

**FILED**  
**02-19-2020**  
**CIRCUIT COURT**  
**DANE COUNTY, WI**  
**2020CV000454**

STATE OF WISCONSIN

CIRCUIT COURT

DANE COUNTY

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JOHN and JANE DOE 1, et al.,

Plaintiffs,

Case No. 20-CV- 454

v.

MADISON METROPOLITAN SCHOOL DISTRICT

Defendant.

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**EXPERT AFFIDAVIT OF**  
**DR. STEPHEN B. LEVINE, M.D.**

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STATE OF OHIO                     )  
  ) SS  
CUYAHOGA COUNTY             )

Stephen B. Levine, being duly sworn, states as follows:

**I. CREDENTIALS & SUMMARY OF OPINIONS**

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

2. Since July 1973 my specialties have included psychological problems and conditions relating to sexuality and sexual relations, therapies for sexual problems, and the relationship between love and intimate relationships and wider mental health. In 2005, I received the Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research. I am a Distinguished Life Fellow of the American Psychiatric Association.

3. I have served as a book and manuscript reviewer for numerous professional publications. I have been the Senior Editor of the first (2003), second (2010) and third (2016) editions of the *Handbook of Clinical Sexuality for Mental Health Professionals*. In addition to five other solo-authored books, I have authored *Psychotherapeutic Approaches to Sexual Problems*, published in 2020; it has a chapter titled “The Gender Revolution”.

4. I first encountered a patient suffering what we would now call gender dysphoria in July 1973. In 1974, I founded the Case Western Reserve University Gender Identity Clinic, and have served as Co-Director of that clinic since that time. Across the years, our Clinic treated hundreds of patients who were experiencing a transgender identity. An occasional child was seen during this era. I was the primary psychiatric care-giver for several dozen of our patients and

supervisor of the work of other therapists. I was an early member of the Harry Benjamin International Gender Dysphoria Association (later known as WPATH) and served as the Chairman of the Standards of Care Committee that developed the 5th version of its Standards of Care. In 1993 the 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.

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

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

7. A fuller review of my professional experience, publications, and awards as well as identification of cases in which I have provided expert testimony within the last 13 years, is provided in my curriculum vitae, a copy of which is attached hereto as Exhibit A.

8. In this declaration, I offer, explain, and identify my opinions and the bases for my opinions in this matter. Each of the opinions set forth herein is based on my professional expertise and experience as described above and I hold each of the opinions set forth herein to a reasonable degree of certainty within my field. The facts upon which I rely are the type of facts reasonably relied upon by experts within my field. A summary of my opinions is as follows:

- a. Sex as defined by biology and reproductive function cannot be changed.

While hormonal and surgical procedures may enable some individuals to “pass” as the opposite gender during some or all of their lives, such procedures carry with them physical, psychological, and social risks, and no procedures can enable an individual to perform the reproductive role of the opposite sex. (Section II.A.)

- b. The diagnosis of “gender dysphoria” encompasses a diverse array of

conditions, with widely differing pathways and characteristics depending on age of onset among other things. Data from one population (e.g. adults) cannot be assumed to be applicable to others (e.g. children). (Section II.B.)

- c. Among psychiatrists and psychotherapists who practice in the area, there are

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

- d. A majority of children (in several studies, a large majority) who are diagnosed

with gender dysphoria “desist”—that is, their gender dysphoria does not persist—by puberty or adulthood. It is not currently known how to distinguish children who will persist from those who will not. (Section IV.)

- e. Some recent studies suggest that active affirmation of transgender identity in

young children will substantially reduce the number of children “desisting” from transgender identity. This raises concern that this will increase the number of individuals who suffer the multiple long-term physical, mental, and social limitations that are strongly associated with living life as a transgender person. (Section IV.)

f. Thus, social transition is itself an important intervention with profound implications for the long term mental and physical health of the child. When a mental health professional evaluates a child or adolescent and then recommends social transition, presumably that professional is available to help with interpersonal, familial, and psychological problems that may arise. However, many adolescents transition without mental health assessment and ongoing care, leaving themselves and their families on their own to deal with subsequent problems. (Section IV.)

g. In most cases, parental involvement is necessary for an accurate and thorough diagnosis of a child or adolescent presenting with gender dysphoria or a desire for a transgender identity, as well as for effective psychotherapeutic treatment and support of the young person. (Section V.)

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

i. There are no studies that show that affirmation of transgender identity in young children reduces suicide, suicidal ideation, or improves long-term outcomes as compared to other therapeutic approaches. Meanwhile, multiple studies show that adult individuals living transgender lives suffer much higher rates of suicide and negative physical and mental health conditions than does the general population. (Section VI.)

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

k. Putting a child or adolescent on a pathway towards life as a transgender person puts that individual at risk of a wide range of long-term or even life-long harms, including: sterilization (whether chemical or surgical) and associated regret and sense of loss; inability to experience orgasm (for trans women); physical health risks associated with exposure to elevated levels of cross-sex hormones; surgical complications and life-long after-care; alienation of family relationships; inability to form healthy romantic relationships and attract a desirable mate; elevated mental health risks. (Section VII.)

l. Informed consent is ethically required for potentially life-altering psychological or medical procedures. However, the informed consent process is not simple. In some cases, it may not be possible to obtain meaningful informed consent to place a child on a psychological pathway that carries with it all the lifetime risks (including sterilization, limited sexual response, and social marginalization) that I detail in this report. The child is not competent to weigh how these risks or issues will impact his or her lifetime happiness. At a minimum, informed consent of parents is essential, although it may not be sufficient. (Section VIII.)

m. With rare exceptions, educators do not have the professional training and experience necessary to guide children and parents through the difficult and potentially life-altering decisions surrounding social transition to a transgender identity, nor can they effectively fill the place of parents in the complex process of diagnosis and therapeutic support of children who suffer from gender dysphoria. Educators have a limited time of involvement with their students, whereas the children's developmental challenges persist as they change grades or schools. (Section VIII.A.)



## **II. BACKGROUND ON THE FIELD**

### **A. The biological base-line of sex**

9. The sex of a human individual at its core structures the individual's biological reproductive capabilities—to produce ova and bear children as a mother, or to produce semen and beget children as a father. Sex determination occurs at the instant of conception, depending on whether a sperm's X or Y chromosome fertilizes the egg. Medical technology can be used to determine a fetus's sex before birth. It is thus not literally correct to assert that doctors “assign” the sex of a child at birth; anyone can identify the sex of an infant by genital inspection. What the general public may not understand, however, is that every nucleated cell of an individual's body is chromosomally identifiably male or female—XY or XX.

10. The self-perceived gender of a child, in contrast, arises in part from how others label the infant: “I love you, son (daughter).” This designation occurs thousands of times in the first two years of life when a child begins to show awareness of the two possibilities. As acceptance of the designated gender corresponding to the child's sex is the outcome in >99% of children everywhere, anomalous gender identity formation begs for understanding. Is it biologically shaped? Is it biologically determined? Is it the product of how the child was privately regarded and treated? Does it stem from trauma-based rejection of maleness or femaleness, and if so flowing from what trauma? Is it a symptom of another, as of yet unrevealed emotional disturbance? The answers to these relevant questions are not scientifically known.

11. Under the influence of hormones secreted by the testes or ovaries, numerous additional sex-specific differences between male and female bodies continuously develop post-natally, culminating in the dramatic maturation of the primary and secondary sex characteristics with puberty. These include differences in hormone levels, height, weight, bone mass, shape and development, musculature, body fat levels and distribution, and hair patterns, as well as

physiological differences such as menstruation. These are genetically programmed biological consequences of sex which also serve to influence the consolidation of gender identity during and after puberty.

12. Despite the increasing ability of hormones and various surgical procedures to reconfigure some male bodies to visually pass as female, or vice versa, the biology of the person remains as defined by his (XY) or her (XX) chromosomes, including cellular, anatomic, and physiologic characteristics and the particular disease vulnerabilities associated with that chromosomally-defined sex. For instance, the XX (genetically female) individual who takes testosterone to stimulate certain male secondary sex characteristics will nevertheless remain unable to produce sperm and father children. Contrary to assertions and hopes that medicine and society can fulfill the aspiration of the trans individual to become “a complete man” or “a complete woman,” this is not biologically attainable.<sup>1</sup> It is possible for some adolescents and adults to pass unnoticed as the opposite gender that they aspire to be—but with limitations, costs, and risks, as I detail later.

**B. Definition and diagnosis of gender dysphoria**

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

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<sup>1</sup> S. Levine (2018), *Informed Consent for Transgendered Patients*, J. OF SEX & MARITAL THERAPY, at 6, DOI: 10.1080/0092623X.2018.1518885 (“*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*”).

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

14. There are at least five distinct pathways to gender dysphoria: early childhood onset; onset near or after puberty with no prior cross gender patterns; onset after homosexual life style; adult onset after years of heterosexual transvestism; and onset in later adulthood with few or no prior indications of cross-gender tendencies or identity. The early childhood onset pathway and the more recently observed onset around puberty pathway are relevant to this matter.

15. Gender dysphoria has very different characteristics depending on age and sex at onset. Young children who are living a transgender identity commonly suffer materially fewer symptoms of concurrent mental distress than do older patients.<sup>2</sup> The developmental and mental health patterns for each of these groups are sufficiently different that data developed in connection with one of these populations cannot be assumed to be applicable to another. (*Id.* at 9.)

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

17. When these criteria in children, (or adolescents, or adults) are not met, two other diagnoses may be given. These are: Other Specified Gender Dysphoria and Unspecified Gender

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<sup>2</sup> K. Zucker (2018), *The Myth of Persistence: Response to "A Critical Commentary on Follow-Up Studies & 'Desistance' Theories about Transgender & Gender Non-Conforming Children"* by Temple Newhook et al., INT'L J. OF TRANSGENDERISM at 10, DOI: 10.1080/15532739.2018.1468293 ("Myth of Persistence").

Dysphoria. Specialists sometimes refer to children who do not meet criteria as being “subthreshold.”

18. Children who conclude that they are transgender are often unaware of a vast array of adaptive possibilities for how to live life as a man or a woman—possibilities that become increasingly apparent over time to both males and females. A boy or a girl who claims or expresses interest in pursuing a transgender identity often does so based on stereotypical notions of femaleness and maleness that are based on constrictive notions of what men and women can be.<sup>3</sup> A young child’s—or even adolescent’s—understanding of this topic is quite limited. Nor do they have the perspective that discomfort with the body and perceived social role is not new to civilization; what is new is the option to become a trans person.

