one conclusion, carefully setting out the criteria for including or excluding specific studies from the review, and providing detailed analyses of each included study. The whole was made publicly available, consistent with good practice.

82. The reviews' results were unambiguous: For both puberty blockers and cross-sex hormones, "The critical outcomes for decision making are the impact on gender dysphoria, mental health and quality of life." The quality of evidence for these outcomes was assessed as "very low" using the established GRADE procedures for assessing clinical research evidence. (NICE 2020a at 4; NICE 2020b at 4.) The reviews also assessed as "very low" the quality of evidence regarding "body image, psychosocial impact, engagement with health care services, impact on extent of satisfaction with surgery and stopping treatment" or (in the case of cross-sex hormones) of "detransition." (NICE 2020a at 5; NICE 2020b at 6.) The review of puberty blockers concluded that of the existing research, "The studies included in this evidence review

are all small, uncontrolled observational studies, which are subject to bias and confounding," "They suggest little change with GnRH analogues [puberty blockers] from baseline to follow-up." (NICE 2020a at 13.) The cross-sex hormone review likewise reported a lengthy list of methodological defects or limitations affecting all available studies. (NICE 2020b at 13-14.)

83. The NHS changed the language on its website describing puberty blockers and cross sex hormones. It removed the statement that "The effects of treatment with GnRH analogues are considered to be fully reversible,"[2] replacing that text with:[3]

> Little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria. . . . [I]t is not known what the psychological effects may be. It's also not known whether hormone blockers affect the development of the teenage brain or children's bones.

84. As mentioned in the McMaster review, the highly respected Cochrane Library, based in England, undertook a systematic review of studies of the safety and efficacy of the administration of cross-sex hormones to natal males. That review focused primarily on adults (age 16 and older). The results, including a detailed explanation of methodology and inclusion criteria, were published in 2020. Unfortunately, but importantly, the Cochrane review found *zero* studies, globally, that were sufficiently reliable to meet the inclusion criteria even at a "very low" level of evidentiary quality. The authors reported:

> Despite more than four decades of ongoing efforts to improve the quality of hormone therapy for women in transition, we found that no RCTs or suitable cohort studies have yet been conducted to investigate the efficacy and safety of hormonal treatment approaches for transgender women in transition….We found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches…for transgender women in transition. The evidence is very incomplete, demonstrating a gap between current clinical practice and clinical research. (Haupt 2020 at 10-11.)

The authors' frustration at the total lack of reliable research was evident: "The lack of reliable

[2] BBC. Retrieved from https://www.bbc.co.uk/sounds/play/m000kgsj; Kurkup, J. (2020, June 4). *The Spectator*. Available from https://www.spectator.co.uk/article/the-nhs-has-quietly-changed-its-trans-guidance-to-reflect-reality/
[3] NHS. Retrieved from https://www.nhs.uk/conditions/gender-dysphoria/treatment/

data on hormone therapy for transitioning transgender women should encourage the development of well-planned RCTs and cohort studies to evaluate widespread empirical practice in the treatment of gender dysphoria." (Haupt 2020 at 10.)

E. Sweden

85. Sweden similarly commissioned a systematic review, published in 2022 and charged with addressing these three questions:

> *Are there any scientific studies explaining the increase in numbers seeking for gender dysphoria?*
>
> *Are there any scientific studies on long-term effects of treatment for gender dysphoria?*
>
> *What scientific papers on diagnosis and treatment of gender dysphoria has been published after the National Board of Health and Welfare in Sweden issued its national support for managing children and adolescents with gender dysphoria in 2015?* (SBU Scoping Review Summary 2019.)

The databases searched included CINAHL (EBSCO), Cochrane Library (Wiley), EMBASE (Embase.com), PsychINFO (EBSCO), PubMed (NLM), Scopus (Elsevier), and SocINDEX (EBSCO). A total of 8,867 abstracts were identified, from which 315 full text articles were assessed for eligibility. The review concluded that "literature on management and long-term effects in children and adolescents is sparse," that no RCTs have been conducted, and that there remains no explanation for the recent and dramatic increases in numbers of minors presenting with gender dysphoria. (SBU Scoping Review Summary 2019.) I have quoted other conclusions from the Swedish systematic review in Section II above.

F. Finland

86. Finland's Ministry of Social Affairs and Health commissioned a systematic review, completed in 2019, of the effectiveness and safety of medicalized transition. (COHERE Recommendation 2020.) The review spanned both minors and adults and included both puberty

blockers and cross-sex hormones (Pasternack 2019). Three reviewers tabulated the results. In total, 38 studies were identified, of which two pertained to minors: de Vries (2011) and Costa (2015). The report noted that, because the methodological quality of the studies was already "weak" (no study including any control groups), the assessors declined detailed quality assessment of the existing studies. (Pasternack 2019 at 3.) I have quoted other conclusions from the Finnish systematic review in Section II above.

G. Norway

87. Norway's investigation of its health care policy for gender dysphoric minors also revealed substantial safety concerns:

> There are unsettled questions related to puberty blockers in young people. A published study shows that puberty-inducing hormones cause slower height growth and a slower increase in bone density. It is also noted that the effects on cognitive development have not been mapped. Unexplained side effects and long-term effects of both puberty blockers (hormone treatment) and gender-affirming hormone treatments are increasingly being questioned. However, experience with other patient groups shows that long-term use of sex hormones can affect disease risk. When people with gender incongruence are treated, it is with significantly longer duration and intensity of hormone treatment than hormone treatments for other conditions. (Ukom 2023.)

VI. The Endocrine Society, WPATH, and the American Academy of Pediatrics did not conduct systematic reviews of safety and efficacy in establishing clinical guidelines, despite systematic reviews being the foundation and gold standard of evidence-based care.

88. I have also examined the reviews conducted by the U.S.-based professional associations that have published standards and guidelines for the treatment of gender dysphoric youth. As detailed herein, and unlike the European reviews, none of the U.S.-based professional associations conducted a systematic review of both effectiveness and safety, without which they are unable to assess the risk:benefit ratio posed by medicalized transition of minors.

A. The Endocrine Society reviewed cross-sex hormones, but not puberty blockers. They reviewed safety, but did not review effectiveness research.

89. The Endocrine Society appointed a task force which commissioned two systematic reviews as part of updating their 2009 recommendations. (Hembree 2017.) The scopes of the two reviews were limited to physiological effects of cross-sex hormones, narrowly defined: "The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes….The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals." (Hembree 2017 at 3873.) As described in the Endocrine Society Guidelines, those reviews did not, however, include the effectiveness of any treatment on mental health (quality of life, suicidality, rates of detransition, cosmetic or functional outcomes, or improvements in feelings of gender dysphoria). What appears to be the referenced review of lipids and cardiovascular outcomes (Maraka 2017) did not identify any study of adolescents, noting "literature addressing this clinical question in the pediatric/adolescent population is completely lacking." (Maraka at 3921.) What appears to be the referenced review of bone health (Singh-Ospina 2017) identified only one small study on adolescents, involving 15 male-to-female and 19 female-to-male cases.

(Klink 2015.) Notably, the median duration of puberty-blocker administration was 1.2 years, leaving unknown the effects on children receiving blockers from puberty onset (usually age 9–10) to age 14 or 16.

90. Further, the Endocrine Society does not claim to have conducted or consulted any systematic review of the efficacy of puberty blockers or cross-sex hormones to reduce gender dysphoria or increase mental health or well-being by any metric. Nor does it claim to have conducted or consulted any systematic review of safety of any of these treatments for minors with respect to brain development, future fertility, actual reversibility, or any other factor of safety or adverse event other than cardiovascular disease and bone strength.

91. For all these reasons, I concur with the opinion of Dr. Guyatt, who has said that he finds "serious problems" with the Endocrine Society guidelines, among other reasons because the only systematic reviews those guidelines refer to did not look at the efficacy of the recommended hormonal interventions to improve gender dysphoria, which he termed "the most important outcome." (Block, Gender Dysphoria 2023 at 4.)

92. The current Endocrine Society guidelines, released in 2017, include this disclaimer:

> The Endocrine Society makes no warranty, express or implied, regarding the guidelines and specifically excludes any warranties of merchantability and fitness for a particular use or purpose. The Society shall not be liable for direct, indirect, special, incidental, or consequential damages related to the use of the information contained herein. (Hembree 2017 at 3895.)

The previous, 2009, version included no disclaimers. (Hembree 2009.)

B. WPATH reviewed effectiveness, but not the safety of medicalized transition of minors.

93. WPATH engaged in a multi-step process in updating its Standards of Care from version 7 to version 8. That process included commissioning a systematic review, which was published as Baker, *et al.* (2021) which included the disclaimer "The authors are responsible for

its content. Statements in this report do not necessarily reflect the official views of or imply endorsement by WPATH." (Baker 2021 at 14.)

94. The literature search was completed in June 2020, and spanned 13 questions. Two questions related to the effectiveness of medicalized transition of minors: Question #10 was "[W]hat are the effects of suppressing puberty with GnRH agonists on quality of life?", and question #11 was "[W]hat are the psychological effects (including quality of life) associated with hormone therapy?" (Sharma 2018; Baker 2021.) That is, the review included studies of the effectiveness of puberty blockers and cross-sex hormones, but, remarkably, did not include any effort to determine the *safety* of either.

95. Baker (2021) identified that among all experimental evidence published on medicalized transition, a total of "Three studies focused on adolescents." (Baker 2021 at 1.) These were Achille, *et al.* (2020), López de Lara, *et al.* (2020), and de Vries, *et al.* (2011, 2014). (Baker 2021 considered the two de Vries articles as a single study, because the later one included the subset of patients from the earlier one who continued in treatment. I will refer to this set as four studies, however, to be consistent with the other reviews.) Notably, in contrast with WPATH's review, the Swedish review entirely excluded Achille *et al.* (2020), López de Lara *et al.* (2020), and de Vries *et al.* (2011) due to their high risks of bias. (SBU Scoping Review Appendix 2.) The Baker team did not use the GRADE system for assessing the quality of evidence, instead using the Methods Guide for Conducting Comparative Effectiveness Reviews.

96. The Baker team noted "no study reported separate results by gender identity for transgender youth." (Baker 2021 at 3.) They also found that "No study reported on hormone therapy among nonbinary people." (at 3.) (Despite this finding, WPATH SOC-8 now includes recommendations for people who identify as nonbinary.)

97. My assessment of the Baker review revealed that there were substantial discrepancies and misleading ambiguities in their reporting: Baker, *et al.* indicated in the abstract that "Hormone therapy was associated with increased QOL [quality of life], decreased depression, and decreased anxiety" (Baker 2021 at 1,) and that "Associations were similar across gender identity and age" (Baker 2021 at 12). This is not what its actual data tables showed, however. Table 2 presented the only study of QOL specifically among adolescents included in the review and indicated that "Mean QOL scores did *not* change." (Baker 2021 at 7, italics added.)

98. The review, however, did not rate the quality of the studies of adolescents on their own, instead combining them with the studies of adults. (at 10, italics added.) Table 4 of that study presented three analyses of anxiety: One showed a decrease, and on the other two, "Mean anxiety score did *not* change." (at 11, italics added.) Finally, the review also concluded, "It was impossible to draw conclusions about the effects of hormone therapy on death by suicide." (at 12.) Even for the combined set, the review read the strength of evidence to be "low" for each of QOL, depression, and anxiety, and to be "insufficient" for death by suicide. (Baker 2021 at 13, Table 6.) Specifically, the review indicated, "There is insufficient evidence to draw a conclusion about the effect of hormone therapy on death by suicide among transgender people." (at 13, Table 6.) Overall, "The strength of evidence for these conclusions is low due to methodological limitations." (at 12.) Of particular concern was that "Uncontrolled confounding was a major limitation in this literature." (at 12.)

99. Additionally, although WPATH commissioned the Baker review, WPATH did not follow its results. Baker 2021 indicated the use of two systematic quality assessment methods, called RoB 2 and ROBINS-I (Baker 2021 at 3); however, WPATH modified the conclusions that that process yielded. WPATH SOC-8 states, "This evidence is not only based on the published

literature (direct as well as background evidence) but also on consensus-based expert opinion." (Coleman 2022 at S8.) Moreover:

> Recommendations in the SOC-8 are based on available evidence supporting interventions, a discussion of risks and harms, as well as feasibility and acceptability within different contexts and country settings. Consensus on the final recommendations was attained using the Delphi process that included all members of the guidelines committee and required that recommendation statements were approved by at least 75% of members. (Coleman 2022 at S8.)

100. By allowing "consensus-based expert opinion" to modify or overrule conclusions supported by systematic reviews that apply accepted criteria of evidentiary strength, WPATH has explicitly abandoned evidence-based medicine. As indicated already by the Pyramid of Evidence, "expert opinion" represents the *lowest* level of evidence in science, whereas systematic review, the highest. (Also, it is unclear what the authors mean by "background evidence.") To modify systematic results according to committee opinion is to re-introduce the very biases that the systematic process is meant to overcome. The WPATH document attempts to claim the authority of a systematic review, while reserving the ability to "overrule" results that WPATH members did not like.

101. As to evidence supporting hormonal interventions in minors, WPATH asserted that "a systematic review regarding outcomes of [hormonal] treatment in adolescents is not possible" due to the lack of "outcome studies that follow youth into adulthood." (Coleman 2022 at S46.) WPATH is correct that essential outcome studies have not been done, but incorrect that this authorizes issuance of guidelines or standards in the absence of a systematic review. As Dr. Guyatt has stated, "systematic reviews are always possible"—and indeed an important conclusion from such a review may be (as here) that insufficient evidence exists to support any evidence-based guideline. As Dr. Guyatt further elaborated, if an organization issues recommendations without performing an on-point systematic review, "they'd be violating

standards of trustworthy guidelines." (Block, Dysphoria Rising, 2023 at 3.)

102. Finally, the WPATH SOC-8 were revised immediately after their release, removing all age minimums to all recommendations. None of these studies and none of these reviews support such a change, and WPATH cites no studies or other document in support of the change.

103. In sum, the WPATH SOC8 cannot be called evidence-based guidelines under any accepted meaning of that term.

C. The American Academy of Pediatrics did not conduct a systematic review either of safety or effectiveness.

104. While the AAP policy statement is often referenced, the AAP did not report conducting any systematic review of any aspect of transgender care in producing its policy statement on gender-diverse children and adolescents. (Rafferty 2018.) Further, the AAP policy statement on its face is the work of a single author rather than of any committee or the membership more broadly (Dr. Rafferty "conceptualized," "drafted," "reviewed," "revised," and "approved" the statement), and the statement explicitly states that it does not "indicate an exclusive course of treatment" nor "serve as a standard of medical care." (Rafferty 2018 at 1.)

VII. Definitions of sex, gender identity, and gender dysphoria.

A. Sex and sex-assigned-at-birth represent objective features.

105. Sex is an *objective* feature: It can be ascertained regardless of any declaration by a person, such as by chromosomal analysis or visual inspection. Gender identity, however, is *subjective:* There exists no means of either falsifying or verifying people's declarations of their gender identities. In science, it is the objective factors—and only the objective factors—that matter to a valid definition. Objectively, sex can be ascertained, not only in humans or only in the modern age, but throughout the animal kingdom and throughout its long history in natural evolution.

106. I use the term "sex" in this report with this objective meaning, which is consistent with definitions articulated by multiple medical organizations:

> Endocrine Society (Bhargava 2021 at 220.)
> "Sex is dichotomous, with sex determination in the fertilized zygote stemming from unequal expression of sex chromosomal genes."
>
> American Academy of Pediatrics (Rafferty 2018 at 2 Table 1.):
> "An assignment that is made at birth, usually male or female, typically on the basis of external genital anatomy but sometimes on the basis of internal gonads, chromosomes, or hormone levels."
>
> American Psychological Association (APA Answers 2014):
> "Sex is assigned at birth, refers to one's biological status as either male or female, and is associated primarily with physical attributes such as chromosomes, hormone prevalence, and external and internal anatomy."
>
> American Psychological Association (APA Resolution 2021 at 1):
> "While gender refers to the trait characteristics and behaviors culturally associated with one's sex assigned at birth, in some cases, gender may be distinct from the physical markers of biological sex (e.g., genitals, chromosomes)."
>
> American Psychiatric Association (Am. Psychiatric Ass'n Guide):
> "Sex is often described as a biological construct defined on an anatomical, hormonal, or genetic basis. In the U.S., individuals are assigned a sex at birth based on external genitalia."

107. The phrases "assigned male at birth" and "assigned female at birth" are increasingly

popular, but they lack any scientific merit. Science is the systematic study of natural phenomena, and nothing objective changes upon humans' labelling or re-labelling it. That is, the objective sex of a newborn was the same on the day before as the day after the birth. Indeed, the sex of a fetus is typically known by sonogram or amniocentesis many months before birth. The use of the term "assign" insinuates that the label is arbitrary and that it was possible to have been assigned a different label that is equally objective and verifiable, which is untrue. Infants were born male or female before humans invented language at all. Indeed, it is exactly because an expected child's sex is known before birth that there can exist the increasingly popular "gender reveal" events. Biologically, the sex of an individual (for humans and almost all animal species) as male or female is irrevocably determined at the moment it is conceived. Terms such as "assign" obfuscate rather than clarify the objective evidence.

B. Gender identity refers to subjective feelings that cannot be defined, measured, or verified by science.

108. It is increasingly popular to define gender identity as a person's "inner sense," however, neither "inner sense" nor any similar phrase is scientifically meaningful. In science, a valid construct must be both objectively measurable and falsifiable with objective testing. The concept of an "inner sense" fits none of these requirements.

VIII. Gender Dysphoria is a mental health diagnosis.

109. Gender Dysphoria is a mental health condition identified by diagnostic criteria set out in the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM") 5-TR. (American Psychiatric Ass'n 2022.) While the criteria contain multiple components and vary modestly for children, adolescents, and adults, all cases are characterized by a strong and lasting desire to be the opposite sex, and "clinically significant" distress of sufficient severity to impair the individuals' ability to function in their daily life setting. Gender dysphoria is nowhere defined as a medical (as opposed to mental health) diagnosis, and it is not characterized by any disability or impairment or ill health affecting any part of the physical body.

IX. Distinct mental health phenomena must not be—but frequently are—confused or conflated.

110. One of the most widespread public misunderstandings about people expressing gender dysphoria is that all such cases represent the same phenomenon; however, the clinical science has long and consistently demonstrated that prepubescent children expressing gender dysphoria represent a phenomenon distinct from that of adults starting to experience it. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in virtually every objective variable measured, including in their responses to treatments. A third presentation has recently become increasingly observed among people presenting to gender clinics: these cases appear to have an onset in adolescence—after the onset of puberty and before adulthood—and occur in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or "rapid-onset" gender dysphoria (ROGD). Despite having only recently been observed, they have quickly and greatly outnumbered the better characterized types. Moreover, large numbers of adolescents are today self-identifying in surveys as "gender fluid" and "non-binary." These are not recognized mental health diagnoses, and do not relate in any known way to gender dysphoric groups that have been the subject of previous treatment outcome studies. Because each of these phenomena differ in multiple objective features, it is scientifically invalid to extrapolate findings from one type to the others.

A. Adult-Onset Gender Dysphoria consists predominantly of males sexually attracted to females.

111. Whereas Childhood-Onset Gender Dysphoria occurs in biological males and females and is strongly associated with later homosexuality (next section), Adult-Onset Gender Dysphoria consists primarily of biological males sexually attracted to females. (Lawrence 2010.) They typically report being sexually attracted to women and rarely showed gender atypical

(effeminate) behavior or interests in childhood (or adulthood). Some individuals express being sexually attracted to both men and women, and some profess asexuality, but very few indicate having a primary sexual interest only in men. (Blanchard 1998.) Cases of adult-onset gender dysphoria are typically associated with a sexual interest pattern involving themselves in female form (a paraphilia called autogynephilia). (Blanchard 1989a, 1989b, 1991.)

112. Because of the numerous objective differences between adult-, childhood-, and adolescent-onset gender dysphoria, it is not possible to extrapolate from these results to juvenile populations, which responsible authors are careful not to do.

B. Childhood-onset gender dysphoria (prepubertal-onset) is a distinct phenomenon characterized by high rates of desistance in the absence of social or medical transition.

113. For many decades, small numbers of prepubescent children have been brought to mental health professionals for help with their unhappiness with their sex and in the belief they would be happier living as the other sex. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 2–6 biological male children to each female. (Cohen-Kettenis 2003; Steensma Evidence 2018; Wood 2013.)

1. Eleven cohort studies followed children not permitted social transition, all showing the majority to desist feeling gender dysphoric upon follow-up after puberty.

114. Currently, the studies of outcomes among children who experience gender dysphoria before puberty that provide the most evidentiary strength available are only "cohort studies," which follow people over time, recording the outcomes of the treatments they have undergone. Such studies supersede (i.e., overrule) the outcomes of surveys, which are much more prone to substantial error. As I have explained above, however, cohort studies can describe developmental pathways, but cannot provide evidence of causation.

115. In total, there have been 11 cohort studies showing the outcomes for these children, listed in Table 2. I first published this comprehensive list of studies in my own peer-reviewed article on the topic. (Cantor 2019.)

Table 2. Cohort studies of gender dysphoric, prepubescent children.

Count	Group	Study
2/16 4/16 10/16	gay trans-/crossdress straight/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
2/16 2/16 12/16	trans- uncertain gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19,* 363–369.
0/9 9/9	trans- gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
2/45 10/45 33/45	trans-/crossdress uncertain gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
1/10 2/10 3/10 4/10	trans- gay uncertain straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,* 511–517.
1/44 43/44	trans- cis-	Green, R. (1987). The "sissy boy syndrome" and the development of homosexuality. New Haven, CT: Yale University Press.
0/8 8/8	trans- cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
21/54 33/54	trans- cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
3/25 6/25 16/25	trans- lesbian/bi- straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*, 34–45.
47/127 80/127	trans- cis-	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. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.

17/139 122/139	trans- cis-	Singh, D., Bradley, S. J., Zucker, K. J. (2021). A follow-up study of boys with Gender Identity Disorder. *Frontiers in Psychiatry*, 12:632784.

*For brevity, the list uses "gay" for "gay and cis-", "straight" for "straight and cis-", etc.

116. The children in these studies were receiving professional mental health support during the study period, but did not "socially transition." In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, at various times across four decades, every study without exception has come to the identical conclusion: among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies. Such cases are often referred to as "desisters," whereas children who continue to feel gender dysphoric are often called "persisters."

117. This interpretation of these studies is widely accepted, including by the Endocrine Society, which concluded:

> In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. . . . [T]he large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence. (Hembree 2017 at 3879.)

The developers of the Dutch Protocol, at the Vrije University gender clinic, likewise concluded based on these studies that "Although the persistence rates differed between the various studies…the results unequivocally showed that the gender dysphoria remitted after puberty in the vast majority of children." (Steensma & Cohen-Kettenis 2011 at 2.)

118. The consistent observation of high rates of desistance among pre-pubertal children who present with gender dysphoria demonstrates a pivotally important—yet often overlooked—feature: because gender dysphoria so often desists on its own, clinical researchers cannot assume that therapeutic intervention cannot facilitate or speed desistance for at least some patients. That

is, it cannot be assumed that gender identity is immune to influence such as from psychotherapy. Such is an empirical question, and there has not yet been any such research.

119. These same studies are often vaguely cited to assert that the high desistance rates uniformly reported in these 11 studies do not apply to children who have persisted until "the start of puberty" (which is taken to mean Tanner Stage 2), or in an alternative phrasing, that children "who persist until the start of puberty" are likely to continue to persist into adulthood. But these studies taken together do not support that degree of precision. Rather, the studies do not specify at exactly what developmental stage the reported desistance occurred—what they report is that the subjects had desisted by late adolescence or early adulthood. I am aware of no systematic study that establishes that—in the absence of social and/or medical transition—children who experience gender dysphoria are unlikely to desist if they have not desisted by the start of Tanner Stage 2.

2. One cohort study followed children who were permitted social transition. In contrast with children not permitted to transition socially, most persisted in expressing gender dysphoria.

120. In contrast, Olson et al. have now published a single cohort study of prepubescent children, ages 3–12 (average of 8), who had already made a complete, binary (rather than intermediate) social transition, including a change of pronouns. (Olson 2022.) The study did not employ DSM-5 diagnosis, as "Many parents in this study did not believe that such diagnoses were either ethical or useful and some children did not experience the required distress criterion." (Olson 2022.) Unlike the prior research studies, only 7.3% of these (socially transitioned) children ceased to feel gender dysphoric.

121. Although the team publishing this cohort study did not discuss it, their finding matches the prediction of other researchers, that social transition itself represents an active

intervention, such that social transition may *cause* the persistence of gender dysphoria when it would have otherwise resolved, avoiding any need for subsequent medicalization and its attendant risks. Conversely stated, social transition seems to prevent desistance. (Singh 2021; Zucker 2018, 2020.)

122. As recognized by multiple authors, the potential impact of social transition on rates of desistance is pivotal. The Endocrine Society cautions that "social transition...has been found to contribute to the likelihood of persistence." (Hembree 2017 at 3879.) WPATH has stated that after social transition, "A change back to the original gender role can be highly distressing and [social transition can] even result in postponement of this second transition on the child's part." (Coleman 2012 at 176.) In 2013, prominent Vrije University researchers observed:

> Childhood social transitions were important predictors of persistence, especially among natal boys. Social transitions were associated with more intense GD in childhood, but have never been independently studied regarding the possible impact of the social transition itself on cognitive representation of gender identity or persistence. [Social transition] may, with the hypothesized link between social transitioning and the cognitive representation of the self, influence the future rates of persistence. (Steensma 2013 at 588-589.)

