TAB #3

Gender and Transgender Issues

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER et al.,

Plaintiffs,

v.

KAY IVEY, et al.

Defendants.

Case No. 2:22-cv-184-LCB-SRW

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Civil Procedure 7.1, the undersigned counsel for the American Academy of Pediatrics ("AAP"), the Alabama Chapter of the American Academy of Pediatrics ("AL-AAP"), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry ("AACAP"), the American Academy of Family Physicians ("AAFP"), the American Academy of Nursing ("AAN"), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality ("GLMA"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Osteopathic Pediatricians ("ACOP"), the American College of Physicians ("ACP"), the American Medical Association ("AMA"), the American Pediatric Society ("APS"), the American Psychiatric Association ("APA"), the Association of American Medical Colleges ("AAMC"), the Association of Medical School Pediatric Department Chairs ("AMSPDC"), the Endocrine Society, the National Association of Pediatric Nurse Practitioners ("NAPNAP"), the Pediatric Endocrine Society ("PES"), the Society for Adolescent Health and Medicine ("SAHM"), the Society for Pediatric Research ("SPR"), the Society of Pediatric Nurses ("SPN"), the Societies for Pediatric Urology, and the World Professional Association for Transgender Health ("WPATH") certify that:

1. AAP, AL-AAP, the Academic Pediatric Association, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AMA, APS, APA, AAMC, AMSPDC, the Endocrine Society, NAPNAP, PES, SAHM, SPR, SPN, SPU, and WPATH, respectively, have no parent corporation.

2. No corporations hold any stock in AAP, AL-AAP, the Academic Pediatric Association, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AMA, APS, APA, AAMC, AMSPDC, the Endocrine Society, NAPNAP, PES, SAHM, SPR, SPN, SPU or WPATH.

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae are the American Academy of Pediatrics ("AAP"), the Alabama Chapter of the American Academy of Pediatrics ("AL-AAP"), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry ("AACAP"), the American Academy of Family Physicians ("AAFP"), the American Academy of Nursing ("AAN"), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality ("GLMA"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Osteopathic Pediatricians ("ACOP"), the American College of Physicians ("ACP"), the American Medical Association ("AMA"), the American Pediatric Society ("APS"), the American Psychiatric Association ("APA"), the Association of American Medical Colleges ("AAMC"), the Association of Medical School Pediatric Department Chairs ("AMSPDC"), the Endocrine Society, the National Association of Pediatric Nurse Practitioners ("NAPNAP"), the Pediatric Endocrine Society ("PES"), the Society for Adolescent Health and Medicine ("SAHM"), the Society for Pediatric Research ("SPR"), the Society of Pediatric Nurses ("SPN"), the Societies for Pediatric Urology, and the World Professional Association for Transgender Health ("WPATH").[1]

[1] Plaintiffs and Plaintiff-Intervenor have consented to the filing of this brief; Defendants have not consented to the filing of this brief. *Amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* or their counsel made any monetary contributions intended to fund the preparation or submission of this brief.

Amici are professional medical and mental health organizations seeking to ensure that all children and adolescents, including those with gender dysphoria, receive the optimal medical and mental healthcare they need and deserve. *Amici* represent thousands of healthcare providers who have specific expertise with the issues raised in this brief. The Court should consider *amici*'s brief because it provides important expertise and addresses misstatements about the treatment of transgender adolescents.

INTRODUCTION

Alabama Senate Bill 184 ("the Healthcare Ban") would prohibit healthcare providers from providing or even referring patients under the age of 19 for critical, evidence-based treatments for gender dysphoria. Denying such evidence-based medical care to adolescents who meet the requisite medical criteria puts them at risk of significant harm to their mental health. The legislative findings in the Healthcare Ban mischaracterize the well-accepted medical guidelines for treating gender dysphoria in adolescents and the guidelines' supporting evidence. Below, *amici* provide the Court with an accurate description of these well-accepted treatment guidelines and summarize the scientific evidence supporting the medical interventions prohibited by the Healthcare Ban.

Gender dysphoria is a clinical condition that is marked by distress due to an incongruence between the patient's gender identity (i.e., the innate sense of oneself

as being a particular gender) and sex assigned at birth. This incongruence can lead to clinically significant distress and impair functioning in many aspects of the patient's life.[2] If not treated, or treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with higher rates of suicide. As such, the effective treatment of gender dysphoria saves lives.

The widely accepted recommendation of the medical community, including that of the respected professional organizations participating here as *amici*, is that the standard of care for treating gender dysphoria is "gender-affirming care,"[3] which Plaintiffs refer to as "transition."[4] Gender-affirming care is care that supports a child or adolescent as they explore their gender identity—in contrast with efforts to change the individual's gender identity to match their sex assigned at birth, which are known to be ineffective and harmful. For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical interventions to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including gender-affirming medical interventions, can alleviate clinically significant distress and lead to significant

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[2] *See* Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142(4) *Pediatrics* e20182162, at 2 (tbl. 1), 3 (2018) (hereinafter, "AAP Policy Statement"), https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for.

[3] *Id.* at 10.

[4] *See, e.g.*, Memorandum in Support of Preliminary Injunction at 12-16 (Dkt. # 8) (April 21, 2022).

improvements in the mental health and overall well-being of adolescents with gender dysphoria.

The Healthcare Ban disregards this medical evidence by threatening providers with a felony conviction simply for treating adolescent patients in accordance with the accepted standard of care. In addition, the Healthcare Ban prevents healthcare providers from utilizing their medical expertise in treating these adolescent patients and profoundly intrudes on the patient-provider relationship by banning referrals for gender-affirming medical treatments. Accordingly, *amici* urge this Court to grant Plaintiffs' motion for a temporary restraining order and preliminary injunction.

ARGUMENT

This brief first provides background on gender identity and gender dysphoria. It then describes the well-accepted medical guidelines for treating gender dysphoria as they apply to adolescents and the evidence that suggests the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief explains how the Healthcare Ban would irreparably harm adolescents with gender dysphoria by denying care to those who need it.

I. Understanding Gender Identity and Gender Dysphoria.

A person's gender identity is a person's deep internal sense of belonging to a

particular gender.[5] Most people have a gender identity that aligns with their sex assigned at birth.[6] However, transgender people have a gender identity that does not align with their sex assigned at birth.[7] In the United States, it is estimated that approximately 1.4 million individuals are transgender.[8] Of these individuals, approximately 10% are teenagers aged 13 to 17.[9] Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

While being transgender is a normal variation of human identity,[10] many transgender people suffer from gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to "impairment in peer and/or family relationships, school performance, or other aspects of their life."[11] Gender dysphoria is a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5).

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[5] AAP Policy Statement at 2 (tbl. 1).

[6] *See* Am. Psychological Ass'n, *Guidelines for psychological practice with transgender and gender nonconforming people*, 70(9) American Psychologist 832, 862 (2015) (hereinafter, "Am. Psychological Ass'n Guidelines"), https://www.apa.org/practice/guidelines/transgender.pdf.

[7] *See id.* at 863.

[8] *See* Jody L. Herman et al., *Ages of Individuals Who Identify as Transgender in the United States*, Williams Inst., at 2 (Jan. 2017), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Age-Trans-Individuals-Jan-2017.pdf.

[9] *See id.* at 3.

[10] James L. Madara, *AMA to states: Stop interfering in healthcare of transgender children*, Am. Med. Ass'n (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children; *see also* Am. Psychological Ass'n, *APA Resolution on Gender Identity Change Efforts*, 4 (2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.

[11] AAP Policy Statement at 3.

If untreated or inadequately treated, gender dysphoria can cause depression, anxiety, self-harm, and suicidality.[12] Indeed, over 60% of transgender adolescents and young adults reported having engaged in self-harm during the preceding 12 months, and over 75% reported symptoms of generalized anxiety disorder in the preceding two weeks.[13] Even more troubling, more than 50% of this population reported having seriously considered attempting suicide,[14] and more than one in three transgender adolescents reported having attempted suicide in the preceding 12 months.[15]

II. The Widely Accepted Guidelines for Treating Adolescents With Gender Dysphoria Provide for Medical Interventions When Indicated.

The widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria and that, for some adolescents, gender-affirming medical interventions are necessary.[16] This care

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[12] *See* Brayden N. Kameg & Donna G. Nativio, *Gender dysphoria in youth: An overview for primary care providers*. 30(9) J. Am. Assoc. Nurse Pract. 493 (2018), https://pubmed.ncbi.nlm.nih.gov/30095668.

[13] *See* Amit Paley, *The Trevor Project 2020 National Survey*, at 1, https://www.thetrevorproject.org/wp-content/uploads/2020/07/The-Trevor-Project-National-Survey-Results-2020.pdf.

[14] *See id.* at 2.

[15] *See* 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*, US Dep't of Health and Human Servs., Centers for Disease Control & Prevention, 68(3) MMWR 67, 70 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf.

[16] *See, e.g.*, Endocrine Soc'y, *Transgender Health: An Endocrine Society Position Statement* (2020) (hereinafter, "Endocrine Soc'y Position Statement"), https://www.endocrine.org/advocacy/position-statements/transgender-health.

greatly reduces the negative physical and mental health consequences that result when gender dysphoria is untreated.[17]

A. The Guidelines for Treating Gender Dysphoria Include Thorough Mental Health Assessments and, for Some Adolescents, Medical Interventions.

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (together, the "Guidelines").[18]

The Guidelines provide that youth with gender dysphoria should be evaluated, diagnosed, and treated by a qualified mental health professional ("MHP"). Further, the Guidelines provide that each patient who receives gender-affirming care receives only evidence-based, medically necessary, and appropriate interventions that are tailored to the patient's individual needs.

1. A Robust Mental Health Assessment Is Required Before Medical Interventions Are Provided.

According to the Guidelines, gender-affirming care begins with a thorough

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[17] *See id.*

[18] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. Clinical Endocrinology & Metabolism 3869 (Nov. 2017) (hereinafter, "Endocrine Society Guidelines"), https://academic.oup.com/jcem/article/102/11/3869/4157558; WPATH, *Standards of Care* (7th Version), https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf (hereinafter, "WPATH Guidelines").

evaluation by a qualified mental health professional, who: (1) is trained in childhood and adolescent developmental psychopathology, (2) is competent in diagnosing and treating the ordinary problems of children and adolescents, and (3) meets the competency requirements for MHPs working with adults.[19] These include: (1) a master's degree or equivalent in a clinical behavioral science field, (2) competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes, (3) the ability to recognize and diagnose coexisting mental health concerns and distinguish them from gender dysphoria, (4) documented supervised training and competence in psychotherapy or counseling, (5) being knowledgeable about gender identities and expressions and the assessment and treatment of gender dysphoria, and (6) continuing education in the assessment and treatment of gender dysphoria.[20]

When evaluating a patient with gender dysphoria, the MHP must, among other things, assess the patient's "gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends,

[19] *See* WPATH Guidelines at 13.

[20] *See id.* at 22.

and peers."[21] The MHP also must screen for coexisting mental health concerns, [22] which "need to be optimally managed prior to, or concurrent with, treatment of gender dysphoria."[23] If gender dysphoria is diagnosed, the Guidelines provide that the MHP should discuss treatment for gender dysphoria and any coexisting concerns, including potential risks.[24]

2. The Guidelines Recommend Only Non-Physical Interventions for Prepubertal Children Suffering From Gender Dysphoria.

For prepubertal children suffering from gender dysphoria, the Guidelines provide for mental healthcare and support for the child and their family.[25] The Guidelines do *not* recommend that any physical interventions (such as medications or surgery) be provided to prepubertal children with gender dysphoria.[26]

3. In Certain Circumstances, the Guidelines Provide for the Use of Medical Interventions to Treat Adolescents Suffering From Gender Dysphoria.

For patients whose gender dysphoria continues into adolescence—after the onset of puberty—the Guidelines provide that, in addition to mental healthcare, medical interventions may also be indicated. Before an adolescent may receive any

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[21] *Id.* at 23-24.

[22] *Id.* at 24-25.

[23] *Id.* at 25.

[24] *Id.* at 24.

[25] *See id.* at 16-17; Endocrine Society Guidelines at 3877-78.

