IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, ,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Case No. 4:15-cv-54
	)	
GLOUCESTER COUNTY SCHOOL BOARD,	)	
	)	
Defendant.	)	
	)	

DECLARATION OF SHAYNA MEDLEY-WARSOFF

I, Shayna Medley-Warsoff, submit the following declaration in support of Plaintiff Gavin Grimm's motion for summary judgment. I am one of the attorneys for Gavin Grimm, and I have personal knowledge of the facts in this attorney declaration. If called upon to testify, I could competently testify to the matters set forth in this declaration.

1. A copy of Defendant's Answers to Plaintiff's First Set of Interrogatories is attached to this Declaration as Exhibit 1.

2. A copy of Defendant's Supplemental Answer to Plaintiff's Interrogatory No. 1. is attached to this Declaration as Exhibit 2.

3. A copy of the Expert Report and Declaration of Dr. Melinda Penn is attached to this Declaration as Exhibit 3.

4. A copy of Dr. Melinda Penn's curriculum vitae, which was originally attached as Exhibit A to the Expert Report and Declaration of Dr. Melinda Penn, is attached to this Declaration as Exhibit 4.

5. A copy of the World Professional Association for Transgender Health ("WPATH)" Standards of Care, which was originally attached as Exhibit B to the Expert Report and Declaration of Dr. Melinda Penn, is attached to this Declaration as Exhibit 5.

6. A copy of the Endocrine Society's Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, which was originally attached as Exhibit C to the Expert Report and Declaration of Dr. Melinda Penn, is attached to this Declaration as Exhibit 6.

7. A copy of the Expert Report of Dr. Quentin Van Meter is attached to this Declaration as Exhibit 7.

8. A copy of the Rebuttal Expert Report and Declaration of Dr. Melinda Penn is attached to this Declaration as Exhibit 8.

9. A copy of the deposition of Nathan Collins in this case is attached to this Declaration as Exhibit 9.

10. A copy of the deposition of Walter Clemons in this case is attached to this Declaration as Exhibit 10.

11. A copy of the deposition of Tiffany Durr in this case is attached to this Declaration as Exhibit 11.

12. A copy of the deposition of Matthew Lord in this case is attached to this Declaration as Exhibit 12.

13. A copy of the 30(b)(6) deposition of Troy Anderson in this case is attached to this Declaration as Exhibit 13.

14. A copy of the deposition of Quentin Van Meter is attached to this Declaration as Exhibit 14.

15. A copy of Mr. Collins's memorandum to Deirdre Grimm dated October 14, 2014, which was originally produced as GCSB 0894 and attached as Exhibit 8 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 15.

16. A copy of Dr. Clemons's email to the School Board dated October 22, 2014, originally produced as WAVY TV FOIA 007 and attached as Exhibit 5 to the Deposition of Walter Clemons, is attached to this Declaration as Exhibit 16.

17. A copy of Mr. Collins's memorandum to Dr. Clemons dated October 23, 2014, which was originally produced as GCSB 4121-22 and attached as Exhibit 2 to the Deposition of Dr. Clemons, is attached to this Declaration as Exhibit 17.

18. A copy of the emails from Carla Hook to a constituent dated October 24-27, 2014, which were originally produced as GCSB 0853-55, is attached to this Declaration as Exhibit 18.

19. A copy of the email from Carla Hook to a constituent dated October 31, 2014, which was originally produced as GCSB 0844, is attached to this Declaration as Exhibit 19.

20. A copy of the email from Carla Hook to the School Board dated November 4, 2014, which was originally produced as GCSB 0513, is attached to this Declaration as Exhibit 20.

21. A copy of the email and attachment from Carla Hook to the School Board dated November 9, 2014, which was originally produced as GCSB 0507-08, is attached to this Declaration as Exhibit 21.

22. A copy of the School Board's press release dated December 3, 2014, which was originally produced as GCSB 0592-94 and attached as Exhibit 10 to the Deposition of Dr. Clemons, is attached to this Declaration as Exhibit 22.

23. A copy of the Recorded Minutes of Gloucester County School Board meeting on December 9, 2014, which is available online at http://gets.gc.k12.va.us/Portals/Gloucester/District/docs/SBAgenda2014/Minutes2014/MIN-12-09-2014.pdf, is attached to this Declaration as Exhibit 23.

24. A copy of the Mr. Collins's memorandum to Deirdre and David Grimm dated December 10, 2014, which was originally produced as GCSB 0893 and attached as Exhibit 15 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 24.

25. A copy of an email from Amy Bergh to Mr. Collins dated November 14, 2014, which was originally produced as GCSB 3932 and attached as Exhibit 12 to the Deposition of Nathan Collins, is attached to this Declaration was Exhibit 25.

26. A copy of Gavin's final transcript, which was originally produced as GCSB 4283 and attached as Exhibit 22 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 26.

27. A copy of the presentation given at the 2014 Virginia School Board Association conference, originally produced as GCSB 4221-31 and attached as Exhibit 9 to the Deposition of Walter Clemons, is attached to this Declaration as Exhibit 27.

28. A copy of the map of Gloucester High School, originally produced as GCSB 1276 and attached as Exhibit 4 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 28.

29. An annotated copy of the Gloucester High School map, on which I have marked the locations of school restrooms based on pages 33-36 and 94-108 of the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 29.

30. A copy of the list of restrooms at Gloucester High School, which was originally produced as GCSB 03944 and attached as Exhibit 5 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 30.

31. A copy of the letter from Joshua Block to David Corrigan dated December 23, 2016, is attached to this Declaration as Exhibit 31.

32. A copy of the letter from David Corrigan to Joshua Block dated January 18, 2017, is attached to this Declaration as Exhibit 32.

33. A copy of the letter from Joshua Block to Denise McNerney dated January 18, 2017, is attached to this Declaration as Exhibit 33.

34. A copy of the letter from Kyle Duncan to Denise McNerney dated January 19, 2017, is attached to this Declaration as Exhibit 34.

35. A copy of the Gloucester County School Board press release dated February 13, 2019, is attached to this Declaration as Exhibit 35.

36. A copy of the Gloucester County School Board press release dated February 21, 2019, is attached to this Declaration as Exhibit 36.

37. A copy of the Recorded Minutes of Gloucester County School Board meeting on November 11, 2014, which is available online at http://gets.gc.k12.va.us/Portals/Gloucester/District/docs/SBAgenda2014/Minutes2014/MIN-11-11-2014.pdf, is attached to this Declaration as Exhibit 37.

38. A copy of the Amicus Brief of American Academy of Pediatrics, et al. in support of Plaintiff-Appellant, *G.G. v. Gloucester Cty. Sch. Bd.*, No. 15-2056, ECF No. 244 (4th Cir.), is attached to this Declaration as Exhibit 38.

39. A copy of the Amicus Brief of School Administrators from Thirty-Three States and the District of Columbia in support of Plaintiff-Appellant, *G.G. v. Gloucester Cty. Sch. Bd.*, No. 15-2056, ECF No. 155 (4th Cir.), is attached to this Declaration as Exhibit 39.

40. A copy of the Amicus Brief of the National PTA, et al. in support of Plaintiff-Appellant, *G.G. v. Gloucester Cty. Sch. Bd.*, No. 15-2056, ECF No. 145-1 (4th Cir.), is attached to this Declaration as Exhibit 40.

41. A copy of the American Psychological Association & National Association of School Psychologists' 2015 *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools*, available online at https://goo.gl/AcXES2, is attached to this Declaration as Exhibit 41.

42. A copy of Gender Spectrum's 2016 *Transgender Students and School Bathrooms: Frequently Asked Questions*, available online at https://goo.gl/Z4xejp, is attached to this Declaration as Exhibit 42.

43. A copy of the National Association of Secondary School Principals' 2016 *Position Statement on Transgender Students*, available online at https://goo.gl/kcfImn, is attached to this Declaration as Exhibit 43.

44. I have reviewed the video recording of the Gloucester County School Board meeting dated December, 9, 2014, which is available online at http://gloucester.granicus.com/MediaPlayer.php?view_id=10&clip_id=1090. At 42:20, a person identified as Savannah Williams says, "I just filled out my voter's registration card a week ago and I can tell you that you can make any decision you want but if you don't vote to protect your constituents you will not be reelected. I can certainly say that my vote will go to someone else. Fact. If you choose to vote that Gloucester County public school restrooms

should be made coed, you will be replaced and we the citizens of Gloucester will reverse your decision with a new School Board."

45. At 50:53, a person identified as Andrew Palas says, "We do have the power to vote you out of office and we will do that."

46. At 59:53, a person identified as Karen Pauley says, "And like many have said, I also have a voter's card and I'm not afraid to use it. And I will vote every single one of you off of this Board if you do not protect our children."

47. At 1:18:00, a person identified as Janet West says, "I have a voter's card and all will lose their job."

48. At 1:17:40, Janet West says, "Now we're here talking about this young lady, where's my child respect?"

49. At 1:22:55, a person identified as Don Mitchell says, "Here we have a thousand students versus one freak."

50. At 1:23:25, Don Mitchell says, "If you want to consider yourself a dog, must we use tax dollars to install fire hydrants where you can publicly relieve yourselves?"

51. At 58:56, Karen Pauley says, "Put him in a separate bathroom if that's what it's going to take."

52. I have reviewed the video recording of the Gloucester County School Board meeting dated February 19, 2019, which is available online at http://gloucester.granicus.com/MediaPlayer.php?view_id=10&clip_id=2043. At 10:34, David Corrigan, attorney for the Gloucester County School Board, says, "the proposed resolution would allow those students to use the restroom consistent with their new gender identity as long as they meet three criteria: First, the student must have a medical diagnosis

from a health care provider, with expertise in the gender identity field. Second the student must have been living as the new gender identity for a period of at least 6 months, and third, the student must have been receiving treatment in the form of social transition or hormones for a period of 6 months."

53. At 11:20, Corrigan says, "The proposed resolution comes as result of discussions that have occurred between representatives of the school board, along with me as the school board attorney for Gloucester County in this litigation, the plaintiff and legal counsel for the plaintiff, under the supervision of a federal magistrate judge from Newport News named Douglas Miller. Judge Miller is not seeking to force a settlement or enforce a settlement, but he's been instrumental in helping the parties develop language which the plaintiff has agreed to and which the school board has agreed to present here tonight."

54. At 11:57, Corrigan says, "A significant issue raised previously was that a student could just, on a whim, decide for a day to use the restroom of the opposite sex. This resolution eliminates that possibility."

55. At 12:10, Corrigan says, "With the changes already made to existing restrooms ensuring greater privacy and the creation of the single-stall restrooms throughout the high school, the issue of individual privacy is also addressed."

56. At 1:59:35, an individual identified as Brian Bird says, "our sons are being demasculinated by this country. Our daughters are being defeminized. I don't want to see us promote that."

57. At 59:24, an individual identified as Kenny Smith says, "when we talk about social transition and gender identity we're talking about issues that we've created. God didn't create those."

58. At 47:53, an individual identified as a current Gloucester High School student named Elizabeth S. says, "I've heard some transgender students say that they have to wait till they get home in order to use the restroom because they're scared of what the security guards are going to say."

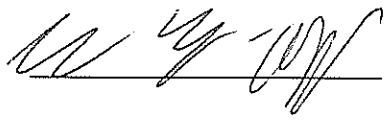
59. At 1:05:52, an individual identified as a Gloucester High School student named Marie Hutchins says, "I see every single day people that are afraid to use the bathroom and that do not want to due to discrimination, and I just don't think that's right."

60. At 1:05:15, an individual identified as a transgender student at Gloucester High School named Vincent Staples says, "I'm in favor of the current proposition that is being discussed tonight so that I can feel like I belong in my school."

61. At 1:36:07, an individual identified as Jonathan Hargis says he is the "proud parent of a transgender child" in the Gloucester public schools. At 1:37:00, he says, "I'm quite certain that I will never be able to convince those of you that think that it's a mental disorder. I can tell you there's no medication for it, there's no praying it out of them, and there's no beating it out of them. They are who they are, and they deserve the opportunity to be treated with respect and dignity."