3. There is no reliable method for predicting for which children who present with gender dysphoria will persist versus desist.

123. The Endocrine Society Guidelines stated in 2017 that "With current knowledge, we cannot predict the psychosexual outcome for any specific child" (Hembree 2017 at 3876), and this remains true today. Research has not yet identified any reliable procedure for discerning which children who present with gender dysphoria will persist, as against the large majority who will desist, absent transition and "affirmation." Such a method would be valuable, as the more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can be weighted. Such "risk prediction" and "test construction" are standard components of applied statistics in the behavioral sciences. Multiple research teams have

reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to usefully predict the course of any particular child. (Singh 2021; Steensma 2013.)

124. In contrast, one research team (the aforementioned Olson group) claimed the opposite, asserting that they developed a method of distinguishing persisters from desisters, using a single composite score representing a combination of children's "peer preference, toy preference, clothing preference, gender similarity, and gender identity." (Rae 2019 at 671.) They reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they indicated, "Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability." (Rae 2019 at 673.) Although the Olson team declared that "social transitions may be predictable from gender identification and preferences" (Rae 2019 at 669), their actual results suggest the opposite: the gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75. (Rae 2019, Supplemental material at 6, Table S1.) Both of those are lower than the value of .75, so both of those would be more likely than not to desist, rather than to proceed to transition. That is, Olson's model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

125. Further, in the absence of long-term follow-up, it cannot be known what proportion of those who transition and persist through the early stages of puberty will later (for example as young adults) come to regret having transitioned and then *de*transition. Because only a minority

of gender dysphoric children persist in feeling gender dysphoric in the first place, "transition-on-demand" increases the probability of unnecessary transition and unnecessary medical risks.

4. Temple Newhook's attempts to dismiss evidence of high rates of desistance from childhood gender dysphoria are invalid.

126. The unanimous consistency across all 11 cohort studies of (non-transitioned) gender dysphoric children offers high confidence in the conclusion that most childhood-onset cases desist during the course of puberty. In 2018, however, a commentary was published, contesting that conclusion, criticizing four studies. (Temple Newhook 2018.) Multiple accomplished international researchers studying outcomes of gender dysphoric children responded (Zucker 2018; Steensma & Cohen-Kettenis 2018), to which the Temple Newhook team wrote a rejoinder. (Winters 2018.) I have reviewed each of these arguments, finding that the Temple Newhook comments rely on demonstrable falsehoods, whereas the responses remain consistent with the peer-reviewed evidence. The Temple Newhook commentary has not altered the consensus of the international medical community, which continues to cite and rely upon these cohort studies.

127. Before delineating each of their arguments, it should be noted that the Temple Newhook team based their analysis on the wrong research reports, attacking only a straw-person version of the contents of the research literature. Table 3 repeats the 11 cohort studies (on the left left) and the four studies Temple Newhook criticized (right):

Table 3.

• Lebovitz (1972)	
• Zuger (1978)	
• Money & Russo (1979)	
• Davenport (1986)	
• Green (1987)	
• Kosky (1987)	
• Wallien & Cohen-Kettenis (2008)	Wallien & Cohen-Kettenis (2008)
• Drummond, *et al.* (2008)	Drummond, *et al.* (2008)

- Steensma, *et al.* (2013)
- Singh, 2012/Singh, *et al.* (2021)[4]

Steensma, *et al.* (2011, 2013)

128. It should also be noted that the Temple Newhook 2018 commentary does not represent a systematic review. Temple Newhook did not indicate search strategies, inclusion/exclusion criteria, coding methods, reliability checks, or other standard procedures used for ensuring objective and unbiased assessment of all relevant studies. Rather, the Temple Newhook analysis targeted a small and selective subset of the research available—a scientifically invalid endeavor, which the systematic review process is meant to prevent. Not only did Temple Newhook skip most of the relevant science, but conversely, Temple Newhook inserted the Steensma 2011 study, which should have been rejected. (The data it reported was already included in Wallien & Cohen-Kettenis 2008.) The Temple Newhook commentary claimed it was "systematically engaging scholarly literature." (Temple Newhook 2018 at 2.) However, as the above reference lists demonstrate, that commentary involved no such systematic procedures.

129. Temple Newhook does not report any research evidence of its own. Rather, the commentary hypothesizes issues they assert could, theoretically, have affected the rates of desistance consistently detected. Scientifically, such a criticism is vacuous: In science, it is always possible for additional, external factors to have affected what was observed.

130. Also, as already detailed herein, the currently available level of evidence for outcomes of medicalized transition is the cohort study. The methodological issues highlighted by Temple Newhook are exactly why randomized, controlled trials (RCTs) need to be conducted, as such studies would be capable of resolving exactly those questions (in whichever direction). In the absence of randomized, controlled studies, however, the correct scientific process is to follow the results of the cohort studies (that is, the systematic reviews of the cohort studies).

[4] At the time of the 2018 Temple Newhook commentary, the Singh *et al.,* 2021 study was available as Singh, 2012.

131. In the science process, one cannot merely continue to retain a desired hypothesis, rejecting all counter-evidence until a perfect study emerges. This is especially important in clinical science, when the hypothesis relates to physical interventions, in children, with the potential to affect them for their entire lives. Rather, the scientific process proceeds by successive approximation, with results from the best available research replacing lesser quality research, increasing in confidence, but always with the possibility of changes imposed by future evidence.

132. By involving only a few of the full set of cohort studies, the Temple Newhook commentary removes one of the most compelling implications of the existing (cohort) studies: Their results are unanimous. However unlikely it might be for four studies to produce the same result randomly, it is even more unlikely for eleven studies all to come to the same result randomly.

133. Temple Newhook emphasized that gender identity issues differ across times and contexts/political environments, hypothesizing that children attending her clinic might differ from children attending the Toronto and the Amsterdam clinics. Returning once again to the full set of all studies, however, the evidence shows the very opposite: All studies yielded the same result, whether from the 1970s, 80s, 90s, 2000s, 2010s, and wherever in the world any clinic was. Acknowledging the possibility that future studies may lead to a different conclusion, the existing evidence shows majority desistance, constantly and across all time periods.

134. Consideration of the full set of studies also indicates that the contrast is not Toronto and Amsterdam versus whatever "reality" Temple Newhook perceives. Rather, they show the contrast is between Temple Newhook and every facility in every country ever reporting desistance data on childhood-onset gender dysphoria. Moreover, despite Temple Newhook's

mention of influences of political cultures, that commentary does not point out that Canada and the Netherlands are much more politically liberal than the U.S. Although the commentary offers the hypothesis that the Canadian and Dutch contexts might decrease persistence, the commentary does not include the inverse possibility: that these liberal environments might be *"iatrogenic"*—that is, causing dysphoria to continue when it might otherwise remit.

135. Also, the very evidence suggesting that gender dysphoria can be influenced by local environmental factors is itself evidence that gender identity is not, in fact, an innate and immutable feature, potentially amenable to change.

C. Adolescent-Onset Gender Dysphoria, the predominant clinical population today, is a distinct and largely unstudied phenomenon.

136. Concurrent with the advent of social media, a third profile began appearing clinically and socially, characteristically distinct from the two previously identified profiles. (Kaltiala-Heino 2015; Littman 2018.) Despite lacking any history before the current generation, this profile has now numerically overwhelmed the previously known and better characterized types in clinics and on Internet surveys. Unlike adult-onset or childhood-onset gender dysphoria, this group is predominately biologically female. This group typically presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is that feature which led to the term Rapid Onset Gender Dysphoria (ROGD). (Littman 2018.)[5] Cases commonly appear to occur within clusters of peers in association with increased social media use (Littman 2018), and among people with autism or other mental health issues. (Kaltiala-Heino 2015; Littman 2018; Warrier 2020.) (See section XI on Mental Health.)

137. There do not yet exist any cohort studies of people with adolescent-onset gender

[5] After initial criticism, the publishing journal conducted a reassessment of the article. The article was expanded with additional detail and republished. The relevant results were unchanged. Littman's paper as revised has been widely cited.

dysphoria undergoing medicalized transition. Current studies are limited to surveys typically of volunteers from activist and support groups on the Internet.

138. Moreover, no study has yet been organized in such a way as to allow for a distinct analysis of the adolescent-onset group, as distinct from childhood-onset or adult-onset cases. Many published studies fail to distinguish between people who had childhood-onset gender dysphoria and have aged into adolescence versus people whose onset was not until adolescence. (Analogously, there are reports failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria.) Studies selecting groups according to their current age instead of their ages of onset produces confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

X. Suicide and suicidality are distinct phenomena representing different mental health issues and indicating different clinical needs.

139. *Suicide* refers to completed suicides and the sincere intent to die. It is substantially associated with impulsivity, using more lethal means, and being a biological male. (Freeman 2017.) *Suicidality* refers to *para*-suicidal behaviors, including suicidal ideation, threats, and gestures.

A. Rates of suicidality among all adolescents have skyrocketed with the advent of social media.

140. The CDC's 2019 Youth Risk Behavior Survey found that 24.1% of female and 13.3% of male high school students reported "seriously considering attempting suicide." (Ivey-Stephenson 2020 at 48.)

141. The CDC survey reported not only that these already alarming rates of suicide attempt were still increasing (by 8.1%–11.0% per year), but also that this increase was occurring only among female students. No such trend was observed among male students. That is, the demographic increasingly reporting suicidality is the same demographic increasingly reporting gender dysphoria. (Ivey-Stephenson 2020 at 51.)

142. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) produces a series of evidence-based resource guides which includes their Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth. It noted (italics added):

> [F]rom 1999 through 2018, the suicide death rate doubled for females aged 15 to 19 and 20 to 24. For youth aged 10 to 14, the suicide death rate more than tripled from 2001 to 2018. Explanations for the increase in suicide may include bullying, social isolation, increase in technology and *social media*, increase in *mental illnesses*, and economic recession. (SAMHSA 2020 at 5.)

The danger potentially posed by social media follows from suicidality spreading as a social contagion, as suicidality increases after media reports, occurs in clusters of social groups, and in

adolescents after the death of a peer. (Gould & Lake 2013.)

143. Social media voices today loudly advocate "hormones-on-demand" while issuing hyperbolic warnings that teens will commit suicide unless this is not granted. Both adolescents and parents are exposed to the widely circulated slogan that "I'd rather have a living son than a dead daughter," and such baseless threats or fears are treated as a justification for referring to affirming gender transitions as 'life-saving' or 'medically necessary'. Such claims grossly misrepresent the research literature, however. Indeed, they are unethical: Suicide prevention research and public health campaigns repeatedly warn against circulating messages that can be taken to publicize or even glorify suicide, due to the risk of copy-cat behavior they encourage. (Gould & Lake 2013.)

144. Systematic review of 44 studies of suicidal thoughts and behaviors in LGBTQ youth and suicidality found only a small association between suicidality and sexual minority stress. (Hatchel 2021.) The quantitative summary of the studies (an especially powerful type of systematic review called *meta-analysis*) found no statistically significant association between suicidality and any of having an unsupportive school climate, stigma and discrimination, or outness/openness. There were, however, significant associations between suicidality and indicators of social functioning problems, including violence from intimate partners, victimization from LGBT peers and from non-LGBT peers, and sexual risk taking.

B. *Suicidality* is substantially more common among females, and *suicide,* among males. Sexual orientation is strongly associated with suicidality, but much less associated with suicide.

145. Notwithstanding public misconceptions about the frequency of suicide and related behaviors, the highest rates of death by suicide are among middle-aged and elderly men in high income countries. (Turecki & Brent 2016 at 3.) Males are at three times greater risk of death by

suicide than are females, whereas suicidal ideation, plans, and attempts are three times more common among females. (Klonsky 2016; Turecki & Brent 2016.) In contrast with completed suicides, the frequency of suicidal ideation, plans, and attempts is highest during adolescence and young adulthood, with reported ideation rates spanning 12.1–33%. (Borges 2010; Nock 2008.) Relative to other countries, Americans report elevated rates of each of suicidal ideation (15.6%), plans (5.4%), and attempts (5.0%). (Klonsky 2016.) Suicide attempts occur up to 30 times more frequently than completed suicides. (Bachmann 2018.) The rate of completed suicides in the U.S. population is 14.5 per 100,000 people. (WHO 2022.)

146. There is substantial research associating sexual orientation with suicidality, but much less so with completed suicide. (Haas 2014.) More specifically, there is some evidence suggesting gay adult men are more likely to die by suicide than are heterosexual men, but there is less evidence of an analogous pattern among lesbian women. Regarding suicidality, surveys of self-identified LGB Americans repeatedly report rates of suicidal ideation and suicide attempts 2–7 times higher than their heterosexual counterparts. Because of this association of suicidality with sexual orientation, one must apply caution in interpreting findings allegedly about gender identity: because of the overlap between people who self-identify as non-heterosexual and as transgender or gender diverse, correlations detected between suicidality and gender dysphoria may instead reflect (be confounded by) sexual orientation. Indeed, other authors have made explicit their surprise that so many studies, purportedly of gender identity, entirely omitted measurement or consideration of sexual orientation, creating the situation where features that seem to be associated with gender identity instead reflect the sexual orientation of the members of the sample. (McNeil 2017.)

C. There is no evidence that medicalized transition reduces rates of suicide or suicidality.

147. It is repeatedly asserted that despite the known risks, despite the lack of research into the reality or severity of unquantified risks, it is essential and "the only ethical response" to provide medical transition to minors because medical transition is known to reduce the likelihood of suicide among minors who suffer from gender dysphoria. This is simply untrue. *No studies* have documented any reduction in suicide rates in minors (or any population) as a result of medical transition. No methodologically sound studies have provided meaningful evidence that medical transition reduces suicidality in minors. Instead, multiple studies show tragically high rates of suicide after medical transition, with that rate beginning to spike several years after medical transition.

148. Among post-transition adults, completed suicide rates remain elevated. (Wiepjes 2020.) Among post-operative transsexual adults in Sweden's highly tolerant society, death by suicide is 19 times higher than among the cisgendered. (Dhejne 2011.) Systematic review of 17 studies of suicidality in transsexual adults confirmed suicide rates remain elevated even after complete transition. (McNeil 2017.) Among post-operative patients in the Netherlands, long-term suicide rates of six times to eight times that of the general population were observed depending on age group. (Asscheman 2011 at 638.) Also studying patients in the Netherlands, Wiepjes et al. (2020) reported the "important finding" that "suicide occurs similarly" before and after medical transition. (Wiepjes 2020 at 490.) In other words, *transition did not reduce suicide*. A very large dataset from the U.K. GIDS clinic showed that those referred to the GIDS clinic for evaluation and treatment for gender dysphoria committed suicide at a rate five times that of the general population, both before and after commencement of medical transition (Biggs 2022). Finally, in a still-ongoing longitudinal study of U.S. patients, Chen *et al.* have reported a

shockingly high rate of completed suicide among adolescent subjects in the first two years *after* hormonal transition, although they provide no pre-treatment data for this population to compare against. (Chen 2023 at 245.)

149. WPATH's systematic review of the effectiveness of puberty blockers and cross-sex hormones on suicide in minors concluded that "It was impossible to draw conclusions about the effects of [either] hormone therapy on death by suicide." (Baker 2021 at 12.) In short, I am aware of no respected voice that asserts that medical transition reduces suicide among minors who suffer from gender dysphoria.

150. As to the separate and far more common phenomenon of suicidality, of course, that claim is widely made. McNeil's systematic review revealed, however, a complicated set of interrelated factors rather than supporting the common hypothesis that rates of suicidal ideation and suicidal attempts would decrease upon transition. Rates of suicidal ideation did not show the same pattern as suicide attempts, male-to-female transitioners did not show the same patterns as female-to-male transitioners, and social transition did not show the same patterns as medical transition. Importantly, the review included one study that reported "a positive relationship between higher levels of social support from leaders (e.g., employers or teachers) and increased suicide attempt, which they suggested may be due to attempts instigating increased support from those around the person, rather than causing it." (McNeil 2017 at 348.)

151. Moreover, the 2020 Kuper, *et al.* cohort study of minors receiving hormone treatment found *increases* in each of suicidal ideation (from 25% to 38%), attempts (from 2% to 5%), and non-suicidal self-injury (10% to 17%). (Kuper 2020 at Table 5.) Research has found social support to be associated with *increased* suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support. (Bauer 2015; Canetto 2021.)

152. Overall, the research evidence is only minimally consistent with the hypothesis that an absence of transition causes mental health issues and suicide, but very strongly consistent with the hypothesis that mental health issues, such as *Borderline Personality Disorder* (BPD), cause both suicidality and unstable identity formation (including gender identity confusion). (See section XI.) BPD is repeatedly documented to be greatly elevated among sexuality minorities (Reuter 2016; Rodriguez-Seiljas 2021; Zanarini 2021), and both suicidality and identity confusion are symptoms of that disorder. Thus, diverting distressed youth towards transition necessarily diverts youth away from receiving the psychotherapies designed for treating the issues actually causing their distress.

153. Despite the fact that mental health issues, including suicidality, are repeatedly required by clinical standards of care to be resolved before transition, threats of suicide are instead oftentimes used as the very justification for labelling transition a “medical necessity”. However plausible it might seem that failing to affirm transition causes suicidality, the epidemiological evidence does not support that hypothesis.

XI. Mental health profiles differ across adult-, adolescent-, and childhood-onset gender dysphoria.

A. Mental health issues in Adult-Onset Gender Dysphoria.

154. Systematic review of all studies examining mental health issues in transgender adults identified 38 such studies. (Dhejne 2016.) The review indicated that many studies were methodologically weak, but nonetheless consistently found (1) that the average rate of mental health issues among adults is highly elevated both before *and after* transition, (2) but that the average was less elevated among adults who completed transition. It could not be concluded that transition improves mental health, however. Patients were commonly receiving concurrent psychotherapy, introducing a confound (meaning, again, that it cannot be determined whether the change was caused by the transitioning or the mental health treatment). Further, several studies showed more than 40% of patients to become "lost to follow-up." It remains unknowable to what extent the information from the remaining participants accurately reflects the whole population.

B. Mental health issues in Childhood-Onset Gender Dysphoria.

155. Elevated rates of multiple mental health issues among gender dysphoric children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed that 52% fulfilled criteria for a formal DSM diagnosis of a clinical mental health condition other than Gender Dysphoria. (Wallien 2007 at 1307.) A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, and a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment instruments (Child Behavior Check List, or CBCL) demonstrated that among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample satisfied the diagnostic criteria for one or more mental health conditions other than gender dysphoria. (Cohen-Kettenis 2003 at 46-47.)

156. A systematic review of all studies of Autism Spectrum Disorders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children diagnosed with gender dysphoria was recently conducted. (Thrower 2020.) It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD youth with gender dysphoria. Studies reviewing medical records of children and adolescents referred to gender clinics showed 6–26% to have been diagnosed with ASD. (Thrower 2020 at 695.) Moreover, those authors gave specific caution on the "considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results." (Thrower 2020 at 703.) The rate of ADHD among children with GD was 8.3–11%. Conversely, data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported "gender variance." (Janssen 2016 at 63.)

157. As shown by the outcomes studies (see Section XIII), there is little reliable evidence that transition improves the mental well-being of children. As shown repeatedly by clinical guidelines from multiple professional associations, mental health issues are expected or required to be resolved *before* undergoing transition. The reasoning behind these conclusions is that children may be expressing gender dysphoria, not because they are experiencing what gender dysphoric adults report, but because they mistake what their experiences indicate or to what they might lead. For example, a child experiencing depression from social isolation might develop the hope—and the unrealistic expectation—that transition will help them fit in, as a member of the other sex.

158. In cases where gender dysphoria is secondary to a different issue, efforts at transition

are aiming at the wrong target and leave the primary issue(s) unaddressed. Given the highly reliable, repeatedly replicated finding that childhood-onset gender dysphoria resolves with puberty for the large majority of children, the evidence indicates that blocking a child's puberty blocks the child's natural maturation that itself would resolve the dysphoria.

C. Mental health issues in Adolescent-Onset Gender Dysphoria (ROGD).

159. The literature varies in the range of gender dysphoric adolescents with co-occurring disorders. In addition to self-reported rates of suicidality (see Section X), clinical assessments reveal elevated rates not only of depression (Holt 2016; Skagerberg 2013; Wallien 2007), but also anxiety disorders, disruptive behavior difficulties, Attention Deficit/Hyperactivity Disorder, Autism Spectrum Disorder, and personality disorders, especially Borderline Personality Disorder (BPD). (Anzani 2020; de Vries 2010; Jacobs 2014; Janssen 2016; May 2016; Strang 2014, 2016; Swedish Socialstyrelsen, Evolution 2020.)

160. Of particular concern in the context of adolescent-onset gender dysphoria is Borderline Personality Disorder (BPD; diagnostic criteria in Table 4 below). Symptoms of BPD overlap in important respects with symptoms commonly interpreted as signs of gender dysphoria, and it is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria actually represent cases of BPD. (E.g. Anzani 2020; Zucker 2019.) That is, some people may be misinterpreting their experiencing of the broader "identity disturbance" of symptom Criterion 3 to represent a gender identity issue specifically. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence, is three times more common in biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people. (Thus, if even only a portion of people with BPD experienced an identity disturbance, and focused that disturbance on gender identity resulting in transgender identification, they could

easily overwhelm the number of genuine cases of gender dysphoria.)

Table 4. DSM-5-TR Diagnostic Criteria for Borderline Personality Disorder.

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
> 2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.
> 3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
> 4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
> 5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
> 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
> 7. Chronic feelings of emptiness.
> 8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
> 9. Transient, stress-related paranoid ideation or severe dissociative symptoms.
>
> (Italics added.)

(American Psychiatric Association 2022 at 752-753.)

161. Mistaking cases of BPD for cases of Gender Dysphoria may prevent such youth from receiving the correct mental health services for their condition. A primary cause for concern is symptom Criterion 5: *recurrent suicidality.* (See Section X on suicide and suicidality.) Regarding the provision of mental health care, the distinction between these conditions is crucial: A person with BPD going undiagnosed will not receive the appropriate treatments (the currently most effective of which is Dialectical Behavior Therapy). The problem was not about *gender* identity, but about having an *unstable* identity.

162. Regarding research, there have now been several attempts to document rates of suicidality among gender dysphoric adolescents. The scientific concern presented by BPD is that

it poses a potential confound: samples of gender dysphoric adolescents could appear to have elevated rates of suicidality, not because of the gender dysphoria (or transphobia in society), but because of the number of people with BPD in the sample.

D. Neuroimaging studies have associated brain features with sex and with sexual orientation, but not gender identity.

163. Claims that transgender identity is an innate property resulting from brain structure remain unproven. Neuroimaging and other studies of brain anatomy repeatedly identify patterns distinguishing male from female brains, but when analyses search for those patterns among transgender individuals, "gender identity and gender incongruence could not be reliably identified." (Baldinger-Melich 2020 at 1345.) Although much smaller than male/female differences, statistically significant neurological differences are repeatedly associated with sexual orientation (termed "homosexual" vs "nonhomosexual" in the research literature). Importantly, despite the powerful associations between transsexuality and homosexuality, as explicated by Blanchard, many studies analyzing gender identity failed to control for sexual orientation, representing a problematic and centrally important confound. I myself pointed this out in the research literature, noting that neuroanatomical differences attributed to gender dysphoria should instead be attributed to sexual orientation. (Cantor 2011, Cantor 2012.) A more recent review of the science, by Guillamon, et al. (2016), agreed, stating:

> Following this line of thought, Cantor (2011, 2012, but also see Italiano, 2012) has recently suggested that Blanchard's predictions have been fulfilled in two independent structural neuroimaging studies. Specifically, Savic and Arver (2011) using VBM on the cortex of untreated nonhomosexual MtFs and another study using DTI in homosexual MtFs (Rametti et al., 2011b) illustrate the predictions. *Cantor seems to be right*". (Guillamon 2016 at 1634, italics added; see also Italiano 2012.)

In addition to this confound, because snapshot neurobiological studies can provide only correlational data, it would not be possible for such studies to distinguish whether brain

differences cause gender identity or if gender atypical behavior modifies the brain over time, such as through neuroplasticity. As noted by one team of neuroscientists, "[I]t remains unclear if the differences in brain phenotype of transgender people may be the result of a sex-atypical neural development or of a lifelong experience of gender non-conformity." (Fisher 2020 at 1731.) In sum, at present assertions that transgender identity is caused by neurology represent faith, not science.

XII. Medicalized transition of gender remains *experimental,* lacking causal evidence of mental health improvement.

A. Criteria distinguishing *'experimental'* from *'established'.*

164. In science, the term "experimental" has a specific technical meaning. Within the scientific method, research studies can be *observational* or *experimental.* Among observational studies, such as surveys, the researchers do not administer any treatment and instead only describe the features of the group observed. Among experimental studies, treatments are actively administered by the researchers, who then compare the treated and untreated groups (or compare a group to itself, before versus after treatment). Also, within a given treatment study, the term "experimental treatment" would be used to distinguish it from the "control treatment" or "treatment-as-usual" being provided to the control group.