[26] *See* WPATH Guidelines at 17-18, Endocrine Society Guidelines at 3871.

medical interventions for gender dysphoria, a qualified MHP must determine that: (1) the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria, (2) the gender dysphoria emerged or worsened after the onset of puberty, (3) any coexisting psychological, medical, or social problems that could interfere with treatment have been addressed, and (4) the adolescent and the parents or guardians have given informed consent.[27] Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (5) agree with the indication for treatment, (6) confirm the patient has started puberty, and (7) confirm that there are no medical contraindications.[28]

If all of the above criteria are met, the Guidelines instruct that gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," may be offered beginning at the onset of puberty.[29] The purpose of puberty blockers is to delay pubertal development until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments.[30] Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible changes such as protrusion of the Adam's apple or breast

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[27] WPATH Guidelines at 19.

[28] Endocrine Society Guidelines at 3878 (tbl. 5).

[29] WPATH Guidelines at 18; Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 New Eng. J. Med. 579 (2021), https://www.nejm.org/doi/full/10.1056/NEJMp2106314.

[30] WPATH Guidelines at 19.

growth.[31] Puberty blockers have well-known efficacy and side-effect profiles.[32] In addition, their effects are generally reversible.[33] In fact, puberty blockers have been used by pediatric endocrinologists for more than 30 years for the treatment of precocious puberty.[34] The risks of any serious adverse effects of these treatments are exceedingly rare when provided under clinical supervision.[35]

Later in adolescence—and if the criteria below are met—hormone therapy may be used to initiate puberty consistent with the patient's gender identity.[36] Hormone therapy is only prescribed when a qualified MHP has confirmed the persistence of the patient's gender dysphoria, the patient's mental capacity to assent to the treatment, and that any coexisting problems have been addressed.[37] A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, the patient and their parents or guardians must be informed of the potential effects and side effects, and the patient and the patient's

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[31] *See* AAP Policy Statement at 5.

[32] Martin, *supra* note 29 at 2.

[33] *See id.*

[34] *See id.*

[35] *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty suppression and executive functioning: an fMRI-study in adolescents with gender dysphoria*, 6 Psychoneuroendocrinology 190 (2015), https://pubmed.ncbi.nlm.nih.gov/25837854 (no adverse impact on executive functioning); Ken C. Pang, et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) Pediatrics e20191606 (2019), https://watermark.silverchair.com/peds_20191606.pdf (exceedingly low risk of delayed bone mineralization from hormone treatment).

[36] Martin, *supra* note 29 at 2.

[37] Endocrine Society Guidelines at 3878 (tbl. 5).

parents or guardians must give their informed consent.[38] Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[39] Although some of these changes become irreversible after those secondary sex characteristics are fully developed, others are partially reversible if the patient discontinues use of the hormones.[40]

The Guidelines contemplate that the prescription of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications and close monitoring to mitigate any potential risks.[41] Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents or guardians, and the medical and mental healthcare team. There is "no one-size-fits-all approach to this kind of care."[42]

B. The Guidelines for Treating Gender Dysphoria Were Developed Through a Robust and Transparent Process, Employing the Same Scientific Rigor That Underpins Other Medical Guidelines.

The Guidelines are the product of careful and robust deliberation following the same types of processes—and subject to the same types of rigorous

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[38] *See id.*

[39] *See* AAP Policy Statement at 6.

[40] *See id.* at 5-6.

[41] *See* Endocrine Society Guidelines at 3871, 3876.

[42] Martin, *supra* note 29, at 1.

requirements—as other guidelines promulgated by *amici* and other medical organizations.

For example, the Endocrine Society's Guidelines were developed following a 26-step, 26-month drafting, comment, and review process.[43] The Endocrine Society imposes strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.[44] That GRADE assessment is then reviewed, re-reviewed, and reviewed again by multiple, independent groups of professionals. [45] Further, the Endocrine Society continually reviews its own guidelines and recently determined the 2017 transgender care guidelines continue to reflect the best available evidence.

The WPATH standards are the result of a drafting, comment, and review process that took five years.[46] The draft guidelines went through journal peer-review and were publicly available for discussion and debate, including multiple rounds of feedback from experts in the field as well as from transgender individuals.[47] They

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[43] *See, e.g.,* Endocrine Society Guidelines at 3872-73 (high-level overview of methodology).

[44] *See* Gordon Guyatt et al., *GRADE guidelines: 1. Introduction - GRADE evidence profiles and summary of findings tables*, 64 J. Clinical Epidemiology 383 (2011), https://www.who.int/alliance-hpsr/resources/publications/HSR-synthesis-Guyatt-2011.pdf; Gordon H. Guyatt et al., *GRADE: an emerging consensus on rating quality of evidence and strength of recommendations*, 336 BMJ 924 (2008), https://www.who.int/hiv/topics/treatment/grade_guyatt_2008.pdf.

[45] Endocrine Society, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology (last visited May 4, 2022).

[46] *See* WPATH Guidelines at 109-10.

[47] *See id.*

are periodically updated to account for new developments in the research and practice, and WPATH is in the process of its eighth revision.[48]

C. Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines.

The results of multiple studies indicate that adolescents suffering from gender dysphoria who receive medical interventions as part of their gender-affirming care experience improvements in their overall well-being.[49] Eight studies have been published that investigated the use of puberty blockers on adolescents suffering from gender dysphoria,[50] and six studies have been published that investigated the use of hormone therapy to treat adolescents suffering from gender dysphoria.[51] These

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[48] WPATH, *Standards of Care 8: History and Purpose*, https://www.wpath.org/soc8/history.

[49] *See* Martin, *supra* note 29, at 2.

[50] *See, e.g.*, Christal Achille, et al., *Longitudinal impact of gender-affirming endocrine intervention on the mental health and wellbeing of transgender youths: preliminary results*, 8 Int'l J Pediatric Endocrinology 1-5 (2020), https://pubmed.ncbi.nlm.nih.gov/32368216; Polly Carmichael, et al., *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*, 16(2) PloS One e0243894 (2021), https://pubmed.ncbi.nlm.nih.gov/33529227; Rosalia Costa, et al., *Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria*, 12(11) J. Sexual Med. 2206–2214 (2015), https://pubmed.ncbi.nlm.nih.gov/26556015; Annelou L.C. de Vries, et al., *Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study*, 8(8) J. Sexual Med. 2276-2283 (2011), https://pubmed.ncbi.nlm.nih.gov/20646177; Annelou L.C. de Vries, et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134(4) Pediatrics 696-704 (2014), https://pubmed.ncbi.nlm.nih.gov/25201798; Laura E. Kuper, et al., *Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy*, 145(4) Pediatrics e20193006 (2020), https://pubmed.ncbi.nlm.nih.gov/32220906; Jack L. Turban, et al., *Pubertal suppression for transgender youth and risk of suicidal ideation*, 145(2) Pediatrics e20191725 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269; Anna I.R. van der Miesen, *Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers*, 66(6) J. Adolescent Health 699-704 (2020).

[51] *See, e.g.*, Christal Achille, et al., *Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results*, 8 Int'l J. Pediatric Endocrinology 1-5 (2020), https://pubmed.ncbi.nlm.nih.gov/32368216; Luke R. Allen, et al.,

studies find positive mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.

For example, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not.[52] The study found that those who received puberty blocking hormone treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support.[53] Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it

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Well-being and suicidality among transgender youth after gender-affirming hormones, 7(3) Clinical Prac. Pediatric Psych. 302 (2019), https://psycnet.apa.org/record/2019-52280-009; Diego Lopez de Lara, et al., *Psychosocial assessment in transgender adolescents*, 93(1) Anales de Pediatria 41-48 (English ed. 2020), https://www.researchgate.net/publication/342652073; Annelou L.C. De Vries, et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134(4) Pediatrics 696-704 (2014); Rittakerttu Kaltiala, et al., *Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria*, 74(3) Nordic J. Psychiatry 213 (2020); Laura E. Kuper, et al., *Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy*, 145(4) Pediatrics e20193006(2020), https://pubmed.ncbi.nlm.nih.gov/32220906; Amy E. Green, et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, J. Adolescent Health (2021), https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext; Jack L. Turban, et al., *Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults*, J. Plos One (2022), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0261039.

[52] *See* Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145(2) Pediatrics e20191725 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269.

[53] *See id.*

reported lifetime suicidal ideation.[54] Additionally, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically-significant degree after receiving gender-affirming hormone treatment.[55]

As another example, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning.[56] A six-year follow-up study of 55 individuals from the 2011 study found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety.[57] "Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age-matched controls from the general population."[58]

As scientists and researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming

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[54] *See id.*

[55] *See* Luke R. Allen et al., *Well-being and suicidality among transgender youth after gender-affirming hormones*, 7(3) Clinical Prac. Pediatric Psych. 302 (2019), https://psycnet.apa.org/record/2019-52280-009.

[56] *See* Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, 8(8) J. Sexual Medicine 2276 (2011), https://pubmed.ncbi.nlm.nih.gov/20646177.

[57] Annelou L.C. de Vries et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134(4) Pediatrics 696 (2014), https://pubmed.ncbi.nlm.nih.gov/25201798.

[58] Stephen M. Rosenthal, *Challenges in the care of transgender and gender-diverse youth: an endocrinologist's view*, 17(10) Nature Rev. Endocrinology 581, 586 (Oct. 2021), https://pubmed.ncbi.nlm.nih.gov/34376826.

treatments prohibited by the Healthcare Ban are effective for the treatment of gender dysphoria. For these reasons, and as at least one court has recognized, the use of the gender-affirming medical interventions specified in the Guidelines is supported by all mainstream pediatric organizations, representing thousands of physicians across multiple disciplines.[59]

D. The Legislative Findings Are Factually Inaccurate and Ignore the Recommendations of the Medical Community.

1. There Is No Accepted Protocol of "Watchful Waiting" for Adolescents With Gender Dysphoria.

The Healthcare Ban's legislative findings endorse a "wait-and-see approach," based on the assumption that "a large majority" of children with signs of gender nonconformity will ultimately "resolve[] to an identity congruent with their sex by late adolescence."[60] This assertion lacks scientific support.

While some prepubertal children who experience gender dysphoria may go on to identify with their sex assigned at birth by the time they reach puberty, there are *no* studies to support the proposition that *adolescents* with gender dysphoria will come to identify with their sex assigned at birth, whether they receive treatment or

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[59] *See, e.g.*, *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 890 (E.D. Ark. 2021) ("The consensus recommendation of medical organizations is that the only effective treatment for individuals at risk of or suffering from gender dysphoria is to provide gender-affirming care.")

[60] Ala. Vulnerable Child Compassion and Protection Act, S.B. 184, No. 2022-289, § 2(5) (Ala. 2022).

not.[61] On the contrary, "[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult."[62] In this regard, while some practitioners use "watchful waiting"—i.e., waiting until puberty begins before considering social transition[63]—with prepubertal children, it is not recommended for *adolescents*. Using "watchful waiting" with gender-dysphoric adolescents can cause immense harm by denying them treatment that could alleviate their distress and forcing them to experience full endogenous puberty, resulting in physical changes that may be reversed—if at all—only through surgery.

2. Claims That the Medical Community Is "Aggressively Pushing" for Medical Interventions Are False.

The Healthcare Ban's legislative findings assert that "[s]ome in the medical community are aggressively pushing for interventions on minors."[64] This is false—adolescents are only provided medical interventions if they meet the rigorous criteria under the Guidelines. While it is true that the number of referrals to gender clinics has increased in recent years, this increase has coincided with a decrease in the

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[61] *See, e.g.*, Stewart L. Adelson, *Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents*, 51 J. Am. Acad. of Child & Adolescent Psychiatry 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/22917211 ("In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood").

[62] Rosenthal, *supra* note 58 at 585.

[63] AAP Policy Statement at 4.

[64] S.B. 184 § 2(6).

stigma against transgender people, an increase in public awareness of the existence of gender dysphoria and the availability of gender-affirming care, and improvements in insurance coverage, all of which likely led more people with gender identity issues to seek help. In any event, not all patients who seek care at gender clinics receive medical interventions. In fact, a 2018 study showed that the percentage of patients who presented to a gender clinic for evaluation and received medical interventions has actually *decreased* over time.[65]

III. The Healthcare Ban Would Irreparably Harm Many Adolescents With Gender Dysphoria By Denying Them the Treatment They Need.