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

Dated: March 25, 2019



Shayna Medley-Warsoff

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-00054

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

DEFENDANT'S ANSWERS TO PLAINTIFF'S FIRST INTERROGATORIES

Comes now the defendant, Gloucester County School Board ("School Board"), and for its Answers to Plaintiff's First Interrogatories, states as follows:

GENERAL OBJECTIONS

A. Defendant objects to the Instructions contained in Plaintiff's interrogatories to the extent they alter, amend, or exceed the scope of the Federal Rules of Civil Procedure.

B. The information supplied in these answers is not based solely on the knowledge of the executing party but includes knowledge of the party, its agents, representatives, and attorneys, unless privileged. Such knowledge may or may not be known to the Defendant other than as provided.

C. The word usage and sentence structure may be that of the attorney and staff assisting in the preparation of these answers and thus do not necessarily purport to be the precise language of the executing party.

D. These answers will be supplemented in accordance with the Rule 33 of the Federal Rules of Civil Procedure, the Local Rules of the Eastern District of Virginia, and any Orders regarding discovery.

E. Defendant objects to interrogatories, etc., that invade or attempt to invade the attorney/client, work product, or any other applicable privilege.

ANSWERS TO INTERROGATORIES

1. Identify all complaints received by Gloucester County School Board ("the Board") or its employees related to transgender students' use of restrooms during the 2014-2015 school year, and for each complaint identify the date of the complaint, the recipient of the complaint, the content of the complaint, how the complaint was communicated or transmitted, whether the complainant was from a Gloucester High School student or parent of a Gloucester High School student, and whether the complaint related to any incident in which a student reported being in the restroom at the same time as Plaintiff.

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection,[1] Gloucester County High School Principal Nate Collins gave Grimm permission to use the male restroom on October 20, 2014. Two to three days later, Superintendent Dr. Walter Clemons received two complaints from parents regarding a transgender student using the restroom inconsistent with that student's biological sex. Dr. Clemons does not recall the identity of those parents. The parents indicated that they did not approve of a biologically female student using the male restroom. Additionally, a male student met with Collins in person and expressed concern about a biologically female student using the male restroom and a lack of privacy. Collins does not recall the specific identity of this student.

Moreover, after Grimm began to use the male restroom, Dr. Clemons, Collins and the individual members of the School Board received numerous complaints via email, which are listed below.

Emails sent to all members of the School Board

- **On October 23, 2014, Kathryn Lindsay, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 23, 2014, Stacie and Paul Martin, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

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[1] **The School Board specifically reasserts its objection that Plaintiff's use of the term "complaint" in this Interrogatory is vague and ambiguous. The School Board has included in its Answer communications with individuals who generally opposed a transgender student using a restroom inconsistent with that student's biological sex. The School Board's Answer includes communications with individuals who did not agree with Gloucester High School allowing a transgender student to use a restroom inconsistent with that student's biological sex and communications with individuals who supported the School Board's December 9, 2014 resolution and the School Board's litigation of this matter.**

- **On October 27, 2014, Susannah Hogge sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 27, 2014, Jennifer Spears, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 28, 2014, Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 10, 2014, Elisa Nelson, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 10/11, 2014, Stuart and Seth Bunting, parents of student(s) enrolled in Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 11, 2014, Mary Diggs, upon information and belief a resident of Gloucester County, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 11, 2014, David Turner sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 12, 2014, Haley Poulson, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 12, 2014, Kelly Williams, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 13, 2014, Melissa Alexander, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 17, 2014, Kelly Cooper, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 7, 2014, Jenny Poole, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, Mike Enz, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, Heather Schott, a parent of student(s) enrolled in the Gloucester County Public School System, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 10, 2014, Tommie Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 10, 2014, Paul Martin, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 20, 2014, Chuck Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 20, 2014, Clayton Rogers sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On January 2, 2015, an individual named Jena sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 10, 2015, Tim Tompkins sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On April 21, 2016, Kathryn Lindsay, a parent of students(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On April 21, 2016, Paul Martin, parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On May 12, 2016, Kenneth Larson sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Troy Anderson

In addition to receiving emails sent to the entire School Board, Mr. Anderson received the following communications:

- **On December 7, 2014, Ginger Enz, parent of student(s) enrolled in Gloucester High School, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 27, 2015, Leland Pike, a resident of Kentucky, sent Mr. Anderson an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 14, 2016, Florence Alpert, a resident of New York, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Randy Burak

In addition to receiving emails sent to the entire School Board, Mr. Burak received the following communications:

- **On November 12, 2014, Gina Thayer, a parent of student(s) enrolled in Gloucester High School, sent Mr. Burak an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 3, 2014, Lisa Wood, a resident of the Abingdon District, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 7, 2014, Mike Enz, a parent of student(s) who attended Gloucester High School, sent the Mr. Burak an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, a resident of Gloucester County named Ginger emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 11, 2014, Sharon Kass, a resident of Washington D.C., emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Kimberly Hensley

In addition to receiving emails sent to the entire School Board, Ms. Hensley received the following communications:

- **On November 19, 2014, Tracey Parks Carter, a parent of student(s) at Gloucester High School, emailed Ms. Hensley regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 13, 2014, Cliff and Brandi Blackwood, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, emailed Ms. Hensley regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Carla Hook

In addition to receiving emails sent to the entire School Board, Ms. Hook received the following communications:

- **On December 7, 2014, Steven Davis, a parent of high school student(s) in the York District, sent an email to Ms. Hook regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Charles Records

In addition to receiving emails sent to the entire School Board, Mr. Records received the following communications:

- **On April 21, 2016, Jean Lassiter sent an email to Mr. Records regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Dr. Clemons

In addition to receiving some of the emails sent to the entire Board, Dr. Clemons received the following communications:

- **On October 22, 2016 Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent Dr. Clemons an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 7, 2016, Ralph VanNess sent Dr. Clemons an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Additionally, the following School Board members received complaints via telephone, which are listed below.

Telephone Complaints made to Carla Hook

- **Upon information and belief, before October 28, 2014, Ms. Hook spoke with Season and Andrew Palas, whose children were enrolled in Gloucester County Public Schools, regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Additionally, the issue of transgender bathroom use was discussed at public School Board meetings on November 11, 2014 and December 9, 2014. Video links to those meetings are available at: http://www.gloucesterva.info/640/Meeting-Portal.

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the November 11, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Eddie Aliff**
- **Savannah Williams (student at Gloucester High School)**
- **Terry Brennan**
- **Joy Sampson (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kelly Williams (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Marc Jenkins (parent of student(s) enrolled in Gloucester County Public Schools)**

- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Brian Byrd (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Tricia Ray**
- **Kim Ward (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Melissa Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Ray Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Season Palas (parent of student(s) enrolled in Gloucester County Public Schools)**

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the December 9, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Scott Williams (student at Gloucester High School)**
- **Savannah Williams (student at Gloucester High School)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Karen Pauly**
- **Mike Enz (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Katherine Foley (parent of student(s) enrolled at Gloucester High School)**
- **Howard Mowry**
- **Janet West (parent of student(s) enrolled at Gloucester High School)**
- **Linda Walk**
- **Don Mitchell**

- **Terry Brennan**

- **Marista Cooper (grandparent of student(s) enrolled in Gloucester County Public Schools)**

- **Kelly Williams**

The School Board also incorporates by reference any additional "complaints" not described herein that are contained in the documents the School Board has produced in response to Plaintiff's First Request for Production of Documents.

2. State whether any of the complaints identified in Interrogatory No. 1 were from the student (or the parent of the same student) identified in GCSB 03541 in the email subject "Gavin and [redacted]."

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection, upon information and belief, neither the student nor the parent of the student referenced in this Interrogatory made a "complaint" to the School Board.

3. State whether any of the complaints identified in Interrogatory No. 1 were from the student (or the parent of the student) identified in GCSB 03541 as "[redacted] – NOT reliable."

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds

that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection, upon information and belief, neither the student nor the parent of the student referenced in this Interrogatory made a "complaint" to the School Board.

4. State whether any of the complaints identified in Interrogatory No. 1 were from a student (or the parent of a student) named Austin.

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection, upon information and belief, the School Board does not know whether a student named Austin, or the parent of a student named Austin, made a "complaint" as is referenced above.

5. State whether there is an "alternative appropriate private facility" available for "students with gender identity issues" within 200 feet of the most remote location of Gloucester High School.

OBJECTION: The School Board objects on the grounds that the phrase "within 200 feet of the most remote location of Gloucester High School" is vague and ambiguous. The School Board further objects on the grounds that the Interrogatory is overly broad, vague, and ambiguous because it does not set forth a time frame for the School Board's Answer.

ANSWER: Without waiving and subject to the foregoing objection, there are locations of Gloucester High School that are farther than 200 feet away from the single-user restrooms installed at Gloucester High School.

6. Identify all documents and resources relied upon by Defendants in creating the "biological gender" restroom policy passed by the School Board in 2014.

OBJECTION: The School Board objects on the grounds that Plaintiff's Interrogatory is vague and ambiguous. Further, the School Board objects to the extent this Interrogatory seeks information and/or materials protected from disclosure by the attorney-client privilege, the attorney work-product doctrine, and/or as materials prepared in anticipation of litigation.

ANSWER: Without waiving and subject to the foregoing objection, Carla Hook prepared the resolution at issue in this litigation. Upon information and belief, Ms. Hook did not rely on any documents or resources in preparing the resolution.

7. Identify all persons consulted in creating the "biological gender" restroom policy passed by the School Board in 2014.

OBJECTION: The School Board objects on the grounds that Plaintiff's Interrogatory is vague and ambiguous. Further, the School Board objects to the extent this Interrogatory

seeks information and/or materials protected from disclosure by the attorney-client privilege, the attorney work-product doctrine, and/or as materials prepared in anticipation of litigation.

ANSWER: Without waiving and subject to the foregoing objection, Carla Hook prepared the resolution at issue in this litigation. Upon information and belief, Ms. Hook did not consult with any persons in preparing the resolution.

GLOUCESTER COUNTY SCHOOL BOARD

By _____

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CERTIFICATE

I hereby certify that on the 13th day of December, 2018, I emailed the document to the following:

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-00054

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

DEFENDANT'S SUPPLEMENTAL ANSWER TO PLAINTIFF'S INTERROGATORY NO. 1

Comes now the defendant, Gloucester County School Board ("School Board"), and for its Supplemental Answer to Plaintiff's Interrogatory, states as follows:

GENERAL OBJECTIONS

A. Defendant objects to the Instructions contained in Plaintiff's interrogatories to the extent they alter, amend, or exceed the scope of the Federal Rules of Civil Procedure.

B. The information supplied in these answers is not based solely on the knowledge of the executing party but includes knowledge of the party, its agents, representatives, and attorneys, unless privileged. Such knowledge may or may not be known to the Defendant other than as provided.

C. The word usage and sentence structure may be that of the attorney and staff assisting in the preparation of these answers and thus do not necessarily purport to be the precise language of the executing party.

D. These answers will be supplemented in accordance with the Rule 33 of the Federal Rules of Civil Procedure, the Local Rules of the Eastern District of Virginia, and any Orders regarding discovery.

E. Defendant objects to interrogatories, etc., that invade or attempt to invade the attorney/client, work product, or any other applicable privilege.

ANSWERS TO INTERROGATORIES

1. Identify all complaints received by Gloucester County School Board ("the Board") or its employees related to transgender students' use of restrooms during the 2014-2015 school year, and for each complaint identify the date of the complaint, the recipient of the complaint, the content of the complaint, how the complaint was communicated or transmitted, whether the complainant was from a Gloucester High School student or parent of a Gloucester High School student, and whether the complaint related to any incident in which a student reported being in the restroom at the same time as Plaintiff.

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection,[1] Gloucester County High School Principal Nate Collins gave Grimm permission to use the male restroom on October 20, 2014. Two to three days later, Superintendent Dr. Walter Clemons received two complaints from parents regarding a transgender student using the restroom inconsistent with that student's biological sex. Dr. Clemons does not recall the identity of those parents. The parents indicated that they did not approve of a biologically female student using the male restroom. Additionally, a male student met with Collins in person and expressed concern about a biologically female student using the male restroom and a lack of privacy. Collins does not recall the specific identity of this student.

Moreover, after Grimm began to use the male restroom, Dr. Clemons, Collins and the individual members of the School Board received numerous complaints via email, which are listed below.

