UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY,

Plaintiff,

v.

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

Defendants.

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

Expert Decl. of Dr. Stephen B. Levine
in Supp. of MPI
Civil No. 3:21-cv-5359

ALLIANCE DEFENDING FREEDOM
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I. CREDENTIALS & SUMMARY ................................................................. 1

II. BACKGROUND ON THE FIELD ...................................................... 7
    A. The biological baseline of sex ...................................................... 7
    B. Definition and diagnosis of gender dysphoria .............................. 9
    C. Impact of gender dysphoria on minority and vulnerable groups .... 13
    D. Three competing conceptual models of gender dysphoria and
       transgender identity ................................................................. 14
    E. Four competing models of therapy ............................................. 19
       (1) The “watchful waiting” therapy model .................................. 19
       (2) The psychotherapy model: Alleviate distress by identifying and
           addressing causes (model #3) ............................................. 20
       (3) The affirmation therapy model (model #4) .............................. 23
    F. Patients differ widely and must be considered individually .......... 26

III. GENDER IDENTITY, GENDER DYSPHORIA, AND THERAPIES FOR
     GENDER DYSPHORIA IN YOUNGER CHILDREN ............................... 27
    A. Natural desistance is by far the most frequent resolution of gender
       dysphoria in young children absent social transition .................. 27
    B. Social transition of young children is a powerful psychotherapeutic
       intervention that changes outcomes ......................................... 29
    C. The administration of puberty blockers to children as a treatment for
       gender dysphoria is experimental, presents obvious medical risks, and
       appears to affect identity outcomes ......................................... 33

IV. THE AVAILABLE DATA DOES NOT SUPPORT THE CONTENTION THAT
    “AFFIRMATION” OF TRANSGENDER IDENTITY IN CHILDREN AND
    ADOLESCENTS REDUCES SUICIDE OR RESULTS IN BETTER
    PHYSICAL OR MENTAL HEALTH OUTCOMES GENERALLY ............... 37

V. KNOWN, LIKELY, OR POSSIBLE DOWNSIDE RISKS ATTENDANT ON
    MOVING QUICKLY TO “AFFIRM” TRANSGENDER IDENTITY IN
    CHILDREN AND ADOLESCENTS ..................................................... 46
A. Physical risks associated with transition .............................................. 48
B. Social risks associated with transition .................................................. 51
C. Mental health costs or risks ................................................................. 52
D. The risk of regret following transition .................................................. 56
I, Dr. Stephen B. Levine, declare as follows:

I. CREDENTIALS & SUMMARY

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 individuals’ sexuality and sexual relations, therapies for sexual problems, and the relationship between love, 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 which “recognizes extraordinary contributions to clinical sexuality and/or sexual research over the course of a lifetime and achievement of excellence in clinical and/or research areas of sexual disorders.”1 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 previously solo-authored books for

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professionals, I have recently published *Psychotherapeutic Approaches to Sexual Problems* (2020). The book 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. As the incidence of gender dysphoria has increased among children and youth in recent years, larger numbers of minors presenting with actual or potential gender dysphoria have presented to our clinic. I currently am providing psychotherapy for several minors in this area. I also counsel distressed parents of these teens.

5. I was an early member of the Harry Benjamin International Gender Dysphoria Association (now known as the World Professional Association for Transgender Health or WPATH) and served as the Chairman of the committee that developed the 5th version of its Standards of Care. The vast majority of the 6th version contains the exact prose that my committee wrote for the 5th version. In 1993 our Gender Identity Clinic was renamed, moved to a new location, and became independent of Case Western Reserve University. I continue to serve as Co-Director.
6. In 2006, Judge Mark Wolf of the Eastern District of Massachusetts asked me to serve as an independent, court-appointed expert in 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.

7. In 2019, 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 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.

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

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

10. A summary of the key points that I explain in this statement is as follows:
a. Sex as defined by biology and reproductive function cannot be changed. While hormonal and surgical procedures may enable a female-identifying male to “pass” as being female (or vice versa) 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, biological sex, mental health, intelligence, motivations for gender transition, socioeconomic status, country of origin, etc. Data from one population (e.g., adults) cannot be assumed to be applicable to others (e.g., children). (Section II.B.) Generalizations about the treatment children in one country (e.g., Holland) do not necessarily apply to another (e.g., United States).

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 unless transgender-affirming therapeutic or medical interventions modify the normal course of maturation. It is not currently known how to distinguish children who will persist from those who will not. (Section III.)

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

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

h. There are no studies that show with any methodological and statistical validity that affirmation of transgender identity in young children reduces suicide or 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 suicidal ideation, completed suicide, and negative physical and mental health conditions than does the general population before and after transition, hormones, and surgery. There are no randomized studies that compare outcomes among older teens and adults with gender dysphoria who have affirmation treatment with those who do not. (Section IV.)

i. 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 therefore unethical, to assert that a child or adolescent who expresses an interest in a transgender identity will kill him- or herself unless adults and peers affirm that child in a transgender identity. (Section IV.)

j. 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 (first chemical, then 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 lasting romantic
relationships and attract a desirable mate; and elevated mental health risks
of depression, anxiety, and substance abuse. (Section V.)

