

EXHIBIT A

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY,

Plaintiff,

v.

ROBERT W. FERGUSON, in his official capacity as Attorney General for the State of Washington; **UMAIR A. SHAH**, in his official capacity as Secretary of Health for the State of Washington; and **KRISTIN PETERSON** in her official capacity as Assistant Secretary of the Health Systems Quality Assurance division of the Washington State Department of Health,

Defendants.

Civil No. ____-_____

**EXPERT DECLARATION OF
DR. STEPHEN B. LEVINE
IN SUPPORT OF PLAINTIFF'S
MOTION FOR PRELIMINARY
INJUNCTION**

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

2 I. CREDENTIALS & SUMMARY

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

9
10 2. Since July 1973, my specialties have included psychological problems
11 and conditions relating to individuals' sexuality and sexual relations, therapies for
12 sexual problems, and the relationship between love, intimate relationships, and
13 wider mental health. In 2005, I received the Masters and Johnson Lifetime
14 Achievement Award from the Society of Sex Therapy and Research which
15 "recognizes extraordinary contributions to clinical sexuality and/or sexual research
16 over the course of a lifetime and achievement of excellence in clinical and/or
17 research areas of sexual disorders."¹ I am a Distinguished Life Fellow of the
18 American Psychiatric Association.

19
20 3. I have served as a book and manuscript reviewer for numerous
21 professional publications. I have been the Senior Editor of the first (2003), second
22 (2010), and third (2016) editions of the *Handbook of Clinical Sexuality for Mental*
23 *Health Professionals*. In addition to five previously solo-authored books for
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27 ¹ Society for Sex Therapy & Research Awards, <https://sstarnet.org/awards/>.

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

3 4. I first encountered a patient suffering what we would now call gender
4 dysphoria in July 1973. In 1974, I founded the Case Western Reserve University
5 Gender Identity Clinic and have served as Co-Director of that clinic since that time.
6 Across the years, our Clinic treated hundreds of patients who were experiencing a
7 transgender identity. An occasional child was seen during this era. I was the
8 primary psychiatric care-giver for several dozen of our patients and supervisor of
9 the work of other therapists. As the incidence of gender dysphoria has increased
10 among children and youth in recent years, larger numbers of minors presenting
11 with actual or potential gender dysphoria have presented to our clinic. I currently
12 am providing psychotherapy for several minors in this area. I also counsel
13 distressed parents of these teens.
14

15 16 17 18 19 20 21 22 23 24 25 26 27
5. I was an early member of the Harry Benjamin International Gender
Dysphoria Association (now known as the World Professional Association for
Transgender Health or WPATH) and served as the Chairman of the committee that
developed the 5th version of its Standards of Care. The vast majority of the 6th
version contains the exact prose that my committee wrote for the 5th version. In
1993 our Gender Identity Clinic was renamed, moved to a new location, and became
independent of Case Western Reserve University. I continue to serve as Co-
Director.

1 6. In 2006, Judge Mark Wolf of the Eastern District of Massachusetts
2 asked me to serve as an independent, court-appointed expert in litigation involving
3 the treatment of a transgender inmate within the Massachusetts prison system. I
4 have been retained by the Massachusetts Department of Corrections as a
5 consultant on the treatment of transgender inmates since 2007.
6

7 7. In 2019, I was qualified as an expert and testified concerning the
8 diagnosis, understanding, developmental paths and outcomes, and therapeutic
9 treatment of transgenderism and gender dysphoria, particularly as it relates to
10 children, in the matter of *In the Interest of J.A.D.Y. and J.U.D.Y.*, Case No. DF-15-
11 09887-S, 255th Judicial District, Dallas County, TX.
12

13 8. A fuller review of my professional experience, publications, and awards
14 is provided in my curriculum vitae, a copy of which is attached hereto as Exhibit A.
15

16 9. My many years of experience in working with adults or older young
17 adults who are living in a transgender identity or who suffer from gender dysphoria
18 provide a wide lifecycle view which, along with my familiarity with the literature
19 concerning them, provides an important cautionary perspective. The psychiatrist or
20 psychologist treating a trans child or adolescent of course seeks to make the young
21 patient happy, but the overriding consideration is the creation of a happy, highly
22 functional, mentally healthy person for the next 50 to 70 years of life. I refer to
23 treatment that keeps this goal in view as the “life course” perspective.
24

25 10. A summary of the key points that I explain in this statement is as
26 follows:
27

1 a. Sex as defined by biology and reproductive function cannot be
2 changed. While hormonal and surgical procedures may enable a female-
3 identifying male to “pass” as being female (or vice versa) during some or all of
4 their lives, such procedures carry with them physical, psychological, and
5 social risks, and no procedures can enable an individual to perform the
6 reproductive role of the opposite sex. (Section II.A.)
7

8 b. The diagnosis of “gender dysphoria” encompasses a diverse array of
9 conditions, with widely differing pathways and characteristics depending on
10 age of onset, biological sex, mental health, intelligence, motivations for
11 gender transition, socioeconomic status, country of origin, etc. Data from one
12 population (e.g., adults) cannot be assumed to be applicable to others (e.g.,
13 children). (Section II.B.) Generalizations about the treatment children in one
14 country (e.g., Holland) do not necessarily apply to another (e.g., United
15 States).
16
17

18 c. Among psychiatrists and psychotherapists who practice in the area,
19 there are currently widely varying views concerning both the causes of and
20 appropriate therapeutic response to gender dysphoria in children. Existing
21 studies do not provide a basis for a scientific conclusion as to which
22 therapeutic response results in the best long-term outcomes for affected
23 individuals. (Sections II.E, II.F.)
24

25 d. A majority of children (in several studies, a large majority) who are
26 diagnosed with gender dysphoria “desist”—that is, their gender dysphoria
27

1 does not persist—by puberty or adulthood unless transgender-affirming
2 therapeutic or medical interventions modify the normal course of maturation.
3 It is not currently known how to distinguish children who will persist from
4 those who will not. (Section III.)
5

6 e. Some recent studies suggest that active affirmation of transgender
7 identity in young children will substantially reduce the number of children
8 who would desist from transgender identity through the course of puberty.
9 This raises the ethical concern that this will increase the number of
10 individuals who suffer the multiple long-term physical, mental, and social
11 harms and limitations that are strongly associated with living life as a
12 transgender person. (Sections III, V.)
13

14 f. Typically, social transition is a first step in gender affirmation. It is
15 itself an important intervention with profound implications for the long-term
16 mental and physical health of the child. When a mental health professional
17 (MHP) evaluates a child or adolescent and then recommends social
18 transition, that professional should be available to help with interpersonal,
19 familial, and psychological problems that may already exist and will likely
20 arise after transition. However, today many children are started on puberty
21 blockers, and adolescents are medically transitioned, without a thorough,
22 long-lasting mental health assessment and psychological ongoing care,
23 leaving themselves and their families on their own to deal with ongoing and
24 subsequent problems. (Sections III, V.)
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1 g. The knowledge base concerning the cause and treatment of gender
2 dysphoria available today has low scientific quality. (Section IV.)

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

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

19 j. Putting a child or adolescent on a pathway towards life as a
20 transgender person puts that individual at risk of a wide range of long-term
21 or even life-long harms, including: sterilization (first chemical, then surgical)
22 and associated regret and sense of loss; inability to experience orgasm (for
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1 trans women); physical health risks associated with exposure to elevated
2 levels of cross-sex hormones; surgical complications and life-long after-care;
3 alienation of family relationships; inability to form lasting romantic
4 relationships and attract a desirable mate; and elevated mental health risks
5 of depression, anxiety, and substance abuse. (Section V.)
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7 **II. BACKGROUND ON THE FIELD**

8 **A. The biological baseline of sex**

9 11. Gender identity advocates commonly refer to the sex of an individual
10 as “assigned at birth.” This phrase is misleading. The sex of a human individual at
11 its core structures the individual’s biological reproductive capabilities—to produce
12 ova and bear children as a mother, or to produce semen and beget children as a
13 father. As physicians know, sex determination occurs at the instant of conception,
14 depending on whether a sperm’s X or Y chromosome fertilizes the egg. Medical
15 technology can now determine a fetus’s sex before birth almost as easily as after
16 birth. It is thus not correct to assert that doctors “assign” the sex of a child at birth.
17 Instead, they simply recognize the existing fact of that child’s sex. Barring rare
18 disorders of sexual development, anyone can identify the sex of an infant by genital
19 inspection. What the general public may not understand, however, is that every
20 nucleated cell of an individual’s body is chromosomally identifiably male or
21 female—XY or XX.
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25 12. The self-perceived gender of a child, in contrast, arises in part from
26 how others label the infant: “I love you, son (daughter).” This designation occurs
27 thousands of times in the first two years of life when a child begins to show

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

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

24 14. Despite the increasing use of cross-sex hormones and various surgical
25 procedures to reconfigure some male bodies to visually pass as female, or vice versa,
26 the biology of the person remains as defined by his (XY) or her (XX) chromosomes,
27

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

16 15. Specialists have used a variety of terms over time, with somewhat
 17 shifting definitions, to identify and speak about a distressing incongruence between
 18 an individual’s sex as determined by their chromosomes and their thousands of
 19 genes, and the gender with which they eventually subjectively identify or to which
 20 they aspire. Today’s American Psychiatric Association *Diagnostic and Statistical*
 21 *Manual of Mental Disorders* (“DSM-5”) employs the term Gender Dysphoria and
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26 ² S. Levine (2018), *Informed Consent for Transgendered Patients*, J. OF SEX & MARITAL THERAPY at 6
 27 (“*Informed Consent*”); S. Levine (2016), *Reflections on the Legal Battles Over Prisoners with Gender*
Dysphoria, J. AM. ACAD. PSYCHIATRY LAW 44, 236 at 238 (“*Reflections*”).

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

3 16. There are at least five distinct pathways to gender dysphoria: early
4 childhood onset; onset near or after puberty with no prior cross gender patterns;
5 onset after defining oneself as gay or lesbian for several or more years and
6 participating in a homosexual life style; adult onset after years of heterosexual
7 transvestism; and onset in later adulthood with few or no prior indications of cross-
8 gender tendencies or identity.
9

10 17. Gender dysphoria has very different characteristics depending on age
11 and sex at onset. Young children who are living a transgender identity commonly
12 suffer materially fewer symptoms of concurrent mental distress than do older
13 patients.³ The developmental and mental health patterns for each of these groups
14 are sufficiently different that data developed in connection with one of these
15 populations cannot be assumed to be applicable to another.
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18 18. The criteria used in DSM-5 to identify Gender Dysphoria include a
19 number of signs of discomfort with one's natal sex and vary somewhat depending on
20 the age of the patient, but in all cases require "clinically significant distress or
21 impairment in . . . important areas of functioning" such as social, school, or
22 occupational settings.
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26 ³ K. Zucker (2018), *The Myth of Persistence: Response to "A Critical Commentary on Follow-Up*
27 *Studies & 'Desistance' Theories about Transgender & Gender Non-Conforming Children*" by Temple
Newhook et al., INT'L J. OF TRANSGENDERISM at 10 ("*Myth of Persistence*").