Emails sent to all members of the School Board

- **On October 23, 2014, Kathryn Lindsay, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 23, 2014, Stacie and Paul Martin, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

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[1] The School Board specifically reasserts its objection that Plaintiff's use of the term "complaint" in this Interrogatory is vague and ambiguous. The School Board has included in its Answer communications with individuals who generally opposed a transgender student using a restroom inconsistent with that student's biological sex. The School Board's Answer includes communications with individuals who did not agree with Gloucester High School allowing a transgender student to use a restroom inconsistent with that student's biological sex and communications with individuals who supported the School Board's December 9, 2014 resolution and the School Board's litigation of this matter.

- **On October 27, 2014, Susannah Hogge sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 27, 2014, Jennifer Spears, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 28, 2014, Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 10, 2014, Elisa Nelson, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 10/11, 2014, Stuart and Seth Bunting, parents of student(s) enrolled in Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 11, 2014, Mary Diggs, upon information and belief a resident of Gloucester County, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 11, 2014, David Turner sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 12, 2014, Haley Poulson, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 12, 2014, Kelly Williams, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 13, 2014, Melissa Alexander, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 17, 2014, Kelly Cooper, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 7, 2014, Jenny Poole, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, Mike Enz, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, Heather Schott, a parent of student(s) enrolled in the Gloucester County Public School System, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 10, 2014, Tommie Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 10, 2014, Paul Martin, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 20, 2014, Chuck Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 20, 2014, Clayton Rogers sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On January 2, 2015, an individual named Jena sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 10, 2015, Tim Tompkins sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On April 21, 2016, Kathryn Lindsay, a parent of students(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On April 21, 2016, Paul Martin, parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On May 12, 2016, Kenneth Larson sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Troy Anderson

In addition to receiving emails sent to the entire School Board, Mr. Anderson received the following communications:

- **On December 7, 2014, Ginger Enz, parent of student(s) enrolled in Gloucester High School, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 27, 2015, Leland Pike, a resident of Kentucky, sent Mr. Anderson an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 14, 2016, Florence Alpert, a resident of New York, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Randy Burak

In addition to receiving emails sent to the entire School Board, Mr. Burak received the following communications:

- **On November 12, 2014, Gina Thayer, a parent of student(s) enrolled in Gloucester High School, sent Mr. Burak an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 3, 2014, Lisa Wood, a resident of the Abingdon District, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 7, 2014, Mike Enz, a parent of student(s) who attended Gloucester High School, sent the Mr. Burak an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, a resident of Gloucester County named Ginger emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 11, 2014, Sharon Kass, a resident of Washington D.C., emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Kimberly Hensley

In addition to receiving emails sent to the entire School Board, Ms. Hensley received the following communications:

- **On November 19, 2014, Tracey Parks Carter, a parent of student(s) at Gloucester High School, emailed Ms. Hensley regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 13, 2014, Cliff and Brandi Blackwood, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, emailed Ms. Hensley regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Carla Hook

In addition to receiving emails sent to the entire School Board, Ms. Hook received the following communications:

- **On December 7, 2014, Steven Davis, a parent of high school student(s) in the York District, sent an email to Ms. Hook regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Charles Records

In addition to receiving emails sent to the entire School Board, Mr. Records received the following communications:

- **On April 21, 2016, Jean Lassiter sent an email to Mr. Records regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Dr. Clemons

In addition to receiving some of the emails sent to the entire Board, Dr. Clemons received the following communications:

- **On October 22, 2016 Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent Dr. Clemons an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 7, 2016, Ralph VanNess sent Dr. Clemons an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Additionally, the following School Board members received complaints via telephone, which are listed below.

Telephone Complaints made to Carla Hook

- **Upon information and belief, before October 28, 2014, Ms. Hook spoke with Season and Andrew Palas, whose children were enrolled in Gloucester County Public Schools, regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Additionally, the issue of transgender bathroom use was discussed at public School Board meetings on November 11, 2014 and December 9, 2014. Video links to those meetings are available at: http://www.gloucesterva.info/640/Meeting-Portal.

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the November 11, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Eddie Aliff**
- **Savannah Williams (student at Gloucester High School)**
- **Terry Brennan**
- **Joy Sampson (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kelly Williams (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Marc Jenkins (parent of student(s) enrolled in Gloucester County Public Schools)**

- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Brian Byrd (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Tricia Ray**
- **Kim Ward (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Melissa Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Ray Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Season Palas (parent of student(s) enrolled in Gloucester County Public Schools)**

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the December 9, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Scott Williams (student at Gloucester High School)**
- **Savannah Williams (student at Gloucester High School)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Karen Pauly**
- **Mike Enz (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Katherine Foley (parent of student(s) enrolled at Gloucester High School)**
- **Howard Mowry**
- **Janet West (parent of student(s) enrolled at Gloucester High School)**
- **Linda Walk**
- **Don Mitchell**

- **Terry Brennan**

- **Marista Cooper (grandparent of student(s) enrolled in Gloucester County Public Schools)**

- **Kelly Williams**

The School Board also incorporates by reference any additional "complaints" not described herein that are contained in the documents the School Board has produced in response to Plaintiff's First Request for Production of Documents.

SUPPLEMENTAL ANSWER:

In its Answers to Plaintiff's First Interrogatories, the School Board provided a list of email communications between board members and various individuals regarding the use of restrooms by transgender students. Further, the School Board provided the emails identified in those Answers in response to Plaintiff's First Requests for Production of Documents. The emails speak for themselves, and each School Board member's knowledge of any "complaint" sent by email relating to the use of restrooms by transgender students is consistent with the contents of those emails.

Further, in addition to the information provided in the School Board's Answers to Plaintiff's First Interrogatories, the following School Board members recall receiving non-email communications from individuals concerning the use of school restrooms by transgender students:

- **Carla Hook received approximately five (5) telephone calls from parents of students enrolled in Gloucester County Public Schools who said their children were uncomfortable with a girl using the boys' restroom. Ms. Hook does not recall the names of either the parents with whom she spoke or their children. To Ms. Hook's knowledge, the children had no direct interaction with Grimm in the boys' restroom.**

- **Kevin Smith received dozens of communications before the December 9, 2014, School Board meeting regarding a transgender student using the restroom**

inconsistent with that student's biological sex. To Mr. Smith's best recollection, approximately seventy-five (75) percent of those communications came from parents of students enrolled in Gloucester County Public Schools. Mr. Smith does not recall the names of either the individuals with whom he spoke or their children. The individuals indicated that they were not in favor of a transgender student using the restroom inconsistent with that student's biological sex. Additionally, parents indicated that they did not want their children using the same bathroom as a member of the opposite sex. To Mr. Smith's knowledge, the children had no direct interaction with Grimm in the boys' restroom.

- **Troy Andersen received approximately five (5) telephone calls from parents of students at Gloucester County Public Schools regarding a transgender student using the restroom inconsistent with that student's biological sex. Mr. Andersen does not recall the names of either the parents or their children. The parents did not want their children using the same bathroom as a member of the opposite sex, and they were concerned about the privacy and safety of students, including their children. Mr. Andersen believes that he followed any telephone conversation on this issue with an email to the parent, and that the telephone conversations were substantively similar to the email exchanges. To the best of Mr. Andersen's knowledge, the children had no direct interaction with Grimm in the boys' restroom.**

- **Randy Burak received two telephone calls on October 20, 2014, from parents of students at Gloucester County Public Schools regarding a transgender student using the restroom inconsistent with that student's biological sex. One telephone call came from "Mr. Wood," a parent of two boys enrolled in Gloucester County Public Schools. Mr. Burak does not recall the first name of Mr. Wood. Mr. Wood indicated that he and his children were not in favor of a girl using the same restroom as boys. The other telephone call came from a parent, whose name Mr. Burak cannot recall, who likewise did not approve of a transgender student using the restroom inconsistent with that student's biological sex. This parent expressed concern that young male students would be uncomfortable with a student who was biologically female using the male restroom. Mr. Burak does not know whether or not the children of the two parents had any direct interaction with Grimm in the boys' restroom.**

This Answer will be supplemented further as additional information is received.

GLOUCESTER COUNTY SCHOOL BOARD

By _____

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CERTIFICATE

I hereby certify that on the 11th day of January, 2019, I mailed and emailed the document to the following:

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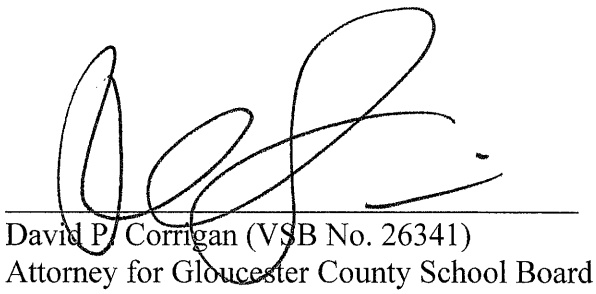

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, Plaintiff, v. GLOUCESTER COUNTY SCHOOL BOARD, Defendant.	)	Civil No. 4:15-cv-00054-AWA-RJK

EXPERT REPORT AND DECLARATION OF
DR. MELINDA PENN, M.D.

1. I, Melinda Penn, M.D., have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

PROFESSIONAL BACKGROUND

2. My professional background, experience, and publications are detailed in my curriculum vitae ("CV"), attached as Exhibit A.

3. I am a pediatric endocrinologist currently practicing at Children's Hospital of the King's Daughters in Norfolk, Virginia. I am board certified in pediatric endocrinology by the American Board of Pediatrics, and I specialize in transgender health and Type-1 diabetes.

4. After graduating from Eastern Virginia Medical School in 2004, I completed my residency at Medical University of South Carolina in 2007, followed by a fellowship at Children's Hospital of Philadelphia in 2010.

5. After completing my medical training, I returned to Virginia and worked for 8 years as a practicing pediatric endocrinologist at Virginia Commonwealth University ("VCU") in

Richmond. I began treating transgender patients in 2013, and I founded and co-directed VCU's Pediatric and Adolescent Transgender Clinic in 2016 with an adolescent psychiatrist.

6. In July 2018, I moved to the Hampton Roads area to practice at the Children's Hospital of the King's Daughters.

7. As part of my practice, I provide transition-related endocrine care to transgender adolescents in accordance with the World Professional Association for Transgender Health ("WPATH") Standards of Care (attached as Exhibit B) and the Endocrine Society's Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons (attached as Exhibit C).

8. I am a member of WPATH and the Pediatric Endocrine Society. I am also a member of the Pediatric Endocrinology Society's Special Interest Group for Transgender Health and have attended several of their meetings at the annual Pediatric Endocrinology Society conferences, and stay involved in communications among members. I currently serve as a part of my hospital's Transgender Working Group which is made up of health professionals committed to increasing compassionate and knowledgeable care for transgender patients.

9. Over the past 5 years, I have treated over 100 transgender youth and adolescents in Virginia.

10. In my work with transgender youth, I collaborate closely with mental health professionals to provide comprehensive care. My clinic at VCU was a multidisciplinary clinic with a pediatric psychiatrist who specializes in transgender care, and we frequently collaborated with a psychologist who specializes in pediatric and adolescent LGBT care. Currently, I work with a social worker who is available to see my patients and can offer mental health resources and referrals.

11. I regularly keep up to date with the professional literature on the treatment of children and adolescents with gender dysphoria.

12. In preparing this report, I relied on my scientific education and training, my professional experience, clinical guidelines that represent the contemporary standard of care for treating transgender youth, and scientific literature on the topic.

13. The materials I have relied upon in preparing this report are the same types of materials that experts in my field regularly rely upon when forming professional opinions.

14. I may supplement these opinions in response to information produced by Defendants in discovery or in response to Defendant's expert disclosures.

15. I have not testified as an expert at a trial or deposition in the last four years.

16. I am being compensated at an hourly rate of $300 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

OPINIONS

17. The term "gender identity" refers to a person's innate sense of belonging to a particular gender. Although the precise etiology of gender identity is unknown, biological and environmental factors are believed to contribute to this fundamental aspect of human development.