165. Outside research studies and within public and legal contexts, the term 'experimental' typically denotes '*unverified by experimental evidence'.* A treatment would continue to be experimental until the demonstration of (1) reliable, clinically meaningful improvement and (2) the reliable estimation of safety risks in randomized, controlled trials (RCTs) or research of equivalent level of evidence. A treatment would remain experimental while its effects, including side effects, remain uninvestigated.

166. Being long-standing, popular, or familiar do not, of themselves, impact whether a treatment is experimental—they suggest opportunities for the experiments to have been done. Clinicians' feelings of self-confidence do not impact status as experimental.

B. International consensus explicitly regards gender transition to be experimental.

167. In England, after a thorough review of the literature and the current practice, Dr. Cass stated that the critical and currently unanswered question "is whether the evidence for the use

and safety of the medication is strong enough as judged by reasonable clinical standards." She recognized that these treatments cannot formally be called "experimental" not because they are proven, but because the experiments needed to test their efficacy and safety have not only not been done, but are not even being attempted. (Cass 2022 at 37.) To address this, Dr. Cass called for "the rapid establishment of the necessary research infrastructure to prospectively enrol young people being considered for hormone treatment into a formal research programme." (Cass Review Letter 2022). In response, in its interim service specification NHS England states that it "will only commission GnRHa [i.e., puberty blockers] in the context of a formal research protocol." (NHS 2022 at 12.)

168. Finland, by law, restricts all assessment and treatment activities for gender dysphoric minors to its two research clinics, Helsinki University Central Hospital and Tampere University Hospital. (COHERE Summary.) Further, after conducting a systematic review of the research, the council responsible for the assessment of public health care services in Finland (COHERE Finland) concluded, "In light of available evidence, gender reassignment of minors is *an experimental practice.*" (COHERE Summary, italics added.)

169. Sweden's research on gender transition is conducted at the Karolinska Institutet in Stockholm. In 2015, that facility registered its research on medicalized transition with the U.S. National Institutes for Health (NIH), noting "[H]ormonal treatment includes inhibition of one's own sex hormone production followed by treatment with testosterone or estrogen levels that are normal for the opposite sex. *Seen as experimental model,* this is a process that provides an opportunity to study the sex hormone dependent influences." (Clinicaltrials.gov.) In its policy updates in 2021, Sweden limited medicalized treatments for gender dysphoria in minors to clinical research studies approved by the Swedish national research ethics board ("EPM").

(Medscape Psychiatry 2021.)

170. Norway reviewed its own national policy on transition in minors in 2023, explicitly concluding such medical procedures to be experimental. (Ukom 2023.)

171. The widely cited Dutch studies were co-conducted by Dr. Thomas Steensma. Despite being an originator and international leader of medicalized transition of gender dysphoric minors, Dr. Steensma stated in an interview in 2021 that he still considers it to be experimental: "Little research has yet been done on the treatment with puberty inhibitors and hormones in young people. That is why it is also *seen as experimental*." Dr. Steensma decried other clinics for "blindly adopting our research" despite the indications that those results may not actually apply: "We don't know whether studies we have done in the past are still applicable to today. Many more children are registering, and also a different type." Steensma opined that "every doctor or psychologist who is involved in transgender care should feel the obligation to do a good pre- and post-test." (Tetelepta 2021.) But few if any are doing so.

C. Claims that medical transition is "medically necessary" are undefined, unsupported, and self-interested.

172. While European health authorities have examined the science and concluded that medical transition for minors remains "experimental" and of unproven benefit, terminology has been distorted in the U.S. because the U.S. lacks a public health care system and the terms "medically necessary" and "experimental" impact health insurance coverage. "Medically necessary" justifies coverage for these procedures; advocates know or fear that the term "experimental" will preclude coverage.

173. WPATH's 2016 statement asserting "medical necessity" was explicitly made in order to facilitate insurance claims, as is clear in their document entitled, "Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A."

(WPATH Position Statement.) The AMA released a similar statement supporting insurance coverage for medical transition as a result of being assertedly medically necessary.[6] U.S. medical associations' advocacy corresponds to the financial interests of their members.

174. Moreover, there do not exist a scientific definition or objective criteria of "medically necessary." An analysis published in the *Canadian Medical Association Journal,* however (not pertaining to gender dysphoria or transition), attempted to define 'medically necessary.' (Caulfield 2012.) The article quoted Timothy Caulfield, Research Chair in Health, Law, and Policy at the University of Alberta (Edmonton), Canada: "As for putting great effort into coming up with a tidy, all-encompassing definition of 'medically necessary'—it's probably a waste of time…Given the history of the concept of 'medically necessary' and the numerous failed attempts to define it, a practical, operational and meaningful definition is likely unattainable." (Caulfield at 1771–1772.) According to Mark Stabile, director of the School of Public Policy and Governance and professor of economics and public policy at the Rotman School of Management at the University of Toronto, "Providers of those services will naturally be critical of the decision if they feel that the demand for their services will decline as a result." (Caulfield at 1772.)

D. WPATH repeatedly warns of untested hypotheses, continuing unknowns, and lack of research.

175. The latest (2022) WPATH Standards of Care v8 document avoided the word "experimental" in its guidelines, but instead repeatedly deployed terms and phrases that are synonymous with being experimental: "The criteria in this chapter [on assessment of adults] have been significantly revised from SOC-7 to reduce requirements and unnecessary barriers to care. *It is hoped that future research will explore the effectiveness* of this model." (Coleman

[6] Available from https://www.ama-assn.org/system/files/2019-03/transgender-coverage-talking-points.pdf

2022 at S33, italics added.)

176. The WPATH Standards of Care v8 (Coleman 2022) indicates the lack of experimental evidence available again and again (italics added):

- "It primarily includes an assessment approach that uses specific criteria that are examined by [a Health Care Provider, or] HCP in close cooperation with a TGD adult and does not include randomized controlled trials or long-term longitudinal research" (at S33.)
- "While there was *limited supportive research,* this recommendation was considered to be good clinical practice as it allows a more reversible experience prior to the irreversible experience of surgery" (at S40.)
- "Due to *the limited research in this area,* clinical guidance is based primarily on individual case studies and the expert opinion of HCPs" (at S41.)
- "While available research shows consistent positive outcomes for the majority of TGD adults who choose to transition…some TGD adults may decompensate or experience a worsened condition following transition. *Little research has been conducted to systematically examine variables that correlate with poor or worsened biological, psychological, or social conditions following transition"* (at S42.)
- "Future research would shed more light on gender identity development if conducted over long periods of time with diverse cohort groups" (at S45.)
- "In addition, elevated scrotal temperatures can be associated with poor sperm characteristics, and genital tucking could theoretically affect spermatogenesis and fertility (Marsh 2019) although *there are no definitive studies evaluating these adverse outcomes.* Further *research is needed to determine the specific benefits and risks* of tucking in youth" (at S54.)
- *"There is no formal research evaluating* how menstrual suppression may impact gender incongruence and/or dysphoria" (at S54-55.)
- "Currently, there are only preliminary results from retrospective studies evaluating transgender adults and the decisions they made when they were young regarding the consequences of medical-affirming treatment on reproductive capacity. It is important not to make assumptions about what future adult goals an adolescent may have" (at S57.)
- *"Only limited empirical research exists* to evaluate such interventions" (at S75.)
- *"Research has not been conclusive* about when in the life span such detransition is most likely to occur, or what percentage of youth will eventually experience gender fluidity and/or a desire to detransition" (at S77.)
- "Research on pitch-lowering surgeries is limited" (at S139.)
- "The number and quality of research studies evaluating pitch-lowering surgeries are currently insufficient" (at S141.)

- "To date, *research on the long-term impact of [Gender Affirming Hormone Treatment or] GAHT on cancer risk is limited*…We have *insufficient evidence* to estimate the prevalence of cancer of the breast or reproductive organs among TGD populations (Joint et al., 2018.)" (at S144.)
- "Contraceptive *research gaps within this population are profound. No studies have examined* how the use of exogenous androgens (e.g., testosterone) may modify the efficacy or safety profile of hormonal contraceptive methods (e.g., combined estrogen and progestin hormonal contraceptives, progestin-only based contraceptives) or non-hormonal and barrier contraceptive methods" (at S162.)
- "TGD individuals AFAB undergoing abortion still represents a critical gap in research" (at S162.)
- "The effects of current TGD-related medical treatments on sexuality are heterogeneous (Ozer et al., 2022; T'Sjoen et al., 2020), and *there has been little research on the sexuality of TGD adolescents"* (at S163.)
- "While sex-positive approaches to counseling and treatment for sexual difficulties experienced by TGD individuals have been proposed (Fielding, 2021; Jacobson et al., 2019; Richards, 2021), to date *there is insufficient research on the effectiveness of such interventions"* (at S163.)

XIII. There have been 14 cohort studies of puberty blockers and cross-sex hormones in minors. They provide no reliable evidence of effectiveness for improving mental health relative to mental health treatments that lack medical risk.

177. Several studies are cited by plaintiffs' experts and in the media as purporting to show that medical transition in minors brings important improvements in mental health beyond the issues of suicide and suicidality that I have already addressed. In fact, there is no reliable evidence of any such benefit.

178. In this section, I summarize the results of all cohort studies investigating the mental health outcomes of puberty blockers and cross-sex hormones on minors. These include all such studies identified by any of the systematic reviews of effectiveness from England, Sweden, Finland, and WPATH. (Listed in Table 1, *Cohort studies of effectiveness and safety of puberty blockers and cross-sex hormones in minors.*)

179. As enumerated in the following section, all of these studies that reported improved mental health among transitioners were also providing psychotherapy at the same time. (See Section VI on confounding.) None of these studies was able to differentiate which of them was contributing to the improvement.

180. The problem imposed by confounding medicalized transition with psychotherapy is widely recognized. As explicated in the NICE review from England:

> [V]ery little data are reported on how many children and adolescents needed additional mental health support, and for what reasons, or whether additional interventions, and what form and duration (for example drug treatment or counselling) that took. This is a possible confounder for the treatment outcomes in the studies because *changes in critical and important outcomes may be attributable to external care rather than the psychological support or GnRH analogues used in the studies.* (NICE 2020a at 41, italics added.)

Similarly, WPATH's own systematic review noted that "[T]his conclusion is limited by high risk of bias in study designs, small sample sizes, and *confounding with other interventions."* (Baker

2021 at 1, italics added.)

181. The need to disentangle the roles of these two treatments has been largely ignored despite that several issues depend upon them. If medicalized transition does not show mental health improvement superior to that of mental health treatment, it cannot readily be called "medically necessary" for insurance purposes or other institutional needs. Clinicians may be subjecting minors to known and potential (but unstudied) harms without any scientific justification.

182. Moreover, without a control group for comparison (i.e., another group of similar age, sex, and mental health status), these studies are also unable to identify when and if any changes are due to regression to the mean or maturation over time.

A. Of the cohort studies, five found little to no improvement in mental health.

183. Cantu, *et al.* (2020) studied 80 youth, 11–18 years of age (average of 15.1 years), measuring patients' levels of anxiety, depression, and suicidality. This sample was 18.75% male-to-female, 72.5% female-to-male, and 8.75% nonbinary, but the report did not include the patients' ages of onset. The study authors compared youth according to those receiving puberty blockers only, cross-sex hormones only, both treatments, or neither. No significant differences in mental health were detected on any of these variables. Of the 27 youth reporting suicidality before medicalized treatment, 81% continued to report suicidality after medicalized treatment. Remarkably, although the authors reported that "the results of this study suggest that no clinically significant changes in mood symptoms occur" (Cantu 2020 at 199), they did not convey the logical interpretation that transition failed to help these youth. Instead, they emphasized that "findings suggest changes may actually take longer to occur." (Cantu 2020 at 196.)

184. Kaltiala, *et al.* (2020) similarly reported that after cross-sex hormone treatment, "Those who had psychiatric treatment needs or problems in school, peer relationships and managing everyday matters outside of home continued to have problems during real-life." (Kaltiala 2020 at 213.) They concluded:

> Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development. (Kaltiala 2020 at 213.)

185. Carmichael, *et al.* (2021) released their findings from the Tavistock and Portman clinic in the U.K. (Carmichael 2021.) Study participants were ages 12–15 (Tanner stage 3 and above for natal males, Tanner stage 2 and above for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious mental illnesses (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients' or their parents' perspective.

186. Hisle-Gorman, *et al.* (2021) analyzed military families' healthcare data to compare 963 transgender and gender-diverse youth before versus after hormonal treatment, using their non-gender dysphoric siblings as a control group. The study participants included youth undergoing puberty-blocking as well as those undergoing cross-sex hormone treatment, but these subgroups did not differ from each other. Study participants had a mean age of 18 years when beginning hormonal treatments, but their initial clinical contacts and diagnoses occurred at a mean age of 10 years. According to the study, "mental health care visits overall did not significantly change following gender-affirming pharmaceutical care" (Hisle-Gorman 2021 at 1448), yet, "psychotropic medication use *increased*," (Hisle-Gorman 2021 at 1448, italics added)

indicating *deteriorating* mental health.

187. Tordoff, *et al.* (2022) reported on the mental health of youth (mean age 15.8) as they underwent their first year of puberty blocker or cross-sex hormone treatment. The study began with 104 youth, 39 of whom dropped out by the end of the study. Of the initial 104, 62.5% were receiving psychotherapy at the same time. (Tordoff 2022 at 5 Table 1.) Tordoff did not separate participants into an experimental group and control group. Rather, the study began with the youth as non-medicated and then shifted them from the non-medicated to the medicated group when eligible. (Tordoff 2022 suppl eFigure 1.) At the beginning of the study, seven of the 104 initial participants were already receiving medication (6.7%). By the end of the study, 57 of the remaining 65 participants were receiving medication (i.e., 87.7%). At the beginning of the study, 59.0% of the youth were experiencing moderate to severe depression, and at the end, 58.5% were. At the beginning, 52.0% were experiencing moderate to severe anxiety, and at the end, 51.5%. At the beginning, 45% were experiencing suicidality or thoughts of self-harm, and at the end, 42.2%. Importantly, the report failed to indicate its procedures for assessing the mental health readiness of prospective transitioners, and the results are highly susceptible to selection bias between those deemed eligible for hormones or puberty blockers, and those who were not.

B. Six of the cohort studies confounded medical treatment with psychotherapy.

188. The initial enthusiasm for medical blocking of puberty followed largely from early reports from the Dutch clinical research team suggesting at least some mental health improvement. (de Vries 2011, 2014.)

189. The Dutch clinical research team followed up a cohort of youth at their clinic undergoing puberty suppression (de Vries 2011), and later cross-sex hormone treatment and surgical sex reassignment (de Vries 2014). The youth improved on several variables upon

follow-up as compared to pre-suppression measurement, including depressive symptoms and general functioning. No changes were detected in feelings of anxiety, or anger, or in gender dysphoria itself as a result of puberty suppression. Moreover, natal females suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics. (Biggs 2020.)

190. The reports' own authors noted that while it remains possible that the improvement on some variables was due to the puberty blockers, it was also possible that the improvement was due to the mental health support or to natural maturation. The study authors noted this explicitly: "All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents." (de Vries 2011 at 2281.)

191. van der Miesen, et al. (2020) provided an update of the Dutch clinic's sample, reporting continued improvement in transitioners' psychological functioning, but the medical and psychological treatments remained confounded. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. The study authors expressly noted, "The present study can, therefore, not provide evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes." (van der Miesen 2020 at 703.)

192. Allen, *et al.* (2019) reported on a sample of 47 youth, ages 13–20, undergoing cross-sex hormone treatment. They reported observing increases in measures of well-being and decreases in measures of suicidality; however, as the authors also noted, "whether a patient is actively receiving psychotherapy" may have been a confounding variable. (Allen 2019.)

193. Becker-Hebly, *et al.* (2021) assessed the quality of life and overall functioning of a sample of German youth both before and after undergoing treatment with GnRHa, CSHT, or

both. Excluded from participating were youth with severe psychiatric issues, including suicidality. Of the sample, 79% of the sample participated in psychotherapy at the same time. As the study authors were careful to indicate, "Because this study did not test for statistically significant differences between the four intervention groups or before and after treatment, the findings cannot be generalized to other samples of transgender adolescents." (Becker-Hebly 2021 at 1755.)

194. In Kuper, *et al.* (2020), a multidisciplinary team from Dallas used a battery of mental health tests to assess 148 youth undergoing either puberty-blocking or cross-sex hormone treatment. The tests revealed highly inconsistent results: Most revealed no significant change, some indicated improvement, and some indicated deterioration. Because 144 of the 148 participants were also in treatment with a therapist or counselor (Kuper at 7, Table 4), no conclusions can be drawn regarding the cause of the improvements. Similarly, 47% of the sample were receiving psychiatric medication at the time of their initial assessments, but it was 61% of the sample at the follow-up time: It cannot be known to what extent mental health improvement was associated with transition-related or with psychiatric medication. Importantly, the variables demonstrating deterioration included each of the ones indicating suicidality and self-harm: At follow-up time, the sample showed *higher* levels of suicidal ideation (from 25% to 38%), suicide attempts (from 2% to 5%), and "non-suicidal self-injury" (from 10% to 17%) (Kuper at 8, Table 5).

195. This evidence of worsening mental health was highly obscured in the Kuper report, however. Rather than provide the standard comparison of pre- and post-treatment rates, Kuper instead listed the post-treatment rates alongside the full *lifetime* rates: "Lifetime and follow-up rates were 81% and 39% for suicidal ideation, 16% and 4% for suicide attempt, and 52% and

18% for NSSI, respectively" (p. 1). Rates from over a lifetime are necessarily higher numbers, and putting them where pre-treatment rates normally appear conveys the statistical illusion of a decrease, exactly opposite to the actual pattern.

C. Two found no advantage of medicalization over psychotherapy.

196. Costa, *et al.* (2015) provided preliminary outcomes from a small study conducted with patients of the GIDS clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication (representing an "active comparator" group. See Section III.C.2). The "untreated" group, however, was different from the treated group in another important respect, in that these were the patients who began with such severe psychiatric co-morbidities that they were deemed ineligible to begin puberty blockers until mental health improved. Further, the study suffered a dramatic loss-to-follow-up, with almost two thirds of participants dropping out across just 18 months. (Biggs 2019.) In this preliminary report, both groups improved in psychological functioning over the course of the study, but no statistically significant difference between the groups was detected at any point. (Costa 2015 at 2212, Table 2.) In any event, all these findings have been superseded, however, and are moot. The final outcomes report for this cohort was subsequently published (as Carmichael 2021, above), finding that neither group actually had experienced any significant improvement at all. (Carmichael 2021.)

197. Achille, *et al.* (2020) at Stony Brook Children's Hospital in New York studied a sample of 95 youth with gender dysphoria, but 45 were lost-to-follow-up within just 12 months, failing to complete follow-up surveys at 6 month and or 1 year. That is, outcomes were available only for the 50 who remained in the study. As well as receiving puberty blocking medications,

"Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional." (Achille 2020 at 2.) Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, "*most predictors did not reach statistical significance*." (Achille 2020 at 3, italics added.) That is, puberty blockers did not improve mental health any more than did mental health care on its own. More specifically, only one of the 12 predictors reached statistical significance. (Achille 2020 at Table 4.) That is, medicalized transition was not associated with improved mental health beyond improvement associated with the mental health care received. Moreover, the single predictor reaching the threshold for statistical significance is not reliable: the study authors made a methodological error by failing to account for the multiple comparisons it conducted. Had the study applied the standard adjustment for correcting for multiple comparisons, that remaining predictor would also have ceased to be statistically significant.

D. One failed to report whether psychotherapy was provided.

198. Chen, *et al.* (2023) reported finding some improvement in some mental health variables associated with the cosmetic changes after two years of cross-sex hormone treatment in a sample of 315 youth (mean age, 16 years). Unlike the other studies, Chen et al. did not report how many participants were receiving psychotherapy or psychiatric medication at the same time as the hormone treatments. It is therefore not possible to assess to what extent any changes were due to hormone treatment versus the potential confounds. Because the study did not include a control group, it is not possible to assert that changes were due to hormone treatment rather than representing regression to the mean (see Section III.C.1. *Biases representing 'regression to the mean'*). Potential conclusions are also hampered by the large proportion of mental health data

that were missing: Of the 315 youth in the sample, analyses could be conducted with only 208–217 (Chen 2023, supp. Material at 12, Table S5). The purported changes in mental health variables were statistically significant, but not clinically meaningful. The depression test used by Chen et al consisted of 21 items, with each item contributing up to 3-points to the total score. For example:

> 0 I do not feel sad.
> 1 I feel sad.
> 2 I am sad all the time and I can't snap out of it.
> 3 I am so sad and unhappy that I can't stand it.

Thus, the total scores range from 0 to 63. Scores 0–13 represent minimal difficulty; 14–19 represent mild depression; 20–28, moderate; and 29–63, severe. The change that Chen et al. found after two years of hormone treatment was from 16.39 to 13.95 (at Table S5). Changes of this size are unlikely to be associated with patients reporting they feel better. Such scores are below the "minimum clinically important difference." (Button 2015.) Although the report did not include data on co-morbid mental health diagnoses, it noted that two patients receiving cross-hormone treatment died by suicide (representing 0.6% mortality within just two years). (Chen 2023 at 240.)

199. In addition to the incomplete reporting of key aspects of the project and large proportion of missing data, Chen et al appears to have provided only a selected subportion of the information it collected. A knowledgeable journalist investigating transgender issues, Jesse Singal, identified documentation representing the full set of information the Chen et al team planned to collect. I have verified that documentation and have come to the same conclusion. As described by Singal:

> In their study protocol, including a version that they submitted into a preregistration database, the researchers hypothesized that members of this cohort would experience improvement on eight measures, including ones that are just about universally recognized by youth gender researchers as important outcomes, such as

> gender dysphoria, suicidality, and self-harm. Then, in the published *NEJM* paper, the researchers changed their hypothesis and six of those variables were nowhere to be found. The two remaining—anxiety and depression—moved in a positive direction for trans boys (natal females) but not trans girls (natal males). The researchers reported on three other variables, too, without explaining how they picked them (two improved for trans girls and boys, and one just for trans boys). (Singal 2023.)

200. This appears to represent "cherry-picking" of the findings being reported, rather than a comprehensive reporting on the complete set of evidence. Further, Chen et al. failed to balance the concrete and strikingly high rate of *completed* suicide among their sample against the very incremental mental health changes they claim, even though the ethical and clinical importance of those suicides is obvious.

XIV. Known and potential harms associated with administration of puberty blockers and cross-sex hormones to children and adolescents.

201. As I have explained, any conclusion about safety requires knowledge about and balancing of both risks and benefits.

202. In concluding that safety has not been established (see Section V above), national health authorities, authors of systematic reviews, and researchers have identified a number of harms which are either known to result from administration of puberty blockers and cross-sex hormones to children and adolescents, or can be reasonably anticipated but have not been sufficiently studied to reach any conclusion as to the likelihood or severity of harm.

203. When applying research regarding harms to clinical policy, several considerations need to be included: (1) The harms of medicalized transition of gender does or may differ between male-to-female and female-to-male cases, differ between ages of transition, and differ according to age-of-onset of the gender dysphoria. Evidence and conclusions about harms (and safety) cannot be generalized or extrapolated across such cases. (2) The evidence has strongly shown that after social transition of gender, minors are much more likely than otherwise to undergo medicalized transition of gender. Thus, the appropriate assessment of the risk:benefit ratio for social transition must include the increased risks posed by the medicalized path to which it is likely to lead. (3) The evidence has shown strongly that youth who undergo puberty blocking are highly likely to undergo cross-sex hormone treatment. Thus, the appropriate risk:benefit evaluation must also consider its potential implications over the full lifespan.

204. Systematic reviews of the evidence have identified fewer than 10 studies investigating potential harms of medicalized transition of minors at all, (NICE 2020a at 6) and most of these have been limited to bone and skeletal health. As concluded by the NICE systematic review, “A key limitation to identifying the effectiveness and safety of GnRH

analogues for children and adolescents with gender dysphoria is the lack of reliable comparative studies." (NICE 2020a at 40.) With that said, numerous harms are either known, or reasonably anticipated by respected health authorities but thus far unmeasured.

A. Sterilization without proven fertility preservation options.

205. Clinical guidelines for the medical transition of gender among children include the need to caution and counsel patients and parents about what are euphemistically called "options for fertility preservation." (e.g., Endocrine Society Guidelines, Hembree 2017 at 3872.) For children who are placed on puberty blockers at Tanner Stage 2, however, because most continue onto cross-sex hormones once they begin a medicalized approach to their dysphoria, no viable fertility preservation options exist. The decision to undergo medicalized transition also represents the decision never to have biological children of one's own.

206. For the large new population of young people who are first being put on puberty blockers and/or cross-sex hormones at a somewhat later stage of puberty, no studies at all have been done of when, whether, or with what probability either males or females can achieve healthy fertility if they later regret their transition decision and cease taking puberty blockers and/or cross-sex hormones. Much less has this been studied as a function of the stage of development at which they began puberty blockers and/or cross-sex hormones, and how long their gonads were subjected to cross-sex hormones.

B. Permanent loss of capacity for breast-feeding in adulthood.

207. While the removal of the breasts of a biological female adolescent or young adult may be cosmetically revised, it is functionally irreversible; even if the person later regrets and detransitions before or during adulthood, breast-feeding a child will never be possible. To the adolescent determined to transition, this may seem no cost at all. To the future adult mother, it

may be a very severe harm indeed.