1 19. When these criteria in children (or adolescents, or adults) are not met,
2 two other diagnoses may be given. These are: Other Specified Gender Dysphoria
3 and Unspecified Gender Dysphoria. Specialists sometimes refer to children who do
4 not meet criteria as being “subthreshold.”

5
6 20. Children who conclude that they are transgender are often unaware of
7 a vast array of adaptive possibilities for how to live life as a man or a woman—
8 possibilities that become increasingly apparent over time to both males and
9 females. A boy or a girl who claims or expresses interest in pursuing a transgender
10 identity often does so based on stereotypical notions of femaleness and maleness
11 that reflect constrictive notions of what men and women can be.⁴ A young child’s—
12 or even an adolescent’s—understanding of this topic is quite limited. Nor can they
13 grasp what it may mean for their future to be sterile. These children and
14 adolescents consider themselves to be relatively unique; they do not realize that
15 discomfort with the body and perceived social role is neither rare nor new to
16 civilization. What is new is that such discomfort is thought to indicate that they
17 must be a trans person.

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20 21. “Gender identity,” as that term is commonly used in public discourse
21 as well as academic publication, is distinct from sex. Unfortunately, “gender
22 identity” has no distinct objective definition by which a subject’s gender identity
23 may be confirmed. The Department of Health and Human Services has defined
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26 _____
27 ⁴ S. Levine (2017), *Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria*, J.
OF SEX & MARITAL THERAPY at 7 (“*Ethical Concerns*”) (available at
<http://dx.doi.org/10.1080/0092623X.2017.1309482>.)

1 “gender identity” as “an individual’s internal sense of gender, which may be male,
2 female, neither, or a combination of male and female, and which may be different
3 from an individual’s sex assigned at birth.”⁵ A publication sponsored by the ACLU,
4 National Center for Lesbian Rights, Human Rights Campaign, and National
5 Education Association asserts that gender identity encompasses any “deeply-felt
6 sense of being male, female, both or neither,” and can include a “gender spectrum”
7 “encompassing a wide range of identities and expressions.” That source goes on to
8 say that an individual may have an “internal sense of self as male, female, both or
9 neither,” and that “each person is in the best position to define their own place on
10 the gender spectrum.”⁶ The medical text *Principles of Transgender Medicine and*
11 *Surgery*, states that “Gender identity can be conceptualized as a continuum, a
12 Mobius, or patchwork.”⁷

15 22. In sum, gender identity is said to refer to an individual’s subjective
16 perceptions of where that person falls on a continuum of genders ranging from very
17 masculine gender to very feminine, but is also said to include genders which are
18 some of either or something else entirely, or no gender at all (e.g., agender). There
19 are no objective indicia that define or establish one’s gender within this paradigm.
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24 ⁵ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) at
25 31,384.

26 ⁶ Asaf Orr et al., NATIONAL CENTER FOR LESBIAN RIGHTS, *Schools in Transition: A Guide for*
27 *Supporting Transgender Students in K-12 Schools*, at 5-7 (2015), <https://www.nclrights.org/wp-content/uploads/2015/08/Schools-in-Transition-2015-Online.pdf>.

⁷ R. Ettner, et al. (2016), *Principles of Transgender Medicine and Surgery* (Routledge 2nd ed.) at 43.

1 23. In clinical experience, I observe patients experiencing gender identity
2 as an often-evolving mixture of male and female identification, which may be
3 influenced by the patient’s reactions to cultural stereotypes, and/or by the patient’s
4 past and present family dynamics. The gender identity composite, however, is just
5 one-third of the self-labels that constitute sexual identity. The other two
6 components are the dimensions of sexual orientation—heterosexual, homosexual,
7 and bisexual--and the generally avoided dimension of sexual intention—what one
8 wants to do with a partner’s body and what one wants done to his or her body. In
9 my view gender identity is merely a part of sexual identity, and an even smaller
10 part of the individual’s total self-identification.
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13 C. Impact of gender dysphoria on minority and vulnerable groups

14 24. In considering the appropriate response to gender dysphoria, it is
15 important to know that certain groups of children and adolescents have an
16 increased prevalence and incidence of trans identities. These include: children of
17 color,⁸ children with mental developmental disabilities,⁹ including children on the
18 autistic spectrum (at a rate more than 7x the general population),¹⁰ children
19 residing in foster care homes, adopted children (at a rate more than 3x the general
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23 ⁸ G. Rider et al. (2018), *Health and Care Utilization of Transgender/Gender Non-Conforming Youth: A Population Based Study*, PEDIATRICS 141:3 at 4 (In a large sample, non-white youth made up 41% of the set who claimed a transgender or gender-nonconforming identity, but only 29% of the set who had a gender identity consistent with their sex.).

24 ⁹ D. Shumer & A. Tishelman (2015), *The Role of Assent in the Treatment of Transgender Adolescents*, INT. J. TRANSGENDERISM at 1 (available at doi: 10.1080/15532739.2015.1075929).

25 ¹⁰ D. Shumer et al. (2016), *Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic*, LGBT HEALTH, 3(5) 387 at 387.

1 population),¹¹ children with a prior history of psychiatric illness,¹² and more
2 recently adolescent girls (in a large recent study, at a rate more than 2x that of
3 boys) (Rider, 2018 at 4).

4
5 25. The social transitioning, hormonal, and surgical paths often
6 recommended and facilitated by gender clinics may lead to sterilization by the time
7 the patient reaches young adulthood. They may add a future source of despair in an
8 already vulnerable person. Caution and time to reflect as the patient matures are
9 prudent when dealing with a teen’s sense of urgency about transition.

10
11 D. Three competing conceptual models of gender dysphoria and
12 transgender identity

13 26. Discussions about appropriate responses by MHPs to actual or sub-
14 threshold gender dysphoria are complicated by the fact that various speakers and
15 advocates (or a single speaker at different times) view transgenderism through at
16 least three very different paradigms, often without being aware of, or at least
17 without acknowledging, the distinctions.

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21 ¹¹ D. Shumer et al. (2017), *Overrepresentation of Adopted Adolescents at a Hospital-Based Gender Dysphoria Clinic*, TRANSGENDER HEALTH Vol. 2(1) 76 at 77.

22 ¹² L. Edwards-Leeper et al. (2017), *Psychological Profile of the First Sample of Transgender Youth Presenting for Medical Intervention in a U.S. Pediatric Gender Center*, PSYCHOLOGY OF SEXUAL
23 ORIENTATION AND GENDER DIVERSITY, 4(3) 374 at 375; R. Kaltiala-Heino et al. (2015), *Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development*, CHILD & ADOLESCENT PSYCHIATRY & MENTAL HEALTH 9(9) 1 at 5. (In 2015
24 Finland gender identity service statistics, 75% of adolescents assessed “had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria.”); L.
25 Littman (2018), *Parent Reports of Adolescents & Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, PLoS ONE 13(8): e0202330 at 13 (Parental survey concerning
26 adolescents exhibiting Rapid Onset Gender Dysphoria reported that 62.5% of gender dysphoric adolescents had “a psychiatric disorder or neurodevelopmental disability preceding the onset of
27 gender dysphoria.”).

1 27. Gender dysphoria is **conceptualized and described by some**
2 **professionals and laypersons as though it were a serious, physical medical**
3 **illness that causes suffering**, comparable, for example, to prostate cancer, a
4 disease that is curable before it spreads. Within this paradigm, whatever is causing
5 distress associated with gender dysphoria—whether secondary sex characteristics
6 such as facial hair, nose and jaw shape, presence or absence of breasts, or the
7 primary anatomical sex organs of testes, ovaries, penis, or vagina—should be
8 removed to alleviate the illness. The promise of these interventions is the cure of
9 the gender dysphoria.
10

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12 28. It should be noted, however, that gender dysphoria is a psychiatric, not
13 a medical, diagnosis even though that is how it is often introduced into court
14 settings. Since its inception in DSM-III in 1983, it has always been specified in the
15 psychiatric DSM manuals and is not specified in medical diagnostic manuals.
16 Notably, gender dysphoria is the only psychiatric condition to be treated by surgery,
17 even though no endocrine or surgical intervention package corrects any identified
18 biological abnormality. (Levine, *Reflections*, at 240.) This medicalization of gender
19 dysphoria is at some level at odds with psychologists’ longstanding concerns about
20 or even opposition to “practice guidelines that recommend the use of medications
21 over psychological interventions in the absence of data supporting such
22 recommendations.¹³
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27 ¹³ AM. PSYCH. ASS’N (2005) *Report of the 2005 Presidential Task Force on Evidence-Based Practice at*
2 (available at <https://www.apa.org/practice/resources/evidence/evidence-based-report.pdf>.)

1 29. Gender dysphoria is alternatively **conceptualized in**
2 **developmental terms**, as an adaptation to a psychological problem that was first
3 manifested as a failure to establish a comfortable conventional sense of self in early
4 childhood or confusion about the self that intensifies with puberty. This paradigm
5 starts from the premise that all human lives are influenced by past processes and
6 events. Trans lives are not exceptions to this axiom. (Levine, *Reflections* at 238.)
7 MHPs who think of gender dysphoria through this paradigm may work both to
8 identify and address the apparent causes of the basic problem of the deeply
9 uncomfortable self, and also to ameliorate suffering when the underlying problem
10 cannot be solved. They work with the patient and (ideally) the patient’s family to
11 inquire what forces may have led to the trans person repudiating the gender
12 associated with his sex. The developmental paradigm is mindful of temperamental,
13 parental bonding, psychological, sexual, and physical trauma influences, and the
14 fact that young children work out their psychological issues through fantasy and
15 play. The developmental paradigm does not preclude a biological temperamental
16 contribution to some patients’ lives; it merely objects to assuming these problems
17 are biological in origin. All sexual behaviors and experiences involve the brain and
18 the body.
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22 30. In addition, the developmental paradigm recognizes that, with the
23 important exception of genetic sex, essentially all aspects of an individual’s identity
24 evolve—often markedly—across the individual’s lifetime. This includes gender.
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1 31. Some advocates assert that a transgender identity is biologically
 2 caused, fixed from early life, and invariably persists through life in an unchanging
 3 manner. This assertion, however, is not supported by science.¹⁴ Although numerous
 4 studies have been undertaken to attempt to demonstrate a distinctive physical
 5 brain structure associated with transgender identity, as of yet there is no evidence
 6 that these patients have any defining abnormality in brain structure that precedes
 7 the onset of gender dysphoria. The belief that gender dysphoria is the consequence
 8 of brain structure is challenged by the sudden increase in incidence of child and
 9 adolescent gender dysphoria over the last twenty years in North America and
 10 Europe. Meanwhile, multiple studies have documented rapid shifts in gender ratios
 11 of patients presenting for care with gender-related issues, pointing to cultural
 12 influences,¹⁵ while a recent study documented “clustering” of new presentations in
 13 specific schools and among specific friend groups, pointing to social influences.¹⁶
 14 Both of these findings strongly suggest cultural factors. From the beginning of
 15 epidemiological research into this arena, there have always been some countries
 16 (Poland and Australia, for example) where the sex ratios were reversed as compared
 17 to North America and Europe, again demonstrating a powerful effect of cultural
 18 influences.
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24 ¹⁴ Even the advocacy organization The Human Rights Campaign asserts that a person can have “a
 25 fluid or unfixed gender identity.” <https://www.hrc.org/resources/glossary-of-terms>.