18. A person's gender identity usually matches the sex they were designated at birth based on their external genitalia. The terms "sex designated at birth" or "sex assigned at birth" are more precise than the term "biological sex" because all of the physiological aspects of a person's sex are not always aligned with each other. For example, some people with intersex characteristics may have chromosomes typically associated with males but genitalia typically

associated with females. For these reasons the Endocrine Society warns practitioners that the terms "biological sex" and "biological male or female" are imprecise and should be avoided.

19. Most boys were designated male at birth based on their external genital anatomy, and most girls were designated female at birth based on their external genital anatomy. But transgender children have a gender identity that differs from the sex assigned to them at birth. A transgender boy is someone who was assigned a female sex at birth but persistently, consistently, and insistently identifies as male. A transgender girl is someone who was assigned a male sex at birth but persistently, consistently, and insistently identifies as female.

20. Gender identity is a deeply rooted early in life. For some children, a transgender identity presents early in childhood. For others, the onset of puberty, and the resulting physical changes in their bodies, may lead them to recognize that their gender identity is not aligned with their sex assigned at birth.

21. According the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM V"), "gender dysphoria" is the diagnostic term for the condition experienced by some transgender people of clinically significant distress resulting from the lack of congruence between their gender identity and the sex assigned to them at birth. In order to be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

22. Being transgender is not itself a mental disorder or a medical condition to be cured. But gender dysphoria is a serious medical condition that, if left untreated, can result in crippling anxiety, severe depression, self-harm, and suicidality. Spack NP, Edwards-Leeper L, Feldmain HA, et al. *Children and adolescents with gender identity disorder referred to a*

pediatric medical center. Pediatrics. 2012; 129(3):418-425. Olson KR, Durwood L, DeMeules M, McLaughlin KA. *Mental health of transgender children who are supported in their identities.* Pediatrics 2016/137:1-8.

23. WPATH and the National Endocrine Society have published widely accepted standards of care for treating gender dysphoria. The medical treatment for gender dysphoria is to eliminate the clinically significant distress by helping a transgender person live in alignment with their gender identity. This treatment is sometimes referred to as "gender transition," "transition related care," or "gender affirming care." The American Academy of Pediatrics agrees that this care is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria.

24. The precise treatment for gender dysphoria depends on each person's individualized need, and the medical standards of care differ depending on whether the treatment is for a pre-pubertal child, an adolescent, or an adult.

25. Before puberty, gender transition does not include any drug or surgical intervention and is limited to "social transition," which means allowing a transgender child to live and be socially recognized in accordance with their gender identity. Typically, social transition can include allowing children to wear clothing, to cut or grow their hair, to use names and pronouns and restrooms and other sex-separated facilities in line with their gender identity instead of the sex assigned to them at birth.

26. Under the Endocrine Society Clinical Guidelines, hormone therapy may become medically necessary and appropriate as transgender youth reach puberty. In providing hormone therapy pediatric endocrinologists must work in close consultation with qualified mental health professionals experienced in diagnosing and treating gender dysphoria.

27. For many transgender adolescents, going through puberty in accordance with the sex assigned to them at birth can cause extreme distress. Puberty blocking hormone treatment allows transgender youth to avoid going through puberty in accordance with the sex assigned to them at birth, along with the heightened gender dysphoria and permanent physical changes that puberty would cause.

28. Under the Endocrine Society Clinical Guidelines, transgender adolescents may be eligible for puberty-blocking hormone therapy if:

- A qualified mental health professional has confirmed that:
  - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
  - gender dysphoria worsened with the onset of puberty,
  - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
- The adolescent:
  - has sufficient mental capacity to give informed consent to this (reversible) treatment, and
  - has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility, and
  - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
  - agrees with the indication for GnRH agonist treatment,

- has confirmed that puberty has started in the adolescent, and
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

29. Once a transgender adolescent establishes maturity and competence to make decisions about treatment, often around the age of 14, it may then be medically necessary and appropriate to provide gender-affirming hormone therapy to allow them to go through puberty consistently with their gender identity.

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

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

- has confirmed that there are no medical contraindications to sex hormone treatment.

31. Adolescents who receive gender-affirming hormones after puberty blockers never go through puberty in accordance with the sex assigned to them at birth and, instead, go through puberty that matches their gender identity. Pre-pubertal boys and girls are indistinguishable with respect to secondary sex characteristics. If a pre-pubertal child receives puberty blockers, they will never develop the secondary sex characteristics of the sex assigned to them at birth, and when they are provided hormones in accordance with their gender identity, they will develop only the secondary sex characteristics that match their gender identity.

32. For example, transgender boys treated with puberty blockers and gender affirming hormones will receive the same amount of testosterone during puberty that non-transgender boys generate with their gonads or testes. They will develop the phenotypic features of non-transgender boys such as muscle mass, fat distribution, facial and body hair, along with lower vocal pitch. Likewise, transgender girls treated with puberty blockers and gender affirming hormones will receive the same amount of estrogen during puberty that non-transgender girls generate endogenously. They will develop the same muscle mass, fat distribution, skin and female hair patterns, and breasts typically associated with other girls.

33. Under the WPATH standards of care, boys and girls who are transgender may also receive medically necessary chest reconstructive surgeries once they turn 16 and genital surgery once they reach the age of majority.

34. When provided medical treatments in accordance with the standards of care before and during puberty, transgender boys do not resemble and are not perceived as girls in

their day to day life, and transgender girls do not resemble and are not perceived as boys in their day to day life.

35. Blocking a transgender youth from going through puberty in accordance with the sex assigned to them at birth and providing gender-affirming hormones can be lifesaving treatment and change the short and long term health outcomes for transgender youth.

36. Offering safe, healthy, medically supervised gender transition is critical to the healthy growth and development of many transgender children and adolescents who experience gender dysphoria. Transgender youth are a high risk population with increased risk for poor mental health outcomes including suicide, homelessness and becoming a victim of violence. Psychological functioning has been shown to improve with hormone and surgical therapy. Guss, Carly, Shumer, Daniel; Katz-Wise, Sabra L. *Transgender and gender nonconforming adolescent care: psychosocial and medical considerations*. Current Opinions in Pediatrics: August 2015-Volume 27-Issue 4. p 421-426; Lopez, Ximena; Marinkovic, Maja; Eimicke, Toni; Rosenthal, Stephen; Olshan,Jerrold. *Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health*. Current Opinions in Pediatrics: August 2017-Volume 29,Issue 4. 475-480; Cohen-Kettenis PT,Schagn SEE, Steensma TD, de Vries ALC, Delemarre-van de Waal HA; *Puberty suppression in a gender dysphoric adolescent: a 22-year follow-up*. Arch Sex Behav. 2011;40(4): 843-847.

37. I have seen these dramatically improved health outcomes in my own practice as a pediatric endocrinologist. Many of my patients with gender dysphoria have a history of significant depression and anxiety requiring medications and often hospitalizations prior to initiating endocrine care. My patients and their parents have all reported improvement—often dramatic improvement– in the adolescent's functioning and reduction in their gender dysphoria

after initiating care. Many are able to stop or reduce their psychiatric medications and report improved socialization and increased participation in school and other activities. Adolescents who had previously been withdrawn open up and start having goals and making plans for their futures. Parents describe having their happy kid back.

38. The well-being of adolescents with gender dysphoria depends on more than access to medical care to medically transition: The patients who have the most positive outcomes are those who are supported and respected as the gender they identify with by their families, peers, and school. This includes being referred to by the name and gender pronouns that match their identity and being able to participate in activities and access facilities consistent with their gender identity. deVries AL, McGuire JK, Steensma TD, et al. *Young adult psychological outcome after puberty suppression and gender reassignment*. Pediatrics 2014; 134:696-704.

39. Many of my patients wish to use the restroom for their affirmed gender and do not want to be singled out as different or inconvenienced by having to go to a separate restroom that other students are not required to use. While some students – particularly those who are early in their transition – feel safer or more comfortable using a private restroom, forcing transgender students to do so can be harmful to their wellbeing by calling them out as different and rejecting their gender. Many of my patients express that it is important to them to be seen as the boys and girls that they are and not be singled out as transgender. For some, being required to use a separate restroom is a constant reminder that they are different and not accepted as the boy or girl they know they are.

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

Dated: 1/18/2019

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Children's Hospital of Philadelphia
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Resident, General Pediatrics — 7/2004-7/2007
Medical University of South Carolina
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Degree: MD — 8/2000-5/2004
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Degree: BS, Biology — 8/1996-5/2000
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Professional Experience

Physician, Pediatric Endocrionology — 7/2018-present
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Academic Appointments

Assistant Professor, Department of Pediatrics — 9/2010-7/2018
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Associate Program Director, Pediatric Residency — 7/2013- 7/2018
Virginia Commonwealth University
Richmond, VA

Certification and Licensure

American Board of Pediatrics - General Pediatrics — 10/2007

American Board of Pediatrics- Pediatric Endocrinology	11/2011
South Carolina Limited Training Medical License	7/2004-7/2007
Pennsylvania Medical License	7/2007-8/2010
Pennsylvania Medical Training License	7/2007-8/2010
Virginia Medical License	6/2010-present

Professional Memberships and Activities

Lawson Wilkins Pediatric Endocrinology Society	2007-present
World Professional Association for Transgender Health	2014-present
Endocrine Society	2007-2010

Honors and Awards

Virginia Commonwealth University Presidential Scholarship	8/1996-5/2000
Virginia Commonwealth University, University Honors	5/2000
LWPES Fellow Travel Grant	2008,2009,2010
Ruth L. Kirschstein National Research Service Award Institutional Training Grant Recipient Children's Hospital of Philadelphia	7/2008-7/2009
Novo Nordisk Research Fellowship Grant Recipient Lawson Wilkins Pediatric Endocrine Society	7/2009-7/2010
Marilyn Fishman Grant for Diabetes Research Recipient Endocrine Fellows Foundation	7/2009-7/2010
Richmond Magazine "Top Doc"- Pediatric Endocrinology	2014- 2017

Committee Assignments and Administrative Services

Transgender Working Group CHKD	7/2018-present
Diabetes Center Team CHKD	7/2018-present
Laboratory Utilization Committee VCU Health System	7/2017-7/2018
DREAM Team- Inpatient Diabetes Committee VCU Health System	2011

Central Virginia JDRF Board of Directors 2011-2017

Educational Activities

Pediatric Endocrinology Resident Lecture 12/2018
Transgender Medicine
CHKD

Pediatric Endocrinology Fellowship Lecturer 2011-2018
Children's Hospital of Richmond at VCU

Pediatric Resident Lecturer 2011-2017
Pediatric Endocrinology lectures
Children's Hospital of Richmond at VCU

Endocrinology Grand Rounds 2012, 2015
Virginia Commonwealth University

MS2 Lecturer 2015, 2016
Puberty
Virginia Commonwealth University School of Medicine

ACGME Residency Orientation 2016
Walk the Walk
Virginia Commonwealth University School of Medicine

Medical Student Interest Group Lecturer 2016
Pediatric Transgender Medicine
Virginia Commonwealth University School of Medicine

Pediatric Endocrinology Fellow Clinical Mentor 2011-2018
Virginia Commonwealth University School of Medicine

Clinical Educator for Pediatric Endocrinology Fellows, 2010-2018
Pediatric Residents and Medical students
Children's Hospital of Richmond at VCU

Clinical Activities

Director of Pediatric Transgender Health Clinic 2014-2018
Children's Hospital of Richmond at Virginia Commonwealth University

Grants and Contract Awards

Ruth L. Kirschstein National Research Service Award 2008-2009
Institutional Training Grant Recipient
Children's Hospital of Philadelphia

Novo Nordisk Research Fellowship Grant Recipient, $10,000 2009-2010
Lawson Wilkins Pediatric Endocrine Society

Marilyn Fishman Grant for Diabetes Research Recipient, $10,000 2009-2010
Endocrine Fellows Foundation

Publications

Kameswaran V, Bramswig NC, McKenna LB**, Penn M,** Schug J, Hand NJ, Chen Y, Choi I, Vourekas A, Won KJ, Liu C, Vivek K, Naji A, Friedman JR, Kaestner KH. *Epigenetic regulation of the DLK1-MEG3 microRNA cluster in human type 2 diabetic islets.* Cell Metab. 2014 Jan 7;19(1):135-45.
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National
Oral Platform Presentation, LWPES/ESPE 2010
MicroRNA Profile in Type 2 diabetes.