II. BACKGROUND ON THE FIELD

A. The biological baseline of sex

11. Gender identity advocates commonly refer to the sex of an individual
as “assigned at birth.” This phrase is misleading. 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. As physicians know, sex determination occurs at the instant of conception,
depending on whether a sperm’s X or Y chromosome fertilizes the egg. Medical
technology can now determine a fetus’s sex before birth almost as easily as after
birth. It is thus not correct to assert that doctors “assign” the sex of a child at birth.
Instead, they simply recognize the existing fact of that child’s sex. Barring rare
disorders of sexual development, 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.

12. 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? Does it derive from a tense, chaotic interpersonal parental relationship without physical or sexual abuse? Is it a symptom of another, as of yet unrevealed, emotional disturbance or neuropsychiatric condition such as autism? The answers to these relevant questions are not scientifically known.

13. Under the influence of hormones secreted by the testes or ovaries, numerous additional sex-specific differences between male and female bodies continuously develop postnatally, 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.

14. Despite the increasing use of cross-sex 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. Thus in critical respects, gender affirmation
changes can only be anatomically “skin deep.” 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.² It is
possible for some adolescents and adults to pass unnoticed in daily life as the
opposite sex that they aspire to be—but with limitations, costs, and risks, as I detail
later. These risks include a continuing sense of inauthenticity as a member of the
opposite sex.

B. Definition and diagnosis of gender dysphoria

15. 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 term Gender Dysphoria and

² S. Levine (2018), Informed Consent for Transgendered Patients, J. of Sex & Marital Therapy at 6
(“Informed Consent”); S. Levine (2016), Reflections on the Legal Battles Over Prisoners with Gender
defines it with separate sets of criteria for adolescents and adults on the one hand, and children on the other.

16. 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 defining oneself as gay or lesbian for several or more years and participating in a 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.

17. 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. 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.

18. 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.

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

20. 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 reflect constrictive notions of what men and women can be.4 A young child’s—or even an adolescent’s—understanding of this topic is quite limited. Nor can they grasp what it may mean for their future to be sterile. These children and adolescents consider themselves to be relatively unique; they do not realize that discomfort with the body and perceived social role is neither rare nor new to civilization. What is new is that such discomfort is thought to indicate that they must be a trans person.

21. “Gender identity,” as that term is commonly used in public discourse as well as academic publication, is distinct from sex. Unfortunately, “gender identity” has no distinct objective definition by which a subject’s gender identity may be confirmed. The Department of Health and Human Services has defined

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4 S. Levine (2017), Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria, J. OF SEX & MARITAL THERAPY at 7 (“Ethical Concerns”) (available at http://dx.doi.org/10.1080/0092623X.2017.1309482.)
“gender identity” as “an individual’s internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual’s sex assigned at birth.\textsuperscript{5} A publication sponsored by the ACLU, National Center for Lesbian Rights, Human Rights Campaign, and National Education Association asserts that gender identity encompasses any “deeply-felt sense of being male, female, both or neither,” and can include a “gender spectrum” “encompassing a wide range of identities and expressions.” That source goes on to say that an individual may have an “internal sense of self as male, female, both or neither,” and that “each person is in the best position to define their own place on the gender spectrum.”\textsuperscript{6} The medical text \textit{Principles of Transgender Medicine and Surgery}, states that “Gender identity can be conceptualized as a continuum, a Mobius, or patchwork.”\textsuperscript{7}

22. In sum, gender identity is said to refer to an individual’s subjective perceptions of where that person falls on a continuum of genders ranging from very masculine gender to very feminine, but is also said to include genders which are some of either or something else entirely, or no gender at all (e.g., agender). There are no objective indicia that define or establish one’s gender within this paradigm.

\textsuperscript{5} Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) at 31,384.


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

C. Impact of gender dysphoria on minority and vulnerable groups

24. In considering the appropriate response to gender dysphoria, it is important to know that certain groups of children and adolescents have an increased prevalence and incidence of trans identities. These include: children of color,8 children with mental developmental disabilities,9 including children on the autistic spectrum (at a rate more than 7x the general population),10 children residing in foster care homes, adopted children (at a rate more than 3x the general population).8

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8 G. Rider et al. (2018), Health and Care Utilization of Transgender/Gender Non-Conforming Youth: A Population Based Study, PEDIATRICS 141:3 at 4 (In a large sample, non-white youth made up 41% of the set who claimed a transgender or gender-nonconforming identity, but only 29% of the set who had a gender identity consistent with their sex.).


10 D. Shumer et al. (2016), Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic, LGBT HEALTH, 3(5) 387 at 387.
population),\textsuperscript{11} children with a prior history of psychiatric illness,\textsuperscript{12} and more recently adolescent girls (in a large recent study, at a rate more than 2x that of boys) (Rider, 2018 at 4).

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

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

26. Discussions about appropriate responses by MHPs to actual or sub-threshold gender dysphoria are complicated by the fact that various speakers and 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.