The Healthcare Ban denies adolescents with gender dysphoria access to medical interventions that alleviate suffering, are grounded in science, and are endorsed by the medical community. The medical treatments prohibited by the Healthcare Ban can be a crucial part of treatment for adolescents with gender dysphoria and necessary to preserve their health. As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of

[65] *See* Chantal M. Wiepjes et al., *The Amsterdam cohort of gender dysphoria study (1972-2015): trends in prevalence, treatment, and regrets*. 15(4) J. Sexual Med. 582, 582 (Feb. 2018), https://pubmed.ncbi.nlm.nih.gov/29463477.

suicide attempts and significant improvement in quality of life.[66] In light of this evidence supporting the connection between lack of access to gender-affirming care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, Plaintiffs' motion for a temporary restraining order and preliminary injunction should be granted.

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[66] *See* M. Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72(2) Clinical Endocrinology 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; *see also* Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, *supra* note 50.

Dated: May 4, 2022

Respectfully submitted,

/s/ Barry A. Ragsdale

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CERTIFICATE OF SERVICE

I hereby certify that on May 4, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to counsel of record.

/s/ Barry A. Ragsdale
Of Counsel

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.,

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County,

Defendants.

Civil Action No. 2:22-cv-184-LCB

Hon. Liles C. Burke

DECLARATION OF LINDA A. HAWKINS, PH.D., LPC IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Linda A. Hawkins, Ph.D., M.S.Ed., LPC, declare as follows:

1. I submit this expert declaration based upon my personal knowledge.

2. If called to testify in this matter, I would testify truthfully based on my expert opinion.

Qualifications and Experience

3. I am a Licensed Professional Counselor with a M.S.Ed. in Psychological Services from the University of Pennsylvania in 1998, and a Ph.D. in Human Development and Human Sexuality from Widener University in 2009, specializing in working with children and adolescents experiencing gender dysphoria and their families. A true and correct copy of my Curriculum Vitae is attached hereto as **Exhibit A**.

4. I have over two decades of experience in supporting lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth and their families, both in private practice and through my work with hospitals and clinics. During that time, I have individually worked with more than 4,000 LGBTQ children, adolescents, and families from around the world.

5. In January 2014, I helped found and co-direct the Gender & Sexuality Development Program at The Children's Hospital of Philadelphia, which now operates from two clinics: Philadelphia, Pennsylvania and Voorhees, New Jersey. As Program Director, I oversee the care of nearly 3,000 families and field an average of

twenty new referrals a week. I also lead and participate in research for developing best care practices for LGBTQ children and their families, train health care and mental health providers on best care practices, establish gender-affirming hospital policies, and advise local, regional, and national organizations as they create and update guidelines for the care of transgender and gender-expansive children, youth, and their families. This includes direct trainings and policy review with schools, churches, social service agencies, mental health centers, and juvenile correction centers and insurance companies.

6. In January 2018, I helped found the Advanced Training Program in Affirmative Therapy for Transgender Communities, which is a year-long national professional training course for therapists to train them in supporting transgender clients across their clients' lifespans, that now has sites based in Seattle, Washington and Philadelphia, Pennsylvania. I have served as the Founder and Director since the program's inception, which includes both teaching duties and supervising the eight employees who implement the training and supervise the program on a daily basis. The American Psychological Association, U.S. Professional Association of Transgender Health, American Counseling Association, and American Association of Sexuality Educators, Counselors and Therapists are currently considering endorsing the program.

7. My recent publications include *Experience of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth*, Pediatrics, 147(3) (2021); *Transgender Youth Experiences with Implantable GnRH Agonists for Puberty Suppression*, Liebert (https://doi.org/10.1089/trgh.2021.0006) (2021); *Sexual and Gender Minority Adolescents: Meeting the Needs of Our LGBTQ Patients and Their Families*, Clinical Pediatric Emergency Medicine, 20(1), 9–16 (2019); *Sexual Orientation/Gender Identity Cultural Competence: A Simulation Pilot Study*, Clinical Simulation in Nursing, 16, 2–5 (2018); *Barriers to Care for Gender Non-Conforming Youth: Perspectives of Experienced Care Providers, Transgender Youth and Their Parents*, Journal of Adolescent Health, Vol. 62, Issue 2 (2018); *Effective Treatment of Depressive Disorders in Medical Clinics for Adolescents and Young Adults Living with HIV: A Controlled Trial*, Journal of Acquired Immune Deficiency Syndrome, 71(1), 38–46 (2017); *Policy Perspective: Ensuring Comprehensive Care and Support for Gender Nonconforming Children and Adolescents*, Transgender Health, 1(1), 75–86 (2016); and *Creating Welcoming Spaces for Lesbian, Gay, Bisexual and Transgender (LGBT) Patients: An Evaluation of the Healthcare Environment*, Journal of Homosexuality, 63(3), 387–93 (2016). I have also authored chapters of textbooks, including "Sexual Disorders and Transgender Health" in *Fundamentals in Consultation Psychiatry: Principles and Practice*, Eds. Lavakumar, M., Rosenthal, L., & Rabinowitz, T. Nova Medicine & Health: New

York, NY (2019). A listing of my publications is included in my Curriculum Vitae in **Exhibit A**.

8. I belong to a number of professional organizations and associations relating to (i) the overall mental health and well-being of all children, youth and their families; (ii) the health and well-being of children and adolescents, including those who are transgender; and (iii) to appropriate medical treatments for transgender individuals. For example, since 2005, I have been a member of the World Professional Association for Transgender Health ("WPATH"), an international multidisciplinary professional association to promote evidence-based care, education, research, advocacy, public policy and respect in transgender health. I was also elected as a Fellow of the College of Physicians of Philadelphia, invited to join based on my local, regional, national, and international contributions to the medical and mental health and wellness of transgender and gender non-binary children and youth, as well as my contributions to the education of medical professionals as part of this care. A complete list of my involvement in various professional associations is located in my Curriculum Vitae in **Exhibit A**.

9. From 2010-present, I have served as an Editorial Reviewer for Academic Pediatrics and the Society for the Scientific Study of Sexuality.

10. I have previously testified two times at trial or in deposition as an expert witness.

11. My opinions contained in this declaration are based on: (i) my years of experience as a Licensed Counselor and PhD training in treating transgender patients, including children, adolescents and young adults; (ii) my knowledge of the peer-reviewed research, including my own, regarding the treatment of LGBTQ patients and those suffering from gender dysphoria; and (iii) my review of the various declarations submitted in support of the motions. I generally rely on these types of materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this declaration. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

12. I was provided with and reviewed the following case-specific materials: (i) the expert declaration of Stephen Rosenthal, M.D. ("Dr. Rosenthal Decl."), and (ii) Senate Bill 184, as enacted ("the Act").

13. I have not met or spoken with the Plaintiffs or their parents for purposes of this declaration. My opinions are based solely on the information that I have been provided by Plaintiffs' attorneys as well as my extensive experience studying gender dysphoria and treating transgender patients.

14. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of $300 per hour for any review of records, preparation

of reports or declarations, and deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

Gender Identity Development and Gender Dysphoria

15. Because a person's gender identity is unknowable at birth, doctors assign sex based on the appearance of a newborn's external genitalia. For most people, that assignment also turns out to be a consistent reflection of their gender identity. However, for transgender people, their assigned sex does not match their gender identity.

16. Gender identity is a person's innate, inner sense of belonging to a particular gender, such as male or female.

17. Medical, mental health and human development research has repeatedly shown that gender identity is hard wired and a core component of human identity. Every person has a gender identity. Dr. Rosenthal's declaration provides a comprehensive overview of the research demonstrating that gender identity has strong biological ties. (Dr. Rosenthal Decl. at ¶¶ 14-17.)

18. A person's gender identity is not a personal decision, preference, or belief. Like nontransgender people, transgender people do not simply have a "preference" to live consistent with their gender identity; trying to live as a gender they are not feels viscerally wrong and can cause a range of psychological outcomes

from minor distress to overwhelming daily anxiety and depression that can culminate in thoughts of self-harm or death.

19. A key milestone of child development is a child becoming aware of their gender identity. My declaration will focus on that process and the psychological distress young people experience when their assigned sex and gender identity do not match.

20. Children typically become aware of their gender identity between the ages of three and five years old. During these young years, individuals will often gravitate toward toys, clothing, activities, and peer relationships that most typically align with their gender identity. At the same time, those children are also surrounded by gender rules, regulations and expectations in their families, the media, and community. Children assigned male at birth are typically rewarded for following the male-based expectations set out for them and the children assigned female at birth are equally rewarded for following the female-based expectations set out for them, regardless of the child's gender identity.

21. Transgender individuals who become aware in childhood that those expectations do not match with who they are often begin to express their cross-gender identity to their family members and caregivers. The statements and actions transgender children use to communicate their cross-gender identity differ significantly from age-appropriate imaginative play. Transgender children are

insistent, persistent, and consistent over time in their cross-gender identification. Transgender children will also manifest psychological distress as a result of the mismatch between their assigned sex and their gender identity if they are not allowed to live consistent with their gender identity.

22. This sets the experience of transgender children apart from non-transgender children. While non-transgender children may also experience some gender exploration, and some girls will be "tomboys" and some boys will live as feminine boys, the intensity and persistence of the cross-gender identification that transgender children express is of a different order. Historically, earlier studies included a wide range of gender nonconforming children, rather than differentiating between transgender and non-transgender children, and also suffered from other serious methodological flaws that make them unreliable. Today, based on current scientific knowledge and clinical practice, researchers and clinicians are much better equipped to differentiate transgender from non-transgender children and adolescents. Recent studies have found that, when following the standard of care for diagnosing gender dysphoria, the rate of "desistance" for transgender adolescents who are properly diagnosed, evaluated, and treated is virtually nonexistent.

23. A significant proportion of transgender children do not have the ability to clearly understand, state or share the distress they are experiencing. Those children can experience a wide range of psychological distress from difficulty

sleeping to anxiety at school or severe depression and may not fully realize that this distress is linked to being transgender. Over time, their inability to understand the root of their distress and/or to express themselves further exacerbates their psychological distress.

24. Yet another significant proportion of young transgender children may have had an underlying feeling of not fully aligning with the sex they were assigned at birth, but felt "good enough" being supported and perceived as a female identified as a tomboy or a feminine presenting gay male. However, as puberty starts and a young person begins to experience the physical changes associated with their birth sex including developing secondary-sex characteristics (*e.g.*, breast development, menstruation, testicular and penile expansion, and deepening of voice) these youth experience intense distress that cannot be explained as simply being upset about puberty. That distress is caused by gender dysphoria, which is exacerbated by puberty for youth who are transgender, not simply gender nonconforming. These youth share a strong and real awareness of their gender identity not as a female identified as a tomboy, but as male, and not as a feminine male, but a female.

25. Gender Dysphoria is the diagnosis characterized by the severe and unremitting emotional pain resulting from the incongruity between a person's assigned sex and their gender identity. It is a serious condition and is listed in the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5") of the American

Psychiatric Association and has been for decades. Because Gender Dysphoria also has significant implications for a transgender young person's physical health that require medical care, there is also a companion diagnosis in the World Health Organization's International Classification of Diseases (ICD-10). Major medical and behavioral health associations recognize the validity and seriousness of the condition of gender dysphoria and support its treatment consistent with established standards of care. These include the American Medical Association, the Endocrine Society, the American Academy of Pediatrics, the American Psychological Association, the American Psychiatric Association, National Association of Social Workers, and others.

Standards of Care for Working with Transgender Children

26. When loved, supported, and treated consistent with their gender identity by their parents and caretakers and in their social, medical and educational environments, transgender children—like all children—can thrive, grow into healthy adults and have the same capacity for happiness, achievement, and contribution to society as others. For transgender children and youth, that means supporting them to live in a manner consistent with their gender identity.

27. Getting treatment for Gender Dysphoria and ensuring that a transgender child is in an environment that does not undermine that treatment are critical to a transgender child's healthy development and well-being. For young transgender

children, the treatment of Gender Dysphoria consists of social transition, which involves changes that bring the child's outer appearance and lived experience into alignment with the child's gender identity. Changes often associated with a social transition include changes in clothing, name, pronouns, hairstyle, and updating government-issued identity documents to reflect the child's new name and correct the sex listed on those documents so that others interact with them in a manner that affirms and supports their gender identity.

28. Research and clinical experience have shown that social transition for a child with Gender Dysphoria improves that child's mental health and greatly reduces the risk that the child will experience anxiety, depression and possibly engage in self-harming behaviors. *See Kristina Olson, et al., Mental Health of Transgender Children who are Supported in Their Identities*, 137 Pediatrics 1 (2016). In fact, longitudinal studies demonstrate that undergoing a social transition before puberty often provides tremendous and immediate relief because there are few, if any, observable physical differences between boys and girls at that age.