Regional
JDRF TypeOneNation Summit 10/2017
Expert Panel

Virginia TIES Conference 10/2017
Transgender Medical Care for Children and Adolescents

Peds at the Beach 7/2016
Transgender Healthcare for Children and Adolescents

Animas Diabetes Family Conference 4/2011
Expert Panel

Poster Presentations

Penn M, Hsu Y, Hughes N, DeLeon D. *Transitioning Infants with Monogenic Diabetes to Oral Sulfonylurea Therapy*. Abstract for poster presentation, University of Pennsylvania, Institute of Diabetes and Metabolism Research Day, March 2009.

Penn M, Hsu Y, Hughes N, DeLeon D. *Transitioning Infants with Monogenic Diabetes to Oral Sulfonylurea Therapy*. Abstract for poster presentation, LWPES/ESPE, New York, NY 2009.

Penn M, Koren D, Hughes N, Kelly A, DeLeon D. *Neonatal diabetes due to KCNJ11 Mutations.* Abstract for poster presentation, Pediatric Academic Society, Honolulu, HI 2008.

Penn M, Koren D, Hughes N, Kelly A, DeLeon D. *Neonatal diabetes due to KCNJ11 Mutations.* Abstract for poster presentation, CHOP Fellows Research Day, February 2008.

Professional Development

Diabetes Technology Society- Certified Diabetes Technology Clinician 2013

Community Service

Camp Adam Fisher 2005, 2006
Diabetes Camp- Medical staff volunteer
Marion, SC

Setebaid Diabetes Camp- Medical staff volunteer 2008
Shickshinny, PA

ADA Diabetes Camp Donovan McNabb- Medical Supervisor 2008-2010
Philadelphia, PA

Camp WannaCure- Medical Director 2011-2018
Richmond, VA

Central Virginia JDRF Board of Directors 2011-2017

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

www.wpath.org

Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version

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The World Professiona Association for Transgender Health

7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

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Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)[1] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[2] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

II

Global Applicability of the Standards of Care

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

III

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV
Epidemiologic Considerations

Formal epidemiologic studies on the incidence[3] and prevalence[4] of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)
4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII
Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess gender dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide information regarding options for gender identity and expression and possible medical interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If applicable, assess eligibility, prepare, and refer for hormone therapy

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

5. If applicable, assess eligibility, prepare, and refer for surgery

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy is not an absolute requirement for hormone therapy and surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

2. Goals of psychotherapy for adults with gender concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing

gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family therapy or support for family members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).

5. Follow-up care throughout life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. Etherapy, online counseling, or distance counseling

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

Other Tasks of the Mental Health Professional

1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide information and referral for peer support

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII
Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country (if younger, follow the *Standards of Care* outlined in section VI);

4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship between the Standards of Care and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fact compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months[C]	variable
Increased muscle mass/strength	6-12 months	2-5 years[D]
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

[A] Adapted with permission from Hembree et al.(2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Highly dependent on age and inheritance; may be minimal.
[D] Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years[C]
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

[A] Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease[A] Gallstones Elevated liver enzymes Weight gain Hypertriglyceridemia	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	Hypertension Hyperprolactinemia or prolactinom[A]	Elevated liver enzymes Hyperlipidemia
Possible increased risk with presence of additional risk factors[B]	Type 2 diabetes[A]	Destabilization of certain psychiatric disorders[C] Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

4. Initiating hormonal feminization/masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk assessment and modification for masculinizing hormone therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and risk monitoring during feminizing hormone therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and risk monitoring during masculinizing hormone therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for feminizing hormone therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for masculinizing hormone therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and compounded hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX
Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignances that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

X

Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI
Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;

2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for breast/chest surgery (one referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. 12 continuous months of living in a gender role that is congruent with their gender identity;

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dsyphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or "male chest contouring" procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII

Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long

distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII
Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such

as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the Standards of Care to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the Standards of Care to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the SOC

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

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APPENDIX A
GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones*:* Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Crossdressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B
OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely increased risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible increased risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other side effects of feminizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of anti-androgen medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely increased risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible increased risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing**,** may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other side effects of masculinizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C
SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);

6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D
EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E
DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iteratations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the *SOC* and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the *SOC*.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;

2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;

3. Working meeting of the Writing Group;

4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;

5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

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Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

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Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society–appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

ISSN Print 0021-972X ISSN Online 1945-7197
Printed in USA

Received 24 July 2017. Accepted 24 August 2017.
First Published Online 13 September 2017

Abbreviations: BMD, bone mineral density; DSD, disorder/difference of sex development; DSM, Diagnostic and Statistical Manual of Mental Disorders; GD, gender dysphoria; GnRH, gonadotropin-releasing hormone; ICD, International Statistical Classification of Diseases and Related Health Problems; MHP, mental health professional; VTE, venous thromboembolism.

professional for adults (recommended)—should be knowledgeable about the diagnostic criteria and criteria for gender-affirming treatment, have sufficient training and experience in assessing psychopathology, and be willing to participate in the ongoing care throughout the endocrine transition. We recommend treating gender-dysphoric/gender-incongruent adolescents who have entered puberty at Tanner Stage G2/B2 by suppression with gonadotropin-releasing hormone agonists. Clinicians may add gender-affirming hormones after a multidisciplinary team has confirmed the persistence of gender dysphoria/gender incongruence and sufficient mental capacity to give informed consent to this partially irreversible treatment. Most adolescents have this capacity by age 16 years old. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age. For the care of peripubertal youths and older adolescents, we recommend that an expert multidisciplinary team comprised of medical professionals and mental health professionals manage this treatment. The treating physician must confirm the criteria for treatment used by the referring mental health practitioner and collaborate with them in decisions about gender-affirming surgery in older adolescents. For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient. We suggest maintaining physiologic levels of gender-appropriate hormones and monitoring for known risks and complications. When high doses of sex steroids are required to suppress endogenous sex steroids and/or in advanced age, clinicians may consider surgically removing natal gonads along with reducing sex steroid treatment. Clinicians should monitor both transgender males (female to male) and transgender females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, clinicians should persistently monitor adverse effects of sex steroids. For gender-affirming surgeries in adults, the treating physician must collaborate with and confirm the criteria for treatment used by the referring physician. Clinicians should avoid harming individuals (via hormone treatment) who have conditions other than gender dysphoria/gender incongruence and who may not benefit from the physical changes associated with this treatment. (***J Clin Endocrinol Metab*** **102: 3869–3903, 2017)**

Summary of Recommendations

1.0 Evaluation of youth and adults

1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

doi: 10.1210/jc.2017-01658

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕◯◯)
1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕◯)

2.0 Treatment of adolescents

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕◯◯)
2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕◯◯)
2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕◯◯)
2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕◯◯).
2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕◯◯◯)
2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 |⊕⊕◯◯)

3.0 Hormonal therapy for transgender adults

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕◯)
3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 |⊕⊕⊕◯)
3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕◯◯)
3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕◯◯◯)

4.0 Adverse outcome prevention and long-term care

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕◯◯)
4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕◯◯)
4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕◯◯)
4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕◯◯)
4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 |⊕⊕◯◯)
4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕◯◯◯)
4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

5.0 Surgery for sex reassignment and gender confirmation

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 |⊕⊕◯◯)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 |⊕◯◯◯)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 |⊕⊕◯◯).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 |⊕◯◯◯)

Changes Since the Previous Guideline

Both the current guideline and the one published in 2009 contain similar sections. Listed here are the sections contained in the current guideline and the corresponding number of recommendations: Introduction, Evaluation of Youth and Adults (5), Treatment of Adolescents (6), Hormonal Therapy for Transgender Adults (4), Adverse Outcomes Prevention and Long-term Care (7), and Surgery for Sex Reassignment and Gender Confirmation (6). The current introduction updates the diagnostic classification of "gender dysphoria/gender incongruence." It also reviews the development of "gender identity" and summarizes its natural development. The section on clinical evaluation of both youth and adults, defines in detail the professional qualifications required of those who diagnose and treat both adolescents and adults. We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional. We recommend against puberty blocking followed by gender-affirming hormone treatment of prepubertal children. Clinicians should inform pubertal children, adolescents, and adults seeking gender-confirming treatment of their options for fertility preservation. Prior to treatment, clinicians should evaluate the presence of medical conditions that may be worsened by hormone depletion and/or treatment. A multidisciplinary team, preferably composed of medical and mental health professionals, should monitor treatments. Clinicians evaluating transgender adults for endocrine treatment should confirm the diagnosis of persistent gender dysphoria/gender incongruence. Physicians should educate transgender persons regarding the time course of steroid-induced physical changes. Treatment should include periodic monitoring of hormone levels and metabolic parameters, as well as assessments of bone density and the impact upon prostate, gonads, and uterus. We also make recommendations for transgender persons who plan genital gender-affirming surgery.

Method of Development of Evidence-Based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee (CGS) of the Endocrine Society deemed the diagnosis and treatment of individuals with GD/gender incongruence a priority area for revision and appointed a task force to formulate evidence-based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines (1). A detailed description of the grading scheme has been published elsewhere (2). The task force used the best available research evidence to develop the recommendations. The task force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕◯◯◯ denotes very low–quality evidence; ⊕⊕◯◯, low quality; ⊕⊕⊕◯, moderate quality; and ⊕⊕⊕⊕, high quality. The task force has confidence that persons who receive care according to the strong recommendations will derive, on average, more benefit than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each recommendation is a description of the evidence and the

doi: 10.1210/jc.2017-01658

values that the task force considered in making the recommendation. In some instances, there are remarks in which the task force offers technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the task force and their preferences; therefore, one should consider these remarks as suggestions.

In this guideline, the task force made several statements to emphasize the importance of shared decision-making, general preventive care measures, and basic principles of the treatment of transgender persons. They labeled these "Ungraded Good Practice Statement." Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles.

The Endocrine Society maintains a rigorous conflict-of-interest review process for developing clinical practice guidelines. All task force members must declare any potential conflicts of interest by completing a conflict-of-interest form. The CGS reviews all conflicts of interest before the Society's Council approves the members to participate on the task force and periodically during the development of the guideline. All others participating in the guideline's development must also disclose any conflicts of interest in the matter under study, and most of these participants must be without any conflicts of interest. The CGS and the task force have reviewed all disclosures for this guideline and resolved or managed all identified conflicts of interest.

Conflicts of interest are defined as remuneration in any amount from commercial interests; grants; research support; consulting fees; salary; ownership interests [*e.g.*, stocks and stock options (excluding diversified mutual funds)]; honoraria and other payments for participation in speakers' bureaus, advisory boards, or boards of directors; and all other financial benefits. Completed forms are available through the Endocrine Society office.

The Endocrine Society provided the funding for this guideline; the task force received no funding or remuneration from commercial or other entities.

Commissioned Systematic Review

The task force commissioned two systematic reviews to support this guideline. The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes. The review identified 29 eligible studies at moderate risk of bias. In transgender males (female to male), sex steroid therapy was associated with a statistically significant increase in serum triglycerides and low-density lipoprotein cholesterol levels. High-density lipoprotein cholesterol levels decreased significantly across all follow-up time periods. In transgender females (male to female), serum triglycerides were significantly higher without any changes in other parameters. Few myocardial infarction, stroke, venous thromboembolism (VTE), and death events were reported. These events were more frequent in transgender females. However, the quality of the evidence was low. The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals and identified 13 studies. In transgender males, there was no statistically significant difference in the lumbar spine, femoral neck, or total hip BMD at 12 and 24 months compared with baseline values before initiating masculinizing hormone therapy. In transgender females, there was a statistically significant increase in lumbar spine BMD at 12 months and 24 months compared with baseline values before initiation of feminizing hormone therapy. There was minimal information on fracture rates. The quality of evidence was also low.