**C. Definition of an “expert in the field”**

19. In my opinion, in order to be considered an expert qualified to diagnose a child or adolescent who may suffer from gender dysphoria or related conditions, or to advise or opine on therapy options, and associated risks and benefits, for children and adolescents presenting with gender-related issues, a healthcare professional should have at least the following qualifications:

a. Enough knowledge of child development to be able to elicit relevant information by history about situation of the pregnancy (wanted, natural, reproductively-assisted), maternal health during pregnancy, health of the child from birth on, timing of the attainment of pediatric developmental milestones, immediately apparent and later revealed congenital abnormalities, parental relationship, post-partum depression, influence of other children in the family, and onset and progression of the cross-gender behavior. It is to be expected that the clinician be able to ask about what was happening

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<sup>3</sup> S. Levine (2017), *Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria*, J. OF SEX & MARITAL THERAPY at 7, DOI: 10.1080/0092623X.2017.1309482 (“*Ethical Concerns*”).

between parents and child and between parents shortly before the onset of cross-gender behaviors (Levine (2018), *Informed Consent* at 8);

b. The ability to discern attitudes towards homosexuality in parents and grandparents;

c. A familiarity with the controversies concerning ethical considerations surrounding possible interventions in the life of a child and family affected by transgenderism;<sup>4</sup>

d. An understanding of the literature concerning developmental influences on children's gender dysphoria including sensitivity to autistic spectrum influences;

e. Ability to recognize, identify, and treat psychiatric co-morbidities;

f. Experience with psychiatric adolescent outcomes in terms of psychiatric symptoms, orientation, and social problems;

g. An awareness of the negative as well as the positive potential short- and long-term impacts of alternative interventions on the patient and his or her family;

h. Regular reading of journal articles about the treatment of children and adolescents with gender dysphoria;

i. Knowledge of the literature concerning both persistence and desistance of gender dysphoria in children.

20. It is not realistic to expect educators or school counselors to have these qualifications. They are the result of professional training followed by intense concentrated experience with patients with mental illness, developmental difficulties short of serious mental illness, and working with the psychodynamics of individual and family lives.

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<sup>4</sup> K. Zucker (2019), *Debate: Different Strokes for Different Folks*, CHILD & ADOLESCENT MENTAL HEALTH, at 1-2, DOI: 10.1111/camh.12330 ("*Debate*").

**D. Impact of gender dysphoria on minority and vulnerable groups**

21. In considering the appropriate response to gender dysphoria, it is important to know that certain groups of children have an increased prevalence and incidence of trans identities. These include: children of color,<sup>5</sup> children with mental developmental disabilities,<sup>6</sup> including children on the autistic spectrum (at a rate more than 7x the general population),<sup>7</sup> children residing in foster care homes, adopted children (at a rate more than 3x the general population),<sup>8</sup> children with a prior history of psychiatric illness,<sup>9</sup> and more recently adolescent girls (in a large recent study, at a rate more than 2x that of boys). (G. Rider at 4.)

**E. Three competing conceptual models of gender dysphoria and transgender identity**

22. Discussions about appropriate responses by mental health professionals ("MHPs") to actual or sub-threshold gender dysphoria are complicated by the fact that various speakers and

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<sup>5</sup> G. Rider et al. (2018), *Health and Care Utilization of Transgender/Gender Non-Conforming Youth: A Population Based Study*, PEDIATRICS at 4, DOI: 10.1542/peds.2017-1683. (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.)

<sup>6</sup> D. Shumer & A. Tishelman (2015), *The Role of Assent in the Treatment of Transgender Adolescents*, INT. J. TRANSGENDERISM at 1, DOI: 10.1080/15532739.2015.1075929.

<sup>7</sup> D. Shumer et al. (2016), *Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic*, LGBT HEALTH, 3(5) 387 at 387.

<sup>8</sup> D. Shumer et al. (2017), *Overrepresentation of Adopted Adolescents at a Hospital-Based Gender Dysphoria Clinic*, TRANSGENDER HEALTH Vol. 2(1) 76 at 77.

<sup>9</sup> 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 ORIENTATION AND GENDER DIVERSITY, 4(3) 374 at 375 ("Psychological Profile"); 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 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. 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 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 gender dysphoria.")

advocates (or a single speaker at different times) view transgenderism through at least three very different paradigms, often without being aware of, or at least without acknowledging, the distinctions.

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

24. It should be noted, however, that gender dysphoria is a psychiatric rather than a medical diagnosis. Since its inception in DSM-III, it has always and only been specified in the psychiatric DSM manuals. Notably, gender dysphoria is the only psychiatric condition to be treated by surgery, even though no endocrine or surgical intervention package corrects any identified biological abnormality. (Levine, *Reflections*, at 240.)

25. Gender dysphoria is alternatively **conceptualized in developmental terms**, as an adaptation to a psychological problem that was first manifested as a failure to establish a comfortable conventional sense of self in early childhood. This paradigm starts from the premise that all human lives are influenced by past processes and events. Trans lives are not exceptions to this axiom. (Levine, *Reflections*, at 238.) MHPs who think of gender dysphoria through this paradigm may work both to identify and address causes of the basic problem of the deeply uncomfortable self, and also to ameliorate suffering when the underlying problem cannot be

solved. They work with the patient and (ideally) family to inquire what forces may have led to the trans person repudiating the gender associated with his sex. The developmental paradigm is mindful of temperamental, parental bonding, psychological, sexual, and physical trauma influences, and the fact that young children work out their psychological issues through fantasy and play.

26. In addition, the developmental paradigm recognizes that, with the important exception of genetic sex, essentially all aspects of an individual's identity evolve—often markedly—across the individual's lifetime. This includes gender. While some advocates assert that a transgender identity is biologically caused, fixed from early life, and eternally present in an unchanging manner, this is not supported by science. Although numerous studies have been undertaken to attempt to demonstrate a distinctive physical brain structure associated with transgender identity, as of yet there is no evidence that these patients have any defining abnormality in brain structure that precedes the onset of gender dysphoria. The belief that gender dysphoria is the consequence of brain structure is challenged by the sudden increase in incidence of child and adolescent gender dysphoria over the last twenty years in North America and Europe. Meanwhile, multiple studies have documented rapid shifts in gender ratios of patients presenting for care with gender-related issues, pointing to cultural influences,<sup>10</sup> while a recent study documented “clustering” of new presentations in specific schools and among specific friend groups, pointing to social influences (Littman). Both of these findings strongly suggest cultural factors. From the beginning of epidemiological research into this arena, there have always been some countries, Poland and Australia, for example, where the sex ratios were

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<sup>10</sup> Levine, *Ethical Concerns*, at 8 (citing M. Aitken, T. D. Steensma, et al. (2015), *Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria*, J. OF SEXUAL MEDICINE 12(3) 756 at 756-63).



reversed as compared to North America and Europe, again demonstrating a powerful effect of cultural influences.

27. In recent years, for adolescent patients, intense involvement with online transgender communities or “friends” is the rule rather than the exception, and the MHP will also be alert to this as a potentially significant influence on the identity development of the patient.

28. The third paradigm through which gender dysphoria is alternatively conceptualized is from **a sexual minority rights perspective**. Under this paradigm, any response other than medical and societal affirmation and implementation of a patient’s claim to “be” the opposite gender is a violation of the individual’s civil right to self-expression. Any effort to ask “why” questions about the patient’s condition, or to address underlying causes, is viewed as a violation of autonomy and civil rights. In the last few years, this paradigm has been successful in influencing public policy and the education of pediatricians, endocrinologists, and many mental health professionals.

#### **F. Four competing models of therapy**

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

##### **(1) The “watchful waiting” therapy model**

30. I review below the uniform finding of follow-up studies that the large majority of children who present with gender dysphoria will desist from desiring a transgender identity by adulthood if left untreated. (See *infra* ¶ 60.)

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

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

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

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

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

33. Many experienced practitioners in the field of gender dysphoria, including myself, have believed that it makes sense to employ these long-standing tools of psychotherapy for patients suffering gender dysphoria, asking the question as to what factors in the patient’s life are the determinants of the patient’s repudiation of his or her natal sex. (Levine, *Ethical Concerns*, at 8.) I and others have reported success in alleviating distress in this way for at least some patients,

whether or not the patient's sense of discomfort or incongruence with his or her natal sex entirely disappeared. Relieving accompanying psychological co-morbidities leaves the patient freer to consider the pros and cons of transition as he or she matures.

34. Among other things, the psychotherapist who is applying traditional methods of psychotherapy may help—for example—the male patient appreciate the wide range of masculine emotional and behavioral patterns as he grows older. He may discuss with his patient, for example, that one does not have to become a “woman” in order to be kind, compassionate, caring, noncompetitive, and devoted to others' feelings and needs.<sup>11</sup> Many biologically male trans individuals, from childhood to older ages, speak of their perceptions of femaleness as enabling them to discuss their feelings openly, whereas they perceive boys and men to be constrained from emotional expression within the family and larger culture. Men, of course, can be emotionally expressive, just as they can wear pink. Converse examples can be given for girls and women. These types of ideas regularly arise during psychotherapies.

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

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<sup>11</sup> S. Levine (2017), *Transitioning Back to Maleness*, ARCH. OF SEXUAL BEHAVIOR at 7, DOI: 10.1007/s10508-017-1136-9) (“*Transitioning*”).

36. Because “watchful waiting” can include treatment of accompanying psychological co-morbidities, and the psychotherapist who hopes to relieve gender dysphoria may focus on potentially causal sources of psychological distress rather than on the gender dysphoria itself, there is no sharp line between “watchful waiting” and the psychotherapy model in the case of prepubescent children.

37. To my knowledge, there is no evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescents, and men, or return to female identification for genetically female girls, adolescents and women. On the other hand, anecdotal evidence of such outcomes does exist; I and other clinicians have witnessed reinvestment in the patient’s biological sex in some individual patients who are undergoing psychotherapy. The Internet contains many such reports, and I have published a paper recently on a patient who sought my therapeutic assistance to reclaim his male gender identity after 30 years living as a woman and is in fact living as a man today. (Levine, *Transitioning*, at 1.) I have seen children desist even before puberty in response to thoughtful parental interactions and a few meetings of the child with a therapist.