C. Lifetime lack of orgasm and sexual function.

208. There has not been systematic investigation of the effects on adult sexuality among people medically transitioned at an early stage of puberty. Notably, Dr. Marci Bowers, current President of WPATH, and surgeon with substantial experience conducting penis-to-vagina operations, opined, "If you've never had an orgasm pre-surgery, and then your puberty's blocked, it's very difficult to achieve that afterwards.…I consider that a big problem, actually. It's kind of an overlooked problem that in our 'informed consent' of children undergoing puberty blockers, we've in some respects overlooked that a little bit." (Shrier 2021.) In my opinion as a psychologist and sex and couple's therapist, this represents a large potential harm to future relationships and mental health to "overlook," and must be taken into consideration in any serious risk:benefit analysis of "safety."

D. Hormonal treatments during puberty interfere with neurodevelopment and cognitive development.

209. It is well known that pubertal hormone levels drive important stages of neural development and resulting capabilities, although the mechanisms are not yet well understood. Dr. John Strang (Research Director of the Gender Development Program at Children's National Hospital in Washington, D.C.) (Terhune 2022), the Cass Report from the U.K., and the systematic review from Finland all reiterated the central importance and unknown effects of GnRH-agonists on windows, or "sensitive periods," in brain development, notably including adolescence. As Dr. Cass put it:

> A further concern is that adolescent sex hormone surges may trigger the opening of a critical period for experience-dependent rewiring of neural circuits underlying executive function (i.e. maturation of the part of the brain concerned with planning, decision making and judgement). If this is the case, brain maturation may be temporarily or permanently disrupted by puberty blockers, which could have

> significant impact on the ability to make complex risk-laden decisions, as well as possible longer-term neuropsychological consequences. To date, there has been very limited research on the short-, medium- or longer-term impact of puberty blockers on neurocognitive development. (Cass Review Letter 2022 at 6.)

210. In a meta-analysis (a highly rigorous type of systematic review) of studies of neuropsychological performance, non-transsexual males undergoing puberty earlier show a different cognitive profile than those underdoing puberty later. The association of brain development with age of pubertal onset exists in humans as well as non-human animals. (Shirazi 2022.)

211. Even in adults, neuroscience studies employing MRI and other methods have shown that the blockade of normal levels of hormones associated with puberty and adulthood degrade brain performance. Thus, when GnRH-agonists are administered to adult biological women, several brain networks decrease in activity, and cognitive performance, such as working memory, declines. (Craig 2007; Grigorova 2006.)

212. In light of this science, multiple voices have expressed concern that blocking the process of puberty during its natural time could have a negative and potentially permanent impact on brain development (Cass 2022 at 38–39; Chen 2020; Hembree 2017 at 3874.) As Chen *et al.* (2020) observed:

> [I]t is possible these effects are temporary, with youth 'catching up'…However, pubertal suppression may prevent key aspects of development during a sensitive period of brain organization. Neurodevelopmental impacts might emerge over time, akin to the 'late effects' cognitive findings associated with certain [other] oncology treatments. (Chen 2020 at 249.)

Chen et al. (2020) noted that no substantial studies have been conducted to identify such impacts outside "two small studies" (at 248) with conflicting results. I have not identified any systematic review of neurodevelopment or cognitive capacity.

213. A related concern is that by slowing or preventing stages of neural development,

puberty blockers may impair precisely the mature cognitive capabilities that would be necessary to evaluation of, and meaningful informed consent to, the type of life-changing impacts that accompany cross-sex hormones. (See Section XV.)

E. Substantially delayed puberty is associated with medical harms.

214. The research cited by the WPATH Standards of Care includes the evidence that children whose natural puberty started very late (top 2.3% in age) have elevated risks of multiple health issues in adulthood. (Zhu & Chan 2017.) These include elevations in metabolic and cardiovascular disease, lower height, and decreased bone mineral density. It has not been studied whether these correlations also occur in children whose puberty is chemically delayed. Undergoing puberty much later than one's peers is also associated with poorer psychosocial functioning and lesser educational achievement. (Koerselman & Pekkarinen 2018.)

F. Elevated risk of Parkinsonism in adult females.

215. Epidemiological research has shown adult women without gender dysphoria, undergoing surgical removal of both ovaries for other reasons, to have substantially elevated odds of developing parkinsonism, including Parkinson's Disease, relative to age-matched women randomly selected from the local population in an on-going epidemiological study. (Rocca 2022.) The effect was greater among younger women, showing 7–8 times greater odds among women under 43. The observed delay between removal of ovaries and the onset of parkinsonism was 26.5 years. Whether chemically suppressing the ovaries of a biological female via puberty blockers during adolescence followed by cross-sex hormones will cause a similar increase in parkinsonism, or when, remains unknown.

G. Reduced bone density.

216. The systematic reviews by Sweden, Finland, and England all included bone health as

an outcome. *The New York Times* also recently commissioned its own independent review of the available studies. (Twohey & Jewett 2022.) These reviews all identified subsets of the same group of eight studies of bone health. (Carmichael 2021; Joseph 2019; Klink 2015; Navabi 2021; Schagen 2020; Stoffers 2019; van der Loos 2021; Vlot 2017.) These studies repeatedly arrived at the same conclusion. As described by *The New York Times* review:

> [I]t's increasingly clear that the drugs are associated with deficits in bone development. During the teen years, bone density typically surges by about 8 to 12 percent a year. The analysis commissioned by *The Times* examined seven studies from the Netherlands, Canada and England involving about 500 transgender teens from 1998 through 2021. Researchers observed that while on blockers, the teens did not gain any bone density, on average—and lost significant ground compared to their peers.[7] (Twohey & Jewett 2022.)

217. There is some evidence that some of these losses of bone health are regained in some of these youth when cross-sex hormones are later administered. The rebounding appears to be limited to female-to-male cases, while bone development remains deficient among male-to-female cases.

218. The long-term effects of the deficient bone growth of people who undergo hormonal interventions at puberty remain unstudied. The trajectory of bone quality over the human lifetime includes decreases during aging in later adulthood. Because these individuals may enter their senior years with already deficient bone health, greater risks of fracture and other issues are expectable in the long term. As the *New York Times'* analysts summarized, "That could lead to heightened risk of debilitating fractures earlier than would be expected from normal aging—in their 50s instead of 60s." Such harms, should they occur, would not be manifest during the youth and younger adulthood of these individuals. This distinction also represents one of the differences between adult transitioners and childhood transitioners and why their experiences

[7] The eighth study was Lee, *et al.,* 2020, which reported the same deficient bone development.

cannot be extrapolated between them.

219. There does not exist an evidence-based method demonstrated to prevent these outcomes. The recommendations offered by groups endorsing puberty blockers are quite limited. As summarized by *The Times:*

> A full accounting of blockers' risk to bones is not possible. While the Endocrine Society recommends baseline bone scans and then repeat scans every one to two years for trans youths, WPATH and the American Academy of Pediatrics provide little guidance about whether to do so. Some doctors require regular scans and recommend calcium and exercise to help to protect bones; others do not. Because most treatment is provided outside of research studies, there's little public documentation of outcomes. (Twohey & Jewett 2022.)

H. Short-term/Immediate side-effects of puberty blockers include sterile abscesses, leg pain, headache, mood swings, and weight gain.

220. The Cass Report summarized that "In the short-term, puberty blockers may have a range of side effects such as headaches, hot flushes, weight gain, tiredness, low mood and anxiety, all of which may make day-to-day functioning more difficult for a child or young person who is already experiencing distress." (Cass 2022 at 38.)

221. In 2016, the U.S. FDA began requiring drug manufacturers to add a warning about the psychiatric side effects, after reports of suicidal ideation and a suicide attempt began to emerge among children prescribed GnRH-agonists (for precocious puberty).[8] The warning label on Lupron reads that "Psychiatric events have been reported in patients…such as crying, irritability, impatience, anger and aggression."

222. Other than the suicide attempt, such adverse effects may seem minor relative to the major health and developmental risks I have reviewed above, and they may be dismissed by children and by parents confronted by fears of suicidality and an urgent hope that transition will

[8] Reuters Special Report; 2022, Oct. 6. Retrieved from https://www.reuters.com/investigates/special-report/usa-transyouth-care/

resolve the child's unhappiness and mental health issues. However, when assessing risk:benefit ratio for "safety" against the undemonstrated benefits claimed for hormonal interventions, these observed harms should not be ignored.

I. Long-term use of cross-sex hormones in adults with gender dysphoria is associated with unfavorable lipid profiles (cholesterol and triglycerides) and other issues.

223. As the Cass Report correctly and succinctly indicated, "Sex hormones have been prescribed for transgender adults for several decades, and the long-term risks and side effects are well understood. These include increased cardiovascular risk, osteoporosis, and hormone-dependent cancers." (Cass 2022 at 36.)

224. Minors who begin puberty blockers and proceed to cross-sex hormones—as almost all do—will require continuing treatment with cross-sex hormones for life, unless they go through the very difficult process of detransition. Because a lifetime dependence on cross-sex hormones is the expected course, the known adverse effects of cross-sex hormones on adults must also be part of the risk:benefit analysis of the "safety" of putting a minor on cross-sex hormones (and indeed, of the initial decision to put a child on puberty blockers).

225. Systematic review identified 29 studies of the effects of cross-sex hormone treatment on cardiovascular health in adults. (Maraka 2017.) By the two-year follow-up mark among female-to-male transitioners, hormone administration was associated with increased serum triglycerides (indicating poorer health), increased low-density-lipid (LDL) cholesterol (indicating poorer health), and decreased high-density-lipid (HDL) cholesterol (indicating poorer health). Among male-to-female transitioners at the two-year mark, cross-sex hormone treatment was associated with increased serum triglycerides (indicating poorer health).

XV. Assertions that puberty blockers act only as a "fully reversible" "pause button" are not supported by scientific evidence.

226. Plaintiffs' experts, along with many advocates and organizations, have boldly asserted that the administration of puberty blockers to adolescents is "fully reversible." The assertion is not consistent with or supported by any objective assessment of the existing science. Although withdrawal of the medication will allow the pubertal process to resume, that is very far from establishing that the impact of that interruption of natural development is "fully reversible." The evidence is not that the person's life will proceed as if the medical intervention never happened, as the popularized phrase suggests. Rather, the evidence repeatedly indicates that stopping a healthy child's natural onset of puberty imposes multiple substantial harms, risks, or opportunity costs.

227. First, as I have previously mentioned (Section IV.D), it is scientifically invalid to extrapolate results from using puberty blockers to prevent precocious puberty by delaying the pubertal process to its normal age range, to using them to *prevent* normally occurring healthy puberty, merely assuming the effects and side-effects will be the same. The two are very different populations and very different uses.

228. Second, not all the effects of GnRHa's in otherwise healthy children are known: It is therefore not possible to assess whether all effects are reversed or to what extent. Indeed, within the scientific method, it is never possible to demonstrate that any intervention is "fully reversible." In science, it always remains possible for future evidence to identify an effect that does not reverse. To assert that all the effects of GnRHa's are fully reversible is to assert that all its effects have been investigated and checked for reversibility, which is false.

229. Third, and more concretely, I have reviewed above a large number of medical and developmental risks which multiple responsible voices have associated with administration of

puberty blockers to adolescents, and which are either established by studies or have not been shown not to exist. In the face of this knowledge and lack of knowledge, it is scientifically unsupported and irresponsible to assert that this use of puberty blockers is "fully reversible" and "just a pause."

230. Here, I identify additional psycho-social developmental impacts of delaying healthy, naturally-occurring puberty which are likely to be irreversible, but have not been meaningfully studied.

A. Stopping puberty does not stop time: Patients' peers continue to develop and mature, with patients falling increasingly behind.

231. Initiating puberty blockers at Tanner Stage 2 (at the very first signs of puberty, typically ages 9 or 10) holds the child in a prepubescent state, while their peer group and classmates continue to grow. By the time many patients begin cross-sex hormone treatment, their peers will have completed puberty and progressed far into adolescence. Puberty may become unblocked, but these children have irreversibly lost the opportunity and experience of developing with their peers and must instead do so alone.

232. Being a "late bloomer," indeed among the latest possible bloomers, has psychological consequences of its own. Having the body and mind of a prepubescent child while one's friends have grown into physically mature sixteen-year-olds is extreme. Despite being a teenager chronologically, remaining prepubescent both physically and mentally while the lives of one's peers have advanced to teenagers' interests only increases the isolation of children already reporting social distress. There does not exist a means of distinguishing how much of any improvement in mental health that might be observed across these years in a particular study is simply the result of finally undergoing at least some pubertal development and finally catching up with one's peers in at least some parameters.

233. Concretely, undergoing puberty much later than one's peers (as a result of naturally occurring rather than medically induced conditions) has been associated with poorer psychosocial functioning and lesser educational achievement. (Koerselman & Pekkarinen 2018.) Whether this holds true when the late puberty is the result of puberty blockers has not been studied.

B. Blocking puberty blocks the awareness of sexuality and sexual orientation that can play an important role in the individual's understanding of gender identity.

234. As demonstrated unanimously by the cohort studies of prepubescent children with gender dysphoria, the great majority cease to feel gender dysphoric during the course of puberty. (Section IX.B.) Studies also find that many such children subsequently identify as gay or lesbian, providing a potential alternative source and understanding of their atypical childhood gender interests. But for all children, blocking puberty necessarily blocks the onset of adult sexual interest, sexual arousal, and sexual response which are part of "the usual process of sexual orientation and gender identity development." (Cass 2022 at 38.) That is, blocking the experience of sexual feelings and development blocks normal phenomena that enable the young person to understand sexuality and sexual orientation, as distinct from gender identity. As Dr. Cass summarized:

> We do not fully understand the role of adolescent sex hormones in driving the development of both sexuality and gender identity through the early teen years, so by extension we cannot be sure about the impact of stopping these hormone surges on psychosexual and gender maturation. We therefore have no way of knowing whether, rather than buying time to make a decision, puberty blockers may disrupt that decision-making process. (Cass Review Letter 2022 at 5.)

Thus, contrary to the hypothesis that providing time might permit more considered understanding and decision-making, the prevention of puberty blocks the awareness of a central factor that may well influence that understanding.

235. Because puberty blockers prevent prepubescent children from developing any understanding of sexual arousal and sexual relationships they would otherwise gain with maturation, such children are necessarily incapable of providing informed consent. There does not exist—indeed, there cannot exist—an age-appropriate way to equip a child who has not gone through puberty to make an informed decision about age-inappropriate issues, such as their future sex life, choices of sexual partners, sex-bonded relationships including marriage, and sacrificing ever experiencing orgasm.

C. Blocking puberty may block development of adult decision-making capacity.

236. As I have explained above, there are reasons to fear that use of puberty blockers may have permanent negative effects on brain development. That long-term risk aside, blocking puberty nevertheless threatens to prevent the child from growing towards adult decision-making capability during precisely the years in which he or she is being asked to make life-altering decisions about gender identity, gender presentation and cross-sex hormones. Pubertal brain development includes pervasive change in structural and functional connectivity (Chen 2020), re-balancing its capabilities between the acquisition of skills and knowledge and their application. Foremost among these are acquiring the abilities to control impulsivity and engage in rational and long-term decision-making (Crone & Steinbeis 2017), in association with development of a brain region called the "prefrontal cortex," and similarly acquiring the capacity to process adult social interaction, in association with the development of a network of brain areas (Kilford 2016), collectively called the "social brain." To understand medicalized transition of gender and its known and unknown consequences is one of the most complicated questions that a young person today could face, and a prepubescent brain is not equipped to process that information rationally, objectively, and with a whole lifetime rather than immediate desires and

social pressures in mind.

D. Time spent on puberty blockers poses significant opportunity costs.

237. One of the primary, if not the foremost, justifications for medically transitioning children and adolescents is to reduce the psychological distress they report. That hypothesis interprets these children's psychological concerns (e.g., anxiety and depression) to gender dysphoria and/or external sources (e.g., transphobia). As I have noted here previously, however, many gender dysphoric children and adolescents suffer from multiple other mental health issues. In several studies of minors on puberty blockers, a substantial portion of the subjects do not report ongoing psychological care. If years spent on puberty blockers in the hopes that that will relieve distress distract from systematic efforts to directly address comorbidities through psychotherapy, then it diverts the minors from treatment which exhibits substantial evidence of effectiveness for improving mental health and lacks the multiple and significant side-effects of puberty blockers.

XVI. Assessments of clinical guidelines, standards, and position statements.

238. Several sets of recommendations have been offered regarding the clinical treatment of people with gender dysphoria. In this section, I comment on these protocols or recommendations individually.

A. The Dutch Protocol (aka Dutch Approach).

239. The Netherlands' child gender identity clinic in Amsterdam associated with the Vrije University (VU) was one of the international leaders in the use of hormonal interventions to treat gender dysphoria in minors. Researchers associated with that clinic have generated a large portion of the seminal research literature in the field. Key early publications from that group spelled out criteria and procedures that are collectively referred to as the "Dutch Protocol," and this approach has been widely influential internationally.

240. The purpose of the protocol was to compromise conflicting desires and considerations including: clients' initial wishes upon assessment; the long-established and repeated observation that those wishes will change in the majority of (but not in all) childhood cases; and that cosmetic aspects of medical transition are perceived to be better when they occur earlier rather than later in pubertal development.

241. The VU team summarized and explicated their approach in their paper, *Clinical management of gender dysphoria in children and adolescents: The Dutch Approach*. (de Vries & Cohen-Kettenis 2012.) Key components of the Dutch Approach are:

- no social transition at all considered before age 12 (watchful waiting period),
- no puberty blockers considered before age 12,
- cross-sex hormones considered only after age 16, and
- resolution of mental health issues before any transition.

242. For youth under age 12, "the general recommendation is watchful waiting and

carefully observing how gender dysphoria develops in the first stages of puberty." (de Vries & Cohen-Kettenis 2012 at 301.)

243. The age cut-offs of the Dutch Approach were not based on any research demonstrating their superiority over other potential age cut-offs. Rather, they were chosen to correspond to the ages of consent to medical procedures under Dutch law. Nevertheless, whatever the original rationale, the data from this clinic simply contain no information about the safety or efficacy of employing these measures at younger ages.

244. The authors of the Dutch Approach repeatedly and consistently emphasize the need for extensive mental health assessment, including clinical interviews, formal psychological testing with validated psychometric instruments, and multiple sessions with the child and the child's parents.

245. Within the Dutch Approach, there is no social transition before age twelve. That is, social affirmation of the new gender may not begin until age 12—as desistance is less likely to occur past that age. "Watchful Waiting" refers to a child's developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Rather, such children and families typically present with substantial distress involving both gender and non-gender issues, and it is during the watchful waiting period that a child (and other family members as appropriate) would undergo therapy, resolving other issues which may be exacerbating psychological stress or dysphoria. As noted by the Dutch clinic, "[T]he adolescents in this study received extensive family or other social support [and they] were all regularly seen by one of the clinic's psychologists or psychiatrists." (de Vries 2011 at 2281.) One is actively treating the person, while carefully "watching" the dysphoria.

246. The use of hormonal interventions described in the Dutch Protocol, while markedly

more conservative than today's practice in many U.S. clinics, has recently been criticized in detail in a peer-reviewed article as unjustified by reliable evidence (Biggs 2022; Levine 2023; Levine 2022). Certainly, the published research evidence base concerning safety and efficacy available to the VU clinicians is and was no greater than the global evidence base that the NICE review recently labelled as uniformly of "very low quality."

247. Because clinical practices are often justified by alluding to the Dutch Protocol, however, it is important to be aware of the limitations on the use of hormones and puberty blockers specified by the Dutch Protocol and listed above (and thus the limits of the clinical evidence published out of the VU clinic) which are regularly ignored by clinicians in the U.S.

B. World Professional Association for Transgender Health (WPATH).

248. The WPATH standards of care have been lauded as long-established and high quality procedures. This does not reflect any objective assessment, however. The previous WPATH standards (version 7) were subjected to standardized evaluation, the Appraisal of Guidelines for Research and Evaluation ("AGREE II") method. (Dahlen 2021.) That assessment concluded "[t]ransition-related [clinical practice guidelines] tended to lack methodological rigour and rely on patchier, lower-quality primary research." (Dahlen 2021 at 6.) The WPATH guidelines were not merely given low scores, but received unanimous ratings of "Do not recommend." (Dahlen 2021 at 7.)

249. Immediately after the release of the current (2023) version of WPATH's standards (version 8), WPATH fundamentally altered it by removing from it minimum ages previously required for undergoing social or medical transition of gender. (WPATH Correction 2022.) This is despite the fact that age is the central component to young people's emerging understanding of their sexual identities through social identity formation, pubertal development, and the onset of

sexual interest. The removal of age restrictions was not based on any research evidence at all—WPATH provided no reference to any study as justification, and the WPATH leadership have been explicit in indicating that the change was intended to prevent clinical care providers from legal liability for physicians rejecting those minimums. The implementation of such fundamental and dramatic changes, in the complete absence of any supporting science whatsoever, negates entirely any claim that WPATH represents evidence-based or empirically-supported treatment. As explicated herein, on Table 1, the systematic review on which WPATH based its standards for minors included exactly one study on puberty blockers and three studies on cross-sex hormones. All other references represent cherry-picked citations of studies rejected by its own systematic process. Moreover, even among the four studies in WPATH's review, three were rejected by the Swedish review, due to the low quality of the science they contained.

C. Endocrine Society (ES).

250. As I have noted, in preparing its guidelines the Endocrine Society did not conduct systematic reviews of evidence relating to efficacy of any hormonal intervention in children or adolescents, and instead conducted reviews on only two safety-related endpoints.

251. Although outside the professional expertise of endocrinologists, mental health issues were also addressed by the Endocrine Society, repeating the need to handle such issues before engaging in transition, "In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues." (Hembree 2017 at 3877.) This ordering—to address mental health issues before embarking on transition—avoids relying on the unproven belief that transition will solve such issues.

252. The Endocrine Society did not endorse any affirmation-only approach. The guidelines

were neutral with regard to social transitions before puberty, instead advising that such decisions be made only under clinical supervision: "We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional." (Hembree 2017 at 3870.)

253. The Endocrine Society guidelines make explicit that, after gathering information from adolescent clients seeking medical interventions and their parents, the clinician "provides correct information to prevent unrealistically high expectations [and] assesses whether medical interventions may result in unfavorable psychological and social outcomes." (Hembree 2017 at 3877.)

254. The 2017 update of the Endocrine Society's guidelines added a disclaimer not previously appearing:

> The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care….The Endocrine Society makes no warranty, express or implied, regarding the guidelines and specifically excludes any warranties of merchantability and fitness for a particular use or purpose. The Society shall not be liable for direct, indirect, special, incidental, or consequential damages related to the use of the information contained herein. (Hembree 2017 at 3895-3896.)

255. The Endocrine Society guidelines do not rely on any systematic review of evidence of *efficacy* of any form of treatment for gender dysphoria. The Dahlen et al. team also subjected these guidelines to review according to the AGREE II criteria, and two out of three independent reviewers concluded that they should *not* be used clinically. (Dahlen 2021 at 7.)

D. American Academy of Pediatrics (AAP).

256. A "Policy Statement" issued by the American Academy of Pediatrics (AAP) in 2018—which on its face declared to represent exclusively the work of one author who alone is "accountable for all aspects of the work"—is unique among the major medical associations in being the only one to endorse an affirmation-on-demand policy, including social transition

before puberty without any watchful waiting period. (Rafferty 2018.) Although changes in recommendations can obviously be appropriate in response to new research evidence, the AAP identified no such new evidence to justify a radical departure from the "therapy first" approach of the Dutch Protocol. Rather, the research studies AAP cited in support of its policy simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting. (Cantor 2019.) Moreover, of all the outcomes research published, the AAP policy cited *one*, and that without mentioning the outcome data it contained. (Cantor 2019.)

257. Immediately following the publication of the AAP policy, I conducted a point-by-point fact-check of the claims it asserted and the references it cited in support. I submitted that to the *Journal of Sex & Marital Therapy*, a well-known research journal of my field, where it underwent blind peer review and was published. I append that article as part of this report. *See* Appendix 2. A great deal of published attention ensued; however, the AAP has yet to respond to the errors I demonstrated its policy contained. Writing for *The Economist* about the use of puberty blockers, Helen Joyce asked AAP directly, "Has the AAP responded to Dr Cantor? If not, have you any response now?" The AAP Media Relations Manager, Lisa Black, responded: "We do not have anyone available for comment."

XVII. Assessment of expert declaration of Dr. Christine Brady.

258. In the body of my report above, I summarized the nature and strength of the published scientific evidence regarding the central issues pertaining to the medicalized transition of gender in minors. The present section provides additional remarks directed to specific evidentiary or logical defects in the opinions offered in the declaration of Dr. Christine Brady, which I have also reviewed.

259. Dr. Brady's declaration included that "100 percent of my clinical practice are transgender youth" (Brady decl ¶7), which represents a significant conflict of interest: The income she derives from providing services to these children stands to be directly affected by the outcome of this case. Individuals whose incomes would be impacted on the basis of research findings cannot be objective in their assessment of those findings. (See Section I.B. on *Clinical vs. Scientific Expertise* and Section I.C. on the *Professional Standard on Conflict of Interest.)*

A. Dr. Brady's opinions are not the product of the principles and methods accepted as reliable by the fields of medical science or behavioral science.