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

\textsuperscript{12} L. Edwards-Leeper et al. (2017), \textit{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; R. Kaltiala-Heino et al. (2015), \textit{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), \textit{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.”).
27. 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.

28. It should be noted, however, that gender dysphoria is a psychiatric, not a medical, diagnosis even though that is how it is often introduced into court settings. Since its inception in DSM-III in 1983, it has always been specified in the psychiatric DSM manuals and is not specified in medical diagnostic 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.) This medicalization of gender dysphoria is at some level at odds with psychologists’ longstanding concerns about or even opposition to “practice guidelines that recommend the use of medications over psychological interventions in the absence of data supporting such recommendations.13

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29. 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 or confusion about the self that intensifies with puberty. 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 the apparent 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) the patient’s 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. The developmental paradigm does not preclude a biological temperamental contribution to some patients’ lives; it merely objects to assuming these problems are biological in origin. All sexual behaviors and experiences involve the brain and the body.

30. 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.
31. Some advocates assert that a transgender identity is biologically caused, fixed from early life, and invariably persists through life in an unchanging manner. This assertion, however, is not supported by science.14 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,15 while a recent study documented “clustering” of new presentations in specific schools and among specific friend groups, pointing to social influences.16 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 reversed as compared to North America and Europe, again demonstrating a powerful effect of cultural influences.

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14 Even the advocacy organization The Human Rights Campaign asserts that a person can have “a fluid or unfixed gender identity.” https://www.hrc.org/resources/glossary-of-terms.

15 Levine, Ethical Concerns, at 8 (citing M. Aitken et al. (2015), Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria, J. of Sexual Med. 12(3) 756 at 756-63.)

16 Lisa Littman (2018), Parent reports of adolescents and young adults perceived to show signs of a rapid onset of dysphoria, PLoS ONE 13(8): e0202330.
32. Further, as I detail later below, many studies and clinical observations confirm that gender identity can and does change or evolve over time for many individuals. And recent studies and anecdotal reports provide strong if preliminary evidence that therapeutic choices can have a powerful effect on whether and how gender identity does change, or gender dysphoria desists.

33. 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. Finally, the large accumulating reports of late adolescent and young adult individuals who return to their natally assigned gender identity highlight the error of assuming a trans identity is a permanent feature.\(^{17}\)

34. 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. Any attempt to slowly review the risks of affirmative and alternative interventions in detail is viewed as irrelevant. In the last few years, this paradigm has been successful in influencing public policy and the education of

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E. Four competing models of therapy

35. 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

36. 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. (Section III.A)

37. 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 DSM-5—that the child may exhibit (e.g., 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)

38. 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.

39. 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.

40. 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.\textsuperscript{18} 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.

41. 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 the individual’s 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.

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

\textsuperscript{18} S. Levine (2017), \textit{Transitioning Back to Maleness}, \textsc{Arch. of Sexual Behavior} 47(4) at 7 ("Transitioning") (available at https://link.springer.com/article/10.1007/s10508-017-1136-9.)
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.

43. To my knowledge, there is no evidence beyond anecdotal reports that psychotherapy can predictably enable a return to male identification for gender dysphoric genetically male boys, adolescents, and men, or return to female identification for gender dysphoric 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. And from the earliest days of my career, traditional psychotherapy showed both promise and beneficial outcomes in reducing the distress of gender dysphoria. It did so without presuming gender affirmation as a preferred or mandated approach. When distress is significantly lessened, the person may find some comfortable adaptation short of bodily change.

44. More recently, I myself have published a paper 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*), I have seen children desist even before puberty in response to thoughtful parental interactions and a few meetings of the child with a therapist. I have seen patients desist when their intimate relationships change.
(3) The affirmation therapy model (model #4)

45. 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 the transgender identity to which the child expresses an attraction. 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.

46. 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 Sections IV and V below.

47. The idea that social transition is the only accepted treatment for prepubertal children is not correct. On the contrary, one respected academic in the field has recently written that “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.”19 This approach is widely

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

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

\textsuperscript{20} D. Singh et al. (2021), \textit{A Follow-Up Study of Boys With Gender Identity Disorder}, \textit{Frontiers in Psychiatry} Vol. 12:632784 at 12 (available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8039393/).

\textsuperscript{21} \textit{World Prof’l Ass’n for Transgender Health} (2011), \textit{Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People} (7th Version) at 17. I note that I regretfully resigned from the precursor organization of WPATH in 2002 after concluding that many of its positions of enthusiastic and unqualified support of transition for individuals suffering from gender dysphoria were dictated by politics and ideology, rather than by any scientific basis. WPATH is composed of a mix of practitioners and transgender activists with little or no scientific training, and its most recent self-designated “Standards of Care” are not reflective of the practices of a large number of psychiatrists and Ph.D. psychologists who practice in this area. For this reason, WPATH’s cautious position with regard to transition of children who suffer from gender dysphoria is all the more notable.
49. In contrast to WPATH's cautious position with respect to children, in 2018 the American Academy of Pediatrics issued a statement asserting that “gender transition” “is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria.” But in a peer-reviewed paper, based on a careful review of the sources cited in the AAP statement, prominent researcher James Cantor concluded that “In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all,” and described Rafferty 2018 as “a systematic exclusion and misrepresentation of entire literatures.” (Cantor at 312.) Based on my professional expertise and my review of the literature, I agree with Dr. Cantor's evaluation of Rafferty 2018.