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

38. While it is widely agreed that the therapist should not directly challenge a claimed transgender identity in a child, some advocates and practitioners go much further, and promote and recommend that any expression of transgender identity should be immediately accepted as decisive, and thoroughly affirmed by means of consistent use of clothing, toys, pronouns, etc. associated with transgender identity. These advocates treat any question about the causes of the child’s transgender identification as inappropriate, and assume that observed psychological co-morbidities in the children or their families are unrelated or will get better with transition, and

need not be addressed by the MHP who is providing supportive guidance concerning the child's gender identity.

39. Some advocates, indeed, assert that unquestioning affirmation of any claim of transgender identity in children is essential, and that the child will otherwise face a high risk of suicide or severe psychological damage. I address claims about suicide and health outcomes in Section VI below.

40. Some advocates also assert that this “affirmation therapy” model is accepted and agreed with by the overwhelming majority of mental health professionals. However, one respected academic in the field has recently written that, on the contrary, “almost all clinics and professional associations in the world” do not use “gender affirmation” for prepubescent children and instead “delay any transitions after the onset of puberty.”<sup>12</sup>

41. Even the Standards of Care published by WPATH, an organization which in general leans strongly towards affirmation in the case of adults, does not specify affirmation of transgender identity as the indicated therapeutic response for young children, but rather calls for a careful process of discernment and decision specific to each child, by the family in consultation with the mental health professional.

42. Further, the DSM-5 added—for both children and adolescents—a requirement that a sense of incongruence between biological and felt gender must last at least six months as a

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<sup>12</sup> J. Cantor (2019), *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. OF SEX & MARITAL THERAPY at 1, DOI: 10.1080.0092623X.2019.1698481.

precondition for a diagnosis of gender dysphoria, precisely because of the risk of “transitory” symptoms and “hasty” diagnosis that might lead to “inappropriate” treatments.<sup>13</sup>

43. I do not know what proportion of practitioners are using which model. However, in my opinion, in the case of young children, prompt and thorough affirmation of a transgender identity disregards the principles of child development and family dynamics, and is not supported by science. Rather, the MHP must focus attention on the child’s underlying internal and familial issues. Ongoing relationships between the MHP and the parents and the MHP and the child are vital to help the parents, child, other family members, and the MHP to understand over time the issues that need to be dealt with over time by each of them.

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

**G. Understanding the WPATH and its “Standards of Care”**

45. In almost any discussion of the diagnosis and care of patients suffering gender dysphoria or exhibiting transgender characteristics, the World Professional Association for Transgender Health (WPATH) and the Standards of Care that that organization publishes will be mentioned. Accordingly, I provide some context concerning that private organization.

46. I was a member of the Harry Benjamin International Gender Dysphoria Association from 1974 until 2001. From 1997 through 1998, I served as the Chairman of the eight-person International Standards of Care Committee that issued the fifth version of the Standards of Care. I resigned my membership in 2002 due to my regretful conclusion that the organization and its recommendations had become dominated by politics and ideology, rather

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<sup>13</sup> K. Zucker (2015), *The DSM-5 Diagnostic Criteria for Gender Dysphoria*, in C. Trombetta et al. (eds.), *MANAGEMENT OF GENDER DYSPHORIA: A MULTIDISCIPLINARY APPROACH*, DOI 10.1007/978-88-470-5696-1\_4 (Springer-Verlag Italia 2015).

than by scientific process, as it was years earlier. In approximately 2007, the Henry Benjamin International Gender Dysphoria Association changed its name to the World Professional Association for Transgender Health.

47. WPATH is a voluntary membership organization. Since at least 2002, attendance at its biennial meetings has been open to trans individuals who are not licensed professionals. While this ensures taking patients' needs into consideration, it limits the ability for honest and scientific debate, and means that WPATH can no longer be considered a purely professional organization.

48. WPATH takes a decided view on issues as to which there is a wide range of opinion among professionals. WPATH explicitly views itself as not merely a scientific organization, but also as an advocacy organization. (Levine, *Reflections*, at 240.) WPATH is supportive to those who want sex reassignment surgery ("SRS"). Skepticism as to the benefits of SRS to patients, and strong alternate views, are not well tolerated in discussions within the organization. Such views have been known to be shouted down and effectively silenced by the large numbers of nonprofessional adults who attend the organization's biennial meetings.

49. The Standards of Care ("SOC") is the product of an enormous effort to be balanced, but it is not a politically neutral document. WPATH aspires to be both a scientific organization and an advocacy group for the transgendered. These aspirations sometimes conflict. The limitations of the Standards of Care, however, are not primarily political. They are caused by the lack of rigorous research in the field which allows room for passionate convictions on how to care for the transgendered.

50. In recent years, WPATH has fully adopted some mix of the medical and civil rights paradigms. It has downgraded the role of counseling or psychotherapy as a requirement for

these life-changing processes. WPATH no longer considers preoperative psychotherapy to be a requirement. It is important to WPATH that the person has gender dysphoria; the pathway to the development of this state is not. (Levine, *Reflections*, at 240.) The trans person is assumed to have thoughtfully considered his or her options before seeking hormones, for instance.

51. Most psychiatrists and psychologists who treat patients suffering sufficiently severe distress from gender dysphoria to seek inpatient psychiatric care are not members of WPATH. Many psychiatrists and psychologists who treat some patients suffering gender dysphoria on an outpatient basis are not members of WPATH. WPATH represents a self-selected subset of the profession along with its many non-professional members; it does not capture the clinical experiences of others. WPATH claims to speak for the medical profession; however, it does not welcome skepticism and therefore, deviates from the philosophical core of medical science.

52. For example, in 2010 the WPATH Board of Directors issued a statement advocating that incongruence between sex and felt gender identity should cease to be identified in the DSM as a pathology.<sup>14</sup> This position was debated but not adopted by the (much larger) American Psychiatric Association, which maintained the definitions and diagnoses of gender dysphoria as a pathology in the DSM-5 manual issued in 2013.

53. In my experience most current members of WPATH have little ongoing experience with the mentally ill, and many trans care facilities are staffed by MHPs who are not deeply experienced with recognizing and treating frequently associated psychiatric co-morbidities. Because the 7th version of the WPATH SOC deleted the requirement for therapy, trans care facilities that consider these Standards sufficient are permitting patients to be

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<sup>14</sup> WPATH *De-Psycho-pathologisation Statement* (May 26, 2010), available at [wpath.org/policies](http://wpath.org/policies) (last accessed January 21, 2020).



counseled to transition by means of social presentation, hormones, and surgery by individuals with masters rather than medical degrees. As a result of the downgrading of the role of the psychiatric assessment of patients, new “gender affirming” clinics have arisen in many urban settings that quickly (sometimes within an hour’s time) recommend transition. Concerned parents who came wanting to know what is going on in their children are overwhelmed, and feel disoriented, fearful for the health and safety of their children, and dependent on the professional.

### **III. PATIENTS DIFFER WIDELY AND MUST BE CONSIDERED INDIVIDUALLY.**

54. In my opinion, it is not possible to make a single, categorical statement about the proper treatment of children presenting with gender dysphoria or other gender-related issues. Indeed, an MHP cannot responsibly opine on the proper treatment of a particular child presenting with gender dysphoria unless and until he or she has had more than one working session with that child, and has taken a thorough developmental history of the child’s gender-related issues (or has reviewed such a history prepared by another MHP). This is so for multiple reasons.

55. There is no single pathway of development and outcomes governing transgender identity, nor one that predominates over the large majority of cases. Instead, as individuals grow up and age, depending on their differing psychological, social, familial, and life experiences, their outcomes differ widely.

56. As to causes in children, details about the onset of gender dysphoria may be found in an understanding of family relationship dynamics. In particular, the relationship between the parents and each of the parents and the child, and each of the siblings and the child should be well known by the MHP.

57. Further, a disturbingly large proportion of children who seek professional care in connection with gender issues have a wider history of psychiatric co-morbidities. (*See supra* n. 9.) A 2017 study from the Boston Children’s Hospital Gender Management Service program

reported that: “Consistent with the data reported from other sites, this investigation documented that 43.3% of patients presenting for services had significant psychiatric history, with 37.1% having been prescribed psychotropic medications, 20.6% with a history of self-injurious behavior, 9.3% with a prior psychiatric hospitalization, and 9.3% with a history of suicide attempts.” (L. Edwards-Leeper, *Psychological Profile*, at 375.) It seems likely that an even higher proportion will have had prior undiagnosed psychiatric conditions.

58. As to outcomes, as I explain below, for pre-pubertal children, desistance from transgender identification in favor of a gender corresponding to the child’s sex, during or within a few years of puberty, is a likely outcome absent intervention. (*Infra* Section IV.)

59. Because the causes, characteristics, social and relational context, and likely future course of gender dysphoria vary widely from individual to individual, it is essential that the MHP spend significant time with an individual patient over multiple sessions to take a careful developmental history, before attempting to decide on a course of therapy for that individual.

#### **IV. SOCIAL TRANSITION OF PRE-PUBERTAL CHILDREN IS A MAJOR, EXPERIMENTAL, AND CONTROVERSIAL PSYCHOTHERAPEUTIC INTERVENTION THAT SUBSTANTIALLY CHANGES OUTCOMES.**

60. A distinctive and critical characteristic of juvenile gender dysphoria is that multiple studies from separate groups and at different times have reported that in the large majority of patients, absent a substantial intervention such as social transition and/or hormone therapy, it does *not* persist through puberty. A recent article reviewed all existing follow-up studies that the author could identify of children diagnosed with gender dysphoria (11 studies), and reported that “every follow-up study of GD children, without exception, found the same thing: By puberty, the majority of GD children ceased to want to transition.” (Cantor at 1.) Another author reviewed the existing studies and reported that in “prepubertal boys with gender discordance . . . the cross gender wishes usually fade over time and do not persist into adulthood,

with only 2.2% to 11.9% continuing to experience gender discordance.”<sup>15</sup> A third summarized the existing data as showing that “Symptoms of GID at prepubertal ages decrease or disappear in a considerable percentage of children (estimates range from 80-95%).”<sup>16</sup>

61. It is not yet known how to distinguish those children who will desist from that small minority whose trans identity will persist. (Levine, *Ethical Concerns*, at 9.)<sup>17</sup>

62. Desistance within a relatively short period may also be a common outcome for post-pubertal youths who exhibit recently described “rapid onset gender disorder.” I observe an increasingly vocal online community of young women who have reclaimed a female identity after claiming a male gender identity at some point during their teen years. However, data on outcomes for this age group with and without therapeutic interventions is not yet available to my knowledge.