29. A social transition is often eventually coupled with other treatments for Gender Dysphoria once a young person enters adolescence including puberty blockers and hormone therapy to bring a person's body into alignment with their gender identity. The availability and effects of those treatments are discussed in detail in Dr. Rosenthal's declaration. (Dr. Rosenthal Decl. ¶¶ 32-55.) As with social

transition those treatments occur within a context of treatment and assessment by qualified professionals, often in a single multidisciplinary setting meaning that a patient's multiple providers (endocrine, primary care, mental health specialist) all work in consultation and coordination with one another to provide care for the patient.

30. Mental health counseling can have a tremendous positive effect on a patient's mental health. Not only can counseling reduce a young person's psychological distress, but it can help reduce their reliance on harmful coping strategies, if not replace them all together. I have seen many patients make significant progress through counseling to address many, but not all, areas of distress a transgender child or youth may be experiencing with their own identity as well as coping with how others around them may be reacting to their transgender identity.

31. For transgender young people approaching or going through puberty, however, counseling by itself is not sufficient to fully manage their Gender Dysphoria. The physical changes associated with puberty greatly exacerbate a transgender young person's psychological distress because their bodies are becoming more incongruent with their gender identity every day. More importantly, counseling is unable to stop those changes from occurring, nor can it help bring a patient's body into alignment with their gender identity. For many transgender youth, medical care is crucial and vital for survival.

The Role of Mental Health Providers in Assessing Necessity of Medical Treatments for Gender Dysphoria

32. When a child or adolescent experiencing Gender Dysphoria starts to see a mental health provider such as myself, that provider's first objective is assessment, including diagnosis. As with any assessment, the provider must gather a detailed history of the patient and their psychological distress surrounding their gender identity, including its sources and manifestations. To appropriately conduct that assessment, the mental health provider must draw from their professional training and experience in working with transgender young people, exercise professional judgment, and tailor the assessment to each individual patient and their family. The number of sessions that assessment requires will vary greatly depending on the patient's presentation and the complexity of the issues the patient is navigating.

33. In addition to meeting with the patient and family, this assessment process typically includes gathering and reviewing additional information from the child's Primary Care Provider, local therapist and psychiatrist and any additional adult professionals who are part of the patient's care team. Without this thorough and comprehensive assessment, a mental health provider could not accurately diagnose a patient with Gender Dysphoria and provide the recommendations for treatment and care.

34. Once the mental health provider has confirmed that the patient is experiencing Gender Dysphoria, the provider develops a treatment plan, which can

include referrals to medical providers for treatments like puberty-blocking medications and hormone therapy.

35. Over the course of their initial assessment—and subsequent treatment—mental health providers will engage their patients in many discussions about the aspects of the patient's life and appearance that exacerbate their Gender Dysphoria. The purpose of those conversations is two-fold: identify the areas where the patient needs to develop resilience and coping strategies to minimize the effects of their Gender Dysphoria; and evaluate the mental health benefits of future social changes and medical treatment. For example, those discussions may reveal that a transgender patient's distress about the onset of puberty is impairing their ability to engage in peer relationships or routine self-care (*e.g.*, avoiding showering), as well as impairing their ability to focus at school. The mental health provider can then work with the patient to develop psychological and social strategies to reducing the functional limitations caused by the Gender Dysphoria. While this level of care can prove fully beneficial for some young people diagnosed with Gender Dysphoria, in other cases the treatment plan strongly indicates that puberty-blocking medications is necessary to prevent that patient's mental health from deteriorating at the onset of puberty.

36. If the patient and their family decide to pursue medical treatment, the mental health provider will build on those discussions to also assess the patient's

appropriateness and readiness for that treatment. As mentioned above, the appropriateness of any medical treatment is determined by a multidisciplinary team of expert mental and medical care providers. A patient's readiness to begin a particular course of medical treatment requires an evaluation of the patient's understanding of the goals and potential limitations of the contemplated treatment. For example, for puberty-blocking medication, the provider will gauge the patient's ability to comprehend the effects of puberty on their body and mental health. An integral part of that discussion is evaluating a patient's grasp of the consequences of stopping those physical changes from occurring and alternatives to puberty-blocking treatment. And, in cases of the addition of hormone therapy in adolescence, the review of physical impact, including benefits and limitations, is explored over multiple meetings with the patient and parents.[1] The provider will have those discussions with the patient and their parents both individually and together. As with the initial diagnosis, the amount of time required to complete this evaluation will depend on numerous factors including the length of their existing therapist-patient relationship and the complexity of the issues facing that patient.

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[1] *See, e.g., "This Wasn't a Split-Second Decision": An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy*, Clark, BA, Bioethical Inquiry (2021) https://doi.org/10.1007/s11673-020-10086-9.

37. The mental health provider will then document the results of their assessment in a letter to the patient's treating physician. The letter details the provider's diagnostic analysis as well as any professional opinions regarding the benefits of and readiness for the contemplated treatment. The medical provider uses that letter as one piece of their own independent assessment. It is not uncommon for a medical provider to contact the patient's mental health provider to discuss the details of the letter.

Medical Treatment for Gender Dysphoria is Critical to the Mental Health of Transgender Youth

38. Scientific literature and clinical experience consistently find that, like social transition, medical treatment for Gender Dysphoria offers significant psychological benefit to transgender young people. For example, one longitudinal study found that transgender young adults who received the full range of medical and mental health treatments for their gender dysphoria had a mental health profile that was indistinguishable from their non-transgender peers. Annelou L.C. de Vries, et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014). Medical treatments for gender dysphoria are effective because they keep a transgender person's body in alignment with their gender identity, either by stopping that incongruence from growing or by changing the person's body to be more congruent with their gender identity, which in turn help reduce a person's Gender Dysphoria.

39. Conversely, however, the denial of medical treatment will severely hinder a transgender young person's development and well-being. Even if not initially visible to the public, the physical changes associated with puberty widen the incongruence between a transgender young person's body and their gender identity. The permanence of those physical changes can result in distress that is significant and acute because the changes brought on by puberty become constant triggers for Gender Dysphoria, such as monthly menstruation, chest development, deepening of voice and unwanted erections.

40. As puberty progresses, those physical changes become more obvious and will undermine a transgender young person's ability to live in a manner consistent with their gender identity. Their appearance will cause them to be repeatedly referred to by their birth sex, which is different than their gender identity. The incongruence between their gender identity and appearance will also subject them to ridicule, harassment, and discrimination. In either situation, a transgender young person will experience that mistreatment as a rejection of their core self and identity, which will further exacerbate their Gender Dysphoria.

41. If left unaddressed, as under the wait-and-see approach, a transgender young person is likely to develop co-occurring mental health conditions, such as major depression, anxiety or obsessive-compulsive disorders, eating disorders, self-harm, and thoughts of suicide. Transgender young people can also experience

difficulties focusing on schoolwork, building and maintaining friendships, among other serious functional limitations.

42. Those harms are exponentially compounded for a transgender young person living at the intersection of minority identities based on the layered ways in which peers and adults can stigmatize identified differences in race, ethnicity, religion/faith and socioeconomic status. Multiply marginalized children and youth face vastly higher levels of anxiety and depression that are more likely to lead to self-harm and even death by suicide. In the last few years, as individuals in these multiply marginalized communities are coming under direct and indirect attack from political and religious groups, these children are becoming gravely aware that they are not safe in their own neighborhoods and are constantly exposed to negative messages that profoundly state that they do not matter, are not important parts of our community, and otherwise do not belong.

43. Chronic exposure to those levels of sustained stress results in persistent surges of cortisol in the brain for children and youth. This leads to a wide array of short and long-term detrimental consequences, all of which can permanently affect development, emotional, physical and mental health, and quality of life. For example, research has shown that it leads to increased difficulty in differentiating between threatening and safe situations, impaired short-term and long-term memory, struggles with decision-making and attention, and issues with mood control, even in

adulthood. Studies have also shown that chronic stress in childhood and adolescence results in a higher likelihood of developing a myriad of physical health issues, including diabetes, heart disease, and cancer.

44. Once an area of clear and consistent stress and distress has been identified for any child, it should be addressed in a way that provides clear, consistent and safe relief. This is vital based on the research on both the negative health impact of chronic stress/distress on human bodies as well as the clear, safe and consistent guidelines for relieving this stress and distress for transgender children and youth.

Conclusion

45. Criminalizing the provision of medical treatment for Gender Dysphoria will inflict immeasurable harm on transgender young people throughout Alabama that will have long-lasting implications for the mental health of this already vulnerable population and the many family members who support them. Transgender young people will have proven effective, life sustaining medical care dangerously delayed between five and ten years to obtain what are considered time-sensitive medical treatments for gender dysphoria. Not only will their mental health decompensate during that time, but their ability to treat and manage their Gender Dysphoria will be greatly diminished with some body changes being irreversible. For many transgender children, the inability to access essential time-sensitive medical treatment will result in irreparable damage to their physical and

psychological health.

46. Those harms will significantly compound the inability of transgender young people to live in a manner consistent with their gender identity due to body changes that negate their ability to keep private, for those who wish to do so, the deeply personal fact that they are transgender. Additionally, the social and educational harms resulting from profound and debilitating bullying and harassment of transgender children in local social settings (clubs, sports, after school programs, churches) and school settings will frequently result in out of school placements, online schooling and/or complete removal from academic efforts overall. All of these negative outcomes in childhood have far-reaching and exponentially impacting effects on overall health and wellbeing, typically resulting in a significant increase in anxiety, depression, self-harm and death by suicide.

47. Despite claiming to protect transgender children, the Act will have the exact opposite effect.

This declaration was executed this 17th day of April, 2022.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Linda Hawkins, Ph.D., M.S.Ed., LPC

EXHIBIT 3

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

Civil Action No.
2:22-cv-184-LCB

DECLARATION OF STEPHEN ROSENTHAL, MD, IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Stephen M. Rosenthal, M.D., declare as follows:

1. I submit this expert declaration based upon my personal knowledge.

2. If called to testify in this matter, I would testify truthfully based on my expert opinion.

Qualifications and Experience

3. I am a pediatric endocrinologist and have been practicing medicine for over forty years. I received my medical degree from Columbia University, College of Physicians & Surgeons, in 1976, and completed a residency in Pediatrics there. I also completed a fellowship in Pediatric Endocrinology at the University of California, San Francisco ("UCSF").

4. In 2012, I co-founded the Child & Adolescent Gender Center ("CAGC") at UCSF. I am the Medical Director at the Center, as well as a Professor of Clinical Pediatrics at UCSF. A true and correct copy of my Curriculum Vitae is attached hereto as **Exhibit A**.

5. The Child and Adolescent Gender Center (CAGC) is a multidisciplinary program that provides comprehensive medical and mental health care, as well as education and advocacy services for transgender youth and adolescents. Since 2012, the CAGC has seen close to 2,000 transgender young people with gender dysphoria, with an average of 15-20 new patients per month, ranging in age from 3 to 25 years old. As Medical Director of the CAGC, I oversee

the medical portion of the multidisciplinary program, which currently includes two other physicians, a doctor of nursing practice, one psychologist, a clinical social worker, nursing, and administrative staff.

6. As of the date of this declaration, I have published 27 scientific research papers in leading peer-reviewed medical journals and authored seven chapters in authoritative textbooks on the topic of medical treatment for gender dysphoria in children and adolescents. Those publications include "Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View," published in Nature Reviews Endocrinology[1] on August 10, 2021, "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," a guide detailing the standard of medical care for gender dysphoria, and a chapter in the forthcoming standards of care being developed by WPATH. A listing of my publications is included in my Curriculum Vitae in **Exhibit A**.

7. I am also actively serving as a Principal Investigator or Co-Investigator on numerous research projects on the physical and mental health of transgender young people, including a national multi-site study on medical care for transgender young people funded by the NIH.

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[1] Nature Reviews Endocrinology received an impact factor of 43.33 for the 2021-2022 publication year.

8. I am a member and recent past president (2016-2017) of the Pediatric Endocrine Society and, as of March, 2021, have just completed a three-year term as a member of the Board of Directors for the Endocrine Society, and one-year term as Endocrine Society Vice President, Clinical Scientist Position. I am also an elected member of the Board of Directors of the World Professional Association for Transgender Health ("WPATH"), an international multidisciplinary professional association founded in 1979 to promote evidence-based care, education, research, advocacy, public policy and respect in transgender health. A complete list of my professional associations is included in my Curriculum Vitae in **Exhibit A**.