26 ¹⁵ Levine, *Ethical Concerns*, at 8 (citing M. Aitken et al. (2015), *Evidence for an Altered Sex Ratio in
 27 Clinic-Referred Adolescents with Gender Dysphoria*, J. OF SEXUAL MED.12(3) 756 at 756-63.)

¹⁶Lisa Littman (2018), *Parent reports of adolescents and young adults perceived to show signs of a
 rapid onset of dysphoria*, PLoS ONE 13(8): e0202330.

1 32. Further, as I detail later below, many studies and clinical observations
2 confirm that gender identity can and does change or evolve over time for many
3 individuals. And recent studies and anecdotal reports provide strong if preliminary
4 evidence that therapeutic choices can have a powerful effect on whether and how
5 gender identity does change, or gender dysphoria desists.
6

7 33. In recent years, for adolescent patients, intense involvement with
8 online transgender communities or “friends” is the rule rather than the exception,
9 and the MHP will also be alert to this as a potentially significant influence on the
10 identity development of the patient. Finally, the large accumulating reports of late
11 adolescent and young adult individuals who return to their natively assigned gender
12 identity highlight the error of assuming a trans identity is a permanent feature¹⁷.
13

14 34. The third paradigm through which gender dysphoria is alternatively
15 conceptualized is from **a sexual minority rights perspective**. Under this
16 paradigm, any response other than medical and societal affirmation and
17 implementation of a patient’s claim to “be” the opposite gender is a violation of the
18 individual’s civil right to self-expression. Any effort to ask “why” questions about
19 the patient’s condition, or to address underlying causes, is viewed as a violation of
20 autonomy and civil rights. Any attempt to slowly review the risks of affirmative and
21 alternative interventions in detail is viewed as irrelevant. In the last few years, this
22 paradigm has been successful in influencing public policy and the education of
23
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26

27 ¹⁷ P. Expósito-Campos (2021). *A Typology of Gender Detransition and Its Implications for Healthcare Providers*. *J. OF SEX & MARITAL THERAPY*, 47(3), 270–280.

1 pediatricians, endocrinologists, and many mental health professionals. Obviously,
2 however, this is not a medical, psychiatric, or scientific perspective.

3 E. Four competing models of therapy

4 35. Because of the complexity of the human psyche and the difficulty of
5 running controlled experiments in this area, substantial disagreements among
6 professionals about the causes of psychological disorders, and about the appropriate
7 therapeutic responses, are not unusual. When we add to this the very different
8 paradigms for understanding transgender phenomena discussed above, it is not
9 surprising that such disagreements also exist with regard to appropriate therapies
10 for patients experiencing gender-related distress. I summarize below the leading
11 approaches, and offer certain observations and opinions concerning them.
12
13

14 (1) The “watchful waiting” therapy model

15 36. I review below the uniform finding of follow-up studies that the large
16 majority of children who present with gender dysphoria will desist from desiring a
17 transgender identity by adulthood if left untreated. (Section III.A)
18

19 37. When a pre-adolescent child presents with gender dysphoria, a
20 “watchful waiting” approach seeks to allow for the fluid nature of gender identity in
21 children to naturally evolve—that is, take its course from forces within and
22 surrounding the child. Watchful waiting has two versions:
23

- 24 a. Treating any other psychological co-morbidities—that is, other
25 mental illnesses as defined by DSM-5—that the child may exhibit (e.g.,
26 separation anxiety, bedwetting, attention deficit disorder, obsessive-
27 compulsive disorder) without a focus on gender (model #1); and

1 b. No treatment at all for anything but a regular follow-up
2 appointment. This might be labeled a “hands off” approach (model #2).

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

5 38. One of the foundational principles of psychotherapy has long been to
6 work with a patient to identify the causes of observed psychological distress and
7 then to address those causes as a means of alleviating the distress. The National
8 Institute of Mental Health has promulgated the idea that 75% of adult
9 psychopathology has its origins in childhood experience.
10

11 39. Many experienced practitioners in the field of gender dysphoria,
12 including myself, have believed that it makes sense to employ these long-standing
13 tools of psychotherapy for patients suffering gender dysphoria, asking the question
14 as to what factors in the patient’s life are the determinants of the patient’s
15 repudiation of his or her natal sex. (Levine, *Ethical Concerns*, at 8.) I and others
16 have reported success in alleviating distress in this way for at least some patients,
17 whether or not the patient’s sense of discomfort or incongruence with his or her
18 natal sex entirely disappeared. Relieving accompanying psychological co-morbidities
19 leaves the patient freer to consider the pros and cons of transition as he or she
20 matures.
21

22 40. Among other things, the psychotherapist who is applying traditional
23 methods of psychotherapy may help—for example—the male patient appreciate the
24 wide range of masculine emotional and behavioral patterns as he grows older. He
25 may discuss with his patient, for example, that one does not have to become a
26
27

1 “woman” in order to be kind, compassionate, caring, noncompetitive, and devoted to
2 others’ feelings and needs.¹⁸ Many biologically male trans individuals, from
3 childhood to older ages, speak of their perceptions of femaleness as enabling them to
4 discuss their feelings openly, whereas they perceive boys and men to be constrained
5 from emotional expression within the family and larger culture. Men, of course, can
6 be emotionally expressive, just as they can wear pink. Converse examples can be
7 given for girls and women. These types of ideas regularly arise during
8 psychotherapies.
9

10 41. As I note above, many gender-nonconforming children and adolescents
11 in recent years derive from minority and vulnerable groups who have reasons to feel
12 isolated and have an uncomfortable sense of self. A trans identity may be the
13 individual’s hopeful attempt to redefine the self in a manner that increases their
14 comfort and decreases their anxiety. The clinician who uses traditional methods of
15 psychotherapy may not focus on their gender identity, but instead work to help
16 them to address the actual sources of their discomfort. Success in this effort may
17 remove or reduce the desire for a redefined identity. This often involves a focus on
18 disruptions in their attachment to parents in vulnerable children, for instance,
19 those in the foster care system.
20
21

22 42. Because “watchful waiting” can include treatment of accompanying
23 psychological co-morbidities, and the psychotherapist who hopes to relieve gender
24
25
26

27 ¹⁸ S. Levine (2017), *Transitioning Back to Maleness*, ARCH. OF SEXUAL BEHAVIOR 47(4) at 7
 (“Transitioning”) (available at <https://link.springer.com/article/10.1007/s10508-017-1136-9>.)

1 dysphoria may focus on potentially causal sources of psychological distress rather
2 than on the gender dysphoria itself, there is no sharp line between “watchful
3 waiting” and the psychotherapy model in the case of prepubescent children.
4

5 43. To my knowledge, there is no evidence beyond anecdotal reports that
6 psychotherapy can predictably enable a return to male identification for gender
7 dysphoric genetically male boys, adolescents, and men, or return to female
8 identification for gender dysphoric genetically female girls, adolescents, and women.
9 On the other hand, anecdotal evidence of such outcomes does exist. I and other
10 clinicians have witnessed reinvestment in the patient’s biological sex in some
11 individual patients who are undergoing psychotherapy. And from the earliest days
12 of my career, traditional psychotherapy showed both promise and beneficial
13 outcomes in reducing the distress of gender dysphoria. It did so without presuming
14 gender affirmation as a preferred or mandated approach. When distress is
15 significantly lessened, the person may find some comfortable adaptation short of
16
17
18 bodily change.

19 44. More recently, I myself have published a paper on a patient who
20 sought my therapeutic assistance to reclaim his male gender identity after 30 years
21 living as a woman and is in fact living as a man today, (Levine, *Transitioning*), I
22 have seen children desist even before puberty in response to thoughtful parental
23 interactions and a few meetings of the child with a therapist. I have seen patients
24 desist when their intimate relationships change.
25
26
27

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

2 45. While it is widely agreed that the therapist should not directly
3 challenge a claimed transgender identity in a child, some advocates and
4 practitioners go much further, and promote and recommend that any expression of
5 transgender identity should be immediately accepted as decisive, and thoroughly
6 affirmed by means of consistent use of clothing, toys, pronouns, etc., associated with
7 the transgender identity to which the child expresses an attraction. These advocates
8 treat any question about the causes of the child's transgender identification as
9 inappropriate and assume that observed psychological co-morbidities in the children
10 or their families are unrelated or will get better with transition and need not be
11 addressed by the MHP who is providing supportive guidance concerning the child's
12 gender identity.
13
14

15 46. Some advocates, indeed, assert that unquestioning affirmation of any
16 claim of transgender identity in children is essential, and that the child will
17 otherwise face a high risk of suicide or severe psychological damage. I address
18 claims about suicide and health outcomes in Sections IV and V below.
19

20 47. The idea that social transition is the only accepted treatment for
21 prepubertal children is not correct. On the contrary, one respected academic in the
22 field has recently written that "almost all clinics and professional associations in
23 the world" do not use "gender affirmation" for prepubescent children and instead
24 "delay any transitions after the onset of puberty."¹⁹ This approach is widely
25

26 _____
27 ¹⁹ J. Cantor (2020), *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. OF SEX & MARITAL THERAPY VOL. 46, NO. 4, 307-313.

1 practiced because when the intrapsychic, biological, and social developmental
2 processes of puberty are allowed to act unimpaired (but accompanied by supporting
3 therapy), resolution of the gender dysphoria is by far the most common outcome.²⁰
4 Natural desistance offers a reasonable likelihood of sparing the individual the life-
5 long physical, mental, and social stresses associated with living in a transgender
6 identity, which I discuss in Section V.