Introduction

Throughout recorded history (in the absence of an endocrine disorder) some men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism. In modern history, there have been numerous ongoing biological, psychological, cultural, political, and sociological debates over various aspects of gender variance. The 20th century marked the emergence of a social awakening for men and women with the belief that they are "trapped" in the wrong body (3). Magnus Hirschfeld and Harry Benjamin, among others, pioneered the medical responses to those who sought relief from and a resolution to their profound discomfort. Although the term transsexual became widely known after Benjamin wrote "The Transsexual Phenomenon" (4), it was Hirschfeld who coined the term "transsexual" in 1923 to describe people who want to live a life that corresponds with their experienced gender vs their designated gender (5). Magnus Hirschfeld (6) and others (4, 7) have described other types of trans phenomena besides transsexualism. These early researchers proposed that the gender identity of these people was located somewhere along a unidimensional continuum. This continuum ranged from all male through "something in between" to all female. Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience themselves as having both a male and female gender identity, whereas others completely renounce any gender classification (8, 9). There are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity (10) or men who do not experience themselves as men but do not want to live as women (11, 12). In some countries, (*e.g.*, Nepal, Bangladesh, and Australia), these nonmale or nonfemale genders are officially recognized (13). Specific treatment protocols, however, have not yet been developed for these groups.

Instead of the term transsexualism, the current classification system of the American Psychiatric Association uses the term gender dysphoria in its diagnosis of persons who are not satisfied with their designated gender (14). The current version of the World Health Organization's ICD-10 still uses the term transsexualism when diagnosing adolescents and adults. However, for the ICD-11, the World Health Organization has proposed using the term "gender incongruence" (15).

Treating persons with GD/gender incongruence (15) was previously limited to relatively ineffective elixirs or creams. However, more effective endocrinology-based treatments became possible with the availability of testosterone in 1935 and diethylstilbestrol in 1938. Reports of individuals with GD/gender incongruence who were treated with hormones and gender-affirming surgery appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association was founded in September 1979 and is now called the World Professional Association for Transgender Health (WPATH). WPATH published its first Standards of Care in 1979. These standards have since been regularly updated, providing guidance for treating persons with GD/gender incongruence (16).

Prior to 1975, few peer-reviewed articles were published concerning endocrine treatment of transgender persons. Since then, more than two thousand articles about various aspects of transgender care have appeared.

It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable treating physicians to maximize benefit and minimize risk when caring for individuals diagnosed with GD/gender incongruence.

In the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols. Specifically, endocrine treatment protocols for GD/gender incongruence should include the careful assessment of the following: (1) the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development); (2) the effects of treatment in adults on sex hormone levels; (3) the requirement for and the effects of progestins and other agents used to suppress endogenous sex steroids during treatment; and (4) the risks and benefits of gender-affirming hormone treatment in older transgender people.

To successfully establish and enact these protocols, a commitment of mental health and endocrine investigators is required to collaborate in long-term, large-scale studies across countries that use the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools (*e.g.*, the European Network for the Investigation of Gender Incongruence) (17, 18).

Terminology and its use vary and continue to evolve. Table 1 contains the definitions of terms as they are used throughout this guideline.

Biological Determinants of Gender Identity Development

One's self-awareness as male or female changes gradually during infant life and childhood. This process of cognitive and affective learning evolves with interactions with parents, peers, and environment. A fairly accurate timetable exists outlining the steps in this process (19). Normative psychological literature, however, does not address if and when gender identity becomes crystallized and what factors contribute to the development of a gender identity that is not congruent with the gender of rearing. Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression (20) likely reflect a complex interplay of biological, environmental, and cultural factors (21, 22).

With respect to endocrine considerations, studies have failed to find differences in circulating levels of sex steroids between transgender and nontransgender individuals (23). However, studies in individuals with a disorder/difference of sex development (DSD) have informed our understanding of the role that hormones may play in gender identity outcome, even though most persons with GD/gender incongruence do not have a DSD. For example, although most 46,XX adult individuals with virilizing congenital adrenal hyperplasia caused by mutations in *CYP21A2* reported a female gender identity, the prevalence of GD/gender incongruence was much greater in this group than in the general population without a DSD. This supports the concept that there is a role for prenatal/postnatal androgens in gender development (24–26), although some studies indicate that prenatal androgens are more likely to affect gender behavior and sexual orientation rather than gender identity *per se* (27, 28).

Researchers have made similar observations regarding the potential role of androgens in the development of gender identity in other individuals with DSD. For example, a review of two groups of 46,XY persons, each with androgen synthesis deficiencies and female raised, reported transgender male (female-to-male) gender role changes in 56% to 63% and 39% to 64% of patients, respectively (29). Also, in 46,XY female-raised individuals with cloacal

doi: 10.1210/jc.2017-01658

Table 1. Definitions of Terms Used in This Guideline

Biological sex, biological male or female: These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (*e.g.*, a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.
Cisgender: This means not transgender. An alternative way to describe individuals who are not transgender is "non-transgender people."
Gender-affirming (hormone) treatment: See "gender reassignment"
Gender dysphoria: This is the distress and unease experienced if gender identity and designated gender are not completely congruent (see Table 2). In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, which replaced "gender identity disorder" with "gender dysphoria" and changed the criteria for diagnosis.
Gender expression: This refers to external manifestations of gender, expressed through one's name, pronouns, clothing, haircut, behavior, voice, or body characteristics. Typically, transgender people seek to make their gender expression align with their gender identity, rather than their designated gender.
Gender identity/experienced gender: This refers to one's internal, deeply held sense of gender. For transgender people, their gender identity does not match their sex designated at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression (see below), gender identity is not visible to others.
Gender identity disorder: This is the term used for GD/gender incongruence in previous versions of DSM (see "gender dysphoria"). The ICD-10 still uses the term for diagnosing child diagnoses, but the upcoming ICD-11 has proposed using "gender incongruence of childhood."
Gender incongruence: This is an umbrella term used when the gender identity and/or gender expression differs from what is typically associated with the designated gender. Gender incongruence is also the proposed name of the gender identity–related diagnoses in ICD-11. Not all individuals with gender incongruence have gender dysphoria or seek treatment.
Gender variance: See "gender incongruence"
Gender reassignment: This refers to the treatment procedure for those who want to adapt their bodies to the experienced gender by means of hormones and/or surgery. This is also called gender-confirming or gender-affirming treatment.
Gender-reassignment surgery (gender-confirming/gender-affirming surgery): These terms refer only to the surgical part of gender-confirming/gender-affirming treatment.
Gender role: This refers to behaviors, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or that society associates with or considers typical of the social role of men or women.
Sex designated at birth: This refers to sex assigned at birth, usually based on genital anatomy.
Sex: This refers to attributes that characterize biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics.
Sexual orientation: This term describes an individual's enduring physical and emotional attraction to another person. Gender identity and sexual orientation are not the same. Irrespective of their gender identity, transgender people may be attracted to women (gynephilic), attracted to men (androphilic), bisexual, asexual, or queer.
Transgender: This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment.
Transgender male (also: trans man, female-to-male, transgender male): This refers to individuals assigned female at birth but who identify and live as men.
Transgender woman (also: trans woman, male-to female, transgender female): This refers to individuals assigned male at birth but who identify and live as women.
Transition: This refers to the process during which transgender persons change their physical, social, and/or legal characteristics consistent with the affirmed gender identity. Prepubertal children may choose to transition socially.
Transsexual: This is an older term that originated in the medical and psychological communities to refer to individuals who have permanently transitioned through medical interventions or desired to do so.

exstrophy and penile agenesis, the occurrence of transgender male changes was significantly more prevalent than in the general population (30, 31). However, the fact that a high percentage of individuals with the same conditions did not change gender suggests that cultural factors may play a role as well.

With respect to genetics and gender identity, several studies have suggested heritability of GD/gender incongruence (32, 33). In particular, a study by Heylens *et al.* (33) demonstrated a 39.1% concordance rate for gender identity disorder (based on the DSM-IV criteria) in 23 monozygotic twin pairs but no concordance in 21 same-sex dizygotic or seven opposite-sex twin pairs. Although numerous investigators have sought to identify specific genes associated with GD/gender incongruence, such studies have been inconsistent and without strong statistical significance (34–38).

Studies focusing on brain structure suggest that the brain phenotypes of people with GD/gender incongruence differ in various ways from control males and females, but that there is not a complete sex reversal in brain structures (39).

In summary, although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development.

Natural History of Children With GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood (41, 42). With the newer, stricter criteria of the DSM-5 (Table 2), persistence rates may well be different in future studies.

1.0 Evaluation of Youth and Adults

Gender-affirming treatment is a multidisciplinary effort. After evaluation, education, and diagnosis, treatment may include mental health care, hormone therapy, and/or surgical therapy. Together with an MHP, hormone-prescribing clinicians should examine the psychosocial impact of the potential changes on people's lives, including mental health, friends, family, jobs, and their role in society. Transgender individuals should be encouraged to experience living in the new gender role and assess whether this improves their quality of life. Although the focus of this guideline is gender-affirming hormone therapy, collaboration with appropriate professionals responsible for each aspect of treatment maximizes a successful outcome.

Diagnostic assessment and mental health care

GD/gender incongruence may be accompanied with psychological or psychiatric problems (43–51). It is therefore necessary that clinicians who prescribe hormones and are involved in diagnosis and psychosocial assessment meet the following criteria: (1) are competent in using the DSM and/or the ICD for diagnostic purposes, (2) are able to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) are trained in diagnosing psychiatric conditions, (4) undertake or refer for appropriate treatment, (5) are able to do a psychosocial assessment of the patient's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) regularly attend relevant professional meetings.

Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, an MHP who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex.

During assessment, the clinician obtains information from the individual seeking gender-affirming treatment. In the case

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender
   4. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

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

Specify if:
   1. The condition exists with a disorder of sex development.
   2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (*e.g.*, penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

Reference: American Psychiatric Association (14).

doi: 10.1210/jc.2017-01658

of adolescents, the clinician also obtains information from the parents or guardians regarding various aspects of the child's general and psychosexual development and current functioning. On the basis of this information, the clinician:

- decides whether the individual fulfills criteria for treatment (see Tables 2 and 3) for GD/gender incongruence (DSM-5) or transsexualism (DSM-5 and/or ICD-10);
- informs the individual about the possibilities and limitations of various kinds of treatment (hormonal/surgical and nonhormonal), and if medical treatment is desired, provides correct information to prevent unrealistically high expectations;
- assesses whether medical interventions may result in unfavorable psychological and social outcomes.

In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues. Literature on postoperative regret suggests that besides poor quality of surgery, severe psychiatric comorbidity and lack of support may interfere with positive outcomes (52–56).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the adolescent's situation should be part of the diagnostic phase (58).

Social transitioning

A change in gender expression and role (which may involve living part time or full time in another gender role that is consistent with one's gender identity) may test the person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports. It assists both the individual and the clinician in their judgments about how to proceed (16). During social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of the counseling. The optimal timing for social transitioning may differ between individuals. Sometimes people wait until they start gender-affirming hormone treatment to make social transitioning easier, but individuals increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment.

Criteria

Adolescents and adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding (16). Criteria for gender-affirming hormone therapy for adults are in Table 4, and criteria for gender-affirming hormone therapy for adolescents are in Table 5. Follow-up studies in adults meeting these criteria indicate a high satisfaction rate with treatment (59). However, the quality of evidence is usually low. A few follow-up studies on adolescents who fulfilled these criteria also indicated good treatment results (60–63).

Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence

1.1. We advise that only trained MHPs who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or ICD for diagnostic

Table 3. ICD-10 Criteria for Transsexualism

Transsexualism (F64.0) has three criteria:
1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
2. The transsexual identity has been present persistently for at least 2 y.
3. The disorder is not a symptom of another mental disorder or a genetic, DSD, or chromosomal abnormality.

Table 4. Criteria for Gender-Affirming Hormone Therapy for Adults

1. Persistent, well-documented gender dysphoria/gender incongruence
2. The capacity to make a fully informed decision and to consent for treatment
3. The age of majority in a given country (if younger, follow the criteria for adolescents)
4. Mental health concerns, if present, must be reasonably well controlled

Reproduced from World Professional Association for Transgender Health (16).

purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

Evidence

Individuals with gender identity issues may have psychological or psychiatric problems (43–48, 50, 51, 64, 65). It is therefore necessary that clinicians making the diagnosis are able to make a distinction between GD/gender incongruence and conditions that have similar features. Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate) (66), or certain forms of eunuchism (in which a person is preoccupied with or engages in castration and/or penectomy for

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

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

2. And the adolescent:
- has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment
- agrees with the indication for GnRH agonist treatment,
- has confirmed that puberty has started in the adolescent (Tanner stage ≥G2/B2),
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

Adolescents are eligible for subsequent sex hormone treatment if:

1. A qualified MHP has confirmed:
- the persistence of gender dysphoria,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
- the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,

2. And the adolescent:
- has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:
- agrees with the indication for sex hormone treatment,
- has confirmed that there are no medical contraindications to sex hormone treatment.