260. As outlined in the body of the present report (section III.A. *Pyramid of Evidence*), the standard in these fields is to apply systematic reviews of the research evidence, which minimizes opportunities for bias, including the cherry-picking of studies from only one side of an issue or holding studies to higher or lower standards according to whether they favor one's own view (see Section III.B. *Systematic Reviews*). Despite Dr. Brady's referring to her sources as "widely adopted" (e.g., ¶26, ¶27), her declaration (1) excludes the systematic reviews of the safety and effectiveness of the medicalized transition of minors, instead engaging in the very biases which the systematic review process was designed to remove from evidence-based medicine, (2) excludes the international consensus reached by every public health care system that conducted such systematic reviews, and (3) excludes any analysis of the risk-to-benefit ratio of the

alternatives available to minors who express gender dysphoria, instead describing only the medical option, from which she receives income.

261. As explicated in the present report, the strongest level of evidence currently available regarding the safety and effectiveness of medicalized transition of minors are cohort studies. (See Section XIII.) Of the 14 such studies, Dr. Brady included only four (de Vries et al., 2011; de Vries et al., 2014; Costa et al., 2015; and Chen et al., 2023). Dr. Brady left out all studies showing a lack of improvement after medicalized transition (as well as several others). Of the studies she did cite, none was able to distinguish whether mental health improvement was caused by medicalization or by the psychotherapy received at the same time. That is, rather than include all relevant outcomes studies, which would document the unreliability of claims of improvement, Dr. Brady selected to cite only a small minority of studies and included only select portions from within those studies, seeming to suggest improvement, and simply ignored all else.

262. Dr. Brady's opinions rely largely on survey studies, which do not yield reliable facts about the risks or benefits of clinical outcomes. Indeed, her survey citations all represent *the same* survey: Green et al. (2022), Turban et al. (2019), Turban et al. (2020), and Turban et al. (2021). As outlined in the present report, surveys recording the replies of anyone who wants to respond do not appear at all on the standard pyramid of evidence in science. (See section III.A *Pyramid of Evidence.*)

263. Entirely missing from Dr. Brady's report is any discussion, consideration, or comment on the international consensus, unanimous across every public health care system conducting systematic reviews of the evidence. Every national health care system in the world that has conducted such reviews of the safety and efficacy of medicalized transition has come to the same conclusion: For minors, the harms outweigh the benefits. No U.S. professional

association has conducted such a review of the evidence, and the associations' views correspond to their economic interests: Acknowledging transition of minors to be experimental disqualifies the procedures from medical insurance coverage, and permitting governments to ban these medical procedures opens the door to the government regulation of others.

264. Dr. Brady repeatedly based her opinions on personal recollections of providing services to this population, in what science calls *anecdotal evidence.* The advantages of accumulated personal experience is its low cost and potential utility when there do not exist systematic studies of the unique combination of variables represented by some cases. The disadvantages include that it is the most subject to human biases, such as recall bias, confirmation bias, survivorship bias, as well as to sampling biases including both self-selection biases (who decides to come into the clinic in the first place) and any variables which led to dropping out of the clinic, leaving clinicians no capacity for knowing why.

265. If there did not already exist multiple studies systematically studying cohorts of minors undergoing puberty-blocking or cross-sex hormone treatment, then expert opinion based on anecdotal evidence might represent the only option available. That is not the current situation, however: Rather than engage in the scientifically valid research method of accepting higher order evidence over lower order evidence, Dr. Brady accepted and rejected evidence according to their results, that is, *cherry-picking* only the seemingly supportive studies.

266. Dr. Brady's very definition of gender identity, as an "internal sense" (Brady decl ¶13), represents a fundamental violation of the scientific method: Nothing in science can be defined as an internal sense. To be scientifically valid, a claim must be objective, testable, and falsifiable. (See Section VII.B *Subjective feelings.*) Gender identity is unlike emotions, which are associated with objectively measurable physiological changes, such as respiration and brain

activity. (Davidson, 2003; Seeley 2015). Gender identity is unlike sexual orientation, which can be objectively measured by genital and other physiological responses to sexual stimuli. (Freund, 1967; Hess, 1965; Rieger, 2005). Gender identity is unlike disorders of sexual development (DSD's, also called "intersex conditions"), which are objectively detectable with physical measures such as chromosomal analysis. (Vilain, 2006). Definitions based on vague metaphors, such as "a person's core" and "an essential part of one's being" (Brady decl. ¶¶ 13–14) do not possess the fundamental features required of the scientific method.

B. Clinically evaluating rather than assuming literal accuracy of self-report represents competent mental health care, not conversion therapy.

267. To argue that medicalized transition is the only appropriate clinical response, Dr. Brady declared that gender identity cannot be "*voluntarily* changed" (Brady decl ¶15, italics added). That statement would seem to concede that there exist at least some cases of changing gender identities. As already detailed in the present report, gender dysphoria indeed does change in the large majority of youth with prepubescent onset (see section IX.B.1). Accepting that gender identity can change, even if only *involuntarily,* calls for the very policy Dr. Brady rejects: Hold off medicalization until adulthood.

268. Activists and social media increasingly, but erroneously, apply the term "conversion therapy" moving farther and farther from what the research has actually reported. "Conversion therapy" (or "reparative therapy" and other names) was the attempt to change a person's *sexual orientation,* not *gender identity.* With the lay public more frequently accustomed to "LGB" being expanded to "LGBTQ+", however, the claims relevant only to sexual orientation are being misapplied to gender identity. As the field grows increasingly polarized, any therapy failing to provide affirmation-on-demand is mislabeled "conversion therapy" (D'Angelo, *et al.,* 2021). Indeed, even actions of non-therapists, unrelated to any therapy, have been (mis-)labelled

conversion therapy, including the prohibition of biological males competing on female teams (e.g., Turban, 2021, March 16.)

269. The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, one is only very rarely mistaken. That is entirely unlike gender identity: As already noted herein (section IX.B.1), in all 11 of the 11 follow-up studies of children not permitted social transition prepubertally, the great majority of children declaring a cross-gender identity ceased to so identify. Moreover, because highly discrepant rates of persistence and desistence were almost entirely reversed when children were transitioned socially, we have very powerful evidence that the social environment was at the root of the children's gender identities rather than any innate feature.

270. Dr. Brady's reference to actively attempting to *change* gender identity avoids the pertinent issue: As demonstrated in the following, the evidence is much more parsimoniously interpreted to indicate, after the advent of social media, the far more typical situation to be youth who are *mistaken* about their gender identity. That is, socially vulnerable youth are misinterpreting their experiences to indicate they are transgender or are exaggerating their descriptions of their experiences in service of psychological needs, such as attention-seeking or externalizing sources of internal distress.

C. DSM-5 criteria pre-date nearly all outcomes research on adolescents.

271. In ¶¶16–19, Dr. Brady listed the DSM-5 criteria for the formal diagnosis of Gender Dysphoria, noting that "The diagnosis and its criteria have changed over time to reflect the most current research regarding the presentation of this diagnosis" (Brady decl ¶16). Dr. Brady correctly included the current diagnostic criteria to be those from the DSM-5, released in 2013.[9]

[9] The 2022 update from the DSM-5 to the DSM-5-TR represented "text revision" (abbreviated "-TR") and did not include change to the diagnostic criteria in the manual.

Dr. Brady did not include, however, that the DSM-5 criteria for Gender Dysphoria are outdated: They do *not* in fact reflect the current research. In 2013, only two presentation types of gender dysphoria were known: the early- or childhood-onset type and the late- or adulthood-onset type. (See sections IX.A and IX.B.) The third type of presentation, the adolescent- or rapid-onset type, had not yet been observed and reported in the research literature. As illustrated by the timeline below, of the now 14 cohort studies reporting on the outcomes of minors undergoing medicalized transition, only one was available in 2013, and the youth participating in that study are psychologically and epidemiologically unlike the youth currently seeking medicalized interventions. (See section IX.C.)

Year	Professional Association	DSM	Research Studies
2000		DSM-IV-TR	
2006	WPATH v6		
…			
2008			
2009	E.S. v1		
2010			
2011			de Vries
2012	WPATH v7		
2013		DSM-5	
2014			de Vries
2015	APA		Costa
2016			
2017	E.S. v2		
2018	AAP		
2019			Allen
2020	WPATH v8		Achille; Cantu; Kaltiala; Kuper; van der Miesen
2021			Becker-Hebly; Carmichael; Hisle-Gorman
2022		DSM-5TR	Tordoff
2023			Chen

272. Similarly, Dr. Brady repeatedly cited statements from the Endocrine Society (E.S.), WPATH, and the American Psychological Association (APA) as the justification of her claim that strong evidence exists to support medicalized transition of minors (Brady decl ¶¶25–29). As

she wrote:

> They have analyzed all available scientific research, and are widely referenced and endorsed by all major U.S. medical and mental health associations. (Brady decl ¶29.)

In direct contrast with her unsourced claim: (1) None of these groups has conducted a systematic review of the safety and effectiveness of medicalized transition of minors did have the several public health case systems in Europe. (2) As the timeline above makes explicit, at the time of the writing of their statements, most of the outcomes data did not yet exist. Phrases such as Dr. Brady's "all available scientific research" are hollow. The APA statement that Dr. Brady cited: (1) expired in 2022, and (2) pertained to gender dysphoric adults, not minors, with the exception of Guideline No. 8:

> Psychologists working with gender-questioning and TGNC youth understand the different developmental needs of children and adolescents, and that not all youth will persist in a TGNC identity into adulthood. (APA, 2015, p. 841.)

That is, despite Dr. Brady citation of it, that document supports my conclusion, not Dr. Brady's.

273. Dr. Brady referred to the WPATH Standards of Care as (SoC) widely accepted, citing no evidence in support of that belief. In direct contrast with that belief, the WPATH SoC have not only been long seen as providing *insufficient* protection from harm, but also the subsequent revisions have further *decreased* the protections it did include: One early survey of clinics providing medical transition of gender found 74% of those clinics did not adhere to the WPATH standards of that time, instead applying *more conservative* standards (Petersen & Dickey, 1995). Systematic evaluation of subsequent WPATH standards received unanimous ratings of "Do not recommend." (Dahlen 2021 at 7.) After the current set of standards (version 8) were released, all age minimums were removed, all outside the review process used in developing them. (See Section XVI.B. *WPATH.*) Dr. Brady's deposition failed to acknowledge the conclusions, or even the existence, of the systematic reviews of research conducted by the international medical

community that entirely rejected the conclusions asserted in the WPATH standards. (See Section V. *Systematic Reviews.*)

274. For reference, WPATH released version 6 of its "Standards of Care" in 2001, version 7 in 2012, and version 8 in 2022. The criteria of WPATH version 6 included: a DSM diagnosis, indications that hormones will be used responsibly, three months of either psychotherapy or a "real life test" of living as the new sex, increasing consolidation of gender identity during that period, progress in solving life problems, and (for genital surgery) two clinical approval letters, one of which must be a comprehensive psychosocial assessment.

275. These criteria of version 6 were the subject of a systematic assessment, comparing them against the research evidence, in preparation for the development of version 7 of WPATH's standards (De Cuypere & Vercrusse, 2009). The review included an exhaustive search of the research evidence:

> For follow-up studies between 1991 and the present we searched Medline and Embase using the following keywords: "transsexual, gender identity disorder, sex reassignment surgery, follow-up study, regret, standards of care, eligibility criteria." We made a selection of these follow-up studies, retaining only those papers that contained information "on whom and under what circumstances SRS is effective." (De Cuypere & Vercrusse, 2009, p. 195)

276. The results were peer-reviewed, published in the *International Journal of Transgenderism*, included the conclusion that "inadequate diagnosis and major psychiatric co-morbidity are the major indicators for regret" (De Cuypere & Vercrusse, 2009, p. 197), and reiterated the consensus that "Most authors agree that a careful differential diagnosis and screening for co-morbidity is imperative for good clinical practice" (De Cuypere & Vercrusse, 2009, p. 200).

277. In contrast with that assessment, WPATH version 7 did the opposite. Rather than follow the evidence base in the research literature, version 7 *lowered* the criteria that had been

preventing regretful cases and instead adopted the "informed consent model." Comprehensive psychosocial assessment was reduced to an assessment needing only to demonstrate only a capacity to provide informed consent. The requirement for psychotherapy or real life test time was reduced to the requirement that any significant mental health concerns (left undefined) be reasonably well-controlled (left undefined).

278. Importantly, whereas version 6 included:

> The SOC are intended to provide flexible direction for the treatment of persons with gender identity disorders. When eligibility requirements are stated they are meant to be *minimum requirements.* (WPATH, 2002, pp. 1–2, italics added)

version 7 instead included:

> As for all previous versions of the SOC, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. (Coleman, 2012, p. 2.)

279. This contrast is remarkable for two reasons. First, whereas version 6 permitted clinicians only to move criteria up, version 7 removed the words "minimum requirements," thus permitting clinicians to move criteria up *or down*. Second, version 7 added the words "As for all previous versions," which is a demonstrable falsehood. The change to this single passage, embedded in introductory text, allowing clinicians to change any criterion, removes any claim the document might have to being called "standards" at all.

280. A systematic assessment of version 7 was conducted in the lead-up to WPATH's release of version 8 (Dahlen et al., 2021). The evaluation followed a standardized assessment method, the internationally employed *Appraisal of Guidelines for Research and Evaluation* procedure ("AGREE II"). Utilizing community stakeholders to set domain priorities for the evaluation, the assessment concluded that the guidelines regarding HIV and its prevention were of high quality, but that "[t]ransition-related CPGs tended to lack methodological rigour and rely

on patchier, lower-quality primary research" (Dahlen et al., 2021, p. 6). The WPATH guidelines received unanimous ratings of *"Do not recommend"* (Dahlen et al., 2021, p. 7).

281. WPATH's version 8 also included the language again allowing clinicians to change any criterion up or down:

> The SOC-8 guidelines are intended to be flexible to meet the diverse health care needs of TGD people globally….As in all previous versions of the SOC, the criteria put forth in this document for gender-affirming interventions are clinical guidelines; individual health care professionals and programs may modify them in consultation with the TGD person. (Coleman, 2022, p. S6)

D. Dr. Brady's analysis fails to distinguish between the distinct phenomena that can lead to gender dysphoria.

282. In ¶20, Dr. Brady further confuses (or misrepresents) the distinct types of gender dysphoria: Specifically, the Brady declaration erroneously claimed that "For adolescents and adults whose gender identity differs from their sex assigned at birth, it is very unlikely that they will later come to identify with the birth-assigned sex." The present report already listed the results of all 11 cohort studies of childhood-onset gender dysphoria, all showing that feelings of gender dysphoria desist in the large majority of cases, persisting in only some (Table 2, in section IX.B.1). Despite that these cases of persistence were found in—and only in—childhood-onset cases, Dr. Brady (mis)applies it as universally true, expanding it to include adolescent-onset and adult-onset cases, despite their differing on all objective variables. Dr. Brady cites no research studies supporting her claim. No such systematic research has been conducted for these other types of gender dysphoria.

283. Dr. Brady next rejected the conclusion of all 11 of these outcomes studies, writing "There is some research on pre-pubertal children that has been described as showing high rates of 'desistance' of transgender identity among pre-pubertal children" (Brady decl ¶21). First, Dr. Brady is incorrect to say "some" research: As explicated here already, that conclusion has been

unanimous across all studies examining it. The single research study that Dr. Brady claimed to supplant the other 11 was Olson et al. (2022). Second, as already noted in the present report (see section IX.B.2), the Olson study differed from the other 11 in having permitted the children to undergo social transition while the other 11 did not. That is, the Olson study appears to demonstrate that social transition encourages the persistence of gender dysphoria that would otherwise desist. Finally, Dr. Brady's rejection of the demonstration that most childhood-onset cases desist contradicts the Endocrine Society guidelines, which Dr. Brady otherwise repeatedly cited as authoritative. According that document, "the GD/gender incongruence of a *minority* of prepubertal children appears to persist in adolescence….In adolescence, a significant number of these desisters identify as homosexual or bisexual" (Hembree 2017 at 3876, italics added).

E. Anecdotal claims based on one's personal experiences do not constitute reliable clinical evidence.

284. Instead of the principles and methods accepted as reliable in evidence-based medicine, Dr. Brady repeatedly based her opinions only on her non-systematic recollections of her own personal experiences providing services to this population (e.g., Brady decl ¶¶20, 38, 39, 40, 44), in what science calls *anecdotal evidence.* "Clinical experience" is not capable of demonstrating whether treatments are causing improvements. As illustrated by the standard *Pyramid of Evidence,* it represents the lowest rung, due to being the most subject to bias. (See Section III.A.) In research on clinical experience itself, as shown by a recent systematic review of the topic: "We found no clear evidence of an association between measures of physicians' clinical experience and overall healthcare quality." (Ajmi 2021.) A review of the research on the clinical experience of psychotherapists reported that: "Years of clinical experience were found to be positively associated with increased confidence [but] does not suggest that it is associated with improved ability to increase its quality." (Dawson 2018 at 89.) As Dr. Roger Bertholf,

Editor-in-Chief of the peer-reviewed journal, *Laboratory Medicine,* wrote in its 50th anniversary edition: "Anecdotism is the antithesis of medical science" (Bertholf, 2020, p. 555).

285. The advantages of accumulated personal experience is its low cost and potential utility when there do not exist systematic studies of the unique combination of variables presented by some cases. The disadvantages include that it is the most subject to human biases, such as recall bias and confirmation bias, as well as to sampling biases including both self-selection biases (who decides to come into the clinic in the first place) and any variables which lead to dropping out of the clinic, leaving clinicians with little opportunity for knowing the outcome at all.

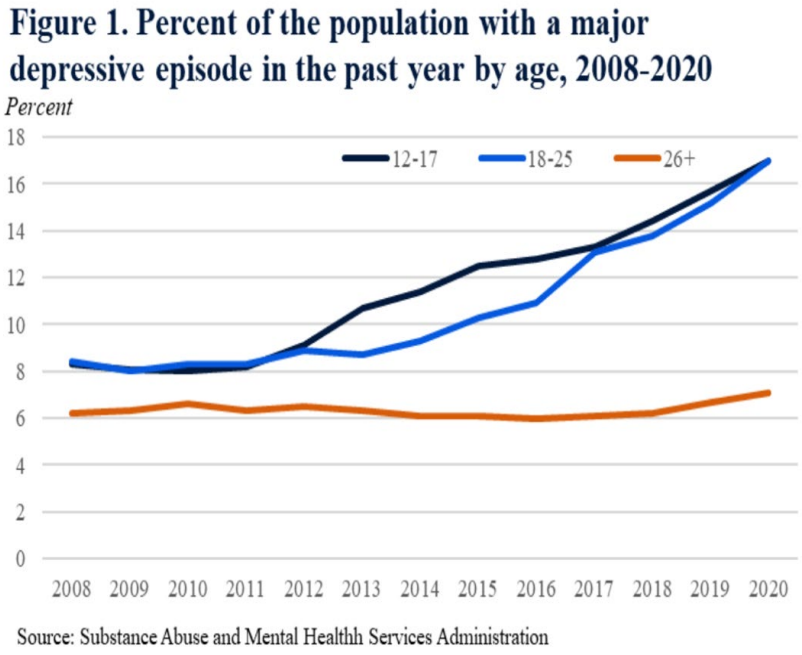
286. If there did not already exist multiple studies systematically studying cohorts of minors undergoing puberty-blocking or cross-sex hormone treatment, then expert opinion based on anecdotal evidence might represent the only option available. That is not the current situation, however: Yet, rather than engage in the scientifically valid research method of accepting higher order evidence over lower order evidence, Dr. Brady cited and ignored reported the reported research evidence according to the favorability of their results, *cherry-picking* only the (seemingly) supportive subset.

F. The mental health issues reported by gender dysphoric adolescents correspond entirely to the mental health issues widely reported by youth of the social media generation.

287. Dr. Brady referred to indications of high levels of emotional distress and poor levels of mental health among youth with gender dysphoria (Brady decl¶ 24–25). Her declaration repeatedly inferred the causal conclusion that the mental health issues are caused by transphobia and failures to support transition. Missing entirely from Dr. Brady's interpretation of the correlations is that high rates of mental distress are not unique to gender dysphoric minors.

Signs of distress are increasing throughout the current generation of youth, especially adolescent females, and these indicators all began their exponential increases at the same time—upon the introduction of social media. The great increases in each of gender dysphoria, mental illness, and suicide and suicidality, are all primarily affecting the same demographic most vulnerable to negative social influence on body image and self-perception: adolescent females.

288. Data from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) show the rapid rise in depressive episodes, more than doubling, accompanying the social media age, and mostly affecting youth under 25:



Available from https://www.whitehouse.gov/cea/written-materials/2022/05/31/reducing-the-economic-burden-of-unmet-mental-health-needs/

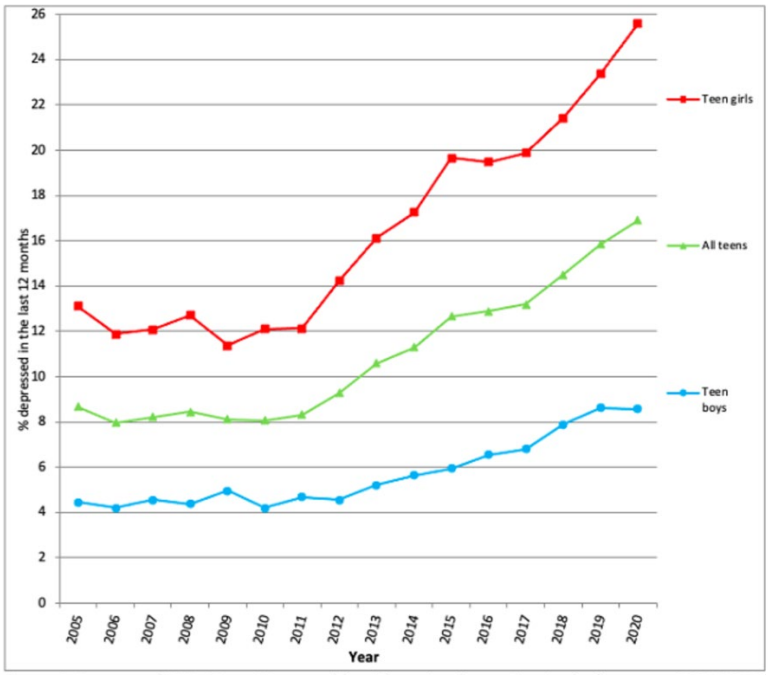
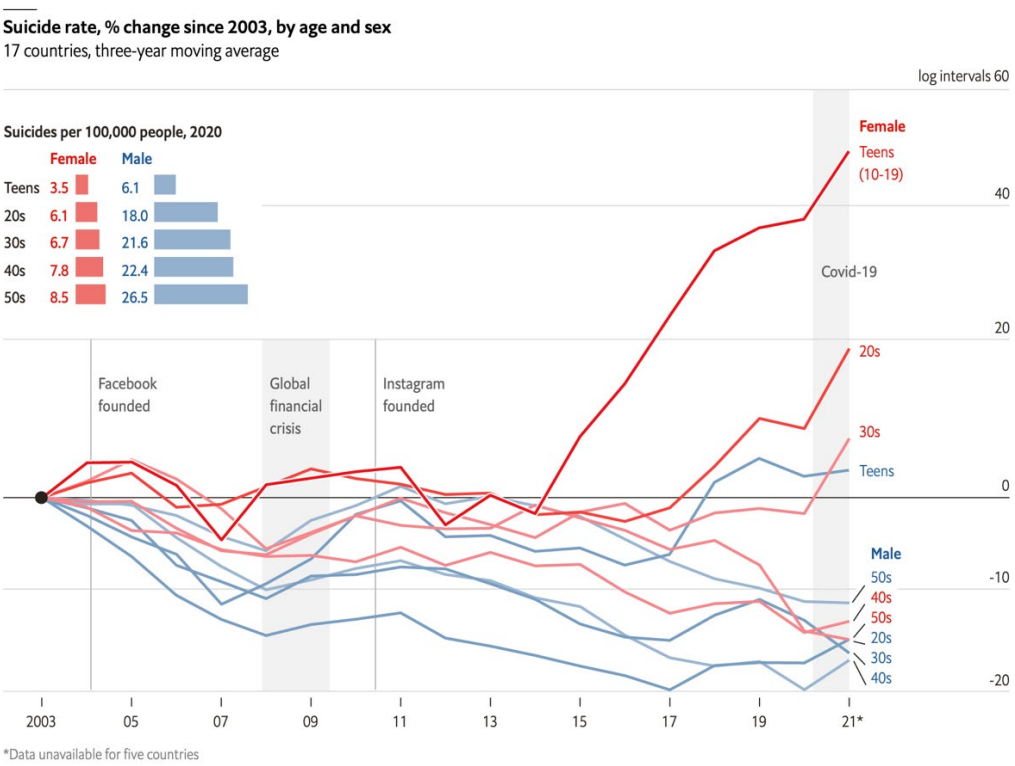


Figure 2: Percent of U.S. 12- to 17-year-olds with major depression in the last year, 2005-2020
Source: National Study of Drug Use and Health. NOTE: Depression assessed using DSM criteria.