9. In addition to my work with transgender children and adolescents, I have treated children and adolescents with differences of sex development ("DSD"), commonly referred to as intersex conditions, as well as with a variety of other endocrine conditions, including growth disorders, pubertal disorders, and diabetes. I previously served as Program Director for Pediatric Endocrinology, Director of the Endocrine Clinics, and Co-Director of the Disorders of Sex Development Clinic, a multi-disciplinary program involving pediatric endocrinology, pediatric urology, psychiatry, and social work at UCSF Benioff Children's Hospital.

10. My opinions contained in this declaration are based on: (i) my clinical experience as a pediatric endocrinologist treating transgender patients, including adolescents and young adults; (ii) my knowledge of the peer-reviewed research,

including my own, regarding the treatment of gender dysphoria, which reflects the clinical advancements in the field of transgender health; and (iii) my review of the expert declaration of Linda A. Hawkins, Ph.D., M.S.Ed., LPC ("Dr. Hawkins Decl.") submitted in support of the motions. I generally rely on these types of materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this declaration. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

11. I was provided with and reviewed the following case-specific materials: the Dr. Hawkins Decl.

12. In the past four years, I have not provided expert testimony.

13. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of $350 per hour for any review of records, preparation of reports or declarations. I will be compensated with a day rate (6 hours) of $2,100 for deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

Scientific and Medical Understanding of Sex

14. By the beginning of the twentieth century, scientific research had established that external genitalia alone are not always an accurate indicator of a person's sex. Instead, a person's sex is comprised of several components, including,

among others, internal reproductive organs, external genitalia, chromosomes, hormones, gender identity, and secondary-sex characteristics. Diversity and incongruence in these components of a person's sex are a naturally occurring source of human biological diversity.

15. Scientific research and medical literature across disciplines demonstrate each component of sex has strong biological ties, including gender identity. For example, there are numerous studies detailing similarities in the brain structure and function of transgender and nontransgender people with the same gender identity. In one such study, the volume of the bed nucleus of the stria terminalis (a collection of cells in the central brain) in transgender women was equivalent to the volume found in nontransgender women. There are also studies highlighting the genetic components of gender identity. A study of identical twins found that if one twin was transgender that the other twin was far more likely to be transgender, as compared to the general population.

16. The above studies are representative examples of the growing body of scientific research and medical literature in this area of study. There is also ongoing research on the effects of the hormonal milieu in utero, and genetic sources for gender identity, among others.

17. Although the specific determinants of gender identity remain unknown, treatment to bring a person's physical characteristics into alignment with their

gender identity is widely accepted as the standard in medical practice.

Determination of an Individual's Sex

18. At birth, newborns are assigned a sex, either male or female, typically based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate and their assigned sex matches that person's gender identity. However, for transgender people, their assigned sex does not align with their gender identity. This lack of alignment can create significant distress for transgender individuals.

19. When there is a divergence between these factors, medical science and the well-established standards of care recognize that treating a person consistent with their gender identity—and prescribing medical treatment to align their body with their gender identity—is essential to that person's health and wellbeing.

20. Gender identity is a person's inner sense of belonging to a particular gender, such as male or female. It is a deeply felt and core component of human identity. Everyone has a gender identity. Children usually become aware of their gender identity early in life.

21. A person's gender identity is innate, cannot be voluntarily changed, and is not undermined by the existence of other sex-related characteristics that do not align with it.

22. Any attempts to "cure" transgender individuals by forcing their gender

identity into alignment with their assigned sex are harmful, dangerous, and ineffective. Those practices have been denounced as unethical by all major professional associations of medical and mental health professionals, such as WPATH, the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association.

23. For more than four decades, the goal of medical treatment for transgender patients has been to alleviate their distress by bringing their lives into closer alignment with their gender identity. The specific treatments prescribed are based on individualized assessment conducted by medical providers in consultation with the patient's treating mental health provider. As discussed in more detail in the following section, and in the declaration of Dr. Hawkins, research and clinical experience have consistently shown those treatments to be safe, effective, and critical to the health and well-being of transgender patients.

Standards of Care for the Treatment of Gender Dysphoria

24. Due to the incongruence between their assigned sex and gender identity, transgender people experience varying degrees of "gender dysphoria," a serious condition listed in both the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") and the World Health Organization's International Classification of Diseases ("ICD-10"), and has been

recognized as such for decades. It is a condition that affects a small percentage of youth and adults.

25. Gender dysphoria is the diagnostic term for the clinically significant distress resulting from the incongruence between a person's gender identity and the sex they are assigned at birth. In order to be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment.

26. Gender dysphoria is highly treatable and can be effectively managed. If left untreated, however, it can result in severe anxiety and depression, self-harm, and suicidality. Spack NP, Edwards-Leeper L, Feldmain HA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012; 129(3):418-425. Olson KR, Durwood L, DeMeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. *Pediatrics*. 2016; 137:1-8.

27. The prevailing standards of care for the treatment of gender dysphoria are developed by WPATH, which has been recognized as the standard-setting organization for the treatment of gender dysphoria for more than forty years.

28. The Endocrine Society is a 100-year-old global membership organization representing professionals in the field of adult and pediatric endocrinology. In 2017, the Endocrine Society published its second clinical practice

guidelines on treatment recommendations for the medical management of gender dysphoria, in collaboration with Pediatric Endocrine Society, the European Societies for Endocrinology and Pediatric Endocrinology, and WPATH, among others. Hembree WC, Rosenthal SM, et al. Endocrine Treatment of Gender Dysphoria/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab* 2017; 102: 3869–3903.

29. Together, the SOC and the Endocrine Society's clinical practice guidelines constitute the prevailing standards guiding the healthcare and treatment of gender dysphoria. The process for writing those standard-setting documents followed well-established methods for developing standards of care, beginning with the convening a core group of experts in the relevant field(s) who are tasked with conducting a comprehensive literature review and preparing a draft document. That draft is then circulated to a larger cross-section of practitioners in the relevant field(s) for review and comment, much like the peer-review process for journals. Those edits and comments are incorporated and compiled into a final document that is reviewed and ratified in a manner consistent with the organization's bylaws. As a result, the SOC and the Endocrine Society's clinical practice guidelines reflect the consensus of experts in the field of transgender medicine, based on the best available science and clinical experience.

30. The major professional associations of medical and mental health providers in the United States, including the American Medical Association, American Academy of Pediatrics, American Psychiatric Association, American Psychological Association, and Pediatric Endocrine Society, treat those documents as the prevailing standards guiding the healthcare and treatment of gender dysphoria.

31. Those documents help ensure that healthcare providers, especially those unfamiliar with transgender medicine, know which treatments are safe and effective for the treatment of gender dysphoria, and are able to deliver that necessary medical care to maximize their patients' overall health and wellbeing.

Transition and Medical Treatments for Gender Dysphoria

32. Undergoing treatment to alleviate gender dysphoria is commonly referred to as a transition. The transition process typically includes one or more of the following three components: (i) social transition, including adopting a new name, pronouns, appearance, and clothing, and correcting identity documents; (ii) medical transition, including puberty-delaying medication and hormone-replacement therapy; and (iii) surgical transition, including surgeries to alter the appearance and functioning of primary- and secondary-sex characteristics.

33. The steps that make up a person's transition will depend on that individual's medical and mental health needs, as well as the person's stage of pubertal development.

34. Dr. Hawkins provides an extensive discussion of social transition in her expert declaration. (Dr. Hawkins Decl. at ¶¶ 26–31.) My declaration will discuss the medications and surgical care used to treat gender dysphoria.

35. There are no drug interventions for gender dysphoria until after the onset of puberty. Medical providers evaluate a patient's level of pubertal development through a physical examination and testing the hormone levels in the patient's blood. Once a provider has determined that a transgender patient has begun puberty, the patient may be prescribed puberty-blocking medications.

36. Those medications work by temporarily pausing endogenous puberty and, therefore, limiting the influence of a person's endogenous sex hormones on their body. For example, a transgender girl (someone designated male at birth with a female gender identity) will experience no progression of physical changes caused by testosterone, including facial and body hair, an Adam's apple, a deepened voice, or masculinized facial structures. And in a transgender boy (someone designated female at birth with a male gender identity), those medications would prevent progression of breast development, menstruation, and widening of the hips. This prevents a transgender adolescent from experiencing the severe psychological distress of developing permanent, unwanted physical characteristics that do not align with the adolescent's gender identity.

37. Temporarily halting a transgender adolescent's pubertal development can also obviate the need for future surgical treatments to address any ongoing gender dysphoria. Avoiding the scarring associated with surgery—and the added stresses of surgery itself—further improve a transgender person's overall health and wellbeing.

38. A transgender adolescent will remain on those puberty-blocking medications until their providers determine, in consultation with the patient, the patient's family, and consistent with the prevailing standards of care, whether additional medical treatment is necessary to treat their gender dysphoria. If the decision is to stop taking puberty blockers, the patient's endogenous puberty will resume.

39. For many transgender youth, it is medically necessary for them to begin hormone-replacement therapy with either testosterone or estrogen. That treatment induces the physical changes of the puberty associated with the patient's gender identity. The result of this treatment is that a transgender boy has the same typical levels of circulating testosterone as his nontransgender male peers. Similarly, a transgender girl will have the same typical levels of circulating estrogen as her nontransgender female peers. Those hormones cause transgender adolescents to undergo the same significant and permanent sex-specific physical changes as their nontransgender peers. For example, a transgender boy will develop a lower voice as

well as facial and body hair, while a transgender girl will experience breast growth, female fat distribution, and softer skin.

40. If a transgender youth who is on puberty blockers and hormone-replacement therapy ceases these medications, the production of endogenous hormones and puberty consistent with the individual's birth sex will resume.

41. Puberty-delaying medication and hormone-replacement therapy—both individually and in combination—also significantly improve a transgender young person's mental health because those medications ensure their physical appearance more closely aligns with their gender identity. This also decreases the likelihood that a transgender young person will be incorrectly identified with their birth sex, further alleviating their gender dysphoria and bolstering the effectiveness of their social transition.

42. The puberty-delaying medications that are used for treating transgender children are the same medications that have been used for decades and are continued to be used to treat a condition in children often referred to as "precocious puberty," a condition that causes a child's body to begin pubertal development too early. In other words, the hormone therapy used to treat transgender adolescents is often used to treat non-transgender adolescents for other medical reasons.

43. Social transition and hormone therapy are often sufficient to treat gender dysphoria for many transgender people.

44. Based on my clinical experience, there are transgender young people for whom getting on puberty blockers and hormones before the age of majority will reduce the likelihood of their needing surgical intervention later in life relating to gender dysphoria.

45. Further, recent studies have observed findings that gender-affirming hormone therapy usage is significantly related to lower rates of depression and suicidality among transgender youth. Green AE et al. Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *J Adolescent Health* 1-7 (2021); Turban JL et al. Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. PLoS ONE 17(1) 2021; https://doi.org/10.1371/journal. pone.0261039.

46. For transgender people who require surgery to treat their gender dysphoria, the SOC do not recommend surgical treatment until the age of majority, except for male chest reconstruction surgery. Like any other treatment, the medical necessity of surgical procedures to treat gender dysphoria is based on an individualized assessment of the patient's needs.

Assessing Medical Necessity of Medical Treatment for Gender Dysphoria

47. As with the initial diagnosis of gender dysphoria, determining whether a particular treatment is medically necessary for a transgender patient follows a

thorough, well-established process that requires healthcare providers to exercise professional judgment. Contrary to what some believe, prescriptions for puberty-blocking medication and hormone-replacement or referrals for surgery are not made on a whim. Every step of a transgender patient's treatment and care is planned out in consultation with the patient's care team, which includes both medical and mental health providers.

48. Prior to considering starting a course of puberty-blockers or hormone-replacement therapy, a transgender patient undergoes an extensive assessment by a mental health provider. The purpose of that assessment is three-fold: (1) obtaining a complete picture of the patient's mental health, including whether the patient has gender dysphoria; (2) determine the patient's psychological readiness to begin the contemplated treatment; and (3) provide the patient and their family the information they need to make an informed decision about whether to proceed with the treatment. If, after that assessment, the mental health provider determines that the patient should be considered for the contemplated treatment, that professional opinion is documented in a letter to the patient's medical provider.