63. In contrast, there is now data that suggests that a therapy that encourages social transition dramatically changes outcomes. A prominent group of authors has written that “The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood.”<sup>18</sup> Similarly, a comparison of recent and older studies suggests that when an “affirming” methodology is used with children, a substantial proportion of children who would

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<sup>15</sup> S. Adelson & American Academy of Child & Adolescent Psychiatry (2012), *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 51(9) 957 at, 963 (“*Practice Parameter*”).

<sup>16</sup> P. T. Cohen-Kettenis, H. A. Delemarre-van de Waal et al. (2008), *The Treatment of Adolescent Transsexuals: Changing Insights*, J. SEXUAL MEDICINE 5(8) 1892 at 1895.

<sup>17</sup> It is also apparent in the adolescent phenomenon of rapid onset of gender dysphoria following a gender normative childhood that childhood gender identity is not inherently stable in either direction.

<sup>18</sup> C. Guss et al. (2015), *Transgender and Gender Nonconforming Adolescent Care: Psychosocial and Medical Considerations*, CURR. OPIN. PEDIATR. 26(4) 421 at 421 (“TGN Adolescent Care”).

otherwise have desisted by adolescence—that is, achieved comfort identifying with their natal sex—instead persist in a transgender identity. (Zucker, *Myth of Persistence*, at 7.)<sup>19</sup>

64. Indeed, a review of multiple studies of children treated for gender dysphoria across the last three decades found that early social transition to living as the opposite sex severely reduces the likelihood that the child will revert to identifying with the child's natal sex, at least in the case of boys. That is, while, as I review above, studies conducted before the widespread use of social transition for young children reported desistance rates in the range of 80-98%, a more recent study reported that fewer than 20% of boys who engaged in a partial or complete social transition before puberty had desisted when surveyed at age 15 or older. (Zucker, *Myth of Persistence*, at 7; Steensma (2013).)<sup>20</sup> Some vocal practitioners of prompt affirmation and social transition even claim that essentially *no* children who come to their clinics exhibiting gender dysphoria or cross-gender identification desist in that identification and return to a gender identity consistent with their biological sex.<sup>21</sup> This is a very large change as compared to the desistance rates documented apart from social transition. Some researchers who generally

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<sup>19</sup> One study found that social transition by the child was found to be strongly correlated with persistence for natal boys, but not for girls. (Zucker, *Myth of Persistence*, at 5 (citing T.D. Steensma, J.K. McGuire 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.).)

<sup>20</sup> Only 2 (3.6%) of 56 of the male desisters observed by Steensma et al. had made a complete or partial transition prior to puberty, and of the twelve males who made a complete or partial transition prior to puberty, only two had desisted when surveyed at age 15 or older. Steensma (2013) at 584.

<sup>21</sup> See, e.g., B. Ehrensaft (2015), *Listening and Learning from Gender-Nonconforming Children*, THE PSYCHOANALYTIC STUDY OF THE CHILD 68(1) 28 at 34: “In my own clinical practice . . . of those children who are carefully assessed as transgender and who are allowed to transition to their affirmed gender, we have no documentation of a child who has ‘desisted’ and asked to return to his or her assigned gender.”

advocate prompt affirmation and social transition also acknowledge a causal connection between social transition and this change in outcomes.<sup>22</sup>

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

66. So far as I am aware, no study yet reveals whether the life-course mental and physical health outcomes for this relatively new class of “persisters” are more similar to those of the general non-transgender population, or to the notably worse outcomes exhibited by the transgender population generally.

67. However, I agree with Zucker who has written, “...we cannot rule out the possibility that early successful treatment of childhood GID [Gender Identity Disorder] will diminish the role of a continuation of GID into adulthood. If so, successful treatment would also reduce the need for the long and difficult process of sex reassignment which includes hormonal and surgical procedures with substantial medical risks and complications.”<sup>23</sup> By the same token, a therapeutic methodology for children that *increases* the likelihood that the child will continue to identify as the opposite gender into adulthood will *increase* the need for the long and potentially problematic processes of hormonal and genital and cosmetic surgical procedures.

68. Not surprisingly, given these facts, encouraging social transition in children remains controversial. Supporters of such transition acknowledge that “Controversies among

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<sup>22</sup> See Guss, *TGN Adolescent Care*, at 2. “The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood.” “Youth with persistent TNG [transgender, nonbinary, or gender-nonconforming] identity into adulthood . . . are more likely to have experienced social transition, such as using a different name . . . which is stereotypically associated with another gender at some point during childhood.”

<sup>23</sup> Zucker, *Myth of Persistence*, at 8 (citing H. Meyer-Bahlburg (2002), *Gender Identity Disorder in Young Boys: A Parent- & Peer-Based Treatment Protocol*, CLINICAL CHILD PSYCHOLOGY & PSYCHIATRY 7, 360 at 362.).

providers in the mental health and medical fields are abundant . . . These include differing assumptions regarding . . . the age at which children . . . should be encouraged or permitted to socially transition . . . . These are complex and providers in the field continue to be at odds in their efforts to work in the best interests of the youth they serve.”<sup>24</sup>

69. In sum, therapy for young children that encourages transition cannot be considered to be neutral, but instead is an experimental procedure that has a high likelihood of changing the life path of the child, with highly unpredictable effects on mental and physical health, suicidality, and life expectancy. Claims that a civil right is at stake do not change the fact that what is proposed is a social and medical experiment. (Levine, *Reflections*, at 241.) Ethically, then, it should be undertaken only subject to standards, protocols, and reviews appropriate to such experimentation.

**V. PARENTAL INVOLVEMENT IS ESSENTIAL IN MOST CASES FOR ETHICAL TREATMENT OF A CHILD WHO SUFFERS FROM GENDER DYSPHORIA OR SEEKS SOCIAL TRANSITION.**

70. For many reasons, in the large majority of cases the involvement of one or both parents will be essential to a responsible, effective, and indeed ethical diagnosis and treatment of a child who is or may be suffering from gender dysphoria or one of the related conditions I have described above.

**A. Parental involvement is necessary for accurate and thorough diagnosis of the child and to discern familial and intrapsychic forces that may contribute to moving the child towards a trans identity.**

71. A claim or expression of interest in a transgender identity by a child must be the beginning, not the end, of a careful diagnostic and therapeutic process. Transgender identification in a child is not a simple, uniform phenomenon; as I have explained, there is no

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<sup>24</sup> A. Tishelman et al. (2015), *Serving Transgender Youth: Challenges, Dilemmas and Clinical Examples*, PROF. PSYCHOL. RES. PR. at 11, DOI: 10.1037/a0037490 (“*Serving TG Youth*”).

single pathway of development and outcomes governing transgender identity, nor one that predominates over the large majority of cases. Instead, as individuals grow up and age, depending on their differing psychological, social, familial, and life experiences, their outcomes differ widely.

72. What can be observed by—for example—a teacher or counselor at school, although important, is only one window into the life and psyche of a child. A teacher's perspective emphasizes learning capacities, social interactions, and gender style relative to other similarly aged children, often during just one school year.

73. As a starting point, any child suffering serious tension between his or her reproductive biology and sense of gender identity (or desired gender identity) should have the assistance and support of a skilled mental health professional, and a meaningful diagnosis of the child's condition will require a sustained relationship between an MHP and the child over time. The involvement of parents will often be essential to establishing and maintaining this type of relationship between an MHP and the child.

74. What the child *means* by a claim of transgender identity may vary widely depending on age. Younger grade school children, for example, have some concept of gender, but what they “know” about the sexes, about the future meaning of male or female, or about gender identity—beyond what they are told by adults or what they pick up unconsciously from mother, father, siblings, and extended family—is limited. Thus, one sees children draw distinctions in colors, clothing, and toys—classic early stereotypes of what it means to be a girl or a boy.

75. The child may or may not actually suffer from gender dysphoria, and this should be determined.<sup>25</sup> Input from parents is likely to be important to evaluating whether a child is suffering from “clinically significant distress or impairment in social, school, or other important areas of functioning.” (DSM-5)

76. Parents, similarly, in many cases will have observed the child over his or her entire lifetime, and so will have unique insight into whether the child’s attraction to a transgender identity is longstanding and stable, or whether on the contrary it has been abrupt and associated with intensive online interaction with transgender “communities.”

77. Likewise, when parental or family dynamics play a role in the child’s discomfort with his or her natal sex (*see supra* ¶ 56), it will not be possible to evaluate these influences without parental involvement in the diagnostic and therapeutic process. A thorough evaluation cannot be done as effectively in a short period. Ideally a long-term relationship with parents enables a clear picture of what happened in the family and to the child because a different level of trust often occurs over time between the parents and the MHP.

78. In addition, as I detail elsewhere, a large proportion of children (and adults) who present with claims of or attraction to a transgender identity suffer from identifiable psychiatric co-morbidities. (*See supra* ¶ 57.) Regardless of whether these are in any way related to the child’s gender identity, it is important that these co-morbidities—if they exist—be identified and that appropriate psychotherapeutic help is obtained for the child. And, regardless of whether co-

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<sup>25</sup> *See* D. Shumer, N. Nokoff & N. Spack (2016), *Advances in the Care of Transgender Children & Adults*, ADV. PEDIATR. (2016) at 7, DOI: 10.1016/j.yapd.2016.04.018: “The Endocrine Society guidelines recommend that children and adolescents with gender concerns be seen by a mental health professional with training in child and adolescent developmental psychology. The mental health professional should: 1) determine whether the individual fulfills DSM criteria for gender dysphoria; 2) inform the individual with respect to possibilities and limitations of sex reassignment and other treatments; and 3) assess for potential psychological comorbidities.”



morbidities might be apparent to an MHP given an opportunity to diagnose the child or adolescent before and apart from an expression of a desire for a transgender identity, most parents are not MHPs, and from their perspective the child or adolescent's transgender interest may come "out of the blue," (Littman at 13), and be the first sign that they appreciate that their child should receive professional evaluation.

79. At the very least, then, a child who exhibits or expresses an interest in a transgender identity should be evaluated for psychiatric co-morbidities. Again, parental involvement will generally be essential for this to be done, and to be done well.

**B. Parental involvement is important for effective psychotherapeutic treatment and support of the child.**

80. Theories as to the causes of particular psychological problems, and how they can best be addressed once identified, continue to vary widely, but a broad consensus has agreed on the importance of identifying and addressing the causes of felt distress. This is accomplished first and foremost by a stable relationship with a professional who has substantial experience in psychotherapy and who is able to form caring and empathetic relationships with the child and parents. It is not possible to be more specific about treatment because child therapists themselves are so diverse in how they think about and perform parent guidance and child interventions.