Twenge, J. Institute for Family Studies. Available from https://ifstudies.org/blog/how-much-is-social-media-to-blame-for-teens-declining-mental-health

The indicators of increasing distress include suicide and suicidality: In 2020, the U.S. Centers for Disease Control (CDC) reported "[A]pproximately 18.8 percent of high school students reported suicidal ideation in the past year, and 8.9 percent of high school students reported a suicide attempt in the past year" (Ivey-Stephenson et al., 2020). The greatest increases in rates of suicide and suicidality were among adolescent females.



Available from https://www.economist.com/graphic-detail/2023/05/03/suicide-rates-for-girls-are-rising-are-smartphones-to-blame

SAMHSA reported "[F]rom 1999 through 2018, the suicide death rate doubled for females aged 15 to 19 and 20 to 24. For youth aged 10 to 14, the suicide death rate more than tripled from 2001 to 2018" (SAMHSA, 2020). Peer reviewed research published in the *American Journal of Public Health* reported rates of high school students reporting purposefully hurting themselves without wanting to die over the past 12 months ranged from 6.4 to 14.8 percent for males and 17.7 to 30.8 percent for females in 2015 (Monto et al., 2018).

From Twenge (2020):

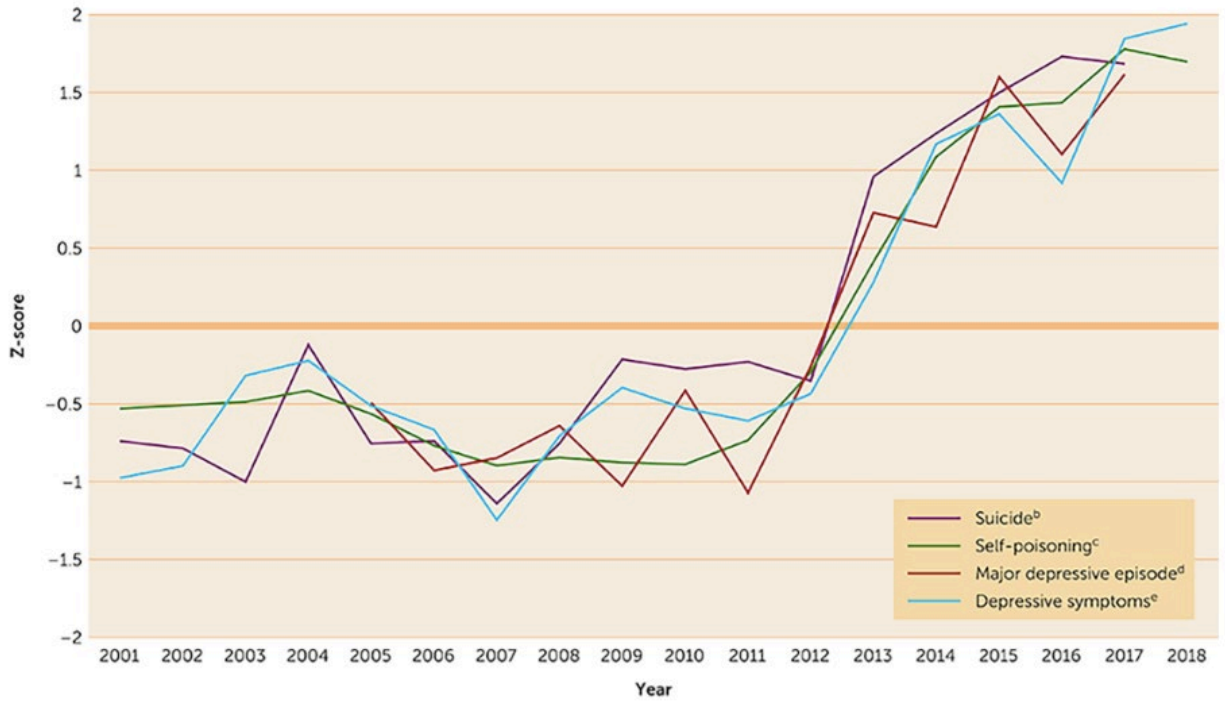
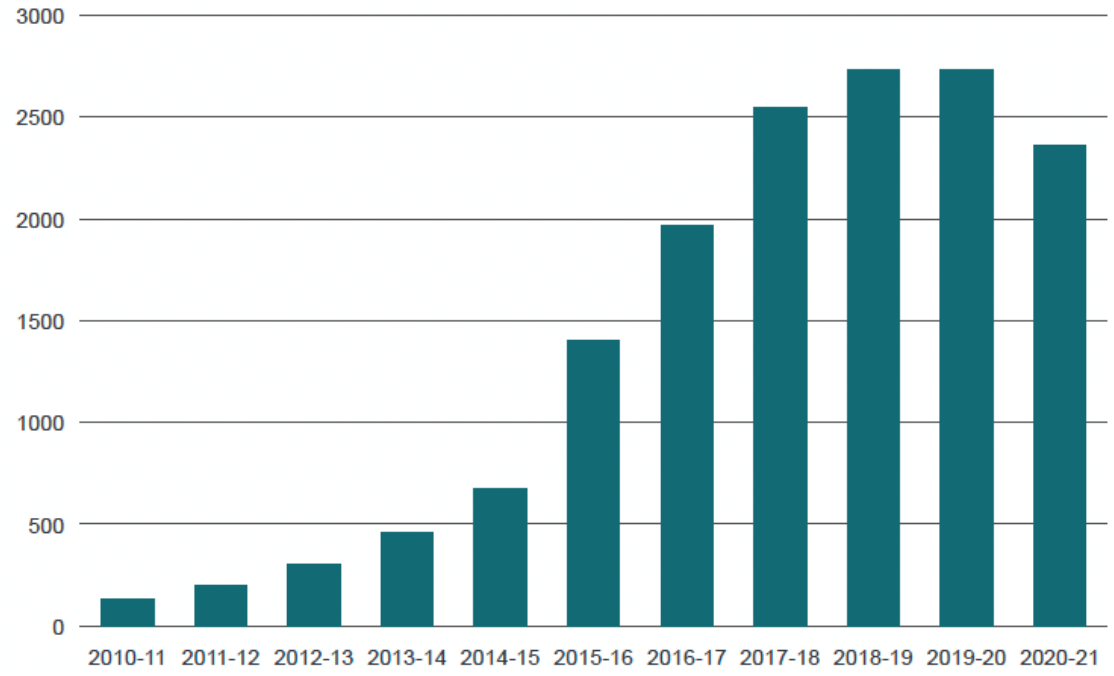


FIGURE 1. Indicators of poor mental health among U.S. girls and young women, 2001–2018[a]

The timeline of these large, sudden increases in multiple indicators of psychological distress coincides exactly with the large, sudden increase in cases of youth expressing gender dysphoria, again primarily among adolescent females:

Figure 2: Referrals to GIDS, 2010-11 to 2020-21



From Cass (2022).

The correlations among mental health, sex, gender dysphoria, and treatment outcomes are all much better explained as individual facets of mental health brought on by social media. The treatments associated with improvement are those that include psychotherapy. Dr. Brady's explanation for these correlations is not an explanation at all: It leaves the conspicuous simultaneity of these phenomena, the consistent demographic repeatedly being the most affected, and the ubiquity of social perception and attachment needs across them all as merely coincidental.

289. Adolescents use social media for social comparison and feedback, and social media use is associated with decreased mental health (Nesi & Prinstein, 2015). Social media exposure to ideals of beauty and appearance reduces body image, especially in adolescent females (Kleeman et al., 2018). Adolescent females are the demographic most vulnerable to social comparison and use social media as the basis of their self-image (Fioravanti et al., 2022),

especially so for those with co-morbid mental illnesses that interfere with social functioning, who are disproportionately influenced negatively by social media (Maheux et al., 2022). The mental illness profiles associated with adolescent-onset gender dysphoria are unlike those shown by the better- and longer-established types of gender dysphoria including in their overrepresentation of issues such as Autism Spectrum Disorder, which reflects problems in social functioning. The mental illness profile associated with sexual minority stress, in contrast, consists of anxiety and depression. Sexual minority stress does not cause Autism Spectrum Disorder, but it can increase vulnerability to social identity development. Although these data are still only correlational, they strongly suggest that to support is to reinforce the belief of these youth that they are not real women or real men because they do fit the exaggerated and perfected social images of femaleness and maleness now flooding their virtual social environments.

G. Dr. Brady is unaware of the status of the science of gender dysphoria.

290. In addition to lacking any mention of the international consensus of the science of adolescent-onset gender dysphoria, Dr. Brady claimed "There are no scientific studies demonstrating that non-medical treatments alone (such as therapy only) are effective in the treatment of gender dysphoria" (Brady decl ¶41). Dr. Brady's claim is simply false and is easily shown to be false. No only do such studies exist, Dr. Brady cited one herself in her declaration (Brady decl ¶39): Costa et al. (2015). Costa compared a group of gender dysphoric youth receiving therapy only with a group receiving both therapy and puberty blockers. The result and conclusion of Costa was exactly the opposite of what Dr. Brady claimed in her report:

> Psychological support and puberty suppression *were both associated* with an improved global psychosocial functioning in GD adolescence. Both these interventions may be considered effective in the clinical management of psychosocial functioning difficulties in GD adolescence (Costa et al., 2015, p. 2206, italics added).

Remarkably, where Dr. Brady did cite that study, it was to support of her claim that "Studies have demonstrated improvements in mental health following gender-affirming *medical* interventions" (Brady decl ¶39, italics added). That is, while Costa was entirely explicit that *both* psychotherapy and puberty suppression were effective in improving mental health, Dr. Brady instead related the half of that the finding for medical intervention, yet outright denied the very same conclusion for psychotherapy from the very same study that provided it in the very same sentence. Additionally, as already detailed within the present report (see Section XIII.B), six of the fourteen follow up studies of adolescent medicalized transition provided *both* psychotherapy *and* medicalized interventions, making it impossible to ascertain which might be responsible for any changes (or in what proportions). This same problem pertains to the other cohort studies Dr. Brady cited in claiming medicalized transition to improve mental health.[10]

291. The distinction between psychotherapy and medicalized transition is not merely an equivalent alternative, however: Because psychotherapy poses no objective risk of harm, whereas medicalized transition of gender poses substantial risk to objectively healthy and functioning tissue, the risk-to-benefit ratio imposed by medical ethics rejects medicalized transition until and unless it demonstrates proportionately greater evidence of benefit to outweigh its greater risks.

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

Executed on 2 Sept 2023.

James M. Cantor, Ph.D.

[10] In her footnote 16, Dr. Brady cited de Vries et al. (2011) and de Vries et al. (2014), both of which included both psychotherapy and medical intervention, and she cited Chen et al. (2023), which did not mention or account for concurrent psychotherapy. The remaining two citations in footnote 16—Green et al. (2022) and Turban et al. (2020)—are survey studies. (Indeed, they are the same survey.) As emphasized already in the present report, surveys are not scientifically capable of demonstrating treatment effects.

References

Abbruzzese, E., Levine, S., & Mason, J. (2023). The myth of "reliable research" in pediatric gender medicine: A critical evaluation of the Dutch Studies—and research that has followed. *Journal of Sex & Marital Therapy*. DOI: 10.1080/0092623X.2022.215046.

Académie Nationale de Médecine. (2022, Feb. 25). Press Release: Medicine in the face of the change of gender identity in children and adolescents. Retrieved from https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en

Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results. *International Journal of Pediatric Endocrinology*. doi: 10.1186/s13633-020-00078-2

Adams, N. J., & Vincent, B. (2019). Suicidal thoughts and behaviors among transgender adults in relation to education, ethnicity, and income: A systematic review. *Transgender Health, 4,* 226–246.

Adelson, S. L., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues. (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*, 957–974.

Ajmi, S. C., Aase, K. (2021) Physicians' clinical experience and its association with healthcare quality: A systematised review BMJ Open Quality, 10, e001545.

Allen, L. R., Watson, L. B., Egan, A. M., & Moser, C. N. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology, 7,* 302-311.

American College of Obstetricians and Gynecologists. (2017). Care for transgender adolescents. Committee Opinion No. 685. Retrieved from www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/01/care-for-transgender-adolescents .

American Psychiatric Association (2017). A guide for working with transgender and gender nonconforming patients. https://www.psychiatry.org/psychiatrists/cultural-competency/transgender-and-gender-nonconforming-patients/a-guide-for-working-with-transgender-and-gender-nonconforming-patients.

American Psychiatric Association (2022). *Diagnostic and statistical manual for mental disorders, fifth edition, text revision (DSM-5-TR).* Washington, DC: Author.

American Psychological Association (2014). Answers to your questions about transgender people, gender identity, and gender expression. https://www.apa.org/topics/lgbtq/transgender.pdf.

American Psychological Association (February 2021). APA resolution on gender identity change efforts.

American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Retrieved from http://www. apa.org/pi/lgbc/publications/therapeutic-resp.html.

Anzani, A., De Panfilis, C., Scandurra, C., & Prunas, A. (2020). Personality disorders and personality profiles in a sample of transgender individuals requesting gender-affirming

treatments. *International Journal of Environmental Research and Public Health, 17,* 1521. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7084367/.

Asscheman, H., Giltay, E. J., Megens, J. A. J., de Ronde W. (P.), van Trotsenburg, M. A. A., & Gooren, L. J. G. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology, 164,* 635–642.

Bachmann, S. (2018). Epidemiology of suicide and the psychiatric perspective. *International Journal of Environmental Research and Public Health, 15,* 1425.

Baker, K. E., Wilson, L. M., Sharma, R., Dukhanin, V., McArthur, K., & Robinson, K. A. (2021). Hormone therapy, mental health, and quality of life among transgender people. *Journal of the Endocrine Society, 5.* Available from https://doi.org/10.1210/jendso/bvab011.

Baldinger-Melich, P., Urquijo Castro, M. F., Seiger, R., Ruef, A., Dwyer, D. B., Kranz, G. S., Klöbl, M., Kambeitz, J., Kaufmann, U., Windischberger, C., Kasper, S., Falkai, P., Lanzenberger, R., & Koutsouleris, N. (2020). Sex matters: A multivariate pattern analysis of sex and gender-related neuroanatomical differences in cis- and transgender individuals using structural Magnetic Resonance Imaging. *Cerebral Cortex, 30,* 1345–1356.

Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: A respondent driven sampling study in Ontario, Canada. *BMC Public Health, 15,* 525.

BBC News. (2021, Sept. 5). NHS child gender identity clinic whistleblower wins tribunal. *British Broadcasting Company.* Retrieved from https://www.bbc.com/news/uk-58453250.

Becker-Hebly, I., Fahrenkrug, S., Campion, F., Richter-Appelt, H., Schulte-Markwort, M., & Barkmann, C. (2021). Psychosocial health in adolescents and young adults with gender dysphoria before and after gender-affirming medical interventions: A descriptive study from the Hamburg Gender Identity Service. *European Child Adolescent Psychiatry, 30,* 1755–1767.

Bell v. Tavistock. United Kingdom Court of Appeal (Civil Division) (1/12/2020). [2021] EWCA Civ 1363.

Bell v. Tavistock. United Kingdom High Courts of Justice Divisional Court (1/12/2020). [2020] EWCA Civ 3274 (Admin).

Bhargava, A., Arnold, A. P., Bangasser, D. A., Denton, K. M., Gupta, A., Hilliard Krause, L. M., Mayer, E. A., McCarthy, M., Miller, W. L., Raznahan, A., & Verma, R. (2021). Considering sex as a biological variable in basic and clinical studies: An Endocrine Society Scientific Statement. *Endocrine Reviews, 20,* 1–40.

Biggs, M. (2019). A letter to the editor regarding the original article by Costa et al: psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *J. Sexual Med.* 2019; 16:2043.

Biggs, M. (2020). Gender dysphoria and psychological functioning in adolescents treated with GnRHa: Comparing Dutch and English prospective studies. *Archives of Sexual Behavior, 49,* 2231–2236.

Biggs, M. (2022). The Dutch Protocol for juvenile transsexuals: Origins and evidence. *Journal of Sex & Marital Therapy*.

Blanchard, R. (1985). Typology of male-to-female transsexualism. *Archives of Sexual Behavior, 14,* 247–261.

Blanchard, R. (1988). Nonhomosexual gender dysphoria. *The Journal of Sex Research, 24,* 188–193.

Blanchard, R. (1989a). The classification and labeling of nonhomosexual gender dysphorias. *Archives of Sexual Behavior, 18,* 315–334.

Blanchard, R. (1989b). The concept of autogynephilia and the typology of male gender dysphoria. *Journal of Nervous and Mental Disease, 177,* 616–623.

Blanchard, R. (1990). Gender identity disorders in adult women. In R. Blanchard & B. W. Steiner (Eds.), *Clinical management of gender identity disorders in children and adults* (pp. 77–91). Washington, DC: American Psychiatric Press.

Blanchard, R. (1991). Clinical observations and systematic studies of autogynephilia. *Journal of Sex and Marital Therapy, 17,* 235–251.

Blanchard, R., Steiner, B. W., Clemmensen, L. H., & Dickey, R. (1989). Prediction of regrets in postoperative transsexuals. *Canadian Journal of Psychiatry, 34,* 43–45.

Block, J. (2023). Norway's guidance on paediatric gender treatment is unsafe, says review. *BMJ* 2023:380,697.

Boivin, L., Notredame, C.-E., Jardri, R., & Medjkane, F. (2020). Supporting parents of transgender adolescents: Yes, but how? *Archives of Sexual Behavior, 49,* 81–83.

Borges, G., Nock, M. K., Haro Abad, J. M., Hwang, I., Sampson, N. A., Alonso, J., Helena Andrade, L.…Kessler, R. C. (2010) Twelve-month prevalence of and risk factors for suicide attempts in the World Health Organization World Mental Health Surveys. *Journal of Clinical Psychiatry, 71,* 1617–1628.

Brignardello-Petersen, R. and Wiercioch, W. (May 16, 2022). Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence. Prepared for the Florida Agency for Health Care Administration.

Button, K. S., et al. (2015). Minimal clinically important difference on the Beck Depression Inventory-II according to the patient's perspective. *Psychological Medicine*, 45, 3269-3279.

Canetto, S. S., Antonelli, P., Ciccotti, A., Dettore, D., & Lamis, D. A. (2021). Suicidal as normal: A lesbian, gay, and bisexual youth script? *Crisis, 42,* 292–300.

Cantor, J. M. (2011). New MRI studies support the Blanchard typology of male-to-female transsexualism. *Archives of Sexual Behavior, 40*, 863–864. doi: 10.1007/s10508-011-9805-6

Cantor, J. M. (2012). Is homosexuality a paraphilia? The evidence for and against. *Archives of Sexual Behavior, 41,* 237–247. doi: 10.1007/s10508-012-9900-3

Cantor, J. M. (2019). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy, 46,* 307–313.

Cantu, A. L., Moyer, D. N., Connely, K. J., & Holley, A. L. (2020). Changes in anxiety and depression from intake to first follow-up among transgender youth in a pediatric endocrinology clinic. *Transgender Health, 5,* 196–200.

Carel, J. C., Eugster, E. A., Rogol, A., Ghizzoni, L., Palmert, M. R.; ESPE-LWPES GnRH Analogs Consensus Conference Group, Antoniazzi, F., Berenbaum, S., Bourguignon, J. P., Chrousos, G. P., Coste, J., Deal, S., de Vries, L., Foster, C., Heger, S., Holland, J., Jahnukainen, K., Juul, A., Kaplowitz, P., Lahlou, N., Lee, M. M., Lee, P., Merke, D. P., Neely, E. K., Oostdijk, W., Phillip, M., Rosenfield, R. L., Shulman, D., Styne, D., Tauber, M., Wit, J. M. (2009). Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics, 123,* e752–e762.

Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., Viner, R. M. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLosONE, 16,* e0243894.

Cass, H. (2022, February). The Cass Review: Independent review of gender identity services for children and young people Interim report. National Health Service (NHS), UK.

Cass, H. (2022, July 19). Independent review of gender identity services for children and young people—Further advice. Letter from H. Cass to J. Stewart, NHS England. *The Cass Review*.

Catley, M. J., & Tomkinson, G. R. (2013). Normative health-related fitness values for children: Analysis of 85347 test results on 9-17-year old Australians since 1985. *British Journal of Sports Medicine, 47,* 98–108.

Caulfield, R. (2012). Medically necessary? How to decide. *CMAJ* 184 (16.

Chen, D., Berona, J., Chan, Y.-M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A. C., & Olson-Kennedy, J. (2023). Psychosocial functioning in transgender youth after 2 years of hormones. *New England Journal of Medicine, 288,* 240–250.

Chen, D., Strang, J. F., Kulbuck, V. D., Rosenthal, S. M., Wallen, K., Waber, D. P., …Garofalo, R. (2020). Consensus parameter: Research methodologies to evaluate neurodevelopmental effects of pubertal suppression in transgender youth. *Transgender Health, 5,* 246–257.

Clinicaltrials.gov (2022). Gender dysphoria treatment in Sweden (GETS). Clinicaltrials.gov identifier NCT02518009.

Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology, 31,* 41–53.

Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences (3rd ed.).* Mahwah, NJ: Lawrence Erlbaum Associates.

COHERE Finland (Council for Choices in Health Care in Finland) (2020, June 16). Medical treatment methods for dysphoria associated with variations in gender identity in minors—Summary of a recommendation. [Translated] Retrieved from https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474

COHERE Finland (Council for Choices in Health Care in Finland) (2020, June 11). Alaikäisten sukupuoli-identiteetin variaatioihin liittyvän dysforian lääketieteelliset hoitomenetelmät [Medical treatment methods for dysphoria related to variations in gender identity of minors]. Available from https://palveluvalikoima.fi/sukupuolidysforia-alaikaiset

Coleman, E., et al. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7 ("SOC 7"). *International Journal of Transgenderism*, 13, 165–232.

Coleman, E., et al. (2022). WPATH standards of care for the health of transgender and gender diverse people, version 8 ("SOC 8"). *International Journal of Transgender Health* 2022, Vol.. 23, No. S1.

Costa, R., Dunsford, M., Skagerberg, E., Holt V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine, 12,* 2206–2214.

Craig, M. C., Fletcher, P. C., Daly, E. M., Rymer, J., Cutter, W .J., Brammer, M., Giampietro, V., Wickham, H., Maki, P. M., Murphy, D.G. (2007). Gonadotropin hormone releasing hormone agonists alter prefrontal function during verbal encoding in young women. *Psychoneuroendocrinology, 32,* 1116–1127.

Crone, E. A., & Steinbeis, N. (2017). Neural perspectives on cognitive control development during childhood and adolescence. *Trends in Cognitive Science, 21,* 205–215.

Cumming, R., Sylvester, K., & Fuld, J. P. (2016). Understanding the effects on lung function of chest binder use in the transgender population. *Thorax, 71, A227.*

Dahlen, S., Connolly, D., Arif, I., Hyder Junejo, M., Bewley, S., & Meads, C. (2021). International clinical practice guidelines for gender minority/trans people: Systematic review and quality assessment. *BMJ Open, 11,* e048943.

D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior, 50,* 7–16.

Daniel, H., & Butkus, R. (2015a). Lesbian, gay, bisexual, and transgender health disparities: Executive summary of a policy position paper from the American College of Physicians. *Annals of Internal Medicine, 163,* 135–137.

Daniel, H., & Butkus, R. (2015b). Appendix: Lesbian, gay, bisexual, and transgender health disparities: A policy position paper from the American College of Physicians. *Annals of Internal Medicine, 163,* [unpaginated].

Davidson, R. J. (2003). Affective neuroscience and psychophysiology: Toward a synthesis. Psychophysiology, 40, 655–665.

Dawson, G. C. (2018). Years of clinical experience and therapist professional development: A literature review. Journal of Contemporary Psychotherapy, 48, 89–97. https://link.springer.com/article/10.1007/s10879-017-9373-8

De Cuypere, G., & Vercruysse, H., Jr. (2009) Eligibility and readiness criteria for sex reassignment surgery: Recommendations for revision of the WPATH Standards of Care. *International Journal of Transgenderism, 11,* 194–205.

de Vries, A. L. C. & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch Approach. *Journal of Homosexuality, 59,* 301–320.

de Vries, A. L. C., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry, 52,* 1195–1202.

de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics, 134,* 1–9.

de Vries, A. L. C., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer- Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, *40,* 930–936.

de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine, 8,* 2276–2283.

Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology, 155* (suppl 1), S131–S137.

Dhejne, C., Van Vlerken, R., Geylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry*, *28,* 44–57.

Dhejneberg, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: Prevalence, incidence, and regrets. *Archives of Sexual Behavior, 43,* 1535–1545.

Donnelly, L. (2019, Dec. 12). Children's transgender clinic hit by 35 resignations in three years as psychologists warn of gender dysphoria 'over-diagnoses'. *The Telegraph.* Retrieved from https://www.telegraph.co.uk/news/2019/12/12/childrens-transgender-clinic-hit-35-resignations-three-years/?WT.mc_id=tmg_share_em

Doward, J. (2019). Politicised trans groups put children at risk, says expert. *The Observer*, July 27, 2019.

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow up study of girls with gender identity disorder. *Developmental Psychology, 44,* 34–45.

Eriksen, M. B., & Frandsen, T. F. (2018). The impact of patient, intervention, comparison, outcome (PICO) as a search strategy tool on literature search quality: A systematic review. *Journal of the Medical Library Association*, *106,* 420–431.