50. In fact, 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 precondition for a diagnosis of gender dysphoria, precisely because of the risk of “transitory” symptoms and “hasty” diagnosis that might lead to “inappropriate” treatments.

51. 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.

52. 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.

F. Patients differ widely and must be considered individually.

53. In my opinion, it is not possible to make a single, categorical statement about the proper treatment of children or adolescents presenting with gender dysphoria or other gender-related issues. 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.

54. As to causes in children and adolescents, 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. Further, a disturbingly large proportion of children and adolescents who seek professional care in connection with gender issues have a wider history of
psychiatric co-morbidities. (See supra n. 12.) 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.” (Edwards-Leeper at 375.) It seems likely that an even higher proportion will have had prior undiagnosed psychiatric conditions.

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

III. GENDER identity, GENDER DYSPHORIA, AND THERAPIES FOR GENDER DYSPHORIA IN YOUNGER CHILDREN

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

56. 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, the dysphoria 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 307.) 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.”24 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%).”25 As cited above, a 2021 extended follow-up of originally evaluated prepubertal boys found a persistence rate of only 12 percent. (Singh 2021.)

57. 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.)

58. 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.

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

59. In contrast, there is now data that suggests that a therapy that encourages social transition before or during puberty 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,” and “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.”

26 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 otherwise have desisted by adolescence—that is, achieved comfort identifying with their sex—instead persist in a transgender identity. (Zucker, Myth of Persistence, at 7).

60. 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

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27 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, 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).)
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).) 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. As one internationally prominent practitioner stated, “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.”
Given the consensus that no method exists to reliably predict which children
suffering from gender dysphoria will desist and which persist, and given the
absence of any study demonstrating the validity of any such method, this is a
disconcerting statement. Certainly, it reflects a very large change as compared to
the desistance rates documented apart from social transition.

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28 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.

PSYCHOANALYTIC STUDY OF THE CHILD 68(1) 28 at 34.
61. Accordingly, I agree with noted researcher in the field Ken Zucker, who has written that social transition in children must be considered “a form of psychosocial treatment.” (Zucker, Debate, at 1.)

62. I also agree with Dr. Zucker's further observation that “...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.”

63. 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.

64. Given these facts, it is the cross-gender affirming methods endorsed by gender identity advocates that are changing the identity outcomes that would otherwise naturally result for the large majority of prepubertal children who suffer from gender dysphoria. It is thus these methods that could most properly be described as “conversion therapy.” By contrast, the watchful waiting approach which monitors the child’s mental health while working to resolve co-morbidities and reduce life stress, and while allowing time for the natural psychosocial

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30 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.)
developmental processes of adolescence to shape the child’s identity, is properly
seen as the far less invasive therapeutic approach.

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

66. In sum, therapy for young children that encourages transition
(including use of names, pronouns, clothing, and restrooms associated with the
opposite sex) 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. In my judgment, many gender clinics today
are encouraging and assisting children to transition without following these
ethically required procedures.

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31 A. Tishelman et al. (2015), Serving Transgender Youth: Challenges, Dilemmas and Clinical
Examples, PROF. PSYCHOL. RES. PR. at 11 (“Serving TG Youth”) (available at
Moreover, it is not clear how these clinics could create a legal, ethical, and practical informed consent process. Parents would need to understand the risks and benefits of the recommended therapy and of alternative approaches, and to grapple with the scientific deficiencies in this arena, including: the absence of randomized controlled studies, the absence of long follow-up studies of previous children who have undergone these interventions, and the rates of success and failure of the intervention. And it is a difficult question when either minors or parents can ethically (and perhaps legally) grant consent to a medical or therapeutic pathway that carries a high probability of leading to prescription of potentially sterilizing drugs while the child is still a minor. In every case, the professional has an ethical obligation to ensure that meaningful and legal informed consent is obtained.

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

Gender clinics are increasingly prescribing puberty blockers for children as young as ten, as a component of a regime that commonly includes social transition. Puberty blockers are often described as merely providing a completely reversible “pause,” which supposedly gives the child additional time to determine his or her gender identity while avoiding distress which would be caused by pubertal development of the body consistent with the child’s biological sex. The language used about puberty blockers often states or implies that this major hormonal disruption of some of the most basic aspects of ordinary human development is a small thing, and entirely benign.
69. In fact, it is important to recognize that the available (limited) evidence suggests that clinically, puberty blockers administered to children at these ages, for this purpose, and in conjunction with social transition, do not operate as a “pause.” After reviewing the evidence provided by experts from different perspectives, including an expert declaration that I submitted, the U.K. High Court recently concluded that “the vast majority of children who take [puberty blockers] move on to take cross-sex hormones,” and thus that puberty blockers in practice act as a “stepping stone to cross-sex hormones.”32 In my opinion, this finding accurately summarizes the available data.