49. The medical provider then conducts their own separate assessment of the patient, including a physical examination and any necessary laboratory testing. In addition to determining the medical necessity of the contemplated treatment and a patient's medical readiness for that treatment, the medical provider will also

discuss the risks, benefits, and alternatives for the contemplated treatment. Medical providers also discuss with parents that the medications are being prescribed for an off-label use, which is particularly common for medications being used in pediatric patients. That discussion occurs with the patient and their family to ensure that everyone involved in the decision-making process has the information they need to make an informed decision.

50. Once the medical provider has finished addressing any questions or concerns raised by the patient and family, the parents/legal guardians and the patient are provided with a detailed informed consent/assent form that outlines in writing the information the medical provider reviewed with them. The patient and family are encouraged to carefully review that paperwork and sign if they choose to consent/assent to treatment.

51. It is only at the end of that intensive assessment and informed-consent process that a patient is prescribed a particular medical treatment for gender dysphoria.

Medical Treatment for Gender Dysphoria is Evidence-Based Medicine

52. Research and clinical experience repeatedly reaffirm that transition significantly improves the mental and physical health of transgender young people.

53. This is true of each stage of a transgender young person's transition. Transgender young people who underwent a social transition in childhood

demonstrated better mental health profiles than prior studies of gender nonconforming children. *See* Lily Durwood, et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. of Child & Adol. Psychiatry 116 (2017); Kristina Olson, et al., *Mental Health of Transgender Children who are Supported in Their Identities*, 137 Pediatrics 1 (2016). This same outcome has also been seen in a longitudinal study of transgender young people who underwent each of the three stages of transition outlined above. Annelou L.C. de Vries, et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014). In a study specifically about male chest reconstruction surgery, post-operative transgender young people demonstrated significant psychological and functional improvements, from a greater willingness to plan for their future and to engage activities of daily living (e.g., bathing, buying clothing). Johanna Olson-Kennedy, et al., *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and Postsurgical Cohorts*, 172 JAMA Pediatrics 431, 434 (2018)

54. Transition also can—and often does—alleviate co-occurring mental health issues a transgender young person experienced prior to transition. Following transition, transgender young people typically see significant improvements in functioning and quality of life. Treating their gender dysphoria also increases a

transgender young person's capacity to develop and maintain better coping strategies to manage any co-occurring conditions.

55. Conversely, delaying or denying transgender young people safe and effective treatment for gender dysphoria—as contemplated by the wait-and-see approach—can have severe consequences on their physical and mental health. Without those medically necessary treatments, transgender young people are likely to develop serious co-occurring mental health conditions (*i.e.* anxiety, depression, suicidality) that will interfere with their ability to learn and impede their psychosocial development.

Conclusion

56. Alabama's law criminalizing the provision of medical treatment for gender dysphoria is contrary to well-established standards of care, peer-reviewed medical literature, and clinical experience. Medical care for transgender young people in Alabama would be guided by fear of criminal penalty, forcing medical providers to abandon their professional and ethical obligations to follow the prevailing standards of care when treating patients with gender dysphoria.

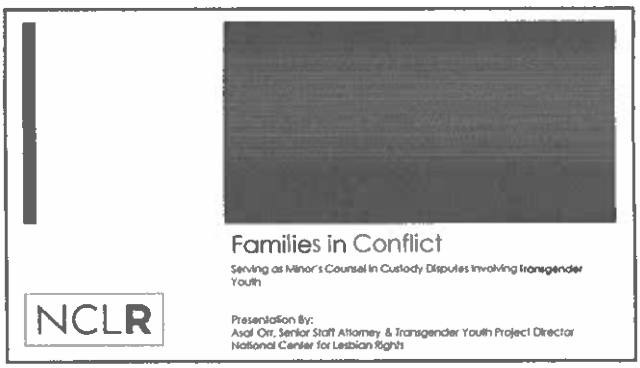
57. Contrary to its stated purpose, this bill will endanger the health and wellbeing of transgender young people experiencing gender dysphoria by creating significant barriers to their receiving medically necessary care. The lack of access to

that time-sensitive care will have lifelong implications for their quality of life and their ability to effectively treat their gender dysphoria.

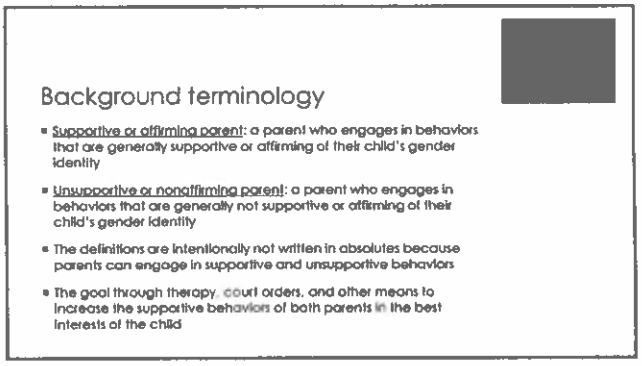
This declaration was executed this 19th day of April, 2022.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

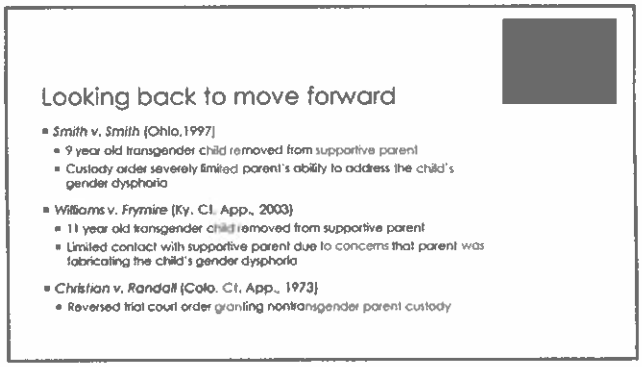
By: Stephen M. Rosenthal
Stephen M. Rosenthal, M.D.


Families in Conflict
Serving as Minor's Counsel in Custody Disputes Involving Transgender Youth
NCLR
Presentation By:
Asaf Orr, Senior Staff Attorney & Transgender Youth Project Director
National Center for Lesbian Rights

1


Background terminology
Supportive or affirming parent: a parent who engages in behaviors that are generally supportive or affirming of their child's gender identity
Unsupportive or nonaffirming parent: a parent who engages in behaviors that are generally not supportive or affirming of their child's gender identity
The definitions are intentionally not written in absolutes because parents can engage in supportive and unsupportive behaviors
The goal through therapy, court orders, and other means to increase the supportive behaviors of both parents in the best interests of the child

2


Looking back to move forward
Smith v. Smith (Ohio, 1997)
9 year old transgender child removed from supportive parent
Custody order severely limited parent's ability to address the child's gender dysphoria
Williams v. Frymire (Ky. Ct. App., 2003)
11 year old transgender child removed from supportive parent
Limited contact with supportive parent due to concerns that parent was fabricating the child's gender dysphoria
Christian v. Randall (Colo. Ct. App., 1973)
Reversed trial court order granting nontransgender parent custody

3

Lessons learned from *Smith* & *Frymire* (and others)

- "Common sense" is no longer common or sensical
- Conflict between parents confuses causation
- Fear and unfamiliarity results in presumptions made against the supportive parent

4

Distinguishing *Smith*, *Frymire*, and others

- Medical literature on transgender youth has grown significantly
- The standards of care have become widely accepted and used throughout the United States
- There has been a massive cultural shift in publicly available information about and in attitudes towards transgender youth

5

Trends in recent cases

- Although there are not published opinions, courts are granting (limited) decision-making authority to the supportive parent
- Courts are excluding expert witnesses that express fringe opinions about gender dysphoria or transgender people
- Courts are finding in favor of transgender youth on other issues such as name changes and restroom access
- Nonsupportive parents are settling disputes around blockers, which opens the potential for increasing family acceptance
- These are still just trends and there are cases where courts rule in favor of unsupportive parents

6

Implicit biases about transgender youth

Common evidentiary traps that arise in custody litigation involving transgender children

7

Children are too young to know

- Medical literature strongly suggests there is a biological basis to gender identity
- The American Psychiatric Association recognizes that children become aware of their gender identity between 2-4 years old
- Studies show that the gender identities of transgender and nontransgender children are indistinguishable
- Studies and anecdotal evidence demonstrate that social transition has tremendous benefits for transgender children
- No pharmacological or surgical treatments are appropriate in childhood

8

The Persister-Desister Dichotomy

- Persisters: a term referring to children who were diagnosed with gender dysphoria in childhood and continue to assert a transgender identity into adolescence
- Studies have reported a wide persistence rate, ranging from 2-50%
- Those studies are unreliable and irrelevant
  - Methodology used to calculate those rates depressed persistence rates
  - Diagnostic criteria swept too broadly, including nontransgender children
  - Study was not designed to assess treatment options
- Subsequent studies helped hone the diagnostic criteria to focus on consistent, insistent, and persistent assertions of gender identity

9

The Persister-Desister Dichotomy (cont'd)

- Scientific literature and anecdotal evidence demonstrate that transgender young people thrive when they receive social supports and able to access treatment for gender dysphoria
- This dichotomy has been used to perpetuate the use of sexual orientation and gender identity change efforts, commonly referred to as "conversion therapy," a discredited and dangerous practice
- More fundamentally, those categories are inconsistent with the literature regarding the importance of family acceptance—and the harms of family rejection

10

Being transgender is a phase or trend

- Even beyond childhood, many challenge the veracity of an adolescent asserting that they are transgender
- Although a young person may become aware of their gender identity early in life, there are many factors that influence whether they disclose that information to others
- Being transgender is not "what all the cool kids are doing"
  - Transgender youth experience high levels of family rejection
  - Studies show that many transgender youth do not feel safe at school due to bullying and harassment
  - Discrimination against transgender people can have other short- and long-term consequences

11

Rapid Onset Gender Dysphoria

- This is NOT a real diagnosis or type of gender dysphoria
- Refers to young people who disclose that they are transgender in adolescence, but the parents had not noticed any previous signs that—in the minds of the parent—corroborate the disclosure
- A recent journal article attempted to support ROGD as real phenomenon, but instead showed:
  - Parents have a lot of fears and anxiety about their child identifying as transgender, especially when it feels "out of the blue"
  - Assessing and treating gender dysphoria in young people requires skill and expertise—it is not a rubber stamp
  - Serious methodological flaws often used to perpetuate misinformation about transgender people

12

The supportive parent is to blame

- This misconception can arise in direct and indirect ways
  - Accusations or claims that the other parent is engaging in parental alienation or has factitious disorder by proxy
  - Allegations that the child is not transgender in the nonsupportive parent's home
  - Or, allegations the supportive parent's behavior is pressuring the child to continue asserting a transgender identity
- A recent study found that children who transitioned for longer periods of time did not show stronger or weaker identities or preferences than youth who transitioned more recently
- There is no evidence that parents can influence a child to be transgender

13

Treatment for gender dysphoria is "experimental"

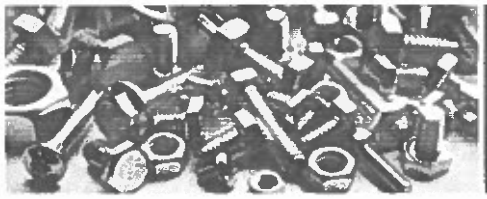
- The World Professional Association for Transgender Health has promulgated standards of care since 1979
- The current version of the standards of care (version 7) has been adopted by every major professional association of medical and mental health providers in the United States
- Transition-related care is the only safe and effective treatment for gender dysphoria
- Likewise, the harms of denying or delaying care are well-documented

14

Treatment for gender dysphoria is ineffective

- This misconception can appear in many different forms
- Some may claim that transgender people are experiencing delusional thinking, thus transition-related care can't treat the issue
  - A common refrain is: "We don't use liposuction to treat anorexia."
  - This is inconsistent with the DSM-5 published by the American Psychiatric Association and decades of medical research
- The more likely claim is that there are studies showing poor health outcomes for transgender adults, despite transition-related care
  - This claim conflates correlation and causation and ignores limitations in study design
  - There are a significant number of studies demonstrating the benefits of transition-related care

15



How to represent a child as Minor's Counsel in a custody dispute

16

Understanding a parent's pre-filing conduct

- Supportive parents will often have taken some steps to support their child prior to seeking the advice of an attorney
- This could range from using a different name for the child or allowing them to wear clothing typically associated with another gender than the child's sex assigned at birth
- Absent extenuating circumstances, those actions should not be seen as unilateral decision-making
  - Those decisions/actions are typically made in a crisis situation or seem totally innocuous at the time to not register as a decision warranting input from the child's other parent
  - Those decision/actions are based on the parent's love and concern for the child, and desire to protect them