Reproduced from World Professional Association for Transgender Health (16).

doi: 10.1210/jc.2017-01658

reasons that are not gender identity related) (11). Clinicians should also be able to diagnose psychiatric conditions accurately and ensure that these conditions are treated appropriately, particularly when the conditions may complicate treatment, affect the outcome of gender-affirming treatment, or be affected by hormone use.

Values and preferences

The task force placed a very high value on avoiding harm from hormone treatment in individuals who have conditions other than GD/gender incongruence and who may not benefit from the physical changes associated with this treatment and placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the good practice statement.

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕◯◯)

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that children should be discouraged from showing gender-variant behaviors or should be punished for exhibiting such behaviors. In individual cases, an early complete social transition may result in a more favorable outcome, but there are currently no criteria to identify the GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty.

Values and preferences

The task force placed a high value on avoiding harm with gender-affirming hormone therapy in prepubertal children with GD/gender incongruence. This justifies the strong recommendation in the face of low-quality evidence.

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕◯)

Remarks

Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision (67, 68). Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormonal interventions, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment.

Treating early pubertal youth with GnRH analogs will temporarily impair spermatogenesis and oocyte maturation. Given that an increasing number of transgender youth want to preserve fertility potential, delaying or temporarily discontinuing GnRH analogs to promote gamete maturation is an option. This option is often not preferred, because mature sperm production is associated with later stages of puberty and with the significant development of secondary sex characteristics.

For those designated male at birth with GD/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient for the cryopreservation of sperm. However, prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression. This can be accomplished by spontaneous gonadotropin recovery after

cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production, as stated above. Note that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In males treated for precocious puberty, spermarche was reported 0.7 to 3 years after cessation of GnRH analogs (69). In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6 to 12 months of gonadotropin treatment. However, sperm numbers when partners of these patients conceive are far below the "normal range" (70, 71).

In girls, no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation (72, 73). Clinicians should inform adolescents that no data are available regarding either time to spontaneous ovulation after cessation of GnRH analogs or the response to ovulation induction following prolonged gonadotropin suppression.

In males with GD/gender incongruence, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. *In vitro* spermatogenesis is currently under investigation. Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In females with GD/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain. There have been reports of an increased incidence of polycystic ovaries in transgender males, both prior to and as a result of androgen treatment (74–77), although these reports were not confirmed by others (78). Pregnancy has been reported in transgender males who have had prolonged androgen treatment and have discontinued testosterone but have not had genital surgery (79, 80). A reproductive endocrine gynecologist can counsel patients before gender-affirming hormone treatment or surgery regarding potential fertility options (81). Techniques for cryopreservation of oocytes, embryos, and ovarian tissue continue to improve, and oocyte maturation of immature tissue is being studied (82).

2.0 Treatment of Adolescents

During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with GD/gender incongruence. In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with GD/gender incongruence, the pubertal physical changes are unbearable. As early medical intervention may prevent psychological harm, various clinics have decided to start treating young adolescents with GD/gender incongruence with puberty-suppressing medication (a GnRH analog). As compared with starting gender-affirming treatment long after the first phases of puberty, a benefit of pubertal suppression at early puberty may be a better psychological and physical outcome.

In girls, the first physical sign of puberty is the budding of the breasts followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, and menarche occurs ~2 years later. In boys, the first physical change is testicular growth. A testicular volume ≥4 mL is seen as consistent with the initiation of physical puberty. At the beginning of puberty, estradiol and testosterone levels are still low and are best measured in the early morning with an ultrasensitive assay. From a testicular volume of 10 mL, daytime testosterone levels increase, leading to virilization (83). Note that pubic hair and/or axillary hair/odor may not reflect the onset of gonadarche; instead, it may reflect adrenarche alone.

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment (Table 5), and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 ⊕⊕◯◯)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2). (2 ⊕⊕◯◯)

Evidence

Pubertal suppression can expand the diagnostic phase by a long period, giving the subject more time to explore options and to live in the experienced gender before making a decision to proceed with gender-affirming sex hormone treatments and/or surgery, some of which is irreversible (84, 85). Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains (86).

Another reason to start blocking pubertal hormones early in puberty is that the physical outcome is improved compared with initiating physical transition after puberty has been completed (60, 62). Looking like a man or woman when living as the opposite sex creates difficult

doi: 10.1210/jc.2017-01658

barriers with enormous life-long disadvantages. We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics. However, adolescents with GD/gender incongruence should experience the first changes of their endogenous spontaneous puberty, because their emotional reaction to these first physical changes has diagnostic value in establishing the persistence of GD/gender incongruence (85). Thus, Tanner stage 2 is the optimal time to start pubertal suppression. However, pubertal suppression treatment in early puberty will limit the growth of the penis and scrotum, which will have a potential effect on future surgical treatments (87).

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Values and preferences

These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.

Remarks

Table 6 lists the Tanner stages of breast and male genital development. Careful documentation of hallmarks of pubertal development will ensure precise timing when initiating pubertal suppression once puberty has started. Clinicians can use pubertal LH and sex steroid levels to confirm that puberty has progressed sufficiently before starting pubertal suppression (88). Reference ranges for sex steroids by Tanner stage may vary depending on the assay used. Ultrasensitive sex steroid and gonadotropin assays will help clinicians document early pubertal changes.

Irreversible and, for GD/gender-incongruent adolescents, undesirable sex characteristics in female puberty are breasts, female body habitus, and, in some cases, relative short stature. In male puberty, they are a prominent Adam's apple; low voice; male bone configuration, such as a large jaw, big feet and hands, and tall stature; and male hair pattern on the face and extremities.

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 l⊕⊕○○)

Evidence

Clinicians can suppress pubertal development and gonadal function most effectively via gonadotropin suppression using GnRH analogs. GnRH analogs are long-acting agonists that suppress gonadotropins by GnRH receptor desensitization after an initial increase of gonadotropins during ~10 days after the first and (to a lesser degree) the second injection (89). Antagonists immediately suppress pituitary gonadotropin secretion (90, 91). Long-acting GnRH analogs are the currently preferred treatment option. Clinicians may consider long-acting GnRH antagonists when evidence on their safety and efficacy in adolescents becomes available.

During GnRH analog treatment, slight development of secondary sex characteristics may regress, and in a later phase of pubertal development, it will stop. In girls, breast tissue will become atrophic, and menses will stop. In boys, virilization will stop, and testicular volume may decrease (92).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploration of his/her transition wish, the individual no longer desires transition, they can discontinue pubertal suppression. In subjects with

Table 6. Tanner Stages of Breast Development and Male External Genitalia

The description of Tanner stages for breast development:
1. Prepubertal
2. Breast and papilla elevated as small mound; areolar diameter increased
3. Breast and areola enlarged, no contour separation
4. Areola and papilla form secondary mound
5. Mature; nipple projects, areola part of general breast contour

For penis and testes:
1. Prepubertal, testicular volume <4 mL
2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 mL
3. Penis longer, testes larger (8–12 mL)
4. Penis and glans larger, including increase in breadth; testes larger (12–15 mL), scrotum dark
5. Penis adult size; testicular volume > 15 ml

Adapted from Lawrence (56).

precocious puberty, spontaneous pubertal development has been shown to resume after patients discontinue taking GnRH analogs (93).

Recommendations 2.1 to 2.3 are supported by a prospective follow-up study from The Netherlands. This report assessed mental health outcomes in 55 transgender adolescents/young adults (22 transgender females and 33 transgender males) at three time points: (1) before the start of GnRH agonist (average age of 14.8 years at start of treatment), (2) at initiation of gender-affirming hormones (average age of 16.7 years at start of treatment), and (3) 1 year after "gender-reassignment surgery" (average age of 20.7 years) (63). Despite a decrease in depression and an improvement in general mental health functioning, GD/gender incongruence persisted through pubertal suppression, as previously reported (86). However, following sex hormone treatment and gender-reassignment surgery, GD/gender incongruence was resolved and psychological functioning steadily improved (63). Furthermore, well-being was similar to or better than that reported by age-matched young adults from the general population, and none of the study participants regretted treatment. This study represents the first long-term follow-up of individuals managed according to currently existing clinical practice guidelines for transgender youth, and it underscores the benefit of the multidisciplinary approach pioneered in The Netherlands; however, further studies are needed.

Side effects

The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development. Few data are available on the effect of GnRH analogs on BMD in adolescents with GD/gender incongruence. Initial data in GD/gender-incongruent subjects demonstrated no change of absolute areal BMD during 2 years of GnRH analog therapy but a decrease in BMD *z* scores (85). A recent study also suggested suboptimal bone mineral accrual during GnRH analog treatment. The study reported a decrease in areal BMD *z* scores and of bone mineral apparent density *z* scores (which takes the size of the bone into account) in 19 transgender males treated with GnRH analogs from a mean age of 15.0 years (standard deviation = 2.0 years) for a median duration of 1.5 years (0.3 to 5.2 years) and in 15 transgender females treated from 14.9 (±1.9) years for 1.3 years (0.5 to 3.8 years), although not all changes were statistically significant (94). There was incomplete catch-up at age 22 years after sex hormone treatment from age 16.6 (±1.4) years for a median duration of 5.8 years (3.0 to 8.0 years) in transgender females and from age 16.4 (±2.3) years for 5.4 years (2.8 to 7.8 years) in transgender males. Little is known about more prolonged use of GnRH analogs. Researchers reported normal BMD *z* scores at age 35 years in one individual who used GnRH analogs from age 13.7 years until age 18.6 years before initiating sex hormone treatment (65).

Additional data are available from individuals with late puberty or GnRH analog treatment of other indications. Some studies reported that men with constitutionally delayed puberty have decreased BMD in adulthood (95). However, other studies reported that these men have normal BMD (96, 97). Treating adults with GnRH analogs results in a decrease of BMD (98). In children with central precocious puberty, treatment with GnRH analogs has been found to result in a decrease of BMD during treatment by some (99) but not others (100). Studies have reported normal BMD after discontinuing therapy (69, 72, 73, 101, 102). In adolescents treated with growth hormone who are small for gestational age and have normal pubertal timing, 2-year GnRH analog treatments did not adversely affect BMD (103). Calcium supplementation may be beneficial in optimizing bone health in GnRH analog–treated individuals (104). There are no studies of vitamin D supplementation in this context, but clinicians should offer supplements to vitamin D–deficient adolescents. Physical activity, especially during growth, is important for bone mass in healthy individuals (103) and is therefore likely to be beneficial for bone health in GnRH analog–treated subjects.

GnRH analogs did not induce a change in body mass index standard deviation score in GD/gender-incongruent adolescents (94) but caused an increase in fat mass and decrease in lean body mass percentage (92). Studies in girls treated for precocious puberty also reported a stable body mass index standard deviation score during treatment (72) and body mass index and body composition comparable to controls after treatment (73).

Arterial hypertension has been reported as an adverse effect in a few girls treated with GnRH analogs for precocious/early puberty (105, 106). Blood pressure monitoring before and during treatment is recommended.

Individuals may also experience hot flashes, fatigue, and mood alterations as a consequence of pubertal suppression. There is no consensus on treatment of these side effects in this context.

It is recommended that any use of pubertal blockers (and subsequent use of sex hormones, as detailed below) include a discussion about implications for fertility (see recommendation 1.3). Transgender adolescents may

doi: 10.1210/jc.2017-01658

want to preserve fertility, which may be otherwise compromised if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones.

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function (107), but animal data suggest there may be an effect of GnRH analogs on cognitive function (108).