70. It is equally important to recognize that administration of puberty blockers as a treatment for gender dysphoria is an off-label use of these powerful drugs which is entirely experimental. This application can by no means be considered equivalent to the only application for which puberty blockers have been tested for efficacy and safety and approved—which is for the delay of precocious puberty until the normal time for pubertal development. The U. K. High Court panel accurately summarized the science when they described the use of puberty blockers as “experimental” and as putting children on a “clinical pathway” which is a “lifelong and life changing treatment . . . with very limited knowledge of the degree to which it will or will not benefit them.” (Tavistock, ¶¶136, 143.)

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

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

73. A number of recent papers have claimed to report beneficent or at least neutral short-term effects of use of puberty blockers. None of these even purports to address long-term effects as the subjects mature into adulthood, and even as to short-term effects these studies suffer from methodological deficiencies that prevent them from supporting such conclusions. Recently, the British National Health Service commissioned the respected National Institute for Health and Care
Excellence (NICE) to conduct a thorough evidence review of all available studies that touch on the efficacy and safety of use of puberty blockers for children with gender dysphoria. The exhaustive, 130-page results of this review were published in October 2020. While of course this report provides extensive detail, its overall summary was that, according to widely accepted criteria for measuring the reliability of clinical evidence, “The quality of evidence for [all claims concerning safety and efficacy of this use of puberty blockers] was assessed as very low certainty.” They found that “the studies all lack appropriate controls” and “were not reliable,” that “the studies that reported safety outcomes provided very low certainty evidence,” and that studies that claimed marginally positive outcomes “could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding bias or chance.” (NICE at 13.)

74. So far as I am aware, no study yet reveals whether the life-course mental and physical health outcomes for the relatively new class of “persisters” (that is, those who would have desisted absent a transgender-affirming social and/or pharmaceutical intervention, but instead persisted as a result of such interventions) are more similar to those of the general non-transgender population, or to the notably worse outcomes exhibited by the transgender population generally.

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75. Taking into account the risks, the lack of any reliable evidence concerning long-term outcomes from the use of puberty blockers, and the inability of pre-adolescents and even adolescents to comprehend the physical, relational, and emotional significance of life as a sexually mature adult, I also agree with the conclusion of the U. K. High Court that “it is highly unlikely that a child age 13 or under would ever be . . . competent to give consent to being treated with [puberty blockers],” and that it is “very doubtful” that a child of 14 or 15 “could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent.” (Tavistock, ¶ 145.)

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

76. I am aware that organizations including The Academy of Pediatrics and Parents 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. Recently, the governing counsel of the American Psychological Association adopted the APA Resolution on Gender Identity Change Efforts, which broadly (and wrongly) categorizes any approach to gender dysphoria other than gender affirming methods as unethical and dangerous. These positions appear 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 and adolescents, who
present indicia of transgender identity. As I have discussed above and further
discuss later below, this belief is scientifically incorrect, and ignores both what is
known and what is unknown.

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

78. 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;

34 The APA Resolution on Gender Identity Change Efforts (APA GICE Resolution) is available at
e. A randomized double-blind clinical trial;

f. A review of multiple trials;

g. A meta-analysis of multiple trials that maximizes the number of patients treated despite their methodological differences to detect trends from larger data sets.

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

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

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

81. Unfortunately, advocates of unquestioning affirmation further complicate efforts to understand the available science by speaking indistinctly, ignoring differences between approaches that are likely to be clinically important. For example, the recent APA resolution speaks of “individuals who have experienced pressure or coercion to conform to their sex assigned at birth.” (APA GICE at 1.) “Pressure or coercion” does not describe either the “watchful waiting” or psychotherapy models I have described above, nor therapy structured around a patient’s own desire to become comfortable with his or her natal sex. Nor is it possible to extrapolate from outcomes experienced by those who have been subjected to “coercive” techniques to predict outcomes for patients who receive responsible “watchful waiting” or psychotherapeutic care as I have described and as many experienced practitioners practice.

82. Unsurprisingly, 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 APA has stated, “because no approach to working with [transgender and gender
contrary to the impression that statements in the recent APA GICE Resolution might leave, recent published research has not changed this situation. It remains the case that no randomized controlled trials of any treatment for gender dysphoria have been conducted, and recently published studies suffer from other serious methodological defects as well.

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

85. But the sample and methodology of Turban, Association (2020) are profoundly flawed and cannot support such a conclusion. A group of researchers has published a detailed critique of these defects,38 which I will not attempt to replicate here. To highlight the most obvious defects, however, Association (2020) relied entirely on data drawn from an online convenience sampling of transgender-identified and genderqueer adults recruited from trans-affirming websites. It is well

36 Am. Psych. Assoc’n (2015), Guidelines for Psychological Practice with Transgender & Gender Nonconforming People, AM. PSYCHOLOGIST 70(9) 832 at 842.
37 77 JAMA PSYCHIATRY 77(1) 68-76.
38 R. D’Angelo, et al., One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria (2021), ARCH. SEX BEHAV. 50, 7-16.
known that one “cannot make statistical generalizations from research that relies on convenience sampling.” Nor did the authors of Association (2020) control for the subjects’ mental health status prior to the reported exposure to what the study deemed a “gender identity change effort.” I agree with D’Angelo et al. (2021) that “failure to control for the subjects’ baseline mental health makes it impossible to determine whether the mental health or the suicidality of subjects worsened, stayed the same, or potentially even improved after the non-affirming encounter.”