8 48. It is notable that even the Standards of Care published by WPATH, an
9 organization which in general leans strongly towards affirmation in the case of
10 adults, do not specify affirmation of transgender identity as the indicated
11 therapeutic response for young children. Instead, the WPATH Standards of Care
12 recognize that social transition in early childhood “is a controversial issue, and
13 divergent views are held by health professionals”; state that “[t]he current evidence
14 base is insufficient to predict the long-term outcomes of completing a gender role
15 transition during early childhood”; and acknowledge that “previously described
16 relatively low persistence rates of childhood gender dysphoria” are “relevant” to the
17 wisdom of social transition in childhood.²¹
18
19
20

21 ²⁰ D. Singh et al. (2021), *A Follow-Up Study of Boys With Gender Identity Disorder*, FRONTIERS IN
22 PSYCHIATRY Vol. 12:632784 at 12 (available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8039393/>.)

23 ²¹ WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH (2011), *Standards of Care for the Health of*
24 *Transsexual, Transgender, and Gender-Nonconforming People* (7th Version) at 17. I note that I
25 regretfully resigned from the precursor organization of WPATH in 2002 after concluding that many
26 of its positions of enthusiastic and unqualified support of transition for individuals suffering from
27 gender dysphoria were dictated by politics and ideology, rather than by any scientific basis. WPATH
is composed of a mix of practitioners and transgender activists with little or no scientific training,
and its most recent self-designated “Standards of Care” are not reflective of the practices of a large
number of psychiatrists and Ph.D. psychologists who practice in this area. For this reason, WPATH’s
cautious position with regard to transition of children who suffer from gender dysphoria is all the
more notable.

1 49. In contrast to WPATH’s cautious position with respect to children, in
 2 2018 the American Academy of Pediatrics issued a statement asserting that “gender
 3 transition” “is safe, effective, and medically necessary treatment for the health and
 4 wellbeing of children and adolescents suffering from gender dysphoria.”²² But in a
 5 peer-reviewed paper, based on a careful review of the sources cited in the AAP
 6 statement, prominent researcher James Cantor concluded that “In its policy
 7 statement, AAP told neither the truth nor the whole truth, committing sins both of
 8 commission and of omission, asserting claims easily falsified by anyone caring to do
 9 any fact-checking at all,” and described Rafferty 2018 as “a systematic exclusion
 10 and misrepresentation of entire literatures.” (Cantor at 312.) Based on my
 11 professional expertise and my review of the literature, I agree with Dr. Cantor’s
 12 evaluation of Rafferty 2018.

15 50. In fact, the DSM-5 added—for both children and adolescents—a
 16 requirement that a sense of incongruence between biological and felt gender must
 17 last at least six months as a precondition for a diagnosis of gender dysphoria,
 18 precisely because of the risk of “transitory” symptoms and “hasty” diagnosis that
 19 might lead to “inappropriate” treatments.²³

21 51. I do not know what proportion of practitioners are using which model.
 22 However, in my opinion, in the case of young children, prompt and thorough
 23

24 _____
 25 ²² J. Rafferty (2018), *Committee on Psychosocial Aspects of Child and Family Health, Committee on*
Adolescence and Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness,
 PEDIATRICS 142(4): 2018-2162.

26 ²³ K. Zucker (2015), *The DSM-5 Diagnostic Criteria for Gender Dysphoria*, in C. Trombetta et al.
 27 (eds.), *MANAGEMENT OF GENDER DYSPHORIA: A MULTIDISCIPLINARY APPROACH* (Springer-Verlag
 Italia).

1 affirmation of a transgender identity disregards the principles of child development
2 and family dynamics and is not supported by science. Rather, the MHP must focus
3 attention on the child's underlying internal and familial issues. Ongoing
4 relationships between the MHP and the parents, and the MHP and the child, are
5 vital to help the parents, child, other family members, and the MHP to understand
6 over time the issues that need to be dealt with over time by each of them.

8 52. Likewise, since the child's sense of gender develops in interaction with
9 his parents and their own gender roles and relationships, the responsible MHP will
10 almost certainly need to delve into family and marital dynamics.

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

13 53. In my opinion, it is not possible to make a single, categorical statement
14 about the proper treatment of children or adolescents presenting with gender
15 dysphoria or other gender-related issues. There is no single pathway of development
16 and outcomes governing transgender identity, nor one that predominates over the
17 large majority of cases. Instead, as individuals grow up and age, depending on their
18 differing psychological, social, familial, and life experiences, their outcomes differ
19 widely.
20

21 54. As to causes in children and adolescents, details about the onset of
22 gender dysphoria may be found in an understanding of family relationship
23 dynamics. In particular, the relationship between the parents and each of the
24 parents and the child, and each of the siblings and the child, should be well known
25 by the MHP. Further, a disturbingly large proportion of children and adolescents
26 who seek professional care in connection with gender issues have a wider history of
27

1 psychiatric co-morbidities. (*See supra* n. 12.) A 2017 study from the Boston
2 Children’s Hospital Gender Management Service program reported that:
3 “Consistent with the data reported from other sites, this investigation documented
4 that 43.3% of patients presenting for services had significant psychiatric history,
5 with 37.1% having been prescribed psychotropic medications, 20.6% with a history
6 of self-injurious behavior, 9.3% with a prior psychiatric hospitalization, and 9.3%
7 with a history of suicide attempts.” (Edwards-Leeper at 375.) It seems likely that an
8 even higher proportion will have had prior undiagnosed psychiatric conditions.
9

10
11 55. In the case of adolescents, as I have noted above, there is evidence that
12 peer social influences through “friend groups” (Littman) or through the internet can
13 increase the incidence of gender dysphoria or claims of transgender identity, so the
14 responsible MHP will want to probe these potential influences to better understand
15 what is truly deeply tied to the psychology of this particular individual, and what
16 may instead be “tried on” by the youth as part of the adolescent process of self-
17 exploration and self-definition.
18

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

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

23 56. A distinctive and critical characteristic of juvenile gender dysphoria is
24 that multiple studies from separate groups and at different times have reported
25 that in the large majority of patients, absent a substantial intervention such as
26 social transition and/or hormone therapy, the dysphoria does *not* persist through
27 puberty. A recent article reviewed all existing follow-up studies that the author

1 could identify of children diagnosed with gender dysphoria (11 studies) and reported
 2 that “every follow-up study of GD children, without exception, found the same
 3 thing: By puberty, the majority of GD children ceased to want to transition.”
 4 (Cantor at 307.) Another author reviewed the existing studies and reported that in
 5 “prepubertal boys with gender discordance . . . the cross gender wishes usually fade
 6 over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to
 7 experience gender discordance.”²⁴ A third summarized the existing data as showing
 8 that “Symptoms of GID at prepubertal ages decrease or disappear in a considerable
 9 percentage of children (estimates range from 80-95%).”²⁵ As cited above, a 2021
 10 extended follow-up of originally evaluated prepubertal boys found a persistence rate
 11 of only 12 percent. (Singh 2021.)
 12
 13

14 57. It is not yet known how to distinguish those children who will desist
 15 from that small minority whose trans identity will persist. (Levine, *Ethical*
 16 *Concerns*, at 9.)
 17

18 58. Desistance within a relatively short period may also be a common
 19 outcome for post-pubertal youths who exhibit recently described “rapid onset gender
 20 disorder.” I observe an increasingly vocal online community of young women who
 21 have reclaimed a female identity after claiming a male gender identity at some
 22
 23

24 _____
 25 ²⁴ S. Adelson & American Academy of Child & Adolescent Psychiatry (2012), *Practice Parameter on*
 26 *Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in*
 27 *Children and Adolescents*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 51(9) 957 at 963 (“*Practice*
Parameter”).

²⁵ P. T. Cohen-Kettenis et al. (2008), *The Treatment of Adolescent Transsexuals: Changing Insights*,
 J. SEXUAL MED. 5(8) 1892 at 1895.

1 point during their teen years. However, data on outcomes for this age group with
 2 and without therapeutic interventions is not yet available to my knowledge.

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

5 59. In contrast, there is now data that suggests that a therapy that
 6 encourages social transition before or during puberty dramatically changes
 7 outcomes. A prominent group of authors has written that “The gender identity
 8 affirmed during puberty appears to predict the gender identity that will persist into
 9 adulthood,” and “Youth with persistent TNG [transgender, nonbinary, or gender-
 10 nonconforming] identity into adulthood . . . are more likely to have experienced
 11 social transition, such as using a different name . . . which is stereotypically
 12 associated with another gender at some point during childhood.”²⁶ Similarly, a
 13 comparison of recent and older studies suggests that when an “affirming”
 14 methodology is used with children, a substantial proportion of children who would
 15 otherwise have desisted by adolescence—that is, achieved comfort identifying with
 16 their sex—instead persist in a transgender identity. (Zucker, *Myth of Persistence*, at
 17 7).²⁷

18 60. Indeed, a review of multiple studies of children treated for gender
 19 dysphoria across the last three decades found that early social transition to living as
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 21
 22
 23

24 _____
 25 ²⁶ C. Guss et al. (2015), *Transgender and gender nonconforming adolescent care: psychosocial and medical considerations*. CURR. OPIN. PEDIATR. 27(4):421 (“TGN Adolescent Care”).

26 ²⁷ One study found that social transition by the child was found to be strongly correlated with
 27 persistence for natal boys, but not for girls. (Zucker, *Myth of Persistence*, at 5 (citing T. D. Steensma, et al. (2013), *Factors Associated with Desistance & Persistence of Childhood Gender Dysphoria: A Qualitative Follow-up Study*, J. OF THE AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 52, 582.))

1 the opposite sex severely reduces the likelihood that the child will revert to
2 identifying with the child’s natal sex, at least in the case of boys. That is, while, as I
3 review above, studies conducted before the widespread use of social transition for
4 young children reported desistance rates in the range of 80-98%, a more recent
5 study reported that fewer than 20% of boys who engaged in a partial or complete
6 social transition before puberty had desisted when surveyed at age 15 or older.
7 (Zucker, *Myth of Persistence*, at 7; Steensma (2013).)²⁸ Some vocal practitioners of
8 prompt affirmation and social transition even claim that essentially *no* children who
9 come to their clinics exhibiting gender dysphoria or cross-gender identification
10 desist in that identification and return to a gender identity consistent with their
11 biological sex. As one internationally prominent practitioner stated, “In my own
12 clinical practice . . . of those children who are carefully assessed as transgender and
13 who are allowed to transition to their affirmed gender, we have no documentation of
14 a child who has ‘desisted’ and asked to return to his or her assigned gender.”²⁹
15
16
17
18 Given the consensus that no method exists to reliably predict which children
19 suffering from gender dysphoria will desist and which persist, and given the
20 absence of any study demonstrating the validity of any such method, this is a
21 disconcerting statement. Certainly, it reflects a very large change as compared to
22 the desistance rates documented apart from social transition.
23

24 _____
25 ²⁸ Only 2 (3.6%) of 56 of the male desisters observed by Steensma et al. had made a complete or
26 partial transition prior to puberty, and of the twelve males who made a complete or partial
27 transition prior to puberty, only two had desisted when surveyed at age 15 or older. Steensma (2013)
at 584.