(Zucker, *Debate*.)

81. Since the child's sense of gender develops in interaction with his parents and their own gender roles and relationships, the responsible MHP will almost certainly need to delve into family and marital dynamics. (*See supra* ¶ 25.) An ongoing relationship between the MHP and the parents and the child is vital to help the parents, child, other family members, and the MHP to understand the issues that need to be dealt with over time by each of them.

82. For a child to live radically different identities at home and at school, and to conceal what he or she perceives to be his or her true identity from parents, is psychologically unhealthy in itself, and could readily lead to additional psychological problems. Meaningful and healthy “support” of a child struggling with gender issues must include parents. Often, parents are more accepting and supportive of non-standard orientation or identity in their child than the child fears they will be. Even where parents in fact have a difficult time accepting some aspect of their child’s identity, the path to psychological health for the child will often require addressing and resolving or reducing that gulf between parent and child, perhaps with the aid of the MHP experienced in family dynamics. Extended secrecy and a “double life” concealed from the parents is rarely the path to psychological health. For this reason at least, schools should not support deceit of parents.

**C. Parental involvement is necessary to obtain informed consent.**

83. Social transition is itself an important psychotherapeutic intervention in the life of a child, and preliminary evidence indicates that it is an intervention that is likely to have a dramatic impact on the child’s life over the long term. The ethical MHP (and the informed and ethical educator) will not undertake such an intervention without obtaining informed consent. The complex and long-term social, medical, and mental health implications of adopting a transgender identity—along with the complicating psychological co-morbidities that accompany transgender feelings in many individuals—make the process of obtaining informed consent lengthy and complex under the best of circumstances. (*See* Section VIII.) Most children are both legally and developmentally *incapable* of giving informed consent to such a life-altering intervention. And parents, of course, cannot give informed consent if the fact of their child’s wish to assume a transgender identity is concealed from them.

84. All mental health professionals are aware that situations occur in which parents act in a manner that seriously imperils the well-being of their child. This is not the general expectation, and is not lightly assumed. When this is thought to be the situation, medical or mental health professionals or educators may seek judicial intervention to remove children from the custody of their parents. But these processes are surrounded by procedures and safeguards to protect against casual disruption of parental authority and the bond between parents and child. The school alone should not make these decisions.

**VI. THE AVAILABLE DATA DOES NOT SUPPORT THE CONTENTION THAT “AFFIRMATION” OF TRANSGENDER IDENTITY REDUCES SUICIDE OR RESULTS IN BETTER PHYSICAL OR MENTAL HEALTH OUTCOMES GENERALLY.**

85. I am aware that organizations including The Academy of Pediatrics and Parents, Families and Friends of Lesbians and Gays (PFLAG)) have published statements that suggest that all children who express a desire for a transgender identity should be promptly supported in that claimed identity. This position appears to rest on the belief—which is widely promulgated by certain advocacy organizations—that science has already established that prompt “affirmance” is best for all patients, including all children, who present indicia of transgender identity. As I discuss later below, this belief is scientifically incorrect, and ignores both what is known and what is unknown.

86. The knowledge-base concerning the causes and treatment of gender dysphoria has low scientific quality.

87. In evaluating claims of scientific or medical knowledge, it is important to understand that it is axiomatic in science that no knowledge is absolute, and to recognize the widely-accepted hierarchy of reliability when it comes to “knowledge” about medical or psychiatric phenomena and treatments. Unfortunately, in this field opinion is too often confused

with knowledge, rather than clearly locating what exactly is scientifically known. In order of increasing confidence, such “knowledge” may be based upon data comprising:

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

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

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

- d. A cohort study;

- 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.

88. Prominent voices in the field have emphasized the severe lack of scientific knowledge in this field. The American Academy of Child and Adolescent Psychiatry has recognized that “Different clinical approaches have been advocated for childhood gender discordance. . . . There have been no randomized controlled trials of any treatment. . . . [T]he proposed benefits of treatment to eliminate gender discordance...must be carefully weighed against... possible deleterious effects.” (Adelson et al., *Practice Parameter*, at 968–69.) Similarly, the American Psychological Association has stated, “...because no approach to

working with [transgender and gender nonconforming] children has been adequately, empirically validated, consensus does not exist regarding best practice with pre-pubertal children.”<sup>26</sup>

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

90. Large gaps exist in the medical community’s knowledge regarding the long-term effects of SRS and other gender identity disorder treatments in relation to their positive or negative correlation to suicidal ideation, attempts, and completion. What is known, however, is not encouraging.

91. With respect to suicide, individuals with gender dysphoria are well known to commit suicide or otherwise suffer increased mortality before and after not only social transition, but also before and after SRS. (Levine, *Reflections*, at 242.) For example, in the United States, the death rates of trans veterans are comparable to those with schizophrenia and bipolar diagnoses—20 years earlier than expected. These crude death rates include significantly elevated suicide rates. (Levine, *Ethical Concerns*, at 10.) Similarly, researchers in Sweden and Denmark have reported on almost all individuals who underwent sex-reassignment surgery over a 30-year period.<sup>27</sup> The Swedish follow-up study found a suicide rate in the post-SRS population 19.1

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<sup>26</sup> American Psychological Association, *Guidelines for Psychological Practice with Transgender & Gender Nonconforming People* (2015), AM. PSYCHOLOGIST 70(9) 832 at 842.

<sup>27</sup> C. Dhejne et al. (2011), *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLOS ONE 6(2) e16885 (“Long Term”); R.

times greater than that of the controls; both studies demonstrated elevated mortality rates from medical and psychiatric conditions. (Levine, *Ethical Concerns*, at 10.)

92. Advocates of immediate and unquestioning affirmation of social transition in children who indicate a desire for a transgender identity sometimes assert that any other course will result in a high risk of suicide in the affected children and young people. Contrary to these assertions, no studies show that affirmation of children (or anyone else) reduces suicide, prevents suicidal ideation, or improves long-term outcomes, as compared to either a “watchful waiting” or a psychotherapeutic model of response, as I have described above.<sup>28</sup>

93. I will also note that any discussion of suicide when considering younger children involves very long-range and very uncertain prediction. Suicide in pre-pubescent children is rare and the existing studies of gender identity issues in pre-pubescent children do not report significant incidents of suicide. The estimated suicide rate of trans adolescents is the same as teenagers who are in treatment for serious mental illness. What trans teenagers do demonstrate is more suicidal ideation and attempts (however serious) than other teenagers.<sup>29</sup>

94. In sum, claims that affirmation will reduce the risk of suicide for children are not based on science. Such claims overlook the lack of even short-term supporting data as well as the lack of studies of long-term outcomes resulting from the affirmation or lack of affirmation of transgender identity in children. It also overlooks the other tools that the profession does have for

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K. Simonsen et al. (2016), *Long-Term Follow-Up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity & Mortality*, NORDIC J. OF PSYCHIATRY 70(4).

<sup>28</sup> A recent article, J. Turban et al. (2020), *Puberty Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS 145(2), DOI: 10.1542/peds.2019-1725, 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.

<sup>29</sup> A. Perez-Brumer, J. K. Day et al. (2017), *Prevalence & Correlates of Suicidal Ideation Among Transgender Youth in Cal.: Findings from a Representative, Population-Based Sample of High Sch. Students*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 56(9), 739 at 739.

addressing depression and suicidal thoughts in a patient once that risk is identified. (Levine, *Reflections*, at 242.)

95. A number of data sets have also indicated significant concerns about wider indicators of physical and mental health, including ongoing functional limitations;<sup>30</sup> substance abuse, depression, and psychiatric hospitalizations;<sup>31</sup> and increased cardiovascular disease, cancer, asthma, and COPD.<sup>32</sup> Worldwide estimates of HIV infection among transgendered individuals are up to 17-fold higher than the cisgender population. (Levine, *Informed Consent*, at 6.)

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

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

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<sup>30</sup> G. Zeluf, C. Dhejne et al. (2016), *Health, Disability and Quality of Life Among Trans People in Sweden—A Web-Based Survey*, BMC PUBLIC HEALTH 16(903), DOI: 10.1186/s12889-016-3560-5.

<sup>31</sup> C. Dhejne, R. Van Vlerken et al. (2016), *Mental Health & Gender Dysphoria: A Review of the Literature*, INT’L REV. OF PSYCHIATRY 28(1) 44.

<sup>32</sup> C. Dragon, P. Guerino, et al. (2017), *Transgender Medicare Beneficiaries & Chronic Conditions: Exploring Fee-for-Service Claims Data*, LGBT HEALTH 4(6) 404, DOI: 10.1089/lgbt.2016.0208.

**VII. KNOWN, LIKELY, OR POSSIBLE DOWNSIDE RISKS ATTENDANT ON MOVING QUICKLY TO “AFFIRM” TRANSGENDER IDENTITY IN CHILDREN.**

98. As I have detailed above, enabling and affirming social transition in a prepubescent child appears to be highly likely to increase the odds that the child will in time pursue pubertal suppression and persist in a transgender identity into adulthood. I consider the ethical implications of this intervention in the next section. Here, I simply note that fact to observe that the MHP (and parent) must therefore consider long term as well as short term implications of life as a transgender individual when deciding whether to permit or encourage a child to socially transition.

99. The multiple studies from different nations that have documented the increased vulnerability of the adult transgender population to substance abuse, mood and anxiety disorders, suicidal ideation, and other health problems warn that assisting the child down the road to becoming a transgender adult is a very serious decision, and stand as a reminder that a casual assumption that transition will improve the child's life is not justified based on numerous scientific snapshots of cohorts of trans adults and teenagers.

100. The possibility that steps along this pathway, while lessening the pain of gender dysphoria, could lead to additional sources of crippling emotional and psychological pain, are too often not considered by advocates of social transition and not considered at all by the trans child. (Levine, *Reflections*, at 243.) Many and likely most educators do not have the information and professional experience to give these possibilities appropriate consideration, or to help a child do so.

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



**A. Physical risks associated with transition**

102. Sterilization. Obviously, SRS that removes testes, ovaries, or the uterus is inevitably sterilizing. While by no means all transgender adults elect SRS, many patients do ultimately feel compelled to take this serious step in their effort to live fully as the opposite sex. More immediately, practitioners recognize that the administration of cross-sex hormones, which is often viewed as a less “radical” measure, and is now increasingly done to minors, creates at least a risk of irreversible sterility.<sup>33</sup> As a result, even when treating a child, the MHP, patient, and parents must consider loss of reproductive capacity—sterilization—to be one of the major risks of starting down the road. The risk that supporting social transition may put the child on a pathway that leads to intentional or unintentional permanent sterilization is particularly concerning given the disproportionate representation of minority and other vulnerable groups among children reporting a transgender or gender-nonconforming identity. (*See supra* ¶ 21.)