(D’Angelo (2021) at 10.)

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

87. What is known is not encouraging. 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

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40 H. Murad et al. (2010), Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. CLINICAL ENDOCRINOLOGY; 72(2): 214-231. See also R. D’Angelo (2018), Psychiatry’s ethical involvement in gender-affirming care, AUSTRALASIAN PSYCHIATRY Vol 26(5) 460-463, noting the large number of non-responders in follow-up outcome studies, and observing that “it is generally not known whether they are alive or dead,” and that “it is . . . pure speculation to assume that none committed suicide.”
88. 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.42

89. In considering “suicide,” mental health professionals distinguish between suicidal thoughts (ideation), suicide gestures, suicide attempts with a


42 A recent article, J. Turban et al. (2020), Puberty Suppression for Transgender Youth and Risk of Suicidal Ideation, PEDIATRICS 145(2), has been described in press reports as demonstrating that administration of puberty-suppressing hormones to transgender adolescents reduces suicide or suicidal ideation. The paper itself does not make that claim, nor permit that conclusion.
lethal potential, and completed suicide. Numerous studies have found suicidal
ideation to have been present at some time in life in ~40-50% of trans-identifying
persons. This figure is approximately twice that reported in gay and lesbian
communities. In the heteronormative communities, ideation is approximately 4%.
Mental health professionals distinguish clearly between gestures and potentially
lethal attempts, which often result in hospitalization.

90. 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.43 Their completed
suicide rates are not known.

91. 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. They also
overlook the other tools that the profession does have for addressing depression and

Youth in Cal.: Findings from a Representative, Population-Based Sample of High Sch. Students, J.
AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 56(9) at 739.
suicidal thoughts in a patient once that risk is identified. (Levine, *Reflections*, at 242.)

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

93. Meanwhile, no studies show that affirmation of pre-pubescent children or adolescents 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 affirmation and social transition for children and adolescents, and the use of puberty blockers for transgender children, are a recent phenomenon, it could hardly be otherwise.

94. Given what is known and what is not known about the incidence and causes of suicide attempts and suicide in children and adolescents who suffer from gender dysphoria, and what is known about the incidence of suicide attempts and suicide in individuals who have transitioned to live in a transgender identity, it is in

\textsuperscript{44} G. Zeluf, et al. (2016), *Health, Disability and Quality of Life Among Trans People in Sweden—A Web-Based Survey*, BMC PUBLIC HEALTH 16, 903.

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

\textsuperscript{46} C. Dragon, et al. (2017), *Transgender Medicare Beneficiaries & Chronic Conditions: Exploring Fee-for-Service Claims Data*, LGBT HEALTH 4(6) 404.
my view unethical for a mental health professional to tell a young patient, or the
parents of a young patient, that social transition, puberty blockers, or use of cross-
sex hormones will reduce the likelihood that the young person will commit suicide.

95. Instead, 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.

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

96. 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. This means that the MHP, patient, and in the case of minors, parents
must 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.

97. Indeed, given the very high rates of children who desist from desiring a
trans identity through the course of uninterrupted puberty, it is efforts to “affirm” a
sex-discordant gender identity in prepubescent children that should be understood
as the therapeutic path that is most likely to “change” or “convert” the child’s adult
gender identification, diverting the child from his or her probable maturation away
from trans-identification.
98. The APA and other gender identity advocates argue that gender affirmation practices are safe and effective. (APA GICE Resolution at 3.) But if we consider the long term—a life course perspective—a great deal of data point in the opposite direction. The multiple studies from different nations (including societies which pride themselves on being actively inclusive of sexual minorities, such as Sweden and Denmark) 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 us that assisting the child or adolescent 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 young person’s life is not justified based on numerous scientific snapshots of cohorts of trans adults and teenagers. American public health professionals repeatedly have published descriptions of trans populations as marginalized and vulnerable to many adversities.47

99. 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.)

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

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A. Physical risks associated with transition

101. Sterilization. It is not uncommon for patients who begin down the path defined by puberty blockers and social transition to end up feeling the need to undergo surgical treatment to alleviate gender dysphoria. As I have noted above, there is not good scientific evidence that SRS results in better long-term mental health outcomes. What is certain, however, is that SRS that removes testes, ovaries, or the uterus is inevitably sterilizing, and irreversible. While some patients who have experienced regret after undergoing SRS have then undergone reconstructive surgery, such surgery cannot restore fertility. And 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.

102. 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. The U.K. High Court in the Tavistock litigation, after reviewing the evidence, concluded that cross-sex hormones “may well lead to a loss of fertility,” and in my opinion that finding accurately summarizes the present medical understanding.48 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

48 Bell v. Tavistock Opinion (December 1, 2020), ¶138. See also 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”).
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 ¶ 24.)