²⁹ D. Ehrensaft (2015), *Listening and Learning from Gender-Nonconforming Children*, THE
PSYCHOANALYTIC STUDY OF THE CHILD 68(1) 28 at 34.

1 61. Accordingly, I agree with noted researcher in the field Ken Zucker,
2 who has written that social transition in children must be considered “a form of
3 psychosocial treatment.” (Zucker, *Debate*, at 1.)

4 62. I also agree with Dr. Zucker’s further observation that “...we cannot
5 rule out the possibility that early successful treatment of childhood GID [Gender
6 Identity Disorder] will diminish the role of a continuation of GID into adulthood. If
7 so, successful treatment would also reduce the need for the long and difficult
8 process of sex reassignment which includes hormonal and surgical procedures with
9 substantial medical risks and complications.”³⁰

10 63. By the same token, a therapeutic methodology for children that
11 *increases* the likelihood that the child will continue to identify as the opposite
12 gender into adulthood will *increase* the need for the long and potentially
13 problematic processes of hormonal and genital and cosmetic surgical procedures.

14 64. Given these facts, it is the cross-gender affirming methods endorsed by
15 gender identity advocates that are changing the identity outcomes that would
16 otherwise naturally result for the large majority of prepubertal children who suffer
17 from gender dysphoria. It is thus these methods that could most properly be
18 described as “conversion therapy.” By contrast, the watchful waiting approach
19 which monitors the child’s mental health while working to resolve co-morbidities
20 and reduce life stress, and while allowing time for the natural psychosocial
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26 ³⁰ Zucker, *Myth of Persistence*, at 8 (citing H. Meyer-Bahlburg (2002), *Gender Identity Disorder in*
27 *Young Boys: A Parent- & Peer-Based Treatment Protocol*, CLINICAL CHILD PSYCHOLOGY &
PSYCHIATRY 7, 360 at 362.)

1 developmental processes of adolescence to shape the child’s identity, is properly
2 seen as the far less invasive therapeutic approach.

3 65. Not surprisingly, given these facts, encouraging social transition in
4 children remains controversial. Supporters of such transition acknowledge that
5 “Controversies among providers in the mental health and medical fields are
6 abundant. . . . These include differing assumptions regarding . . . the age at which
7 children . . . should be encouraged or permitted to socially transition These are
8 complex and providers in the field continue to be at odds in their efforts to work in
9 the best interests of the youth they serve.”³¹
10
11

12 66. In sum, therapy for young children that encourages transition
13 (including use of names, pronouns, clothing, and restrooms associated with the
14 opposite sex) cannot be considered to be neutral, but instead is an experimental
15 procedure that has a high likelihood of changing the life path of the child, with
16 highly unpredictable effects on mental and physical health, suicidality, and life
17 expectancy. Claims that a civil right is at stake do not change the fact that what is
18 proposed is a social and medical experiment. (Levine, *Reflections*, at 241.) Ethically,
19 then, it should be undertaken only subject to standards, protocols, and reviews
20 appropriate to such experimentation. In my judgment, many gender clinics today
21 are encouraging and assisting children to transition without following these
22 ethically required procedures.
23
24
25

26 ³¹ A. Tishelman et al. (2015), *Serving Transgender Youth: Challenges, Dilemmas and Clinical*
27 *Examples*, PROF. PSYCHOL. RES. PR. at 11 (“*Serving TG Youth*”) (available at
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4719579/pdf/nihms706503.pdf>).

1 67. Moreover, it is not clear how these clinics could create a legal, ethical,
2 and practical informed consent process. Parents would need to understand the risks
3 and benefits of the recommended therapy and of alternative approaches, and to
4 grapple with the scientific deficiencies in this arena, including: the absence of
5 randomized controlled studies, the absence of long follow-up studies of previous
6 children who have undergone these interventions, and the rates of success and
7 failure of the intervention. And it is a difficult question when either minors or
8 parents can ethically (and perhaps legally) grant consent to a medical or
9 therapeutic pathway that carries a high probability of leading to prescription of
10 potentially sterilizing drugs while the child is still a minor. In every case, the
11 professional has an ethical obligation to ensure that meaningful and legal informed
12 consent is obtained.
13
14

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

18 68. Gender clinics are increasingly prescribing puberty blockers for
19 children as young as ten, as a component of a regime that commonly includes social
20 transition. Puberty blockers are often described as merely providing a completely
21 reversible “pause,” which supposedly gives the child additional time to determine
22 his or her gender identity while avoiding distress which would be caused by
23 pubertal development of the body consistent with the child’s biological sex. The
24 language used about puberty blockers often states or implies that this major
25 hormonal disruption of some of the most basic aspects of ordinary human
26 development is a small thing, and entirely benign.
27

1 69. In fact, it is important to recognize that the available (limited)
2 evidence suggests that clinically, puberty blockers administered to children at these
3 ages, for this purpose, and in conjunction with social transition, do not operate as a
4 “pause.” After reviewing the evidence provided by experts from different
5 perspectives, including an expert declaration that I submitted, the U.K. High Court
6 recently concluded that “the vast majority of children who take [puberty blockers]
7 move on to take cross-sex hormones,” and thus that puberty blockers in practice act
8 as a “stepping stone to cross-sex hormones.”³² In my opinion, this finding accurately
9 summarizes the available data.
10

11
12 70. It is equally important to recognize that administration of puberty
13 blockers as a treatment for gender dysphoria is an off-label use of these powerful
14 drugs which is entirely experimental. This application can by no means be
15 considered equivalent to the only application for which puberty blockers have been
16 tested for efficacy and safety and approved—which is for the delay of precocious
17 puberty until the normal time for pubertal development. The U. K. High Court
18 panel accurately summarized the science when they described the use of puberty
19 blockers as “experimental” and as putting children on a “clinical pathway” which is
20 a “lifelong and life changing treatment . . . with very limited knowledge of the
21 degree to which it will or will not benefit them.” (*Tavistock*, ¶¶136, 143.)
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26 ³² Opinion of the United Kingdom High Court of Justice Administrative Court, Divisional Court
27 (December 1, 2020), in *Bell and A. v. Tavistock and Portman NHS Trust and Others*, Case No:
CO/60/2020, at ¶¶136-137 (available at <https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf>.)

1 71. This is a very profound experiment being conducted on children. It is
2 well known that the hormonal changes associated with ordinary puberty drive not
3 only the obvious physical and sexual changes in the adolescent, but also drive
4 important steps in cognitive development—that is, in brain functioning—as well as
5 increases in bone density. As the bodies and interests of peers change, the trans
6 adolescent who—as a result of puberty blockade hormones— maintains a puerile
7 appearance and development, risks isolation and social anxiety. This risk is not
8 given adequate weight when the treatment is justified as creating merely a useful
9 pause.
10

11
12 72. We simply do not have meaningful data concerning the long-term
13 effects on brain, bone, and other organs of interrupting or preventing this natural
14 developmental process between the ages of 10 and 16. Psychology likewise does not
15 know the long-term effects on coping skills, interpersonal comfort, and intimate
16 relationships of pubertal blockade and, as it were, standing on the sideline in the
17 years when one’s peers are undergoing their maturational gains in these vital
18 arenas of future mental health.
19

20 73. A number of recent papers have claimed to report beneficent or at least
21 neutral short-term effects of use of puberty blockers. None of these even purports to
22 address long-term effects as the subjects mature into adulthood, and even as to
23 short-term effects these studies suffer from methodological deficiencies that prevent
24 them from supporting such conclusions. Recently, the British National Health
25 Service commissioned the respected National Institute for Health and Care
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27

1 Excellence (NICE) to conduct a thorough evidence review of all available studies
2 that touch on the efficacy and safety of use of puberty blockers for children with
3 gender dysphoria. The exhaustive, 130-page results of this review were published in
4 October 2020. While of course this report provides extensive detail, its overall
5 summary was that, according to widely accepted criteria for measuring the
6 reliability of clinical evidence, “The quality of evidence for [all claims concerning
7 safety and efficacy of this use of puberty blockers] was assessed as very low
8 certainty.”³³ They found that “the studies all lack appropriate controls” and “were
9 not reliable,” that “the studies that reported safety outcomes provided very low
10 certainty evidence,” and that studies that claimed marginally positive outcomes
11 “could represent changes that are either of questionable clinical value, or the
12 studies themselves are not reliable and changes could be due to confounding bias or
13 chance.” (NICE at 13.)

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17 74. So far as I am aware, no study yet reveals whether the life-course
18 mental and physical health outcomes for the relatively new class of “persisters”
19 (that is, those who would have desisted absent a transgender-affirming social and/or
20 pharmaceutical intervention, but instead persisted as a result of such interventions)
21 are more similar to those of the general non-transgender population, or to the
22 notably worse outcomes exhibited by the transgender population generally.
23
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26 ³³ NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (2020), Evidence review: Gonadotrophin
27 releasing hormone analogues for children and adolescence with gender dysphoria (available at
<https://arms.nice.org.uk/resources/hub/1070905/attachment.>)

1 75. Taking into account the risks, the lack of any reliable evidence
2 concerning long-term outcomes from the use of puberty blockers, and the inability of
3 pre-adolescents and even adolescents to comprehend the physical, relational, and
4 emotional significance of life as a sexually mature adult, I also agree with the
5 conclusion of the U. K. High Court that “it is highly unlikely that a child age 13 or
6 under would ever be . . . competent to give consent to being treated with [puberty
7 blockers],” and that it is “very doubtful” that a child of 14 or 15 “could understand
8 the long-term risks and consequences of treatment in such a way as to have
9 sufficient understanding to give consent.” (*Tavistock*, ¶ 145.)
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11
12 IV. THE AVAILABLE DATA DOES NOT SUPPORT THE CONTENTION THAT
13 “AFFIRMATION” OF TRANSGENDER IDENTITY IN CHILDREN AND
14 ADOLESCENTS REDUCES SUICIDE OR RESULTS IN BETTER
PHYSICAL OR MENTAL HEALTH OUTCOMES GENERALLY.