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

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<sup>33</sup> See C. Guss et al., *TGN Adolescent Care* 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”).

104. Other effects of hormone administration. While it is commonly said that the effects of puberty blockers are reversible after cessation, in fact controlled studies have not been done of how completely this is true. However, it is well known that many effects of cross-sex hormones cannot be reversed should the patient later regret his transition. After puberty, the individual who wishes to live as the opposite sex will in most cases have to take cross-sex hormones for life.

105. The long-term health risks of this major alteration of hormonal levels have not yet been quantified in terms of exact risk.<sup>34</sup> However, a recent study found greatly elevated levels of strokes and other acute cardiovascular events among male-to-female transgender individuals taking estrogen. Those authors concluded, “it is critical to keep in mind that the risk for these cardiovascular events in this population must be weighed against the benefits of hormone treatment.”<sup>35</sup> Another group of authors similarly noted that administration of cross-sex hormones creates “an additional risk of thromboembolic events”—which is to say blood clots (Guss et al., *TGN Adolescent Care* at 5), which are associated with strokes, heart attack, and lung and liver failure. Clinicians must distinguish the apparent short-term safety of hormones from likely or possible long-term consequences, and help the patient or parents understand these implications as well. The young patient may feel, “I don’t care if I die young, just as long I get to live as a woman.” The mature adult may take a different view.

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<sup>34</sup> 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”).

<sup>35</sup> D. Getahun et al. (2018), *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, ANNALS OF INTERNAL MEDICINE at 8, DOI:10.7326/M17-2785.

106. Health risks inherent in complex surgery. Complications of surgery exist for each procedure,<sup>36</sup> and complications in surgery affecting the reproductive organs and urinary tract can have significant anatomical and functional complications for the patient's quality of life.

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

**B. Social risks associated with transition**

108. Family and friendship relationships. Gender transition routinely leads to isolation from at least a significant portion of one's family in adulthood. In the case of a juvenile transition, this will be less dramatic while the child is young, but commonly increases over time as siblings who marry and have children of their own do not wish the transgender individual to be in contact with those children. By adulthood, the friendships of transgender individuals tend to be confined to other transgender individuals (often "virtual" friends known only online) and the generally limited set of others who are comfortable interacting with transgender individuals. (Levine, *Ethical Concerns*, at 5.)

109. Long term psychological and social impact of sterility. The life-long negative emotional impact of infertility on both men and women has been well studied. While this impact has not been studied specifically within the transgender population, the opportunity to be a parent is likely a human, emotional need, and so should be considered an important risk factor when considering gender transition for any patient. However, it is particularly difficult for parents of a young child to seriously contemplate that child's potential as a future parent and

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<sup>36</sup> 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 MEDICINE 14(12) 1621.).

grandparent. This makes it all the more critical that the MHP spend substantial and repeated time with parents to help them see the implications of what they are considering.

110. Sexual-romantic risks associated with transition. After adolescence, transgender individuals find the pool of individuals willing to develop a romantic and intimate relationship with them to be greatly diminished. When a trans person who passes well reveals his or her natal sex, many potential cisgender mates lose interest. When a trans person does not pass well, he discovers that the pool of those interested consists largely of individuals looking for exotic sexual experiences rather than genuinely loving relationships. (Levine, *Ethical Concerns*, at 5, 13.) Nor is the problem all on the other side; transgender individuals commonly become strongly narcissistic, unable to give the level of attention to the needs of another that is necessary to sustain a loving relationship.<sup>37</sup>

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

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<sup>37</sup> S. Levine, *Barriers to Loving: A Clinician's Perspective*, at 40 (Routledge, New York 2013).

**C. Mental health costs or risks**

112. One would expect the negative physical and social impacts reviewed above to adversely affect the mental health of individuals who have transitioned. In addition, adult transitioned individuals find that living as the other (or, in a manner that is consistent with the stereotypes of the other as the individual perceives them) is a continual challenge and stressor, and many find that they continue to struggle with a sense of inauthenticity in their transgender identity. (Levine, *Informed Consent*, at 9.)

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

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

proportion of transgender youth accessed inpatient mental health care (22.8% vs. 11.1%) and outpatient mental health care (45.6% vs. 16.1%) services.<sup>38</sup>

**D. Regret following transition is not an infrequent phenomenon.**

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

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

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

118. More dramatically, a surgical group prominently active in the SRS field has published a report on a series of seven male-to-female patients requesting surgery to transform their surgically constructed female genitalia back to their original male form.<sup>39</sup>

119. I noted above an increasingly visible online community of young women who have desisted after claiming a male gender identity at some point during their teen years. (*See supra* ¶ 62.) Given the rapid increase in the number of girls presenting to gender clinics within

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<sup>38</sup> S. Reisner et al. (2015), *Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study*, J. OF ADOLESCENT HEALTH 56(3) at 6, DOI:10.1016/j.jadohealth.2014.10.264; *see also supra* ¶ 21.

<sup>39</sup> Djordjevic et al. (2016), *Reversal Surgery in Regretful Male-to-Female Transsexuals After Sex Reassignment Surgery*, J. Sex Med. 13(6) 1000, DOI: 10.1016/j.jsxm.2016.02.173.

the last few years, the phenomena of regret and desistance by young women deserves careful attention and study by MHPs.

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

## **VIII. MEDICAL ETHICS & INFORMED CONSENT**

### **A. The obligation of the mental health professional to enable and obtain informed consent**

121. I have reviewed above the knowledge and experience that, in my view, a mental health professional should have before undertaking the responsibility to counsel or treat a child who is experiencing gender dysphoria or transgender identification. The MHP who undertakes this type of responsibility must also be guided by the ethical principles that apply to all health care professionals. One of the oldest and most fundamental principles guiding medical and psychological care—part of the Hippocratic Oath—is that the physician must “first, do no harm.” This states an ethical responsibility that cannot be delegated to the patient. Physicians themselves must weigh the risks of treatment against the harm of not treating. If the risks of treatment outweigh the benefits, ethics prohibit the treatment.

122. A distinct ethical responsibility of physicians, when a significant risk exists of adverse consequences to any procedure or therapy, is to ensure that the patient understands and is legally able to consent to the treatment, and does consent. To achieve informed consent, the MHP must do at least the following:

- a. The MHP must reasonably inform himself regarding the particular situation of his patient;

b. The MHP must reasonably inform himself concerning the state of knowledge concerning relevant methodologies and outcomes;

c. The MHP must honestly inform the patient concerning not only the benefits of treatment, but also the risks and downsides of treatment, and alternative treatments.

d. The MHP must conclude that the patient (or the decision maker, such as parent or healthcare power of attorney) has comprehended what he or she has been told and possesses a cognitive capacity to make a decision based on an adequate understanding of his or her unique life circumstances.

123. Perfunctory “consent” is inadequate to fulfill the professional’s ethical obligation to obtain informed consent. At the very least, a patient (or parent) considering the life-altering choice of transition should be helped or indeed required by their clinicians to grapple with four relevant questions:

a. “What benefits do you expect that the consolidation of this identity, gender transition, hormones, or surgery will provide?

b. “What do you understand of the social, educational, vocational, and psychological risks of this identity consolidation and gender role transition?

c. “What do you understand about the common and rare, short- and long-term medical and health risks of hormone and surgical interventions?

d. “What have you considered the nature of your life will be in 10 to 20 years?”

(Levine, *Informed Consent*, at 3.)

124. The answers of the patient will enable the professional to make a judgment about how realistic he or she is being. For example, the biological boy who envisions himself as a happy, attractive, socially accepted 21-year-old girl in future college years has probably not been



adequately informed of—or has mentally blocked—hard data concerning the mental health and social wellbeing of the transgender population in their 20s, and is failing to consider the material risk that he, as a transgender individual, will not be perceived as attractive to either sex, and the impact that this may have on his future well-being.

125. Most commonly, meaningful engagement with difficult and painful questions such as those above requires a process that will consist of multiple discussions in a psychotherapeutic or counseling context, not merely “disclosure” of facts. In my experience, a too-rapid or too-eager attachment to some outcome is a red warning flag that the patient is not able to tolerate knowledge of the risks and alternative approaches.

126. In my experience, in the area of transgender therapy, rather than the type of information and engagement that I have described, even mental health professionals too often encourage or permit decisions based on a great deal of patient and professional blind optimism about the future. (Levine, *Ethical Concerns*, at 3-4.)

127. In my judgment, few if any educators who are not also trained mental health professionals will have the knowledge and the training needed to engage in the probing process of informed consent that I have described above, and few will even be aware of the full implications of this ethical principle. They may also be unaware of—or even reject—the well-recognized developmental, ethical, and legal limits on the ability of children to *grant* consent to serious medical or psychotherapeutic interventions. When the clinical experience and areas of competence of even PhD school psychologists are considered, it is usually apparent that their training and professional experiences to date do not equip them to guide parents and children through the uncertainties and ethical dilemmas inherent in children and adolescents who are struggling with gender identity issues or experiencing a sense of transgender identity.

**B. The interests of the patient, as well as necessary disclosures and consent, must be considered from a life course perspective.**

128. The psychiatrist or psychologist treating a child must have in view not merely (or not even primarily) making the child “happy” now, but making him or her as healthy and happy as possible across the entire trajectory of life, to the extent that is predictable. Certainly, avoiding suicide is one important aspect of a “life course” analysis, and recognizes that “today” is not the only goal. But as I have reviewed above, there is much more across the future decades of the patient’s life that also needs to be taken into account.

129. Further, I do not believe that a patient can meaningfully be said to know what will make him “happy” over the long term, prior to receiving, understanding, and usually discussing the type of information that I have described above in connection with informed consent. With respect to children who are not equipped to understand, evaluate, and feel the life implications of such information, it is doubtful that there is any meaningful way in which they can be said to “know” what will make them happy over the long term. It is for similar reasons that parents ordinarily make a great many decisions, both large and small, for their young children.