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. 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.)

104. **Other effects of hormone administration.** I have discussed the risks
and unknowns associated with puberty blockers above, noting that most children
who are started on puberty blockers continue on the pathway to cross-sex hormones.
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 most
of their life, even after undergoing sex reassignment surgery.
105. The long-term health risks of this major alteration of hormonal levels have not yet been quantified in terms of exact risk.\textsuperscript{49} 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.”\textsuperscript{50} 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., \textit{TGN Adolescent Care} at 5), which are associated with strokes, heart attacks, 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.

106. **Health risks inherent in complex surgery.** Complications of surgery exist for each procedure,\textsuperscript{51} 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.

\textsuperscript{49} See Tishelman et al., \textit{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.”).


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 the child and his siblings mature into adulthood. 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 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.52

111. **Social risks associated with delayed puberty.** The social and psychological impacts of remaining puerile for, e.g., three to five years while one’s peers are undergoing pubertal transformations, 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.)

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.53

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

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

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

53 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; see also supra ¶ 24.
54 Bränström & Pachankis, (2019), Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries, AM. J. OF PSYCHIATRY 177(8) 727-734.
field. Shortly after publication, the study’s analysis and conclusion were trenchantly
criticized, among other reasons because of the study’s failure to compare subjects’
post-surgery mental health with those subjects’ mental health before undergoing
SRS.

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

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

56 Correction to Bränström and Pachankis (2020), AM. J. OF PSYCHIATRY 177:8 at 734.
57 R. Bränström and J. E. Pachankis (2020), Toward Rigorous Methodologies for Strengthening
Causal Inference in the Association Between Gender-Affirming Care and Transgender Individuals’
Mental Health: Response to Letters, 177 AM. J. OF PSYCHIATRY 769-772.
D. The risk of regret following transition

120. 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.

121. 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.”

122. 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.

123. 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 a male form.58

58 Djordjevic et al. (2016), Reversal Surgery in Regretful Male-to-Female Transsexuals After Sex Reassignment Surgery, J. Sex Med. 13(6) 1000.
124. 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 ¶ 58.) Given the rapid increase in the number of girls presenting to gender clinics within the last few years, the phenomena of regret and desistance by young women deserves careful attention and study by MHPs. (See Expósito-Campos, 2021.)

125. 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.

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

By: [Signature]

Dr. Stephen B. Levine

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

[Notary Seal]

Mary J. Lehman
Notary Public, State of Ohio
My Commission expires 3/9/25
EXHIBIT A
Stephen B. Levine, M.D.       Curriculum Vitae

Brief Introduction

Dr. Levine is a Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine. He is the author or coauthor of numerous books on topics relating to human sexuality and related relationship and mental health issues. Dr. Levine 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. Dr. Levine has been co-director of the Center for Marital and Sexual Health/ Levine, Risen & Associates, Inc. in Beachwood, Ohio from 1992 to the present. He 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-Awarded 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; #19909
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
1997-8 Chairman, Standards of Care Committee
1994- 1999 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:

a. Archives of Sexual Behavior
b. Annals of Internal Medicine
c. British Journal of Obstetrics and Gynecology
d. JAMA
e. Diabetes Care
f. American Journal of Psychiatry
g. Maturitas
h. Psychosomatic Medicine
i. Sexuality and Disability
j. Journal of Nervous and Mental Diseases
k. Journal of Neuropsychiatry and Clinical Neurosciences
l. Neurology
m. Journal Sex and Marital Therapy
n. Journal Sex Education and Therapy
o. Social Behavior and Personality: an international journal (New Zealand)
q. International Journal of Transgenderism
r. Journal of Urology
s. Journal of Sexual Medicine
t. Current Psychiatry
u. International Journal of Impotence Research
v. Postgraduate medical journal
w. Academic Psychiatry

Prospectus Reviewer

a. Guilford
b. Oxford University Press
c. Brunner/Routledge
d. Routledge

**Administrative Responsibilities**

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**


Testified by deposition in *Battista vs. Massachusetts Dept of Corrections* (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.


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

**Consultancies**

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 erythematosis and sexuality in women

Sihler Mental Health Foundation
a. Program for Professionals
b. Setting up of Center for Marital and Sexual Health
c. Clomipramine and Premature ejaculation
d. Follow-up study of clergy accused of sexual impropriety
e. 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 I-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


   1. 2006 SSTAR Book Award: Exceptional Merit


10) Senior editor Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals. 3rd 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.