15 76. I am aware that organizations including The Academy of Pediatrics
16 and Parents and Friends of Lesbians and Gays (PFLAG) have published statements
17 that suggest that all children who express a desire for a transgender identity should
18 be promptly supported in that claimed identity. Recently, the governing counsel of
19 the American Psychological Association adopted the *APA Resolution on Gender*
20 *Identity Change Efforts*, which broadly (and wrongly) categorizes any approach to
21 gender dysphoria other than gender affirming methods as unethical and dangerous.
22 These positions appear to rest on the belief—which is widely promulgated by
23 certain advocacy organizations—that science has already established that prompt
24 “affirmance” is best for all patients, including all children and adolescents, who
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1 present indicia of transgender identity.³⁴ As I have discussed above and further
2 discuss later below, this belief is scientifically incorrect, and ignores both what is
3 known and what is unknown.

4 77. The knowledge base concerning the causes and treatment of gender
5 dysphoria has low scientific quality.

6 78. In evaluating claims of scientific or medical knowledge, it is important
7 to understand that it is axiomatic in science that no knowledge is absolute, and to
8 recognize the widely-accepted hierarchy of reliability when it comes to “knowledge”
9 about medical or psychiatric phenomena and treatments. Unfortunately, in this
10 field opinion is too often confused with knowledge, rather than clearly locating what
11 exactly is scientifically known. In order of increasing confidence, such “knowledge”
12 may be based upon data comprising:

13 a. Expert opinion—it is perhaps surprising to educated laypersons
14 that expert opinion standing alone is the lowest form of knowledge, the least
15 likely to be proven correct in the future, and therefore does not garner as
16 much respect from professionals as what follows;

17 b. A single case or series of cases (what could be called anecdotal
18 evidence) (Levine, *Reflections*, at 239.);

19 c. A series of cases with a control group;

20 d. A cohort study;

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³⁴ The APA Resolution on Gender Identity Change Efforts (APA GICE Resolution) is available at
<https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf>.

- e. A randomized double-blind clinical trial;
- f. A review of multiple trials;
- g. A meta-analysis of multiple trials that maximizes the number of patients treated despite their methodological differences to detect trends from larger data sets.

79. The strongest forms of scientific knowledge emerge from the latter three types of research—randomized, blind trials; reviews of multiple randomized, blind trials, and meta-analyses. When the APA Task Force on Promotion and Dissemination of Psychological Procedures considered what criteria would empirically validate a treatment, the task force relied heavily on whether a procedure had been “tested in randomized controlled trials (RCT) with a specific population and implemented using a treatment manual.”³⁵ Social affirmation of children, use of puberty blockers as a treatment for gender dysphoria, and administration of cross-sex hormones to adolescents, have never been clinically tested and validated in this way.

80. Critically, “there are no randomized control trials with regard to treatment of children with gender dysphoria.” (Zucker, *Myth of Persistence*, at 8.) On numerous critical questions relating to cause, developmental path if untreated, and the effect of alternative treatments, the knowledge base remains primarily at the level of the practitioner’s exposure to individual cases, or multiple individual

³⁵ Am. Psych. Assoc’n (2006), *Evidence-Based Practice in Psychology*, AM. PSYCHOLOGIST, Vol. 61, No. 4, 271 at 272.

1 cases. As a result, claims to certainty are not justifiable. (Levine, *Reflections*, at
2 239.)

3 81. Unfortunately, advocates of unquestioning affirmation further
4 complicate efforts to understand the available science by speaking indistinctly,
5 ignoring differences between approaches that are likely to be clinically important.
6 For example, the recent APA resolution speaks of “individuals who have
7 experienced pressure or coercion to conform to their sex assigned at birth.” (APA
8 GICE at 1.) “Pressure or coercion” does not describe either the “watchful waiting”
9 or psychotherapy models I have described above, nor therapy structured around a
10 patient’s own desire to become comfortable with his or her natal sex. Nor is it
11 possible to extrapolate from outcomes experienced by those who have been
12 subjected to “coercive” techniques to predict outcomes for patients who receive
13 responsible “watchful waiting” or psychotherapeutic care as I have described and as
14 many experienced practitioners practice.
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18 82. Unsurprisingly, prominent voices in the field have emphasized the
19 severe lack of scientific knowledge in this field. The American Academy of Child and
20 Adolescent Psychiatry has recognized that “Different clinical approaches have been
21 advocated for childhood gender discordance. . . . There have been no randomized
22 controlled trials of any treatment. . . . [T]he proposed benefits of treatment to
23 eliminate gender discordance . . . must be carefully weighed against . . . possible
24 deleterious effects.” (Adelson et al., *Practice Parameter*, at 968–69.) Similarly, the
25 APA has stated, “because no approach to working with [transgender and gender
26
27

1 nonconforming] children has been adequately, empirically validated, consensus does
2 not exist regarding best practice with pre-pubertal children.”³⁶

3 83. Contrary to the impression that statements in the recent APA GICE
4 Resolution might leave, recent published research has not changed this situation. It
5 remains the case that no randomized controlled trials of any treatment for gender
6 dysphoria have been conducted, and recently published studies suffer from other
7 serious methodological defects as well.

8 84. For example, the APA GICE Resolution cites Turban et al. (2020),
9 *Association between recalled exposure to gender identity conversion efforts and*
10 *psychological distress and suicide attempts among transgender adults*,³⁷
11 (“*Association*”), and this article has been cited to support claims that failing to
12 affirm a transgender identity in children presenting with gender dysphoria results
13 in a higher risk of their attempting suicide.

14 85. But the sample and methodology of Turban, *Association* (2020) are
15 profoundly flawed and cannot support such a conclusion. A group of researchers has
16 published a detailed critique of these defects,³⁸ which I will not attempt to replicate
17 here. To highlight the most obvious defects, however, *Association* (2020) relied
18 entirely on data drawn from an online convenience sampling of transgender-
19 identified and genderqueer adults recruited from trans-affirming websites. It is well
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25 ³⁶ Am. Psych. Assoc’n (2015), *Guidelines for Psychological Practice with Transgender & Gender*
Nonconforming People, AM. PSYCHOLOGIST 70(9) 832 at 842.

26 ³⁷ 77 JAMA PSYCHIATRY 77(1) 68-76.

27 ³⁸ R. D’Angelo, et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*
(2021), ARCH. SEX BEHAV. 50, 7-16.

1 known that one “cannot make statistical generalizations from research that relies
2 on convenience sampling.”³⁹ Nor did the authors of *Association* (2020) control for the
3 subjects’ mental health status prior to the reported exposure to what the study
4 deemed a “gender identity change effort.” I agree with D’Angelo et al. (2021) that
5 “failure to control for the subjects’ baseline mental health makes it impossible to
6 determine whether the mental health or the suicidality of subjects worsened, stayed
7 the same, or potentially even improved after the non-affirming encounter.”
8 (D’Angelo (2021) at 10.)
9

10 86. Looking at the literature in this area more broadly, a review of 28
11 studies of outcomes from hormonal therapy in connection with sex reassignment
12 reported that these studies provided only “very low quality evidence” for a variety of
13 reasons.⁴⁰ Large gaps exist in the medical community’s knowledge regarding the
14 long-term effects of sex-reassignment surgery (SRS) and other gender identity
15 disorder treatments in relation to their positive or negative correlation to suicidal
16 ideation, attempts, and completion.
17

18 87. What is known is not encouraging. With respect to suicide, individuals
19 with gender dysphoria are well known to commit suicide or otherwise suffer
20 increased mortality before and after not only social transition, but also before and
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24 ³⁹ *Handbook of Survey Methodology for the Social Sciences* (2021) (Lior Gideon, ed. Springer).

25 ⁴⁰ H. Murad et al. (2010), *Hormonal therapy and sex reassignment: a systematic review and meta-*
26 *analysis of quality of life and psychosocial outcomes*. CLINICAL ENDOCRINOLOGY; 72(2): 214-231. See
27 also R. D’Angelo (2018), *Psychiatry’s ethical involvement in gender-affirming care*, AUSTRALASIAN
PSYCHIATRY Vol 26(5) 460-463, noting the large number of non-responders in follow-up outcome
studies, and observing that “it is generally not known whether they are alive or dead,” and that “it is
. . . pure speculation to assume that none . . . committed suicide.”

1 after SRS. (Levine, *Reflections*, at 242.) For example, in the United States, the
2 death rates of trans veterans are comparable to those with schizophrenia and
3 bipolar diagnoses—20 years earlier than expected. These crude death rates include
4 significantly elevated suicide rates. (Levine, *Ethical Concerns*, at 10.) Similarly,
5 researchers in Sweden and Denmark have reported on almost all individuals who
6 underwent sex-reassignment surgery over a 30-year period.⁴¹ The Swedish follow-
7 up study found a suicide rate in the post-SRS population 19.1 times greater than
8 that of the controls; both studies demonstrated elevated mortality rates from
9 medical and psychiatric conditions. (Levine, *Ethical Concerns*, at 10.)
10

11
12 88. Advocates of immediate and unquestioning affirmation of social
13 transition in children who indicate a desire for a transgender identity sometimes
14 assert that any other course will result in a high risk of suicide in the affected
15 children and young people. Contrary to these assertions, no studies show that
16 affirmation of children (or anyone else) reduces suicide, prevents suicidal ideation,
17 or improves long-term outcomes, as compared to either a “watchful waiting” or a
18 psychotherapeutic model of response, as I have described above.⁴²
19

20 89. In considering “suicide,” mental health professionals distinguish
21 between suicidal thoughts (ideation), suicide gestures, suicide attempts with a
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24 ⁴¹ C. Dhejne et al. (2011), *Long-Term Follow-Up of Transsexual Persons Undergoing Sex*
25 *Reassignment Surgery: Cohort Study in Sweden*, PLOS ONE 6(2) e16885 (“*Long Term*”); R. K.
26 Simonsen et al. (2016), *Long-Term Follow-Up of Individuals Undergoing Sex Reassignment Surgery:*
27 *Psychiatric Morbidity & Mortality*, NORDIC J. OF PSYCHIATRY 70(4):241-7

⁴² A recent article, J. Turban et al. (2020), *Puberty Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS 145(2), has been described in press reports as demonstrating that administration of puberty-suppressing hormones to transgender adolescents reduces suicide or suicidal ideation. The paper itself does not make that claim, nor permit that conclusion.