17

All sides are approaching this situation from a place of love

- Even unsupportive parents are acting out of love for their child (except in very rare situations)
- Acknowledging that love can help reduce tensions between the parents
- Encourage the unsupportive parent to
  - Find small ways they can be supportive
  - Speak with their child's healthcare providers about their concerns
  - Discuss their fears and reservations with the child's other parent
  - Seek educational resources
- Help parents see beyond the biases created by the instant conflict

18

Allowing healthcare providers to lead

- Unsupportive parents will often consent to their child seeing providers that have experience treating children with gender dysphoria
- Bringing in a new provider can:
  - Add a neutral third-party healthcare provider that both parents can trust and may ease tensions
  - Provide timely needed healthcare for the child
  - Create opportunities for parents to ask questions
- The provider should be encouraged to follow up with the parents in writing and outline their professional opinion regarding treatment for the child

19

Pursue amicable resolution

- Never assume that settlement is not possible
- Settlement can be a good and efficient way to ensure that the child gets the treatment they need without resorting to the expense and uncertainty of litigation
- If a global settlement is not possible, attempt to settle some legal issues or agree to a time-limited stay/settlement
- These measure can help a unsupportive parent see the benefits of transition-related care, which often fosters family acceptance, improves the parent-child relationship, and avoids future litigation

20

Keeping a "child centered" strategy

- The child's providers are all following the child's lead and exercising professional judgment in rendering opinions about diagnoses and treatment options
- The supportive parent is listening to their child and making informed decisions based on all the information
- The legal strategy must reflect that dynamic throughout
  - There are some time-sensitive treatments for gender dysphoria that may require seeking interim relief from the court
  - Puberty-delaying medications and hormone replacement therapy are the most common

21

Defining the child's "best interests"

- Gender dysphoria is a medical and mental health condition that may require specialized healthcare services
- Treatments for gender dysphoria are critical to ensuring that transgender youth thrive
- Supportive parents do not have a stake in their child's gender, but in ensuring their child is able to access medically necessary healthcare services
- Supportive parents are requesting the authority to make decisions based on the expert advice of the child's treating providers
- Supportive parents create a home environment that incorporates the expert advice of the child's treating providers

22

Laying the foundation

- Expert testimony is essential in custody disputes involving transgender youth
- Lawyers should assume that the Court knows nothing about transgender youth
  - Experts provide the Court with the background needed to apply the "best interests" analysis
  - Experts also help allay fears or concerns the Court may have about transgender youth generally, or about the child in your case specifically
- Having an expert will help the Court contextualize the supportive parent's thoughts and actions
- Helps to create a strong basis for an appeal

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Working with Custody Evaluators (and other professionals)

- Assume that professionals involved in the case are unfamiliar with transgender youth and that their initial instincts will not be positive
- Educate all relevant professionals about the needs of transgender youth
  - Have them communicate directly with the experts
  - Provide relevant articles and resources
  - Share information through in-person or phone conversations
- Do not to shame people for not knowing this information—misinformation about transgender youth is still widespread

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Common limitations in custody orders

Provisions to Consider

- Limitations on decision-making
  - Only medical decisions
  - Only gender dysphoria care
  - Decisions regarding hair cuts
- Limitations on conduct
  - Non-disparagement of child's attire
  - Use of correct name and pronouns
- Availability of & access to clothing
- Accessing services and resources

Provisions to Avoid

- Limitations on conduct
  - Prohibiting parents from talking about gender with the child
  - Restricting the child's clothing, name, or pronoun
- Provisions that will shame the child for being transgender
- No contact orders with supportive parent

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A Note on Religion

- Parents are entitled to practice their religion and impart those beliefs and practices on their children
- Some parents may claim their refusal to affirm their transgender child is rooted in deeply held religious beliefs
- In the context of custody disputes, the right to impart religious beliefs, and the First Amendment more generally, is not absolute
- Allowing a parent to take a child to a religious community that refuses to affirm that child's gender identity is not in the child's best interest and can be detrimental to the child's health and well-being

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Questions & Answers

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NCLR

Contact Information

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Attorney for minor children: Minor 1 and Minor 2

SUPERIOR COURT OF CALIFORNIA, COUNTY OF CONTRA COSTA

In Re Marriage of:

Petitioner: Mother

and

Respondent: Father

Case No. XXX-XXX

REPORT OF MINORS' COUNSEL

_____/

1. In the order appointing counsel for the children I was directed to take certain steps and to issue a report to the court. I have taken the following steps:

a. Read the pleadings submitted by the parties.

b. At respondents request I read the following documents:

i. The dissertation of Dr. Singh (partial).

ii. articles from Jesse Singal (partial).

c. I read various documents regarding Dr. Craig Childress.

d. I spoke with Minor 1, born XXXX XX, 2004 and met with him via Zoom.

e. I spoke with Minor 2, born XXXX XX, 2006 and met with him via Zoom.

f. I met with the petitioner/mother (hereinafter referred to as mother) and her counsel via Zoom.

g. I met with respondent/Father (hereinafter referred to as Father) and his counsel via

Zoom.

h. I spoke with LT, Minor 1's therapist and reviewed his session notes.

i. I spoke with AM, Minor 2's therapist.

j. I spoke with DF, the reunification therapist.

k. I spoke with Melissa Holub, a potential therapist for Minor 1.

l. I spoke with Diane Ehrensaft, PhD, a director of the UCSF, Benioff children's Hospital, Child and Adolescent Gender Center.

m. I researched Kenneth Zucker, PhD.

DISCUSSION:

2. There are two significant issues this report will address. The first issue, which appears to be driving much of the conflict is the question of Minor 1's gender dysphoria and his desire to begin addressing the transition from male to female. The 2nd issue is father's claim that mother is alienating Minor 1 from him. This is based on Minor 1's refusal to see or communicate with his father. Mother disputes that she has alienated Minor 1 from father. Minor 1 is clear that mother has taken no steps to alienate him from his father and that his refusal to communicate with father is based on a problematic history and father's reaction to the announcement that Minor 1 is transgender. It should be noted, I am referring to Minor 1 as he/him and not she/her as he is not stated to me a preference as to the pronouns to be used currently.

3. Minor 1 is 16 years old. He came out to his mother as transgender in XXXX 2019. As the Court is aware, he accompanied by his mother subsequently came out to his father

and the announcement did not go well. Minor 1 is clear that he felt his father rejected him and was quite angry regarding the announcement. He described the scene as scary. Minor 1 is a junior at XXXX high school. He gets very good grades. He plays the keyboards, primarily playing classical music. He has a fair amount of friends. He likes school.

4. Minor 2 is 14 years old. He is starting his freshman year at XXXX high school. Minor 2 gets excellent grades. He has a partial scholarship to XXXX high school. He plays guitar, and has recently become interested in late 60s rock 'n' roll music, he plays video games and likes to skateboard. Minor 2 loves both parents. He wants to stay out of the middle of this. He is happy with the current custodial arrangement. Mom's house is closer to the high school he is attending and it is better for him to be there. It should be noted it is unclear as to how the school will be structured this year. My understanding is the goal is to do a hybrid of in person and online education this semester.

5. Minor 1 is extremely clear that he has felt like he was a female for years. He did not disclose this information to anyone until he came out to his mother in XXXX 2019. Minor 1 has been clear this has been an ongoing process. It is not something that has arisen suddenly or been inspired by social media. Minor 2 noted he was not particularly surprised when Minor 1 came out as there have been hints for several years based on his interaction with his brother. Minor 2 has no issues with Minor 1 being transgender. Mother on one hand suspected something was going on with Minor 1 but still she was surprised when in XXXX 2019 he announced he was transgender. She reports they delayed telling father because he was in the middle of a work project which was taking a

substantial amount of time and put him under a lot of stress. However, the disclosure could not be put off for long and when Father was told he became very angry. Father has not been accepting of Minor 1's status as transgender. He has been quite clear that he does not accept that Minor 1 is in fact transgender. He wants a formal diagnosis. For the most part he is not open to Minor 1 being transgender. This will be discussed more thoroughly below.

6. Minor 1 describes his father as having a lot of anger. He describes him as getting angry if he loses a game. He describes much of their communications for the last few years as being not good. He described at times been scared of his father. It is found that his father has not been supportive of him since XXXX 2019.

7. Father provided me with a copy of a dissertation written by Devita Singh in 2012 who was obtaining her PhD in psychology in Canada. The dissertation is entitled a follow-up study of boys would gender identity disorder. The dissertation is a follow-up of 139 boys who were diagnosed with gender identity disorder. The boys mean age was 7.49 years and the range of ages was 3 to 12 years. The focus was on the number of children who desistance, meaning they ceased their claim of being transgender. Father views this as a "landmark" piece of research. There are number of problems with this position.

8. First, this study is not of adolescence but is a review of children under the age of 13 who self-identify as transgender. It addresses problems that these children have, which will be addressed in part below. Minor 1 is 16 years old he is an adolescent. At page 14 the author states: "Treatment for adolescence with GID typically involves biomedical interventions that facilitate the transition from one gender to another. It is also

recommended and, at times, required that adolescent also engage in psychotherapy, though with a different treatment philosophy compared to psychotherapy for children with GID (citation). In general, this approach to treating adolescents and adults with GID is uncontroversial, though there may be cross – clinic/clinician variations in timing of treatment (e.g. minimum age for cross – sex hormones)." In other words, this dissertation does not apply to Minor 1's situation. It specifically focuses on children between the ages of 3 and 12.

9. A second issue is that regarding the focus on Gender Identity Disorder. This is a "disorder" that is no longer recognized by the psychological community. The American Psychiatric Association publishes a Diagnostic And Statistical Manual Of Mental Disorders. It is referred to as the DSM. Currently, the DSM-V is in use. It was published in 2013. GID is referenced in the DSM-IV. It views transgender people as having a mental disorder. GID no longer appears in the DSM. The DSM-V now references gender dysphoria. It is no longer considered something that a person needs to be "cured of".

10. A third issue relates to the person who not only supervised Dr. Singh's dissertation but whose work is cited most frequently by Dr. Singh; Kenneth Zucker. Dr. Zucker is a Canadian psychologist. As to children 12 years and under his position is if they show gender identity issues they need to be encouraged, sometimes strongly, to maintain and reaffirm their birth gender. This includes encouraging parents to require their children to play with stereotypical toys and games applicable to their birth gender. For example, a boy should not be allowed to play with dolls. His views are controversial, and I have been informed are discredited in the psychological community. His clinic was shut down.

There is a concern that his approach is a step away from what is referred to as conversion therapy, if not in fact conversion therapy. However, even Dr. Zucker think that adolescence should be supported in transitioning if the express gender dysphoria.

11. Father also directed me to read articles written by a science writer Jesse Singal. Mr. Singal is clear that he is troubled by transgenders. He refers to Dr. Zucker's work frequently in his articles. He has been criticized as being trans- phobic. It is difficult to see will why a journalist's opinion should be given much weight.

12. As stated above, I have talked with Dr. Ehrensaft one of the directors of the UCSF Benioff Children's Hospital Child and Adolescent Gender Center. Dr. Ehrensaft not only is aware of Dr. Zucker's work but they know each other. She does not agree with his work regarding young children and thinks his approach with children is against all standards of practices and guidelines. However, she thinks they would be on the same page as it relates to a 16-year-old. Dr. Ehrensaft is from the Gender Affirmative Model school of thought. This is the approach taken by the Gender Center and most other mental health providers and hospitals. In fact, per Business and Professions code sections 865-865.2 mental health professions are forbidden from engaging in sexual orientation change efforts. This includes gender identity. The UCSF approach is to do a screening with a multi-disciplinary team to determine if the patient is an appropriate candidate for gender reassignment. The candidate then goes to see a gender specialist and an evaluation is performed to confirm the patient is a good candidate for their program. This evaluation is performed by a trained mental health expert. It can take weeks or months before a determination is made. If it is determined the adolescent is transgender, then the medical

process will commence. They then require either parental consent or court order to proceed.

13. The next step is to determine what treatments should commence for the adolescent. For Minor 1, being over the age of 14 he would not be put on puberty blockers alone. They would be administered along with hormone treatment i.e. estrogen. Hormone treatment can be stopped if the patient ceases the desire to become a woman. Once the hormones are no longer being taken, I am informed and believe the only possible remaining characteristic would be breasts. They can be removed surgically. Except in very unusual cases there would be no genital surgery until after the patient turned 18.