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

5) Some thoughts on the pathogenesis of premature ejaculation. J. Sex & Marital Therapy 1975; 1:326-334


13) 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 dysfunction? Sexual Medicine Today 1977;1:13

14) Corradi RB, Resnick PJ Levine SB, Gold F. For chronic psychologic impotence: sex therapy or psychotherapy? I & II Roche Reports; 1977

15) Marital Sexual Dysfunction: Female dysfunctions 1977; 86:588-597


21) Lothstein LM. Transsexualism or the gender dysphoria syndrome. Journal of Sex & Marital Therapy 1982; 7:85-113

22) Lothstein LM, Levine SB. Expressive psychotherapy with gender dysphoria patients Archives General Psychiatry 1981; 38:924-929
23) Stern RG Sexual function in cystic fibrosis. Chest 1982; 81:422-8
27) A modern perspective on nymphomania. Journal of Sex & Marital Therapy 1982;8:316-324
28) Nymphomania. Female Patient 1982;7:47-54
29) Commentary on Beverly Mead’s article: When your patient fears impotence. Patient Care 1982;16:135-9
32) An analytical approach to problem-solving in sexual medicine: a clinical introduction to the psychological sexual dysfunctions. II. British Journal of Sexual Medicine
34) Althof SE, Coffman CB, Levine SB. The effects of coronary bypass in female sexual, psychological, and vocational adaptation. Journal of Sex & Marital Therapy 1984;10:176-184
37) Introduction to the sexual consequences of hemophilia. Scandinavian Journal of Haemology 1984; 33:(supplement 40).75-
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43) Lets talk about sex. National Hemophilia Foundation January, 1988
52) Is it time for sexual mental health centers? Journal of Sex & Marital Therapy 1989
55) Turner LA, Althof SE, Levine SB, Risen CB, Bodner D, Kurs E, Resnick


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68) Male sexual problems and the general physician, Georgia State Medical


78) “Love” and the mental health professions: Towards an understanding of adult love. Journal of Sex & Marital Therapy 1996; 22(3)191-202


80) Discussion of Dr. Derek Polonsky’s SSTAR presentation on Countertransference. Journal of Sex Education and Therapy 1998; 22(3):13-17

81) Understanding the sexual consequences of the menopause. Women’s Health in Primary Care, 1998

82) Fones CSL, Levine SB. Psychological aspects at the interface of diabetes and erectile dysfunction. Diabetes Reviews 1998; 6(1):1-8

83) Guay AT, Levine SB, Montague DK. New treatments for erectile dysfunction. Patient Care March 15, 1998


1. Reprinted by the Harry Benjamin International Gender Dysphoria Association, Minneapolis, Minnesota


87) Fones CSL, Levine SB, Althof SE, Risen CB. The sexual struggles of 23 clergymen: a follow-up study. Journal of Sex & Marital Therapy 1999


93) Alloggiamento T., Zipp C., Raxwal VK, Ashley E, Dey S. Levine SB, Froelicher VF. Sex, the Heart, and Sildenafil. Current Problems in Cardiology 26 June 2001(6):381-416


98) Laura Davis. What I Did For Love: Temporary Returns to the Male Gender


104) Commentary: Pharmacologic Treatment of Erectile Dysfunction: Not always a simple matter. BJM USA; Primary Care Medicine for the American Physician, 4(6):325-326, July 2004


106) Multiple authors. Efficacy and safety of sildenafil citrate (Viagra) in men with serotonergic antidepressant-associated erectile dysfunction: Results from a randomized, double-blind, placebo-controlled trial. Submitted to Journal of Clinical Psychiatry Feb 2005


118) I am not a sex therapist! Commentary to I. Binik and M. Meana’s article Sex Therapy: Is there a future in this outfit? Archives of Sexual Behavior, Volume 38, Issue 6 (2009), 1033-1034


120) Perelman, MA., Levine SB, Fischkoff SA. Randomized, Placebo-Controlled, Crossover Study to Evaluate the Effects of Intranasal Bremelanotide on Perceptions of Desire and Arousal in Postmenopausal Women with Sexual Arousal Disorder submitted to Journal of Sexual Medicine July 2009, rejected

121) What is Sexual Addiction? Journal of Sex and Marital Therapy.2010 May;36(3):261-75


124) Commentary on Consideration of Diagnostic Criteria for Erectile Dysfunction in DSM V. Journal of Sexual Medicine July 2010

125) Hypoactive Sexual Desire Disorder in Men: Basic types, causes, and treatment. Psychiatric Times 27(6)4-34. 2010

126) Male Sexual Dysfunctions, an audio lecture, American Physician Institute 2013


138) Levine SB, Sheridan DL, Cooper EB. The Quest for a Prosexual Medication for Women, Current Sexual Health Reports (2016) 8: 129. doi:10.1007/s11930-016-
0085-y


141) Sexual Dysfunction in Clinical Psychiatry, Psychiatric Times, March 2017


143) The Psychiatrist’s Role in Managing Transgender Youth: Navigating Today’s Politicized Terrain. CMEtoGO Audio Lecture Series, May 2017


C) Book Chapters


54.


32) Infidelity in Handbook of Clinical Sexuality for Mental Health Professionals edited by Levine SB, Risen, CB, and Althof, SE, Routledge, New York, 2010


35) Levine, SB. Sexual Disorders in Fundamentals of Psychiatry (by Allan Tasman and Wanda Mohr, eds.)


**D) Book Reviews**


12) Sexual Landscapes: Why we are what we are, why we love whom we love. By JD Weinrich, Charles Schribner’s Sons, New York, 1987 in Archives of Sexual Behavior 21 (3):323-26, 1991


Page 20 of 22
American Journal of Psychiatry


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