1 lethal potential, and completed suicide. Numerous studies have found suicidal
2 ideation to have been present at some time in life in ~40-50% of trans-identifying
3 persons. This figure is approximately twice that reported in gay and lesbian
4 communities. In the heteronormative communities, ideation is approximately 4%.
5 Mental health professionals distinguish clearly between gestures and potentially
6 lethal attempts, which often result in hospitalization.
7

8 90. I will also note that any discussion of suicide when considering
9 younger children involves very long-range and very uncertain prediction. Suicide in
10 pre-pubescent children is rare and the existing studies of gender identity issues in
11 pre-pubescent children do not report significant incidents of suicide. The estimated
12 suicide rate of trans adolescents is the same as teenagers who are in treatment for
13 serious mental illness. What trans teenagers do demonstrate is more suicidal
14 ideation and attempts (however serious) than other teenagers.⁴³ Their completed
15 suicide rates are not known.
16
17

18 91. In sum, claims that affirmation will reduce the risk of suicide for
19 children are not based on science. Such claims overlook the lack of even short-term
20 supporting data as well as the lack of studies of long-term outcomes resulting from
21 the affirmation or lack of affirmation of transgender identity in children. They also
22 overlook the other tools that the profession does have for addressing depression and
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26 ⁴³ A. Perez-Brumer, et al. (2017), *Prevalence & Correlates of Suicidal Ideation Among Transgender*
27 *Youth in Cal.: Findings from a Representative, Population-Based Sample of High Sch. Students*, J.
AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 56(9) at 739.

1 suicidal thoughts in a patient once that risk is identified. (Levine, *Reflections*, at
2 242.)

3 92. A number of data sets have also indicated significant concerns about
4 wider indicators of physical and mental health, including ongoing functional
5 limitations;⁴⁴ substance abuse, depression, and psychiatric hospitalizations;⁴⁵ and
6 increased cardiovascular disease, cancer, asthma, and COPD.⁴⁶ Worldwide
7 estimates of HIV infection among transgendered individuals are up to 17-fold
8 higher than the cisgender population. (Levine, *Informed Consent*, at 6.)

9
10 93. Meanwhile, no studies show that affirmation of pre-pubescent children
11 or adolescents leads to more positive outcomes (mental, physical, social, or
12 romantic) by, e.g., age 25 or older than does “watchful waiting” or ordinary therapy.
13 Because affirmation and social transition for children and adolescents, and the use
14 of puberty blockers for transgender children, are a recent phenomenon, it could
15 hardly be otherwise.
16

17
18 94. Given what is known and what is not known about the incidence and
19 causes of suicide attempts and suicide in children and adolescents who suffer from
20 gender dysphoria, and what is known about the incidence of suicide attempts and
21 suicide in individuals who have transitioned to live in a transgender identity, it is in
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25 ⁴⁴ G. Zeluf, et al. (2016), *Health, Disability and Quality of Life Among Trans People in Sweden—A*
Web-Based Survey, BMC PUBLIC HEALTH 16, 903.

26 ⁴⁵ C. Dhejne, et al. (2016), *Mental Health & Gender Dysphoria: A Review of the Literature*, INT’L REV.
OF PSYCHIATRY 28(1) 44.

27 ⁴⁶ C. Dragon, et al. (2017), *Transgender Medicare Beneficiaries & Chronic Conditions: Exploring Fee-
for-Service Claims Data*, LGBT HEALTH 4(6) 404.

1 my view unethical for a mental health professional to tell a young patient, or the
2 parents of a young patient, that social transition, puberty blockers, or use of cross-
3 sex hormones will reduce the likelihood that the young person will commit suicide.
4

5 95. Instead, transition of any sort must be justified, if at all, as a life-
6 enhancing measure, not a lifesaving measure. (Levine, *Reflections*, at 242.) In my
7 opinion, this is an important fact that patients, parents, and even many MHPs fail
8 to understand.

9 V. KNOWN, LIKELY, OR POSSIBLE DOWNSIDE RISKS ATTENDANT ON
10 MOVING QUICKLY TO “AFFIRM” TRANSGENDER IDENTITY IN
11 CHILDREN AND ADOLESCENTS.

12 96. As I have detailed above, enabling and affirming social transition in a
13 prepubescent child appears to be highly likely to increase the odds that the child
14 will in time pursue pubertal suppression and persist in a transgender identity into
15 adulthood. This means that the MHP, patient, and in the case of minors, parents
16 must consider long-term as well as short-term implications of life as a transgender
17 individual when deciding whether to permit or encourage a child to socially
18 transition.
19

20 97. Indeed, given the very high rates of children who desist from desiring a
21 trans identity through the course of uninterrupted puberty, it is efforts to “affirm” a
22 sex-discordant gender identity in prepubescent children that should be understood
23 as the therapeutic path that is most likely to “change” or “convert” the child’s adult
24 gender identification, diverting the child from his or her probable maturation away
25 from trans-identification.
26
27

1 98. The APA and other gender identity advocates argue that gender
2 affirmation practices are safe and effective. (APA GICE Resolution at 3.) But if we
3 consider the long term—a life course perspective—a great deal of data point in the
4 opposite direction. The multiple studies from different nations (including societies
5 which pride themselves on being actively inclusive of sexual minorities, such as
6 Sweden and Denmark) that have documented the increased vulnerability of the
7 adult transgender population to substance abuse, mood and anxiety disorders,
8 suicidal ideation, and other health problems warn us that assisting the child or
9 adolescent down the road to becoming a transgender adult is a very serious
10 decision, and stand as a reminder that a casual assumption that transition will
11 improve the young person’s life is not justified based on numerous scientific
12 snapshots of cohorts of trans adults and teenagers. American public health
13 professionals repeatedly have published descriptions of trans populations as
14 marginalized and vulnerable to many adversities.⁴⁷

15 99. The possibility that steps along this pathway, while lessening the pain
16 of gender dysphoria, could lead to additional sources of crippling emotional and
17 psychological pain, are too often not considered by advocates of social transition and
18 not considered at all by the trans child. (Levine, *Reflections*, at 243.)

19 100. I detail below several classes of predictable, likely, or possible harms to
20 the patient associated with transitioning to live as a transgender individual.

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26 ⁴⁷ K. L. Ard, & A. S. Keuroghlian (2018), *Training in Sexual and Gender Minority Health - Expanding*
27 *Education to Reach All Clinicians*. NEW ENGLAND J. OF MED, 379(25), 2388–2391; W. Liszewski et al.
(2018), *Persons of Nonbinary Gender - Awareness, Visibility, and Health Disparities*. NEW ENGLAND J.
OF MED., 379(25), 2391–2393.

1 A. Physical risks associated with transition

2 101. Sterilization. It is not uncommon for patients who begin down the path
3 defined by puberty blockers and social transition to end up feeling the need to
4 undergo surgical treatment to alleviate gender dysphoria. As I have noted above,
5 there is not good scientific evidence that SRS results in better long-term mental
6 health outcomes. What is certain, however, is that SRS that removes testes, ovaries,
7 or the uterus is inevitably sterilizing, and irreversible. While some patients who
8 have experienced regret after undergoing SRS have then undergone reconstructive
9 surgery, such surgery cannot restore fertility. And while by no means all
10 transgender adults elect SRS, many patients do ultimately feel compelled to take
11 this serious step in their effort to live fully as the opposite sex.
12
13

14 102. More immediately, practitioners recognize that the administration of
15 cross-sex hormones, which is often viewed as a less “radical” measure, and is now
16 increasingly done to minors, creates at least a risk of irreversible sterility. The U.K.
17 High Court in the Tavistock litigation, after reviewing the evidence, concluded that
18 cross-sex hormones “may well lead to a loss of fertility,” and in my opinion that
19 finding accurately summarizes the present medical understanding.⁴⁸ As a result,
20 even when treating a child, the MHP, patient, and parents must consider loss of
21 reproductive capacity—sterilization—to be one of the major risks of starting down
22 the road. The risk that supporting social transition may put the child on a pathway
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25 _____
26 ⁴⁸ *Bell v. Tavistock* Opinion (December 1, 2020), ¶138. *See also* C. Guss et al., *TGN Adolescent Care*
27 at 4 (“a side effect [of cross-sex hormones] may be infertility”) and 5 (“cross-sex hormones . . . may
have irreversible effects”); Tishelman et al., *Serving TG Youth* at 8 (Cross-sex hormones are
“irreversible interventions” with “significant ramifications for fertility”).

1 that leads to intentional or unintentional permanent sterilization is particularly
2 concerning given the disproportionate representation of minority and other
3 vulnerable groups among children reporting a transgender or gender-
4 nonconforming identity. (*See supra* ¶ 24.)

5
6 103. Loss of sexual response. Puberty blockers prevent maturation of the
7 sexual organs and response. Some, and perhaps many, transgender individuals who
8 transitioned as children and thus did not go through puberty consistent with their
9 sex face significantly diminished sexual response as they enter adulthood and are
10 unable ever to experience orgasm. In the case of males, the cross-sex administration
11 of estrogen limits penile genital function. Much has been written about the negative
12 psychological and relational consequences of anorgasmia among non-transgender
13 individuals that is ultimately applicable to the transgendered. (Levine, *Informed*
14 *Consent*, at 6.)

15
16
17 104. Other effects of hormone administration. I have discussed the risks
18 and unknowns associated with puberty blockers above, noting that most children
19 who are started on puberty blockers continue on the pathway to cross-sex hormones.
20 It is well known that many effects of cross-sex hormones cannot be reversed should
21 the patient later regret his transition. After puberty, the individual who wishes to
22 live as the opposite sex will in most cases have to take cross-sex hormones for most
23 of their life, even after undergoing sex reassignment surgery.
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1 105. The long-term health risks of this major alteration of hormonal levels
 2 have not yet been quantified in terms of exact risk.⁴⁹ However, a recent study found
 3 greatly elevated levels of strokes and other acute cardiovascular events among
 4 male-to-female transgender individuals taking estrogen. Those authors concluded,
 5 “it is critical to keep in mind that the risk for these cardiovascular events in this
 6 population must be weighed against the benefits of hormone treatment.”⁵⁰ Another
 7 group of authors similarly noted that administration of cross-sex hormones creates
 8 “an additional risk of thromboembolic events”—which is to say blood clots (Guss et
 9 al., *TGN Adolescent Care* at 5), which are associated with strokes, heart attacks,
 10 and lung and liver failure. Clinicians must distinguish the apparent short-term
 11 safety of hormones from likely or possible long-term consequences, and help the
 12 patient or parents understand these implications as well. The young patient may
 13 feel, “I don’t care if I die young, just as long I get to live as a woman.” The mature
 14 adult may take a different view.

15
 16
 17
 18 106. Health risks inherent in complex surgery. Complications of surgery
 19 exist for each procedure,⁵¹ and complications in surgery affecting the reproductive
 20 organs and urinary tract can have significant anatomical and functional
 21 complications for the patient’s quality of life.
 22

23
 24 ⁴⁹ See Tishelman et al., *Serving TG Youth* at 6-7 (Long-term effect of cross-sex hormones “is an area where we currently have little research to guide us.”).

25 ⁵⁰ D. Getahun et al. (2018), *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, ANN. OF INTERN. MED. 169(4) 205 at 8.