130. Of particular relevance to the life course perspective, when gender-typical men and women undergo elective sterilization, there is a distinct likelihood of eventual regret. It has been documented that the younger the age of sterilization, the greater incidence of regret and increased numbers of requests to reverse the sterilized state. Thus, the medical profession and the courts are quite clear about sterilization: the adult patient must be cognitively able to prudently consider the future consequences in terms of his or her life circumstances. In minors sterilization should be done only to save a life.<sup>40</sup> This observation has implications for facilitating or even

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<sup>40</sup> See S. D. Hillis et al. (1999), *Poststerilization Regret: Findings from the United States Collaborative Review of Sterilization*, OBSTETRICS. & GYN. 93(6) 889; A. Burgart et al. (2017), *Ethical Controversy About Hysterectomy for a Minor*, PEDIATRICS 139(6),

permitting children or adolescents to embark on a path of social transition that within a few years may psychologically steer that individual towards sterilizing chemical or surgical procedures.

**C. Special concerns and ethical rules governing experimentation on patients**

131. When psychiatric or medical research is done on subjects the informed consent process is far more rigorous than in ordinary medical and psychiatric procedures. For example, in a recent study of an agent to assist women who are distressed by their lack of sexual desire that I was a part of, the Informed Consent document was 19 pages long.

132. The absence of long-term studies in the arena of childhood gender dysphoria or the more recently documented phenomenon of “rapid onset gender dysphoria” among adolescents means that therapeutic responses to these conditions are still at a primitive stage of development, and must be considered to be experimental, rendering adequately informed consent all the more essential, and all the more difficult to obtain. Claims that a civil right is at stake do not change the fact that what is proposed is a social and medical experiment. (Levine, *Reflections*, at 241.)

**D. Ethical principles do not permit using patients as “change agents.”**

133. Some advocates assert that various mental health pathologies commonly observed in patients who have transitioned result from societal prejudice, and would not occur if society were different. This is, of course, a hypothesis rather than demonstrated fact, and it is in any case ethically irrelevant to the treatment of an individual patient. If a therapy or life course under consideration for a child will predictably lead to social and family isolation and unemployment

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DOI:10.1542/peds.2016-3992; K. Curtis et al. (2006), *Regret Following Female Sterilization at a Young Age: A Systematic Review*, CONTRACEPTION 73, 205, DOI:10.1016/j.contraception.2005.08.006; A. Tamar-Mattis (2009), *Exploring Gray Areas in the Law About DSD and Sterilization*, ENDOCRINE TODAY, October ed., <https://www.healio.com/endocrinology/reproduction-androgen-disorders/news/print/endocrine-today/%7Bc6029f85-28ac-43f4-9e7e-0fc897f6313f%7D/exploring-gray-areas-in-the-law-about-dsd-and-sterilization>.

later in life given society as it exists, for a MHP or other advisor to recommend or encourage that path nonetheless seems to lose sight of the welfare of the patient. To do so appears to be intentionally using the child as not merely an experiment, but as a change-agent—potentially at great personal cost—rather than seeking the lifetime best interests of that child. (Levine, *Ethical Concerns*, at 9.)

**E. The inability of children to understand major life issues and risks complicates informed consent.**

134. Obviously, most children cannot give legally valid consent to a medical procedure.<sup>41</sup> This is not a mere legal technicality. Instead, it is a legal reflection of a reality of human development that is highly relevant to the ethical requirement of informed consent quite apart from law. The argument that the child is consenting to the transition by his happiness ignores the fact just described.

135. Each age group poses different questions about risk comprehension. (Levine, *Informed Consent*, at 3.) While the older patient is perhaps more likely to be formally mental ill and delusional, the young child is chronically unable to comprehend large and complex issues such as the meaning of biological sex, the meaning of gender, and the risks and life implications attendant on social, hormonal, and ultimately surgical transition.

136. In my experience, when clinicians actually attempt to understand patients' motives for the repudiation of their natal gender, the developmental lack of sophistication underlying their reasons can become apparent. What must a 12-year-old, for example, understand about masculinity and femininity that enables the conviction that "I can never be happy in my body?" (Levine, *Ethical Concerns*, at 8.) Obviously, this unavoidable gap in comprehension and ability to foresee must be still larger for younger children.

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<sup>41</sup> I recognize that in some States or under some circumstances "mature minors" may be legally empowered to grant consent to certain medical procedures.

137. Similarly, one cannot expect a 17-year-old to grasp the complexity of married life with children when 38. One cannot expect a ten-year-old to understand the emotional growth that comes from a first long term love relationship including sexual behavior. One cannot expect a six-year-old to comprehend the changes in his psyche that may come about as the result of puberty.

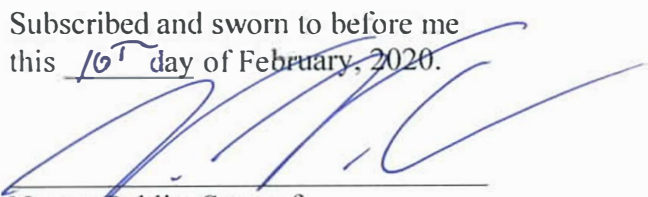
138. For this reason, it is my opinion that asking a child whether he or she wishes to transition to living as the opposite sex, or giving large weight to the child's expressed wishes, by no means satisfies the MHP's ethical obligation to obtain informed consent before assisting that child to transition to living as the opposite sex.

139. In light of the profound uncertainties in the field, and the many highly predictable or probable lifetime costs to the child if he or she persists in a transgender identity into adulthood, in my opinion it is not consistent with principles of medical ethics for physicians or other MHPs to suggest that parents should not or have no right to explore possible therapeutic options to assist their child to achieve comfort with the gender corresponding to his or her sex. The use of the label "reparative therapy" by some advocates to lump all such possible therapies together and disparage them does not change this equation. (Levine, *Informed Consent*, at 7.)

Dated: February 10, 2020.

  
Stephen B. Levine

Subscribed and sworn to before me  
this 16<sup>th</sup> day of February, 2020.

  
Notary Public, State of \_\_\_\_\_  
My Commission expires \_\_\_\_\_.

VICTOR V. ANSELMO, Attorney  
NOTARY PUBLIC -- STATE OF OHIO  
My commission has no expiration date.  
Section 147.03 R.C.

Stephen B. Levine, M.D.

Curriculum Vita

## **Brief Introduction**

Dr. Levine is Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine. He is the solo author of four books, *Sex Is Not Simple* in 1989 (translated to German in 1992 and reissued in English in 1997 as *Solving Common Sexual Problems*); *Sexual Life: A clinician's guide* in 1992; *Sexuality in Midlife* in 1998 and *Demystifying Love: Plain talk for the mental health professional* in 2006; *Barriers to Loving: A clinician's perspective* in October 2013. He is the Senior Editor of the first (2003), second (2010) and third (2016) editions of the *Handbook of Clinical Sexuality for Mental Health Professionals*. *Psychotherapeutic Approaches to Sexual Problems: An Essential Guide For Mental Health Professionals* will be published in the fall 2019. He has been teaching, providing clinical care, and writing since 1973 and has generated original research, invited papers, commentaries, chapters, and book reviews. He has served as a journal manuscript and book prospectus reviewer for many years. He was co-director of the Center for Marital and Sexual Health/ Levine, Risen & Associates, Inc. in Beachwood, Ohio from 1992-2017. He and two colleagues received a lifetime achievement Masters and Johnson's Award from the Society for Sex Therapy and Research in March 2005.

## **Personal Information**

Date of birth 1/14/42

Medical license no. Ohio 35-03-0234-L

Board Certification 6/76 American Board of Neurology and Psychiatry

## **Education**

1963 BA Washington and Jefferson College

1967 MD Case Western Reserve University School of Medicine

1967-68 internship in Internal Medicine University Hospitals of Cleveland

1968-70 Research associate, National Institute of Arthritis and Metabolic Diseases, Epidemiology Field Studies Unit, Phoenix, Arizona, United States Public Health Service

1970-73 Psychiatric Residency, University Hospitals of Cleveland

1974-77 Robert Wood Johnson Foundation Clinical Scholar

## **Appointments at Case Western Reserve University School of Medicine**

1973 - Assistant Professor of Psychiatry

1979 - Associate Professor

1982 - Tenure

1985 - Full Professor

1993 - Clinical Professor

## Honors

Summa Cum Laude, Washington & Jefferson

Teaching Excellence Award - 1990 and 2010 (residency program)

Visiting Professorships:

- Stanford University-Pfizer Professorship program (3 days) - 1995
- St. Elizabeth's Hospital, Washington, DC - 1998
- St. Elizabeth's Hospital, Washington, DC - 2002

Named to America's Top Doctors consecutively since 2001

Invitations to present various Grand Rounds at Departments of Psychiatry and Continuing Education Lectures and Workshops

Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research, April 2005 along with Candace Risen and Stanley Althof

2006 SSTAR Book Award for The Handbook of Clinical Sexuality for Mental Health Professionals: Exceptional Merit

2018 - Albert Marquis Lifetime Achievement Award from Marquis Who's Who. (excelling in one's field for at least twenty years)

## Professional Societies

1971 - American Psychiatric Association; fellow

2005 - American Psychiatric Association - **Distinguished Life Fellow**

1973 - Cleveland Psychiatric Society

1973 - Cleveland Medical Library Association

- 1985 - Life Fellow
- 2003 - Distinguished Life Fellow

1974 - Society for Sex Therapy and Research

- 1987-89 - President

1983 - International Academy of Sex Research

1983 - Harry Benjamin International Gender Dysphoria Association

- 1997-98 - Chairman, Standards of Care Committee

1994-99 - Society for Scientific Study of Sex

## Community Boards

1999-2002 - Case Western Reserve University Medical Alumni Association

1996-2001 - Bellefaire Jewish Children's Bureau

1999-2001 - Physicians' Advisory Committee, The Gathering Place (cancer rehabilitation)

## **Editorial Boards**

1978-80 Book Review Editor Journal Sex and Marital Therapy

Manuscript Reviewer for:

- Archives of Sexual Behavior
- Annals of Internal Medicine
- British Journal of Obstetrics and Gynecology
- JAMA
- Diabetes Care
- American Journal of Psychiatry
- Maturitas
- Psychosomatic Medicine
- Sexuality and Disability
- Journal of Nervous and Mental Diseases
- Journal of Neuropsychiatry and Clinical Neurosciences
- Neurology
- Journal Sex and Marital Therapy
- Journal Sex Education and Therapy
- Social Behavior and Personality: an international journal (New Zealand)
- International Journal of Psychoanalysis
- International Journal of Transgenderism
- Journal of Urology
- Journal of Sexual Medicine
- Current Psychiatry
- International Journal of Impotence Research
- Postgraduate medical journal
- Academic Psychiatry

Prospectus Reviewer for:

- Guilford
- Oxford University Press



- Brunner/Routledge
- Routledge

## **Administrative Responsibilities**

Co-director, Center for Marital and Sexual Health/ Levine, Risen & Associates, Inc. until June 30, 2017

Principal Investigator of approximately 70 separate studies involving pharmacological interventions for sexual dysfunction since 1989.