14. Minor 1 is clear that he would like to start the process at UCSF. He hopes he can start puberty blockers/hormone therapy. He is also clear that he would not commence surgery until after he was 18.

15. Minor 1 did have an appointment with a Dr. Rosenthal, an endocrinologist I'm informed that this appointment was canceled as a result of a phone call from father. Father states he wanted an appointment with the parents only because of the sensitive nature of the questions he had. Minor 1 should be able to start the process with UCSF. If hormone therapy as recommended than mother should have the legal right to authorize it.

16. Father is clear he does not agree with the gender affirmative model. He prefers the Dr. Zucker and the Danish model which looks at the gender identity issue from a more generalized psychological approach which incorporates challenging the individuals gender identification. Father has significant concerns about Minor 1's gender identification. He believes there should be a full medical workup including a

neuropsychological evaluation. He is also concerned that somehow mother has influenced Minor 1 to identify as transgender. He cites his job change in 2015 to go to work for XXXX. His job change caused him to be away from the home a substantial amount of time and he was no longer available to coach baseball. He states that this is about the time that Minor 1 stopped playing baseball and started doing more baking with his mother. It should be noted when Minor 1 was asked about this, he indicated that he was never was "super happy" about playing baseball and father was kidding himself about how much Minor 1 liked baseball.. In our meeting Father cited this change on two occasions, so he put a lot of weight on this behavioral change. During the interview, with his attorney present, Father became very upset and stated that 5 years from now when Minor 1 realizes he is mutilated himself he will have to be there to pick up the pieces not minors counsel. This is indicative of father's view of Minor 1's gender identity. It also gives us an insight as to his view in general about transgender people. He simply does not see this as a viable alternative. He is very frustrated that he has not been able to express all these ideas directly to Minor 1.

17. Minor 1 began seeing his therapist LT in XXXX 2019. He has had approximately 27 sessions with Mr. LT. He is extremely comfortable with Mr. LT and feels that he has made progress with him. When he first started therapy, he was anxious and depressed. Those issues are for the most part behind him. He has been addressing his transgender issues and his relationship with his father, among other issues. There is no reason to change Minor 1's therapist. The purpose of therapy is to provide patient with a safe place to talk and work out their problems. Mr. LT provides this. He has provided a diagnosis of

gender dysphoria, but it is not his responsibility to do a formal workup. UCSF will take the appropriate steps described above to determine if Minor 1 is a good candidate for gender reassignment.

18. Father has been unhappy with Mr. LT as Minor 1's therapist. He apparently believes that one of Mr. LT's obligations is to reunite and with Minor 1. He is also accused Mr. LT of keeping Minor 1 away from him. Mr. LT disputes this. Furthermore Minor 1 has been clear he does not want his father participating in his therapy. There is no rational reason to terminate Minor 1's therapeutic relationship with the person he trusts and who he has made progress with because one of his parents does not like the therapist.

19. Father and Minor 1 were seen by DF for unification therapy. Dr. DF has resigned. His resignation letter is attached hereto as Exhibit 1 and incorporated here by reference as though fully set forth. It is highly questionable whether reunification therapy is appropriate now. In order for reunification therapy to work both people have to look at how they contribute to the breakdown of the relationship and be willing to change. It is not clear to me that father takes any responsibility for the breakdown of his relationship with Minor 1. His focus seems to be on Minor 1's transgender identity and the claim of parental alienation on the part of mother.

20. Father claims that mother has engaged in parental alienation regarding his relationship with Minor 1. Mother denies this. Minor 1 denies this. Minor 1 describes his relationship with his father as being strained for quite a while. He describes father as insistent upon getting his own way and when he does not, he gets very angry. For example, he felt coerced into playing sports that he was not interested in. Minor 1 states

that his father does not listen to him. He simply wants to argue with him about his transgender identity. When he came out his father's response was that he was being brainwashed and threatened to cut him off from the Internet. According to Minor 1 and Mr. LT the one meeting they had did not go well. Father thought it went well and is frustrated that there have not been other follow-up meetings.

21. On XXXX XX, 2019, Minor 1 and father met with Mr. LT and Mr. LT's office. At this meeting father Criticizing mother for alienating Minor 1 from him. Minor 1 made it quite clear that she had not contributed to his transgender identity. That he had felt this way for many years but that he was terrified of his father's anger and so he said nothing to anyone. This apparently had little effect on father who does not recall the conversation the same as Minor 1 and Mr. LT. Mr. LT keeps progress notes of each meeting. Those notes have been provided to counsel. His notes regarding the XXXX XX, 2019 meeting will appear be provided in a confidential file directly to the court so it does not become a part of the public record. These notes support Minor 1's recollection of the meeting.

22. Father claims that mother has alienated Minor 1 from him. He cites the occurrence of XXXX 2019 as evidence of this alienation. He reported that her mother separated from her father and he felt that she was modeling this behavior. He complained that there have been no effort at reconciliation. He states that she has suffered trauma because of her sister being attacked. He was clear that mother make Minor 1 go to school, wear a seatbelt, and do all sorts of other things but will not make him talk to father. He takes no responsibility for the state of his relationship with Minor 1. He blames mother and the therapists but takes no responsibility himself.

23. Father has requested that a parental alienation assessment be performed by Dr. Craig Childress. First, needs to be pointed out that parental alienation is not a proper or accepted term. The appropriate term is alignment. This means the child has aligned themselves with one parent and against the other.

24. Dr. Childress believes that if a child will not see a parent that likely parental alienation has taken place. Dr. Childress tried to get the psychological community to insert parental alienation as a mental disorder in the DSM-V but was refused as the research does not support this position. Dr. Childress characterizes the "aligned parent as "pathogenic" he also describes them as permissive instead of a disciplinarian. Dr. Childress's approach is to focus on the on the results. If a child does not wish to be with a parent, he does not look at the refused parent behavior he looks at the favored a parent's behavior. He sees the favored parent as lax and permissive. He looks at the refused parent as a firm and structured. He twists attachment theory to fit his predisposition that of the child refuses to see a parent there must be alienation occurring. He searches for some psychological problem with the favored parent and uses that as a basis to characterize that parent as pathogenic. Then, if the child is refusing to see the refused parent, they have triangulated their relationship against that parent. He also believes minors counsel should almost never be appointed for children. In his view this gives the children to much power. He is unconcerned if children do not feel comfortable around the refused parent. In Dr. Childress's world this all leads to one conclusion that there has been parental alienation and radial "treatment" is needed. He has no issue with using coercion to force children to be with the refused parent so his solution is to take the child away from the favored

parent and not only turn them over to the refused parent but to insert the child into a program.

25. Dr. Childress will recommend that the child to go into the High Road to Family Reunification program. At a minimum, he is the advisor to this program. This program requires that the refusing child be taken away from the parent he or she is living with and go to a program for 4 to 5 days with the refused parent. This part of the program is usually at a hotel. The child then must spend at least 3 months in phase 2 of the program. In this program the child is isolated from his or her other parent, friends, school, and any other person the program administrators do not want him to have contact with. Their phone is taken away from them. They are not allowed Internet access except as permitted by the program administrator. They then can earn privileges back by altering their behavior. Altering her behavior means they accept the refused parent and basically do what they are told. This is a program based on coercion and isolation. Some would describe this as a form of brainwashing. The program is run by Dorsey Pruter. Ms. Pruter does not have a medical license, a mental health practitioner license, or a teaching certificate. If a child was committed to a mental hospital pursuant to Welfare and Institutions code 5150 they could not be held for more than 72 hours without having a court hearing to determine whether they should continue to be confined. This program confines children for months in order to try to force them to change their behavior. This is all done without due process for the child. Frankly, in my view these types of programs are a form of child abuse. When Father was asked if he was aware of this program, he admitted he was. When asked if this is what he would put Minor 1 in his answer was

evasive. He did say that it would be fair to mother if he was to have custody of Minor 1 for 90 days and she was to have no contact with him. However, he was clear he thought this would not be good for Minor 1.

26. It is concerning that Father has focused on finding experts who support his views. His views seem to be that Minor 1, even at age 16 needs to simply do what he is told and that he should have minimum say and what happens in his life. Father believes Dr. Zucker would support his position that nothing should happen regarding the transgender process until Minor 1 is an adult. (It is not clear that Dr. Zucker agrees with this position regarding an adolescent.) Dr. Zucker has been clear that at least regarding children he thinks they should accept their birth gender. This is in line with father's position. Dr. Childress has taken extreme position regarding alignment issues. He believes there is a Parental Alienation Syndrome. This is not accepted by the psychological community. This concept was brought up in the 90s and has been discredited since then. There are a few psychologists who recommend using coercive behavior to modify children's behaviors. These psychologists rarely focus on the behavior of the refused parent. It is unfortunate but it appears that father is willing to use coercion in an attempt to force Minor 1 to have a relationship with him instead of trying to accept Minor 1, offer them unconditional love and listen to what he wants. I have significant concerns that father is willing to use punitive measures to for Minor 1 to communicate with him on his terms. He withdrew money from Minor 1's 529 account to pay for a portion of [school] tuition for both him and Minor 2. This has never happened before. He views this as his money and not Minor 1's. This is incorrect. It is either community property money belonging to

both parents or it was a gift to Minor 1. There are also substantial assets that could have been used instead of the 529 account to pay tuition. When asked if he would refund the money to the 529 account's response was at all my money anyway just in different pots. It appears transparent that this action was taken an attempt to coerce or punish Minor 1.

27. Father's argument that mother has alienated Minor 1 from him is weak. He is following the format in Dr. Childress writings of blaming the favored parent without looking at his own behavior. He is also not looking at Minor 1 as an independent person. He questioned whether Minor 1 wrote the communications to him because of the sophistication of the language. Minor 1 confirmed he wrote these communications. He had some help on the grammar, but the thoughts are all his. One of the significant problems with father's view and Dr. Childress is view is they look at children regardless of how old they are as people who simply need to do what they are told and that their feelings and interests are for the most part irrelevant. Minor 1 is an independent very bright young person. Facing gender identity issues is difficult I don't think anyone who has not gone through this process can truly understand how difficult it must be the feel that you are on the wrong body and you are willing to go through painful surgery to correct this problem. Minor 1's mother has given him unconditional love. She reports when she asked father if he could give Minor 1 unconditional love and he stated he did not know what that was. I don't know if the description of this conversation is accurate, but it is clear he is extremely uncomfortable with the transgender process.

28. Many parents have an exceedingly difficult time after separation viewing their adolescent children as independent persons who have their own thoughts and feelings. There are also

authoritarian parents who believe their children need to simply do what they are told to do. It has been my experience that both of these types of parents have a very difficult time after separation when they cannot insist that their children continue to do what they are told. Furthermore, when the children refuse to not be heard any longer and they come to see they do have some control over their own lives the results are usually a significant breakdown in the parent-child relationship. These parents have a choice, they can either continue to believe that they should be in total control of their child's life or they can come to an understanding that those days are past and they need to work with their children and give their children some independence and the ability to make some of their own decisions. The first choice usually results in a significant breakdown and their relationship while the 2nd choice allows a relationship to flourish.

RELIEF REQUESTED

29. The current custody and visitation arrangement regarding Minor 2 shall remain in place.
30. The current custody and visitation arrangement regarding Minor 1 shall remain in place.
31. Minor 1 be permitted to pursue the services provided by UCSF as to his gender identity.
32. Minor 1 be permitted to commence hormone therapy if recommended by UCSF.
33. Mother would have sole legal custody regarding Minor 1. Should be obligated to provide monthly updates to father regarding matters that affect Minor 1's health education and welfare.
34. Minor 1 will not undergo any gender identity related surgery until he is an adult absent a

written agreement by the parties or order of court.

35. Minor 1 will continue in therapy with LT.

36. Minor 2 shall continue in therapy with AM.

37. Minor 1 shall have a physical examination. He will not have a neuropsychological evaluation.

38. Minor 1 shall not participate in any assessment by Dr. Craig Childress.

39. Minor 1 will not participate in any assessment by Dr. Kenneth Zucker.

40. Reunification therapy is suspended for the time being.

41. Father will continue in therapy.

42. Father will replace the funds taken out of Minor 1's 529 account.

Dated: August 14, 2020,

Respectfully Submitted:

LAW OFFICE OF DANIEL S. HARKINS

Daniel S. Harkins,
Attorney for Minor Children