Finnish Palveluvalikoima ("Palko") (Health Service Selection Council). Preparation memorandum of the Service Selection Council. Retrieved from https://palveluvalikoima.fi/documents/1237350/22895008/Valmistelumuistio_sukupuoli-identiteetin+variaatiot.pdf/991c7413-3bd5-3e9d-52c4-24c4e2a7a9e5/Valmistelumuistio_sukupuoli-identiteetin+variaatiot.pdf?t=1592317702000.

Fioravanti, G., Bocci Benucci, S., Ceragioli, G., & Casale, S. (2022). How the exposure to beauty ideals on social networking sites influences body image: A systematic review of experimental studies. *Adolescent Research Review, 7,* 419–458.

Fisher, A. D., Ristori, J., Castellini, G., Cocchetti, C., Cassioli, E., Orsolini, S., Sensi, C., Romani, A., Mazzoli, F., Cipriani, A., Ricca, V., Vignozzi, L., Viggiano, M. P., Mascalchi, M., Maggi, M., & Gavazzi, G. (2020). Neural correlates of gender face perception in transgender people. *Journal of Clinical Medicine*, 9, 1731.

Freeman, A., Mergl, R., Kohls, E., Székely, A., Gusmao, R., Arensman, E., Koburger, N., Hegerl, U., & Rummel-Kluge, C. (2017). A cross-national study on gender differences in suicide intent. *BMC Psychiatry, 17,* 234.

Freund, K. (1967). Diagnosing homo- or heterosexuality and erotic age preference by means of a psychophysiological test. Behavioral Research and Therapy, 5, 209–228.

Ghorayshi, A. (2023, June 9). England limits use of puberty-blocking drugs to research only. New York Times. https://www.nytimes.com/2023/06/09/health/puberty-blockers-transgender-children-britain-nhs.html

Goldet, G., & Howick, J (2013). Understanding GRADE: An introduction. *Journal of Evidence-Based Medicine, 6,* 50–54.

Gould, M. S., & Lake, A. M. (2013, Feb. 6). II.4 *The contagion of suicidal behavior.* Forum on Global Violence Prevention, Board on Global Health; Institute of Medicine; National Research Council. Contagion of Violence: Workshop Summary. National Academies

Press: Washington, DC. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK207262/

GRADE Handbook, Quality of evidence definitions table. https://gdt.gradepro.org/app/handbook/handbook.html#h.wsfivfhuxv4r at Section 5.

Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2021). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. *Journal of Adolescent Health, 70, 643–649.*

Green, R. (1987). The "sissy boy syndrome" and the development of homosexuality. New Haven, CT: Yale University Press.

Grigorova, M., Sherwin, B. B., & Tulandi, T. (2006). Effect of treatment with leuprolide acetate depot on working memory and executive functions in young premenopausal women. *Psychoneuroendocrinology, 31,* 935–947.

Gudayol-Ferré, E., Peró-Cebollero, M., González-Garrido, A. A., & Guárdia-Olmos, J. (2015). Changes in brain connectivity related to the treatment of depression measure through fMRI: A systematic review. *Frontiers in Human Neuroscience*, 9. doi: 10.3389/fnhum.2015.00582.

Guillamon, A., Junque, C., & Gómez-Gil, E. (2016). A review of the status of brain structure research in transsexualism. *Archives of Sexual Behavior, 45,* 1615–1648. doi: 10.1007/s10508-016-0768-5

Gulias-González, R., Sánchez-López, M., Olivas-Bravo, A., Solera-Martinez, M., & Marinez-Vuzcaino, V. (2014). Physical fitness in Spanish schoolchildren aged 6–12 years: Reference values of the battery EUROFIT and associated cardiovascular risk. *Journal of School Health, 84,* 625–635.

Guyatt, G., Rennie, D., Meade, M., & Cook, D. (Eds.) (2015). Users' guide to the medical literature: essentials of evidence-based clinical practice, 3rd edition. *JAMAevidence, American Medical Association*.

Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., Silverman, M. M., Fisher, P. W., Hughes, T., Rosario, M., Russell, S. T., Malley, E., Reed, J., Litts, D. A., Haller, E., Sell, R. L., Remafedi, G., Bradford, J., Beautrais, A. L., Brown, G. K., … Clayton, P. J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of homosexuality*, *58,* 10–51.

Haas, A. P., Rodgers, P. L., & Herman, J. L. (2014, Jan.). *Suicide attempts among transgender and gender nonconforming adults.* Williams Institute, UCLA School of Law.

Handelsman, D. J. (2017). Sex differences in athletic performance coinciding with the onset of male puberty. *Clinical Endocrinology, 87,* 68–72.

Hatchel, T., Polanin, J., & Espelage, D. (2021). Suicidal thoughts and behaviors among LGBTQ youth: Meta-analyses and a systematic review. *Archives of Suicide Research,* 25, 1–37.

Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *Cochrane Database of Systematic Reviews, 11,* Art. No.: CD013138.

Hembree, W. C., Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer, W. J., III, Spack, N. P., Tangpricha, V., & Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 94,* 3132–3154.

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, T. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/ gender-incongruent persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 102,* 3869–3903.

Hengartner, M. (2020). Is there a genuine placebo effect in acute depression treatments? A reassessment of regression to the mean and spontaneous remission. *BMJ Evidence-based Medicine* 2020;25:46-48.

Hess, E. H., Seltzer, A. L., & Shlien, J. M. (1965). Pupil responses to hetero- and homosexual males to pictures of men and women: A pilot study. Journal of Abnormal Psychology, 70, 165–168.

Higgins, J. P. T., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M. J., & Welch, V. A. (Eds.). (2022, Feb.) Cochrane Handbook for Systematic Reviews of Interventions (version 6.3). *Cochrane*. Available from www.training.cochrane.org/handbook

Hisle-Gorman, E., Schvey, N. A., Adirim, T. A., Rayne, A. K., Susi, A., Roberts, T. A., & Klein, D. A. (2021). Mental healthcare utilization of transgender youth before and after affirming treatment. *The Journal of Sexual Medicine, 18,* 1444–1454.

Holt, V., Skagerberg, E., & Dunsford, M. (2016). Young people with features of gender dysphoria: Demographics and associated difficulties. *Clinical Child Psychology and Psychiatry, 21*, 108–118.

Institute of Medicine. (2011). *Clinical practice guidelines we can trust.* Washington, DC: The National Academies Press.

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding.* Washington, DC: The National Academies Press.

Italiano, M. (2012). Comment on Cantor (2011). *Archives of Sexual Behavior, 41,* 1079.

Ivey-Stephenson, A., Demissie, Z., Crosby, A., Stone, D., Gaylor, E., Wilkins, N., Lowry, R., & Brown, M. (2020, Aug. 21). Suicidal ideation and behaviors among high school students—Youth Risk Behavior Survey, United States, 2019. US Department of Health/Centers for Disease Control and Prevention. *MMWR, 69,* 47–55.

Jacobs, L. A., Rachlin, K., Erickson-Schroth, L., & Janssen, A. (2014). Gender dysphoria and co-occurring autism spectrum disorders: Review, case examples, and treatment considerations. *LGBT Health, 1*, 277–282.

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 U.S. transgender survey.* National Center for Transgender Equality. Retrieved from https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-final.pdf

Janssen, A., Busa, S., Wernick, J. (2019). The complexities of treatment planning for transgender youth with co-occurring severe mental illness: A literature review and case study. *Archives of Sexual Behavior, 48*, 2003–2009.

Janssen, A., Huang, H., & Duncan, C. (2016). Gender variance among youth with autism spectrum disorders: A retrospective chart review. *Transgender Health, 1*, 63–68.

Joseph, T., Ting, J., & Butler, G. (2019). The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: Findings from a large national cohort. *Journal of Pediatric Endocrinology and Metabolism, 32,* 1077–1081.

Joy, A., Muralidharan, A., Alfaraj, M., Shantharam, D., Cherukuri, A. S. S., & Muthukumar, A. (2022) The role of belimumab in systemic Lupus Erythematosis: A systematic review. *Cureus, 14,* e25887.

Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., & Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health, 9*, 9.

Kaltiala, R, Heino, E., Työläjärvi, & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry, 74,* 213–219.

Karolinska Institutet. (March 2021). Policy change regarding hormonal treatment of minors with gender dysphoria at Tema Barn – Astrid Lindgren Children's Hospital.

Karsan, N., Bose, P. R, O'Daly, O., Zelaya, F. O., & Goadsby, P. J. (2020). Alterations in functional connectivity during different phases of the triggered migraine attack. Headache, 60, 1244–1258.

Khatchadourian, K., Amed, S., & Metzger, D. L. (2014). Clinical management of youth with gender dysphoria in Vancouver. *Journal of Pediatrics, 164,* 906–911.

Kilford, E., Garrett, E., & Blakemore, S. (2016). The development of social cognition in adolescence: An integrated perspective. *Neuroscience & Biobehavioral Reviews* 2016;70:106-120.

Kleemans, M., Daalmans, S., Carbaat, I., & Anschütz, D. (2018). Picture perfect: The direct effect of manipulated instagram photos on body image in adolescent girls. *Media Psychology*, *21*, 93–110.

Klink, D., Caris, M., Heijboer, A., van Trotsenburg, M., & Rotteveel, J. (2015). Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *Journal of Clinical Endocrinology & Metabolism, 100,* E270–E275.

Klonsky, E. D., May, A. M., & Saffer, B. Y. (2016). Suicide, suicide attempts, and suicidal ideation. *Annual Review of Clinical Psychology, 12,* 307–330.

Koerselman, K., & Pekkarinen, T. (2017). The timing of puberty and gender differences in educational achievement. Institute of Labor Economics. *IZA* DP No. 10889.

Kolesar, T. A., Bilevicius, E., Wilson, A. D., & Kornelsen, J. (2019). Systematic review and meta-analyses of neural structural and functional differences in generalized anxiety disorder and healthy controls using magnetic resonance imaging. *NeuroImage: Clinical*, *24*, 102016.

Kregel, J., Meeus, M., Malfliet, A., Dolphens, M., Danneels, L., Nijs, J., & Cagnie, B. (2015). Structural and functional brain abnormalities in chronic low back pain: a systematic review. *Seminars in Arthritis and Rheumatism* 45 (2015) 229-237.

Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender- affirming hormone therapy. *Pediatrics, 145*, e20193006.

Larzelere, R., Kuhn, B., & Johnson, B. (2004). The intervention selection bias: An underrecognized confound in intervention research. *Psychological Bulletin,* 130, 289–303.

Lawrence, A. A. (2010). Sexual orientation versus age of onset as bases for typologies (subtypes) for Gender Identity Disorder in adolescents and adults. *Archives of Sexual Behavior, 39,* 514–545.

Lee, J. Y., Finlayson, C., Olson-Kennedy, J., Garofalo, R., Chan, Y. M., Glidden, D. V., & Rosenthal, S. M. (2020). Low bone mineral density in early pubertal transgender/gender diverse youth: Findings From the Trans Youth Care Study. *Journal of the Endocrine Society, 4,* bvaa065. doi: 10.1210/jendso/bvaa065.

Levine, S., Abbruzzese, E., & Mason, J. (2022). Reconsidering informed consent for trans-identified children, adolescents, and young adults. *Journal of Sex & Marital Therapy*. DOI: 10.1080/0092623X.2022.2046221.

Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a raid onset of gender dysphoria. *PLoS ONE, 13*(8), e0202330.

Ludvigsson, J. F., Adolfsson, J., Höistad, M., Rydelius, P.-A., Kriström, B., & Landén, M. (2023). A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. *Acta Paediatrica.* doi: 10.1111/apa.16791

Maheux, A. J., Roberts, S. R., Nesi, J., Widman, L., & Choukas-Bradley, S. (2022). Longitudinal associations between appearance-related social media consciousness and adolescents' depressive symptoms. *Journal of Adolescence*, *94,* 264–269.

Malta, M., LeGrand, S., Turban, J. L., & Poteat, T. (2020). Gender-congruent government identification is crucial for gender affirmation. [Comment.] *The Lancet Public Health, 5,* E178–E179.

Maraka, S., Ospina, N., Rodriguez-Gutierrez, R., Davidge-Pitts, C., Nippoldt, T., Prokop, L., & Murad, M. (2017). Sex steroids and cardiovascular outcomes in transgender individuals: A systematic review and meta-analysis. *Journal of Clinical Endocrinology and Metabolism*, 102, 3914–3923.

Marsh, S. (2020, Sept. 20). NHS to hold review into gender identity services for children and young people. *The Guardian.* Retrieved from https://www.theguardian.com/society/2020/sep/22/nhs-to-hold-review-into-gender-identity-services-for-children-and-young-people

Marshall, E., Claes, L. L., Bouman, W. P., Witcomb, G. L., & Arcelus, J. (2016). Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature. *International Review of Psychiatry, 28,* 58–69.

May, T., Pang, K., & Williams, K. J. (2016). Gender variance in children and adolescents with autism spectrum disorder from the National Database for Autism Research. *International Journal of Transgenderism, 18*, 7–15.

McCall, B. (2021, October 7). Psychiatrists shift stance on gender dysphoria, recommend therapy. *Medscape Psychiatry.* Retrieved from www.medscape.com/viewarticle/960390?src=soc_tw_share.

McFarlane, T., Zajac, J. D., & Cheung, A. S. (2018). Gender-affirming hormone therapy and the risk of sex hormone-dependent tumours in transgender individuals: A systematic review. *Clinical Endocrinology, 89,* 700–711.

McNeil, J., Ellis, S. J., & Eccles, F. J. R. (2017). Suicide in trans populations: A systematic review of prevalence and correlates. *Psychology of Sexual Orientation and Gender Diversity, 4,* 341–353.

Meyer, I. H. (2003) . Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*, 674–697.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS medicine*, *6,* e1000097.

Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/ role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology, 4*, 29–41.

Monto, M. A., McRee, N., Deryck, F. S. (2018). Nonsuicidal self-injury among a representative sample of US adolescents, 2015. *American Journal of Public Health, 108,* 1042–1048. doi: 10.2105/AJPH.2018.304470.

Moss, L. (2023, June 10). Puberty blockers to be given only in clinical research. *BBC News.* https://www.bbc.com/news/uk-65860272

Moustgaard, H., Clayton, G., Jones, E., Boutron, I., Jorgensen, L, Laursen, D., Olsen, M., Paludan-Muller, A., Ravaud, P., Savovic, J., Sterne, J., Higgins, J., & Hrobjartsson, A. (2020). Impact of blinding on estimated treatment effects in randomised clinical trials: meta-epidemiological study. *British Medical Journal,* 368, 16802.

MSNBC. (2015, Jan. 5). Trans youth and suicide: An epidemic. Retrieved from https://www.msnbc.com/ronan-farrow/watch/trans-youth-and-suicide-an-epidemic-380294211712.

Mueller, S. C., Guillamon, A., Zubiaurre-Elorza, L., Schneider, M. A., T'Sjoen, G., … Luders, E. (2021). The neuroanatomy of transgender identity: Mega-analytic findings from the ENIGMA transgender persons working group. *Journal of Sexual Medicine, 18,* 1122–1129.

Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health, 100*, 2426–2432.

Nainggolan, L. (2021 May 12). Hormonal Tx of youth with gender dysphoria stops in Sweden. *Medscape Psychiatry.* Retrieved from www.medscape.com/viewarticle/950964?src=soc_tw_share.

Navabi, B., Tang, K., Khatchadourian, K., & Lawson, M. L. (2021). Pubertal suppression, bone mass and body composition in youth with gender dysphoria. *Pediatrics, 148,* e2020039339.

Nesi, J., & Prinstein, M. J. (2015). Using social media for social comparison and feedback-seeking: Gender and popularity moderate associations with depressive symptoms. *Journal of Abnormal Child Psychology*, *43,* 1427–1438.

NHS (National Health Service) England. (2020 September 22). NHS announces independent review into gender identity services for children and young people. United Kingdom. Retrieved from https://www.england.nhs.uk/2020/09/nhs-announces-independent-review-into-gender-identity-services-for-children-and-young-people/.

NHS (National Health Service) England. (2022 October 20). Interim service specification for specialist gender dysphoria services for children and young people. Retrieved from https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/user_uploads/b1937-ii-interim-service-specification-for-specialist-gender-dysphoria-services-for-children-and-young-people-22.pdf.

NICE (National Institute for Health and Care Excellence) (2020a). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. Retrieved from https://arms.nice.org.uk/resources/hub/1070905/attachment.

NICE (National Institute for Health and Care Excellence) (2020b). Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria. Retrieved from https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_Gender-affirming-hormones_For-upload_Final.pdf.

Nock, M. K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A.…Williams, D. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. *British Journal of Psychiatry, 192,* 98–105.

Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender identity 5 years after social transition. *Pediatrics*. doi: 10.1542/peds.2021-056082

Orange, R. (2020, Feb 22). Teenage transgender row splits Sweden as dysphoria diagnoses soar by 1,500%: New health report and TV debates highlight backlash against gender reassignment. *The Guardian.* Retrieved from https://www.theguardian.com/society/2020/feb/22/ssweden-teenage-transgender-row-dysphoria-diagnoses-soar

Pasternack, I., Söderström, I., Saijonkari, M., & Mäkelä, M. (2019). Lääketieteelliset menetelmät sukupuolivariaatioihin liittyvän dysforian hoidossa. Systemaattinen katsaus. [Medical methods in the treatment of dysphoria related to gender variations: A systematic review.] Symmaryx Oy Helsinki, Finland. Available from https://palveluvalikoima.fi/documents/1237350/22895008/Valmistelumuistion+Liite+1.+Kirjallisuuskatsaus.pdf/5ad0f362-8735-35cd-3e53-3d17a010f2b6/Valmistelumuistion+Liite+1.+Kirjallisuuskatsaus.pdf?t=1592317703000

Pediatric Endocrine Society & Endocrine Society. (2020, December 15). *Transgender health*. Retrieved from www.endocrine.org/advocacy/position-statements/transgender-health.

Pediatric Endocrine Society. (Online). About PES. Retrieved from https://pedsendo.org/about-pes/

Peitzmeier, S. M., Silberholz, J., Gardner, I. H., Weinand, J., & Acevedo, K. (2021). Time to first onset of chest binding-related symptoms. *Pediatrics, 147,* e20200728.

Peitzmeier, S., Gardner, I., Weinand, J., Corbet A., & Acevedo, K. (2017). Health impact of chest binding among transgender adults: A community-engaged, cross-sectional study. *Culture, Health & Sexuality, 19,* 64–75.

Petersen, M. E., & Dickey, R. (1995). Surgical sex reassignment: A comparative survey of international centers. *Archives of Sexual Behavior, 24,* 135–156.Bertholf, R. L. (2020). Scientific evidence, medical practice, and the insidious danger of anecdotal reports. [Editorial] *Laboratory Medicine, 51,* 555–556

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

Rafferty, J., AAP Committee on psychosocial aspects of child and family health, AAP Committee on adolescence, AAP Section on lesbian, gay, bisexual, and transgender health and wellness. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics, 142*(4), e20182162.

Rayner, G. (2018, Sept. 16). Minister orders inquiry into 4000 percent rise in children wanting to change sex. *The Telegraph.* Retrieved from https://www.telegraph.co.uk/politics/2018/09/16/minister-orders-inquiry-4000-per-cent-rise-children-wanting.

Reisner, S. L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *Journal of Adolescent Health, 56*, 274–279.

Reuter, T. R., Sharp, C., Kalpakci, A. H., Choi, H. J., & Temple, J. R. (2016). Sexual orientation and Borderline Personality Disorder features in a community sample of adolescents. *Journal of Personality Disorders, 30,* 694–707.

Rieger, G., Chivers, M. L., & Bailey, J. M. (2005). Sexual arousal patterns of bisexual men. Psychological Science, 16, 579–584.

Rocca, W. A., Smith, C. Y., Gazzuola Rocca, L., Savica, R., & Mielke, M. M. (2022). Association of premenopausal bilateral oophorectomy with Parkinsonism and Parkinson Disease. *JAMA Network Open, 5,* e2238663.

Rodriguez-Seiljas, C., Morgan, T. A., & Zimmerman, M. (2021). A population-based examination of criterion-level disparities in the diagnosis of Borderline Personality Disorder among sexual minority adults. *Assessment, 28,* 1097–1109.

Royal Australian & New Zealand College of Psychiatrists. (2021, August). *Recognising and addressing the mental health needs of people experiencing Gender Dysphoria/Gender Incongruence* [Position Statement 103]. Retrieved from https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/gender-dysphoria.

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23,* 205–213.

Safer, J. D., Tangpricha, V. (2019). In the clinic: Care of the transgender patient. *Annals of Internal Medicine, 171*(1), ITC1–ITC6.

Samaritans. (2020). Media guidelines for reporting suicide. Ewell, Surrey, UK. Retrieved from https://media.samaritans.org/documents/Media_Guidelines_FINAL_v2_TABa8C6.pdf.

Sauka, M., Priedite, I. S., Artjuhova, L., Larins, V., Selga, G., Dahlström, Ö., & Timpka, T. (2011). Physical fitness in northern European youth: Reference values from the Latvian Physical Health in Youth Study. *Scandinavian Journal of Public Health, 39,* 35–43.

SBU (Statens Beredning för Medicinsk och Social Utvärdering [Swedish National Agency for Medical and Social Evaluation]) (2019, September 6). Gender dysphoria in children and adolescents: An inventory of the literature. A systematic scoping review. Summary retrieved from https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/.

SBU (Statens Beredning för Medicinsk och Social Utvärdering [Swedish National Agency for Medical and Social Evaluation]) (2022). Hormone treatment of children and adolescents with gender dysphoria, Appendix 2: Studies excluded due to high risk of bias.

SBU (Statens Beredning för Medicinsk och Social Utvärdering [Swedish National Agency for Medical and Social Evaluation]. (2019, December). *Gender dysphoria in children and adolescents: An inventory of the literature A systematic scoping review*. Retrieved from https://www.sbu.se/contentassets/bfd7263c06da44ca9168bf1df8a1c7e0/eng_gender-dysphoria-in-children-and-adolescents--an-inventory-of-the-literature.pdf?utm_medium=email&utm_source=govdelivery

Schagen, S. E. E., Wouters, F. M., Cohen-Kettenis, P. T., Gooren, L. J., & Hannema, S. E. (2020). Bone development in transgender adolescents treated with gnrh analogues and

subsequent gender-affirming hormones. *Journal of Clinical Endocrinology & Metabolism, 105,* e4252–e4263.

Scheim, A. I., Perez-Brumer, A. G., & Bauer, G. R. (2020). Gender-concordant identity documents and mental health among transgender adults in the USA: A cross-sectional study. *The Lancet: Public Health, 5*, e196–203.

Schumm, W. R., & Crawford, D. W. (2020). Is research on transgender children what it seems? Comments on recent research on transgender children with high levels of parental support. *The Linacre Quarterly, 87,* 9–24.

Schumm, W. R., Crawford, D. W., Fawver, M. M., Gray, N. K., Niess, Z. M., & Wagner, A. D. (2019). Statistical errors in major journals: Two case studies used in a basic statistics class to assess understanding of applied statistics. *Psychology and Education—An Interdisciplinary Journal, 56,* 35–42.

Scott, E., Kidgell, D. J., Frazer, A. K., & Pearce, A. J. (2020). The neurophysiological responses of concussive impacts: A systematic review and meta-analysis of transcranial magnetic stimulation studies. *Frontiers in Human Neuroscience, 14.* doi: 10.3389/fnhum.2020.00306.

Seeley, S. H., Garcia, E., & Mennin, D. S. (2015). Recent advances in laboratory assessment of emotion regulation. Current Opinion in Psychology, 3, 58–63.

Sharma, R., et al. (2018). Effects of hormone therapy in transgender people. *National Institute for Health Research PROSPERO International prospective register of systematic reviews*. Accessed at https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=115379.

Shirazi, T. N., Self, H., Dawood, K., Cárdenas, R., Welling, L. L. M., Rosenfield, K. A., Ortiz, T. L., Carré, J. M., Balasubramanian, R., Delaney, A., Crowley, W., Breedlove, S. M., & Puts, D. A. (2020). Pubertal timing predicts adult psychosexuality: Evidence from typically developing adults and adults with isolated GnRH deficiency. *Psychoneuroendocrinology, 119,* 104733.

Shirazi, T., Self, H., Cantor, J., Dawood, K., Cardenas, R., Rosenfield, K., Ortiz, T., Carré, J., McDaniel, M., Blanchard, R., Balasubramanian, R., Delaney, A., Crowley, W., S Marc Breedlove, S. M., & Puts, D. (2020). Timing of peripubertal steroid exposure predicts visuospatial cognition in men: Evidence from three samples. *Hormones and Behavior, 121, 104712*.

Shrier, A. (2021). Top trans doctors blow the whistle on 'sloppy' care. *The Free Press.* https://www.thefp.com/p/top-trans-doctors-blow-the-whistle

Singal, J. (7 Feb. 2023). The new, highly-touted study on hormones for transgender teens doesn't really tell us much of anything. https://jessesingal.substack.com/p/the-new-highly-touted-study-on-hormones.

Singh-Ospina, N., Maraka, S., Rodriguez-Gutierrez, R., Davidge-Pitts, C., Nippoldt, T., Prokop, L., and Murad, M. (2017). Effect of sex steroids on the bone health of transgender individuals: A systematic review and meta-analysis. *J. Clin. Endocrinal. Metab*. 2017;102:3904-3913.

Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. *Frontiers in Psychiatry, 12,* 632784.

Skagerberg, E., Parkinson, R., & Carmichael, P. (2013). Self-harming thoughts and behaviors in a group of children and adolescents with gender dysphoria. *International Journal of Transgenderism, 14*, 86–92.

Skelly, A. C., Dettori, J. R., & Brodt, E. D. (2012). Assessing bias: The importance of considering confounding. *Evidence-based Spine-Care Journal, 3,* 9–12.

Skorska, M. N., Chavez, S., Devenyi, G. A., Patel, R., Thurston, L. T., Lai, M.-C., Zucker, K. J.., Chakravarty, M. M., Lobaugh, N. J., & VanderLaan, D. P. (2021). A multi-modal MRI analysis of cortical structure in relation to gender dysphoria, sexual orientation, and age in adolescents. *Journal of Clinical Medicine, 10, 345.*

Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry, 16,* 499–516.

Steensma, T. D., & Cohen-Kettenis, P. T. (2018). A critical commentary on "A critical commentary on follow-up studies and 'desistence' theories about transgender and gender non-conforming children". *International Journal of Transgenderism, 19,* 225–230.

Steensma, T. D., Cohen-Kettenis, P. T., & Zucker, K. J. (2018). Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988–2016). *Journal of Sex & Marital Therapy, 44,* 713–715.

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. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*, 582–590.

Stoffers, I. E., de Vries, M. C., & Hannema, S. (2019). Physical changes, laboratory parameters and bone mineral density during testosterone treatment in adolescents with gender dysphoria. *The Journal of Sexual Medicine, 16,* 1459–1468.

Strang, J. F., Kenworthy, L., Dominska, A., Sokoloff, J., Kenealy, L. E., Berl, M., Wallace, G. L. (2014). Increased gender variance in autism spectrum disorders and attention deficit hyperactivity disorder. *Archives of Sexual Behavior, 43*, 1525–1533.

Strang, J. F., Meagher, H., Kenworthy, L., de Vries, A. L., Menvielle, E., Leibowitz, S., Anthony, L. G. (2016). Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *Journal of Clinical Child and Adolescent Psychology, 47*, 105–115.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *Treatment for suicidal ideation, self-harm, and suicide attempts among youth.* https://store.samhsa.gov/sites/default/files/pep20-06-01-002.pdf.

Swedish Socialstyrelsen. (2020). The evolution of the diagnosis of gender dysphoria: prevalence, co-occurring psychiatric diagnoses and mortality from suicide. www.socialstyrelsen.se Article number 2020-2-6600.

Swedish Socialstyrelsen. (2022, February 22). Uppdaterade rekommendationer för hormonbehandling vid könsdysfori hos unga. [*Updated recommendations for hormone therapy for gender dysphoria in young people.*] Retrieved from https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdaterade-rekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/.

Swedish Socialstyrelsen. (2022, February). Stöd, utredning och hormonbehandling vid könsinkongruens hos barn och ungdomar Delvis uppdatering av kunskapsstöd. [*Support, investigation and hormone treatment at gender incongruity in children and young people.*] Available from https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-2-7774.pdf

Telfer, M. M., Tollit, M. A., Pace, C. C., & Pang, K. C. (2018). Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents. *The Medical Journal of Australia*, *209,* 132–136.

Temple Newhook, J. T., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., Sinnott, M.-L., Jamieson, A., & Pickett, S. (2018). A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children. *International Journal of Transgenderism, 19,* 212–224.

Terhune, C., Respaut, R., & Conlin, M. (2022, Oct. 6). As more transgender children seek medical care, families confront many unknowns. *Reuters Special Report.* Retrieved from https://www.reuters.com/investigates/special-report/usa-transyouth-care/

Tetelepta, B. (2021, Feb 27). More research is urgently needed into transgender care for young people: 'Where does the large flow of children come from?' [translated]. Algemeen Dagblad. Retrieved from https://www.voorzij.nl/more-research-is-urgently-needed-into-transgender-care-for-young-people-where-does-the-large-increase-of-children-come-from/.

The Trevor Project. (2019). The Trevor Project National Survey on LGBTQ Youth Mental Health 2019. Retrieved from https://www.thetrevorproject.org/wp-content/uploads/2019/06/The-Trevor-Project-National-Survey-Results-2019.pdf

Thrower, E., Bretherton, I., Pang, K. C., Zajac, J. D., & Cheung, A. S. (2020). Prevalence of autism spectrum disorder and attention-deficit hyperactivity disorder amongst individuals with gender dysphoria: A systematic review. *Journal of Autism and Developmental Disorders, 50,* 695–706.

Tønnessen, E., Siobhan Svendsen, I., Christoffer Olsen, I., Guttormsen, A., & Haugen, T. (2015). Performance development in adolescent track and field athletes according to age, sex and sport discipline. *PLOSONE, 10*(6), e0129014.

Toomey, R. B., Syvertsen, A. K., Shramko, M. (2018). Transgender adolescent suicide behavior. *Pediatrics, 142,* e20174218.

Tordoff, D. M., Wanta, J. W., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open, 5*(2):e220978.

Tripepi, G., Jager, K., Dekker, F., and Zoccali, C. (2010). Selection bias and information bias in clinical research. *Nephron. Clin. Practice* 2010; 115:94-99.

Turban, J. (2021, March 16). Trans girls belong on girls' sports teams. *Scientific American.* www.scientificamerican.com/article/trans-girls-belong-on-girls-sports-teams/

Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PlosONE*.

Turban, J. L., King, D., Li, J. J., Keuroghlian, A. S. (2021). Timing of social transition for transgender and gender diverse youth, K-12 harassment, and adult mental health outcomes. *Journal of Adolescent Health, 69,* 991–998.

Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors leading to "detransition" among transgender and gender diverse people in the United States: A mixed-methods analysis. *LGBT Health, 8,* 273–280.

Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behavior. *Lancet, 387,* 1227–1239.

Twohey, M., & Jewett, C. (2022). They paused puberty, but is there a cost? *New York Times.* Available from https://www.nytimes.com/2022/11/14/health/puberty-blockers-transgender.html.

Ukom Norway. (March 9, 2023). *Patient safety for children and adolescents with gender incongruence.* Unofficial translation.

van der Loos, M., Hellinga, I., Vlot, M., Klink, D., Den Heijer, M., Wiepjes, C. (2021). Development of hip bone geometry in transgender adolescents resembles the experienced gender if GnRHa treatment is started in early, but not late, puberty. *J. Endocrine Soc*. Volume 5, Issue Supplement 1, April-May 2021.

van der Miesen, A. I. R., Steensma, T. D., de Vries, A. L. C., Bos, H., Popma, A. (2020). Psychological functioning in transgender adolescence before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health, 66*, 699–704.

Vilain, E. (2006). Genetics of intersexuality. *Journal of Gay & Lesbian Psychotherapy, 10,* 9–26.

Vlot, M., Klink, D. T., den Heijer, M., Blankenstein, M. A., Rotteveel, J., & Heijboer, A. C. (2017). Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone, 95,* 11–19.

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*, 1413–1423.

Wallien, M. S., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*, 1307–1314.

Warrier, V., Greenberg, D. M., Weir, E., Buckingham, C., Smith, P., Lai, M.-C., Allison, C., & Baron-Cohen, S. (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature Communications, 11,* 3959.

WHO (World Health Organization). (2022). *Age standardized suicide rates (per 100 000 population.* Retrieved from https://www.who.int/data/gho/data/themes/mental-health/suicide-rates

Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Block, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). *Acta Psychiatrica Scandinavica, 141,* 486–491.

Wiepjes, C. M., Nota, N. M., de Bok, C. J. M., Klaver, M., de Vries, A. L. C., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M-B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels B. P. C., & den Heijer, M. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine, 15*, 582–590.

Wierckx, K., Mueller, S., Weyers, S., Van Caenegem, E., Roef, G., Heylens, G., & T'Sjoen, G. (2012). Long-term evaluation of cross-sex hormone treatment in transsexual persons. *The Journal of Sexual Medicine, 9,* 2641–2651.

Winters, K., Temple Newhook, J., Pyne, J., Feder, S., Jamieson, A., Holmes, C., Sinnott, M.-L., Pickett, S., & Tosh, J. (2018). Learning to listen to trans and gender diverse children: A

response to Zucker (2018) and Steensma and Cohen-Kettenis (2018). *International Journal of Transgenderism, 19,* 246–250.

Woll, A., Kurth, B. M., Opper, E., Worth, A., & Bos, K. (2011). The 'Motorik- Modul' (MoMo): Physical fitness and physical activity in German children and adolescents. *European Journal of Pediatrics, 170,* 1129–1142.

Wood, H., Sasaki, S., Bradley, S. J., Singh, D., Fantus, S., Own-Anderson, A., Di Giacomo, A., Bain, J., & Zucker, K. J. (2013). Patterns of referral to a gender identity service for children and adolescents (1976–2011): Age, sex ratio, and sexual orientation. *Journal of Sex & Marital Therapy, 39,* 1–6.

WPATH. (2016). Position statement on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A..

WPATH. (2022). Correction. Int. J. of Transgender Health, 23:Sup1, S259-261.

Zanarini, M. C., Magni, L. R., Temes, C. M., Hein, K. E., Aguirre, B. A., & Goodman, M. (2021). Sexual orientation and gender of intimate relationship partners among adolescents with BPD and psychiatrically healthy adolescents. *Journal of Personality Disorders, 35 (Suppl. B),* 1–7.

Zhao, J., Dong, L., Lin, Z., Sui, X., Wang, Y., Li, L., Liu, T., & Liu, J. (2023). Effects of selenium supplementation on Polycystic Ovarian Syndrome: A systematic review and meta-analysis on randomized clinical trials. *BMC Endocrine Disorders, 23,* 33.

Zhu, J., & Chan, Y.-M. (2017). Adult consequences of self-limited delayed puberty. *Pediatrics, 13, 9*, e20163177.

Zucker, K. J. (2018). The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender nonconforming children" by Temple Newhook et al. (2018). *International Journal of Transgenderism, 19,* 231–245.

Zucker, K. J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior, 48,* 1983–1992.

Zucker, K. J. (2020). Debate: Different strokes for different folks. *Child and Adolescent Mental Health, 25,* 36–37.

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (2012). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy, 38,* 151–189.

Zucker, K.J. (2018). The myth of persistence: response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018). *International Journal of Transgenderism*. DOI: 10.1080/15532739.2018.1468293.

Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*, 90–97.

List of Appendices

Appendix 1

Curriculum Vita

Appendix 2

Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy, 46,* 307–313. doi: 10.1080/0092623X.2019.1698481

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION
Case No. 1:23-cv-00269

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

Plaintiffs,

-against-

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

Defendants.

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September 21, 2023
10:04 a.m.

Remote Videotaped Deposition of JAMES M. CANTOR, Ph.D., an Expert Witness, taken by Plaintiffs, before Dawn Matera, a Certified Shorthand Reporter and Notary Public for the State of New York.

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alternative is not, therefore, do what you want. This is, this is the best we have until, you know, but we need to fine point and tweak and change criteria but nobody has found anything better yet.
Q. If we can turn to page 413 with the internal pagination of Exhibit 8.
A. Yes.
Q. And in the bottom right-hand column, the first full paragraph, it starts with the sentence "The possibility of discrepant judgments between intelligent and well-informed review authors is more than theoretical."
Do you see that?
A. Yes.
Q. Do you agree with that that it's possible for discrepant judgments between intelligent and well-informed review authors?
A. Yes, that's the reason why these assessments have to be done by several people and for them to be able to hammer out where there are disagreements.
Q. And the paragraph goes on to

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discuss different studies of deep vein thrombosis in airline passengers taking long flights. And if you turn to page 414. At the top of the page, the end of the spillover paragraph, it says that "Even after direct contact and discussion each group adhered to its own position, and it's possible that either group is correct."
Do you see that?
A. Yes.
Q. So possible for there to be reasonable disagreement among review authors even applying GRADE criteria, right?
MR. RAMER: Object to the form.
A. Yes. It is indeed possible.
Q. Okay. You can put this aside for now. I want to turn back to your declaration, Exhibit 1 and go to paragraph 108.
A. I am there.
Q. Here you're discussing the term "gender identity" in this paragraph, correct?

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A. Mostly, really I am discussing people's common, a popular definition of gender identity using a non-scientific one, and trying to attribute to it all kinds of scientific attributes.
Q. You disagree with the idea that gender identity could be defined as a person's inner sense?
A. It can't be scientifically defined as an inner sense.
Q. What do you mean by scientifically defined?
A. Objective, verifiable and falsifiable.
Q. And you say that it's increasing popular to do this. Are you saying this is a new phenomenon?
A. That what's a new phenomenon?
Q. Defining gender identity as a person's inner sense?
A. Yes and no. It's use and application for decision-making is pretty new. It's been used before as just a general description to kind of characterize a phenomenon, generally at a

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time earlier in mental health, where all of mental health was really just a series of metaphors and general descriptions. But again, now, in the social media age and when being used to justify medical transition of minors, it's being given the weight and consideration, not merely of a general description, but as a concrete objective criterion to justify physical interventions.
Where, as I say, it was used, it was originally just used as a general metaphor. But it's no longer being treated as a general metaphor. It's being treated as a physical objective unquestionable truth. That's what's new.
MR. MAY: If we can please mark tab 31 as the next exhibit. I believe that will be Exhibit 9.
(Exhibit 9, Article titled "The Recalled Childhood Gender Identity/Gender Role Questionnaire, Psychometric Properties" by Zucker, et al., was so marked for identification, as of this date.)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION
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PAM POE, by and through her parents and next friends, Penny and Peter Poe; PENNY POE, PETER POE; JANE DOE, by and through her parents and next friends, Joan and John Doe, JOAN DOE; JOHN DOE,

Plaintiffs,

Case No.

v.

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

Defendants.

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10:00 a.m.

September 22, 2023

VIRTUAL DEPOSITION of DR. DANIEL WEISS, an Expert Witness in the above entitled matter, pursuant to Notice, before Stephen J. Moore, a Registered Professional Reporter, Certified Realtime Reporter and Notary Public of the State of New York.

you regarding their gender affirming care?
A No. Well, I should say one person -- two people, sorry, so two people, went recently, recently, last year, I had a biologic male who had an orchiectomy in Philadelphia after being presumably evaluated by a therapist, had an orchiectomy. Within months he regretted it.
So he was on testosterone, same sex hormone, and then he wanted some estrogen, he went back and forth, and then he saw me, and so he was one person.
He was not originally seen by me, so that was one.
There was another man in his -- man, I can call him a he, he lived as a male, he had auto-gynephilia.
He really -- and I realized that later on, he was married to a female, having sex with her, had a ponytail, but lived as a male, basically, and wanted female hormones.
And I obliged him, and he seemed happy with that. He went by he, and

then came back after a hiatus of several months and said I'm having a little harder time getting erections since my surgery.
I said to him, what surgery?
Well, he had undergone orchiectomy, he had his testicles removed, having seen a psychologist first, I won't name the institution, and then had the orchiectomy.
And then he said this is not good, I'm having a hard time getting erections, having sex with my wife.
And so I called the urologist up I said how come you hadn't contacted me? I was following this guy for years, and he seemed to be fine on a little bit of estrogen, he just wanted some breast tissue and a little feminization.
That's all he wanted. And now he's having problems with erection.
So this urologist was surprised that this was the case. And I don't know why they didn't contact me, and the patient regretted having had the

surgery, and I had to put him back on -- I had to put him on testosterone.
So that's a person who's an adult in their, what did I say, 30s, he was in his 40s.
Q So other than those two of your 100 patients, each of whom had orchiectomy, did any of your patients express to you regret over any surgery or cross sex hormone that they had to address their gender dysphoria?
A I had one person who had a vaginoplasty, the full vagina created.
I wouldn't say that person had clearly regret, but was really distressed, had problems after the surgery that were happening related to infection and drainage and -- but strictly speaking, the word regret was not used.
Q So none of the patients expressed regret over the cross sex hormones that you had been providing to them, right?
A Well, no, the two with the orchiectomy, they had regret over the

surgery.
Q Yes, but none of your patients expressed regret over the administration of cross sex hormones, right?
A Correct.
Q Among the patients that you have cared for outside of the gender affirming care context, let's get a number, how many patients have you --
ATTORNEY KORBERG: Withdrawn.
Q Roughly how many patients have you cared for in the course of your career outside of the gender affirming care context?
A Oh, thousands, and thousands. Yes.
Q And have any of them ever expressed regret about some aspect of their treatment?
A Sure.
Q So how many of them would you say have expressed regret over some form of hormone therapy that is not cross sex treatment?

UNITED STATES DISTRICT COURT
DISTRICT OF IDAHO

PAM POE, by and through her parents and next friends, Penny and Peter Poe; PENNY POE; PETER POE; JANE DOE, by and through her parents and next friends, Joan and John Doe; JOAN DOE; JOHN DOE, Plaintiffs, v. RAÚL LABRADOR, in his official capacity as the Attorney General of the State of Idaho; JAN M. BENNETTS, in her official capacity as County Prosecuting Attorney for Ada, Idaho; and the INDIVIDUAL MEMBERS OF THE IDAHO CODE COMMISSION, in their official capacities, Defendants.	Case No. 1:23-cv-00269-CWD

REMOTE VIDEOTAPED DEPOSITION OF JACK TURBAN, M.D., MHS
MONDAY, OCTOBER 16, 2023

Reported By: Amy E. Simmons, CSR, RDR, CRR, CRC

the next page, right column, 3.1. And the final sentence of that paragraph in 3.1 says "A list of excluded studies is provided at the SBU web page," and then includes a hyperlink.
Do you see that?
A. Yes.
Q. All right.
MR. RAMER: I'd like to now introduce Turban Exhibit 20 if you have that, Li.
MS. NOWLIN-SOHL: Yes.
(Deposition Exhibit No. 20 was marked.)
Q. (BY MR. RAMER) And, Dr. Turban, I will represent to you that this document is located at the hyperlink that we just read.
And is this one of the long appendices you were referring to?
A. It looks a lot nicer than the one I remember. I wonder if they fixed some of the formatting in translation.
Q. It could be.
A. But no, that's fine. It's not very long.
Q. And the -- let's see here.
Okay. Can you see in the light blue -- I won't ask you to read Swedish -- but after the backslash, it says "Appendix 2 studies excluded

due to high risk of bias."
A. Yes.
Q. And do you cite -- let me rephrase.
The first study listed is the Achille study you cite, correct?
A. Yes.
Q. And the second study listed is the Allen study you cite, correct?
A. Yes.
Q. And the third study listed is one of the de Vries studies that you cite, correct?
A. Yes.
Q. And at the bottom of this page is the de Lara study that you cite, correct?
A. Yes.
Q. Dr. Turban, are you aware of any systematic reviews that have been able to draw conclusions about the effects of gender-affirming hormone therapy on suicide?
A. Like death from suicide?
Q. Yes.
A. No.
MR. RAMER: I think this is a good breaking point. I also think I've been going for about an hour.

Do we want to take a break here?
MS. NOWLIN-SOHL: Yeah.
THE VIDEOGRAPHER: Okay. So the time is 3:20 p.m. Pacific time, and we are off the record.
(Break taken from 3:20 p.m. to 3:27 p.m.)
THE VIDEOGRAPHER: All right. So we are recording. The time is 3:27 p.m. Pacific time, and we are back on the record.
MR. RAMER: Okay. Dr. Turban, I'd like to introduce Turban Exhibit 21 if that has arrived.
MS. NOWLIN-SOHL: It has not.
MR. RAMER: Then we'll hold that as Turban Exhibit 21 just to keep the numbering clear, and I'll introduce Turban Exhibit 22.
MS. NOWLIN-SOHL: Okay. We have that up.
MR. RAMER: Okay. Great.
(Deposition Exhibit No. 22 was marked.)
Q. (BY MR. RAMER) And, Dr. Turban, have you seen this document before?
A. Yes.
Q. I'm sorry?
A. Yes.
Q. And did you read it?
A. Yes.

Q. And when was the last time you read it?
A. I read this one recently, a few days ago when I was writing my statement.
Q. And I'd like to go to page 3. And under -- there's a blue header that says "Caution in the use of hormonal and surgical treatment." And I'll just read the first sentence and ask if I read it correctly.
It says "At group level (i.e., for the group of adolescents with gender dysphoria as a whole) the National Board of Health and Welfare currently assesses that the risk of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits of these treatments."
Did I read that correctly?
A. Yes.
Q. And a little further down on this page, the second full paragraph -- I guess, sorry. Let me ask first, do you agree that the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits of those treatments?
MS. NOWLIN-SOHL: Object to form.
THE WITNESS: They have a strange clause

of "at a group level (i.e., for the group adolescents with gender dysphoria)" as a whole. They say risks likely outweigh the benefits.

This document later goes on to note that you should consider these interventions on a case-by-case basis for the individual patient, which, in my view, is very similar to WPATH guidelines and how we practice. So we conduct these biopsychosocial evaluations to determine if, for an individual person, the potential benefits outweigh the potential risks.

So I would say that sentence, I agree.

Q. (BY MR. RAMER) You think that the policy set forth by this document is consistent with the WPATH guidelines?

MS. NOWLIN-SOHL: Object to the form; mischaracterizes prior testimony.

THE WITNESS: I think in that it recommends being very thoughtful about who receives gender-affirming medical interventions but still considering them. I think that's a theme of both.

Q. (BY MR. RAMER) If Sweden's policy were implemented in the United States, would treatment change at all?

MS. NOWLIN-SOHL: Object to form.

THE WITNESS: You'll have to give me a minute to read it in detail again for any potential --

Q. (BY MR. RAMER) Sorry. To read what in detail? That sentence?

A. This document of the guidelines. You wanted me to tell you if the guidelines are essentially identical to what's practiced in the U.S.

Q. Well, the question I originally asked was about the first sentence. Do you agree that the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits of these treatments?

And I thought your answer was, well, they're talking about the group level. They have this strange clause about the group level. And we don't practice medicine any different here in the United States because we go on an individualized basis.

And so I guess you were extrapolating from the first sentence to the practice of care here, and that's why I asked the question. So I frankly do not want to take -- you know, I have

some other questions we can ask, but you think that that first sentence is consistent with the practice in the United States currently?

MS. NOWLIN-SOHL: Object to form. Object to prior mischaracterization of testimony.

Q. (BY MR. RAMER) And if that sentence is just not relevant, that's fine, but just following up on your answer.

A. I think I answered the question that it's similar between what's written here and what's practiced in the U.S., that we don't, without a thoughtful biopsychosocial evaluation, routinely provide gender-affirming medical interventions without carefully weighing the potential risks against potential benefits for individuals.

Q. On the same page a little further down, second paragraph, there's a sentence that begins with "In revising its recommendations." I just want to read it and first ask if I read it correctly.

"In revising its recommendations, the National Board of Health and Welfare has taken account of the fact that the efficacy and safety, benefits, and risks of treatments are not proven, and that three factors have shifted the balance

between benefit and risk in a negative direction."

Did I read that correctly?

A. Yes.

Q. And the first bullet they list is -- refers to "the uncertainty resulting from the lack of clarity about the causes that the number of people diagnosed with gender dysphoria has continued to rise since the publication of the guidelines in 2015, particularly in the 13 to 17 age group, and especially among people whose registered sex at birth is female."

Do you see that?

A. Yes.

Q. And do you agree there's uncertainty resulting from the lack of clarity about the cause for the increase of gender dysphoria among adolescents whose registered sex at birth is female?

MS. NOWLIN-SOHL: Object to form.

THE WITNESS: I believe I wrote this in my declaration, but most experts think that the reason for the increase in referrals to gender clinics is due to increased public knowledge that these interventions exist.

I believe I cited a paper from the Dutch

UNITED STATES DISTRICT COURT
DISTRICT OF IDAHO

PAM POE, by and through her parents and next friends, Penny and Peter Poe; PENNY POE; PETER POE; JANE DOE, by and through her parents and next friends, Joan and John Doe; JOAN DOE; JOHN DOE, Plaintiffs, v. RAÚL LABRADOR, in his official capacity as the Attorney General of the State of Idaho; JAN M. BENNETTS, in her official capacity as County Prosecuting Attorney for Ada, Idaho; and the INDIVIDUAL MEMBERS OF THE IDAHO CODE COMMISSION, in their official capacities, Defendants.	Case No. 1:23-cv-00269-CWD

REMOTE VIDEOTAPED DEPOSITION OF KARA CONNELLY, M.D.
MONDAY, AUGUST 28, 2023

Reported By: Amy E. Simmons, CSR, RDR, CRR, CRC

participants may have received, right?
A. That is what they are saying.
Q. And that's similar to the hypothetical I asked earlier today about a study where you have patients receiving medical interventions alongside mental health therapy, right?
A. Medical interventions -- and the mental health therapy being a concomitant treatment?
Q. Right.
A. Yes.
Q. Okay. Let's -- we can move on from this document. I'd like to just go back to your declaration now and go to page 11.
And the header for part IV says "Gender-Affirming medical care for adolescents is safe"; is that right?
A. Yes.
Q. And what do you mean by the word "safe"?
A. In general, I -- in this case I mean that the benefits likely outweigh the risks.
Q. So same page, paragraph 37, and the very last sentence that carries over onto the other page, but my question is only about the part that's on this page.
And you say that GnRHa medications are