Co-leader of case conferences at DELRLLC.com

## **Recent Expert Witness Appearances**

US District Court, Judge Mark L. Wolf's witness in Michelle Kosilek vs. Massachusetts Dept of Corrections et al. case (transsexual issue) in Boston 2007

Deposition in the Battista vs. Massachusetts Dept of Corrections case (transsexual issue) in Cleveland October 2009

Witness for Massachusetts Dept. of Corrections in their defense of a lawsuit brought by prisoner Katheena Soneeya. March 22, 2011 Deposition in Boston and October 2018 in Cleveland

Witness for State of Florida vs. Reyne Keohane July 2017

Expert testimony by deposition and at trial in *In the Interests of the Younger Children*, Dallas, TX, 2019.

## **Consultancy**

Massachusetts Department of Corrections - evaluation of 12 transsexual prisoners and the development of a Gender Identity Disorders Program for the state prison system. Monthly consultation with the GID treatment team since February 2009 and the GID policy committee since February 2010

California Department of Corrections and Rehabilitation; 2012-2015; education, inmate evaluation, commentary on inmate circumstances, suggestions on future policies

Virginia Department of Corrections - evaluation of an inmate

New Jersey Department of Corrections - evaluation of an inmate

Idaho Department of Corrections - workshop 2016

## **Grant Support/Research Studies**

TAP - studies of Apomorphine sublingual in treatment of erectile dysfunction

Pfizer - Sertraline for premature ejaculation

Pfizer - Viagra and depression; Viagra and female sexual dysfunction; Viagra as a treatment for SSRI-induced erectile dysfunction

NIH - Systemic lupus erythematosus and sexuality in women

Sihler Mental Health Foundation

- Program for Professionals
- Setting up of Center for Marital and Sexual Health
- Clomipramine and Premature ejaculation
- Follow-up study of clergy accused of sexual impropriety
- Establishment of services for women with breast cancer

Alza - controlled study of a novel SSRI for rapid ejaculation

Pfizer - Viagra and self-esteem

Pfizer - double-blind placebo control studies of a compound for premature ejaculation

Johnson & Johnson - controlled studies of Dapoxetine for rapid ejaculation

Proctor and Gamble - multiple studies to test testosterone patch for post menopausal sexual dysfunction for women on and off estrogen replacement

Lilly-Icos - study of Cialis for erectile dysfunction

VIVUS - study for premenopausal women with FSAD

Palatin Technologies - studies of bremelanotide in female sexual dysfunction—first intranasal then subcutaneous administration

Medtap - interview validation questionnaire studies

HRA - quantitative debriefing study for Female partners of men with premature ejaculation, Validation of a New Distress Measure for FSD,

Boehringer-Ingelheim - double blind and open label studies of a prosexual agent for hypoactive female sexual desire disorder

Biosante - studies of testosterone gel administration for post menopausal women with HSDD

J&J - a single-blind, multi-center, in home use study to evaluate sexual enhancement effects of a product in females.

UBC - Content validity study of an electronic FSEP-R and FSDS-DAO and usability of study PRO measures in premenopausal women with FSAD, HSDD or Mixed FSAD/HSDD

National registry trial for women with HSDD

Endoceutics - two studies of DHEA for vaginal atrophy and dryness in post menopausal women

Palatin - study of SQ Bremelanotide for HSDD and FSAD

Trimel - a double-blind, placebo controlled study for women with acquired female orgasmic disorder.

S1 Biopharma - a phase 1-B non-blinded study of safety, tolerability and efficacy of Lorexys in premenopausal women with HSDD

HRA - qualitative and cognitive interview study for men experiencing PE

## **Publications**

### **A) Books**

- 1) Pariser SR, Levine SB, McDowell M (eds.), Clinical Sexuality, Marcel Dekker, New York, 1985
- 2) Sex Is Not Simple, Ohio Psychological Publishing Company, 1988; Reissued in paperback as: Solving Common Sexual Problems: Toward a Problem Free Sexual Life, Jason Aronson, Livingston, NJ. 1997
- 3) Sexual Life: A Clinician's Guide. Plenum Publishing Corporation. New York, 1992
- 4) Sexuality in Midlife. Plenum Publishing Corporation. New York, 1998
- 5) Editor. Clinical Sexuality. Psychiatric Clinics of North America, March, 1995.
- 6) Editor, (Candace Risen and Stanley Althof, associate editors) Handbook of Clinical Sexuality for Mental Health Professionals. Routledge, New York, 2003  
(a) 2006 SSTAR Book Award: Exceptional Merit
- 7) Demystifying Love: Plain Talk For The Mental Health Professional. Routledge, New York, 2006
- 8) Senior editor, (Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals. 2<sup>nd</sup> edition Routledge, New York, 2010. See review by Pega Ren, JSex&Marital Therapy
- 9) Barriers to Loving: A Clinician's Perspective. Routledge, New York, 2014.
- 10) Senior editor Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals. 3<sup>rd</sup> edition Routledge, New York, 2016

### **B) Research and Invited Papers**

(When his name is not listed in a citation, Dr. Levine is either the solo or the senior author)

- 1) Sampliner R. Parotid enlargement in Pima Indians. Annals of Internal Medicine 1970; 73:571-73
- 2) Confrontation and residency activism: A technique for assisting residency change: World Journal of Psychosynthesis 1974; 6: 23-26
- 3) Activism and confrontation: A technique to spur reform. Resident and Intern Consultant 173; 2
- 4) Medicine and Sexuality. Case Western Reserve Medical Alumni Bulletin 1974:37:9-11.

- 5) Some thoughts on the pathogenesis of premature ejaculation. J. Sex & Marital Therapy 1975; 1:326-334
- 6) Marital Sexual Dysfunction: Introductory Concepts. Annals of Internal Medicine 1976;84:448-453
- 7) Marital Sexual Dysfunction: Ejaculation Disturbances 1976; 84:575-579
- 8) Yost MA: Frequency of female sexual dysfunction in a gynecology clinic: An epidemiological approach. Archives of Sexual Behavior 1976;5:229-238
- 9) Engel IM, Resnick PJ, Levine SB: Use of programmed patients and videotape in teaching medical students to take a sexual history. Journal of Medical Education 1976;51:425-427
- 10) Marital Sexual Dysfunction: Erectile dysfunction. Annals of Internal Medicine 1976;85:342-350
- 11) Articles in Medical Aspects of Human Sexuality
  - (a) Treating the single impotent male. 1976; 10:123, 137
  - (b) Do men enjoy being caressed during foreplay as much as women do? 1977; 11:9
  - (c) Do men like women to be sexually assertive? 1977;11:44
  - (d) Absence of sexual desire in women: Do some women never experience sexual desire? Is this possibility genetically determined? 1977; 11:31
  - (e) Barriers to the attainment of ejaculatory control. 1979; 13:32-56.
  - (f) Commentary on sexual revenge.1979;13:19-21
  - (g) Prosthesis for psychogenic impotence? 1979;13:7
  - (h) Habits that infuriate mates. 1980;14:8-19
  - (i) Greenberger-Englander, Levine SB. Is an enema an erotic equivalent?1981; 15:116
  - (j) Ford AB, Levine SB. Sexual Behavior and the Chronically Ill Patients. 1982; 16:138-150
  - (k) Preoccupation with wife's sexual behavior in previous marriage 1982; 16:172
  - (l) Co-existing organic and psychological impotence. 1985;19:187-8
  - (m) Althof SE, Turner LA, Kursh ED, Bodner D, Resnick MI, Risen CB. Benefits and Problems with Intracavernosal injections for the treatment of impotence. 1989;23(4):38-40
- 12) Male Sexual Problems. Resident and Staff Physician 1981:2:90-5
- 13) Female Sexual Problems. Resident and Staff Physician 1981:3:79-92
- 14) How can I determine whether a recent depression in a 40 year old married man is due to organic loss of erectile function or whether the depression is the source of the

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- 15) Corradi RB, Resnick PJ Levine SB, Gold F. For chronic psychologic impotence: sex therapy or psychotherapy? I & II Roche Reports; 1977
  - 16) Marital Sexual Dysfunction: Female dysfunctions 1977; 86:588-597
  - 17) Current problems in the diagnosis and treatment of psychogenic impotence. Journal of Sex & Marital Therapy 1977; 3:177-186
  - 18) Resnick PJ, Engel IM. Sexuality curriculum for gynecology residents. Journal of Medical Education 1978; 53:510-15
  - 19) Agle DP. Effectiveness of sex therapy for chronic secondary psychological impotence Journal of Sex & Marital Therapy 1978; 4:235-258
  - 20) DePalma RG, Levine SB, Feldman S. Preservation of erectile function after aortoiliac reconstruction. Archives of Surgery 1978; 113-958-962
  - 21) Conceptual suggestions for outcome research in sex therapy Journal of Sex & Marital Therapy 1981; 6:102-108
  - 22) Lothstein LM. Transsexualism or the gender dysphoria syndrome. Journal of Sex & Marital Therapy 1982; 7:85-113
  - 23) Lothstein LM, Levine SB. Expressive psychotherapy with gender dysphoria patients Archives General Psychiatry 1981; 38:924-929
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  - 26) Psychiatric diagnosis of patients requesting sex reassignment surgery. Journal of Sex & Marital Therapy 1980; 6:164-173
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  - 28) A modern perspective on nymphomania. Journal of Sex & Marital Therapy 1982; 8:316-324
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  - 30) Commentary on Beverly Mead's article: When your patient fears impotence. Patient Care 1982; 16:135-9
  - 31) Relation of sexual problems to sexual enlightenment. Physician and Patient 1983 2:62
  - 32) Clinical overview of impotence. Physician and Patient 1983; 8:52-55.
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- 37) Essay on the nature of sexual desire *Journal of Sex & Marital Therapy* 1984; 10:83-96
- 38) Introduction to the sexual consequences of hemophilia. *Scandinavian Journal of Haemology* 1984; 33:(supplement 40).75-
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