26 ⁵¹ Levine, *Informed Consent*, at 5 (citing T. van de Grift, G. Pigot et al. (2017), *A Longitudinal Study of Motivations Before & Psychosexual Outcomes After Genital Gender-Confirming Surgery in Transmen*, J. SEXUAL MED.14(12) 1621).

1 107. Disease and mortality generally. The MHP, the patient, and in the
2 case of a child, the parent must also be aware of the wide sweep of strongly negative
3 health outcomes among transgender individuals, as I have detailed above.

4 B. Social risks associated with transition

5 108. Family and friendship relationships. Gender transition routinely leads
6 to isolation from at least a significant portion of one's family in adulthood. In the
7 case of a juvenile transition, this will be less dramatic while the child is young, but
8 commonly increases over time as the child and his siblings mature into adulthood.
9 By adulthood, the friendships of transgender individuals tend to be confined to
10 other transgender individuals (often "virtual" friends known only online) and the
11 generally limited set of others who are comfortable interacting with transgender
12 individuals. (Levine, *Ethical Concerns*, at 5.)

13 109. Long term psychological and social impact of sterility. The life-long
14 negative emotional impact of infertility on both men and women has been well
15 studied. While this impact has not been studied specifically within the transgender
16 population, the opportunity to be a parent is likely a human, emotional need, and so
17 should be considered an important risk factor when considering gender transition
18 for any patient. However, it is particularly difficult for parents of a young child to
19 seriously contemplate that child's potential as a future parent and grandparent.
20 This makes it all the more critical that the MHP spend substantial and repeated
21 time with parents to help them see the implications of what they are considering.
22

23 110. Sexual-romantic risks associated with transition. After adolescence,
24 transgender individuals find the pool of individuals willing to develop a romantic
25

1 and intimate relationship with them to be greatly diminished. When a trans person
2 who passes well reveals his or her natal sex, many potential cisgender mates lose
3 interest. When a trans person does not pass well, he discovers that the pool of those
4 interested consists largely of individuals looking for exotic sexual experiences rather
5 than genuinely loving relationships. (Levine, *Ethical Concerns*, at 5, 13.) Nor is the
6 problem all on the other side; transgender individuals commonly become strongly
7 narcissistic, unable to give the level of attention to the needs of another that is
8 necessary to sustain a loving relationship.⁵²

10
11 111. Social risks associated with delayed puberty. The social and
12 psychological impacts of remaining puerile for, e.g., three to five years while one's
13 peers are undergoing pubertal transformations, and of undergoing puberty at a
14 substantially older age, have not been systematically studied, although clinical
15 mental health professionals often hear of distress and social awkwardness in those
16 who naturally have a delayed onset of puberty. In my opinion, individuals in whom
17 puberty is delayed multiple years are likely to suffer at least subtle negative
18 psychosocial and self-confidence effects as they stand on the sidelines while their
19 peers are developing the social relationships (and attendant painful social learning
20 experiences) that come with adolescence. (Levine, *Informed Consent*, at 9.)

22
23 C. Mental health costs or risks

24 112. One would expect the negative physical and social impacts reviewed
25 above to adversely affect the mental health of individuals who have transitioned. In
26

27 ⁵² S. Levine, *Barriers to Loving: A Clinician's Perspective* (Routledge, New York 2013) at 40.

1 addition, adult transitioned individuals find that living as the other (or, in a
2 manner that is consistent with the stereotypes of the other as the individual
3 perceives them) is a continual challenge and stressor, and many find that they
4 continue to struggle with a sense of inauthenticity in their transgender identity.
5
6 (Levine, *Informed Consent*, at 9.)

7 113. In addition, individuals often pin excessive hope in transition,
8 believing that transition will solve what are in fact ordinary social stresses
9 associated with maturation, or mental health co-morbidities. Thus, transition can
10 result in deflection from mastering personal challenges at the appropriate time or
11 addressing conditions that require treatment.
12

13 114. Whatever the reason, transgender individuals including transgender
14 youth certainly experience greatly increased rates of mental health problems. I have
15 detailed this above with respect to adults living under a transgender identity.
16 Indeed, Swedish researchers in a long-term study (up to 30 years since SRS, with a
17 median time since SRS of > 10 years) concluded that individuals who have SRS
18 should have postoperative lifelong psychiatric care. (Dhejne, *Long Term*, at 6-7.)
19
20 With respect to youths a cohort study found that transgender youth had an elevated
21 risk of depression (50.6% vs. 20.6%) and anxiety (26.7% vs. 10.0%); a higher risk of
22 suicidal ideation (31.1% vs. 11.1%), suicide attempts (17.2% vs. 6.1%), and self-harm
23 without lethal intent (16.7% vs. 4.4%) relative to the matched controls; and a
24 significantly greater proportion of transgender youth accessed inpatient mental
25
26
27

1 health care (22.8% vs. 11.1%) and outpatient mental health care (45.6% vs. 16.1%)
2 services.⁵³

3 115. The responsible MHP cannot focus narrowly on the short-term
4 happiness of the patient, but must instead consider the happiness and health of the
5 patient from a “life course” perspective. The many studies that I have cited here
6 warn us that as we look ahead to the patient’s life as a young adult and adult, the
7 prognosis for the physical health, mental health, and social well-being of the child
8 or adolescent who transitions to live in a transgender identity is not good.

9
10 116. A study published in 2019 by the American Journal of Psychiatry
11 reported the high mental health utilization patterns of adults for ten years after
12 surgery for approximately 35% of patients.⁵⁴ That is a very high level of mental
13 health distress, compared to the general population.

14
15 117. This same 2019 study received considerable attention for its claim to
16 discern “a statistically significant relationship between time since surgery and
17 mental health status” based upon the researchers observing “that as of 2015,
18 patients who had surgeries further in the past had better mental health than
19 patients whose surgeries were more recent.”⁵⁵ But this claim is another example of
20 the grave methodological defects that are too common in recent publications in this
21
22

23 ⁵³ S. Reisner et al. (2015), *Mental Health of Transgender Youth in Care at an Adolescent Urban*
24 *Community Health Center: A Matched Retrospective Cohort Study*, J. OF ADOLESCENT HEALTH 56(3)
at 6; see also supra ¶ 24.

25 ⁵⁴ Bränström & Pachankis, (2019), *Reduction in Mental Health Treatment Utilization Among*
26 *Transgender Individuals After Gender-Affirming Surgeries*, AM. J. OF PSYCHIATRY 177(8) 727-734.

27 ⁵⁵ *Correction of a Key Study: No Evidence of “Gender-Affirming” Surgeries Improving Mental Health*,
Society for Evidence Based Gender Medicine (Aug. 30, 2020), https://www.segm.org/ajp_correction_2020 (citing and summarizing professional critiques of the *Reduction* article).

1 field. Shortly after publication, the study’s analysis and conclusion were trenchantly
2 criticized, among other reasons because of the study’s failure to compare subjects’
3 post-surgery mental health with those subjects’ mental health *before* undergoing
4 SRS.
5

6 118. As a result of two post-publication reviews by independent statisticians
7 that rejected the interpretation of the data and additional critical letters to the
8 editor, the authors corrected the article to retract the claim of a statistically
9 significant relationship between gender affirmation surgery and later-improved
10 mental health (while leaving intact a finding of “no evidence of benefits of hormonal
11 treatments”). Specifically, the American Journal of Psychiatry stated that “the
12 results [of the reanalysis] demonstrated no advantage of surgery in relation to
13 subsequent mood or anxiety disorder-related health care visits or prescriptions or
14 hospitalizations following suicide attempts.”⁵⁶
15
16

17 119. The *Reduction* article is notable for another, and positive, reason, as its
18 authors acknowledged valid critiques and corrected the claims in their published
19 work.⁵⁷ This is the way science should work—contending views testing the data and
20 conclusions—something that is increasingly difficult to do in the gender identity
21 field when its advocates insist that only gender affirmation treatments are to be
22 contemplated.
23
24

25 ⁵⁶Correction to Bränström and Pachankis (2020), AM. J. OF PSYCHIATRY 177:8 at 734.

26 ⁵⁷ R. Bränström and J. E. Pachankis (2020), *Toward Rigorous Methodologies for Strengthening*
27 *Causal Inference in the Association Between Gender-Affirming Care and Transgender Individuals’*
Mental Health: Response to Letters, 177 AM. J. OF PSYCHIATRY 769-772.

1 D. The risk of regret following transition

2 120. The large numbers of children and young adults who have desisted as
3 documented in both group and case studies each represent “regret” over the initial
4 choice in some sense.

5 121. The phenomenon of desistance or regret experienced *later* than
6 adolescence or young adulthood, or among older transgender individuals, has to my
7 knowledge not been quantified or well-studied. However, it is a real phenomenon. I
8 myself have worked with multiple individuals who have abandoned trans female
9 identity after living in that identity for years, and who would describe their
10 experiences as “regret.”
11

12 122. I have seen several Massachusetts inmates and trans individuals in
13 the community abandon their [trans] female identity after several years. (Levine,
14 *Reflections*, at 239.) In the gender clinic which I founded in 1974 and to this day, in
15 a different location, continue to co-direct, we have seen many instances of
16 individuals who claimed a transgender identity for a time, but ultimately changed
17 their minds and reclaimed the gender identity congruent with their sex.
18

19 123. More dramatically, a surgical group prominently active in the SRS
20 field has published a report on a series of seven male-to-female patients requesting
21 surgery to transform their surgically constructed female genitalia back to a male
22 form.⁵⁸
23
24

25
26
27 ⁵⁸ Djordjevic et al. (2016), *Reversal Surgery in Regretful Male-to-Female Transsexuals After Sex Reassignment Surgery*, J. SEX MED. 13(6) 1000.

1 124. I noted above an increasingly visible online community of young
2 women who have desisted after claiming a male gender identity at some point
3 during their teen years. (See *supra* ¶ 58.) Given the rapid increase in the number of
4 girls presenting to gender clinics within the last few years, the phenomena of regret
5 and desistance by young women deserves careful attention and study by MHPs.
6 (See Expósito-Campos, 2021.)
7

8 125. Thus, one cannot assert with any degree of certainty that once a
9 transgendered person, always a transgendered person, whether referring to a child,
10 adolescent, or adult, male or female.
11

12 I, Dr. Stephen B. Levine, hereby declare under penalty of perjury that
13 the statements in this affidavit are true and accurate to the best of my
14 knowledge, and represent my professional opinions.

15
16 By: Stephen B. Levine MD
17 Dr. Stephen B. Levine

18 Subscribed and sworn to before me
19 this 10th day of May, 2021.

20 Mary J Mizner
21 Notary Public, State of Ohio
22 My Commission expires 3/9/25