Values and preferences

Our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved (as compared with the alternatives) and a relatively lower value on limiting the cost of therapy. Of the available alternatives, depot and oral progestin preparations are effective. Experience with this treatment dates back prior to the emergence of GnRH analogs for treating precocious puberty in papers from the 1960s and early 1970s (109–112). These compounds are usually safe, but some side effects have been reported (113–115). Only two recent studies involved transgender youth (116, 117). One of these studies described the use of oral lynestrenol monotherapy followed by the addition of testosterone treatment in transgender boys who were at Tanner stage B4 or further at the start of treatment (117). They found lynestrenol safe, but gonadotropins were not fully suppressed. The study reported metrorrhagia in approximately half of the individuals, mainly in the first 6 months. Acne, headache, hot flashes, and fatigue were other frequent side effects. Another progestin that has been studied in the United States is medroxyprogesterone. This agent is not as effective as GnRH analogs in lowering endogenous sex hormones either and may be associated with other side effects (116). Progestin preparations may be an acceptable treatment for persons without access to GnRH analogs or with a needle phobia. If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see adult section).

Remarks

Measurements of gonadotropin and sex steroid levels give precise information about gonadal axis suppression, although there is insufficient evidence for any specific short-term monitoring scheme in children treated with GnRH analogs (88). If the gonadal axis is not completely suppressed—as evidenced by (for example) menses, erections, or progressive hair growth—the interval of GnRH analog treatment can be shortened or the dose increased. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone mineral accretion. Table 7 illustrates a suggested clinical protocol.

Anthropometric measurements and X-rays of the left hand to monitor bone age are informative for evaluating growth. To assess BMD, clinicians can perform dual-energy X-ray absorptiometry scans.

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule (see Table 8) after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years (Table 5). (1 |⊕⊕◯◯)

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕◯◯◯)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment (Table 9). (2 |⊕⊕◯◯)

Table 7. Baseline and Follow-Up Protocol During Suppression of Puberty

Every 3–6 mo
Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
Laboratory: LH, FSH, E2/T, 25OH vitamin D
Every 1–2 y
Bone density using DXA
Bone age on X-ray of the left hand (if clinically indicated)

Adapted from Hembree *et al.* (118).

Abbreviations: DXA, dual-energy X-ray absorptiometry; E2, estradiol; FSH, follicle stimulating hormone; LH, luteinizing hormone; T, testosterone;

Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β-estradiol, increasing the dose every 6 mo:
- 5 μg/kg/d
- 10 μg/kg/d
- 15 μg/kg/d
- 20 μg/kg/d
- Adult dose = 2–6 mg/d
- *In postpubertal transgender female adolescents, the dose of 17β-estradiol can be increased more rapidly:*
  - 1 mg/d for 6 mo
  - 2 mg/d

Induction of female puberty with transdermal 17β-estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d):
- 6.25–12.5 μg/24 h (cut 25-μg patch into quarters, then halves)
- 25 μg/24 h
- 37.5 μg/24 h
- Adult dose = 50–200 μg/24 h
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).*

Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC):
- 25 mg/m^2/2 wk (or alternatively, half this dose weekly, or double the dose every 4 wk)
- 50 mg/m^2/2 wk
- 75 mg/m^2/2 wk
- 100 mg/m^2/2 wk
- Adult dose = 100–200 mg every 2 wk
- *In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:*
  - 75 mg/2 wk for 6 mo
  - 125 mg/2 wk
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).*

Adapted from Hembree *et al.* (118).

Abbreviations: IM, intramuscularly; SC, subcutaneously.

Evidence

Adolescents develop competence in decision making at their own pace. Ideally, the supervising medical professionals should individually assess this competence, although no objective tools to make such an assessment are currently available.

Many adolescents have achieved a reasonable level of competence by age 15 to 16 years (119), and in many countries 16-year-olds are legally competent with regard to medical decision making (120). However, others believe that although some capacities are generally achieved before age 16 years, other abilities (such as good risk assessment) do not develop until well after 18 years (121). They suggest that health care procedures should be divided along a matrix of relative risk, so that younger adolescents can be allowed to decide about low-risk procedures, such as most diagnostic tests and common therapies, but not about high-risk procedures, such as most surgical procedures (121).

Currently available data from transgender adolescents support treatment with sex hormones starting at age 16 years (63, 122). However, some patients may incur potential risks by waiting until age 16 years. These include the potential risk to bone health if puberty is suppressed

Table 9. Baseline and Follow-up Protocol During Induction of Puberty

Every 3–6 mo
- •Anthropometry: height, weight, sitting height, blood pressure, Tanner stages

Every 6–12 mo
- •In transgender males: hemoglobin/hematocrit, lipids, testosterone, 25OH vitamin D
- •In transgender females: prolactin, estradiol, 25OH vitamin D

Every 1–2 y
- •BMD using DXA
- •Bone age on X-ray of the left hand (if clinically indicated)

BMD should be monitored into adulthood (until the age of 25–30 y or until peak bone mass has been reached).
For recommendations on monitoring once pubertal induction has been completed, see Tables 14 and 15.

Adapted from Hembree *et al.* (118).

Abbreviation: DXA, dual-energy X-ray absorptiometry.

doi: 10.1210/jc.2017-01658

for 6 to 7 years before initiating sex hormones (*e.g.*, if someone reached Tanner stage 2 at age 9-10 years old). Additionally, there may be concerns about inappropriate height and potential harm to mental health (emotional and social isolation) if initiation of secondary sex characteristics must wait until the person has reached 16 years of age. However, only minimal data supporting earlier use of gender-affirming hormones in transgender adolescents currently exist (63). Clearly, long-term studies are needed to determine the optimal age of sex hormone treatment in GD/gender-incongruent adolescents.

The MHP who has followed the adolescent during GnRH analog treatment plays an essential role in assessing whether the adolescent is eligible to start sex hormone therapy and capable of consenting to this treatment (Table 5). Support of the family/environment is essential. Prior to the start of sex hormones, clinicians should discuss the implications for fertility (see recommendation 1.5). Throughout pubertal induction, an MHP and a pediatric endocrinologist (or other clinician competent in the evaluation and induction of pubertal development) should monitor the adolescent. In addition to monitoring therapy, it is also important to pay attention to general adolescent health issues, including healthy life style choices, such as not smoking, contraception, and appropriate vaccinations (*e.g.*, human papillomavirus).

For the induction of puberty, clinicians can use a similar dose scheme for hypogonadal adolescents with GD/gender incongruence as they use in other individuals with hypogonadism, carefully monitoring for desired and undesired effects (Table 8). In transgender female adolescents, transdermal 17β-estradiol may be an alternative for oral 17β-estradiol. It is increasingly used for pubertal induction in hypogonadal females. However, the absence of low-dose estrogen patches may be a problem. As a result, individuals may need to cut patches to size themselves to achieve appropriate dosing (123). In transgender male adolescents, clinicians can give testosterone injections intramuscularly or subcutaneously (124, 125).

When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion. Gonadotropin secretion and endogenous production of testosterone may resume and interfere with the effectiveness of estrogen treatment, in transgender female adolescents (126, 127). Therefore, continuation of GnRH analog treatment is advised until gonadectomy. Given that GD/gender-incongruent adolescents may opt not to have gonadectomy, long-term studies are necessary to examine the potential risks of prolonged GnRH analog treatment. Alternatively, in transgender male adolescents, GnRH analog treatment can be discontinued once an adult dose of testosterone has been reached and the individual is well virilized. If uterine bleeding occurs, a progestin can be added. However, the combined use of a GnRH analog (for ovarian suppression) and testosterone may enable phenotypic transition with a lower dose of testosterone in comparison with testosterone alone. If there is a wish or need to discontinue GnRH analog treatment in transgender female adolescents, they may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see section 3.0 "Hormonal Therapy for Transgender Adults").

Values and preferences

The recommendation to initiate pubertal induction only when the individual has sufficient mental capacity (roughly age 16 years) to give informed consent for this partly irreversible treatment places a higher value on the ability of the adolescent to fully understand and oversee the partially irreversible consequences of sex hormone treatment and to give informed consent. It places a lower value on the possible negative effects of delayed puberty. We may not currently have the means to weigh adequately the potential benefits of waiting until around age 16 years to initiate sex hormones vs the potential risks/harm to BMD and the sense of social isolation from having the timing of puberty be so out of sync with peers (128).

Remarks

Before starting sex hormone treatment, effects on fertility and options for fertility preservation should be discussed. Adult height may be a concern in transgender adolescents. In a transgender female adolescent, clinicians may consider higher doses of estrogen or a more rapid tempo of dose escalation during pubertal induction. There are no established treatments yet to augment adult height in a transgender male adolescent with open epiphyses during pubertal induction. It is not uncommon for transgender adolescents to present for clinical services after having completed or nearly completed puberty. In such cases, induction of puberty with sex hormones can be done more rapidly (see Table 8). Additionally, an adult dose of testosterone in transgender male adolescents may suffice to suppress the gonadal axis without the need to use a separate agent. At the appropriate time, the multidisciplinary team should adequately prepare the adolescent for transition to adult care.

3.0 Hormonal Therapy for Transgender Adults

The two major goals of hormonal therapy are (1) to reduce endogenous sex hormone levels, and thus reduce

the secondary sex characteristics of the individual's designated gender, and (2) to replace endogenous sex hormone levels consistent with the individual's gender identity by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with the sex hormones of the chosen gender is codetermined in collaboration with both the person pursuing transition and the health care providers. The treatment team should include a medical provider knowledgeable in transgender hormone therapy, an MHP knowledgeable in GD/gender incongruence and the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being (129, 130).

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕◯)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment (Table 10). (1 |⊕⊕⊕◯)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕◯◯)

Evidence

It is the responsibility of the treating clinician to confirm that the person fulfills criteria for treatment. The treating clinician should become familiar with the terms and criteria presented in Tables 1–5 and take a thorough history from the patient in collaboration with the other members of the treatment team. The treating clinician must ensure that the desire for transition is appropriate; the consequences, risks, and benefits of treatment are well understood; and the desire for transition persists. They also need to discuss fertility preservation options (see recommendation 1.3) (67, 68).

Transgender males

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in transgender males (Appendix A) (113, 114, 131–134). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (135). Clinicians can use either parenteral or transdermal preparations to achieve testosterone values in the normal male range (this is dependent on the specific assay, but is typically 320 to 1000 ng/dL) (Table 11) (136). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions (see section 4.0 "Adverse Outcome Prevention and Long-Term Care") and should be avoided.

Similar to androgen therapy in hypogonadal men, testosterone treatment in transgender males results in increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire (137).

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen
Very high risk of adverse outcomes:
•Thromboembolic disease
Moderate risk of adverse outcomes:
•Macroprolactinoma
•Breast cancer
•Coronary artery disease
•Cerebrovascular disease
•Cholelithiasis
•Hypertriglyceridemia
Transgender male: testosterone
Very high risk of adverse outcomes:
•Erythrocytosis (hematocrit > 50%)
Moderate risk of adverse outcomes:
•Severe liver dysfunction (transaminases > threefold upper limit of normal)
•Coronary artery disease
•Cerebrovascular disease
•Hypertension
•Breast or uterine cancer

doi: 10.1210/jc.2017-01658

Table 11. Hormone Regimens in Transgender Persons

Transgender females[a]	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch (New patch placed every 3–5 d)	0.025–0.2 mg/d
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate[b]	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate[c]	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6%[d]	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.

[a]Estrogens used with or without antiandrogens or GnRH agonist.

[b]Not available in the United States.

[c]One thousand milligrams initially followed by an injection at 6 wk then at 12-wk intervals.

[d]Avoid cutaneous transfer to other individuals.

In transgender males, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, clinicians may consider the addition of a progestational agent or endometrial ablation (138). Clinicians may also administer GnRH analogs or depot medroxyprogesterone to stop menses prior to testosterone treatment.

Transgender females

The hormone regimen for transgender females is more complex than the transgender male regimen (Appendix B). Treatment with physiologic doses of estrogen alone is insufficient to suppress testosterone levels into the normal range for females (139). Most published clinical studies report the need for adjunctive therapy to achieve testosterone levels in the female range (21, 113, 114, 132–134, 139, 140).

Multiple adjunctive medications are available, such as progestins with antiandrogen activity and GnRH agonists (141). Spironolactone works by directly blocking androgens during their interaction with the androgen receptor (114, 133, 142). It may also have estrogenic activity (143). Cyproterone acetate, a progestational compound with antiandrogenic properties (113, 132, 144), is widely used in Europe. 5α-Reductase inhibitors do not reduce testosterone levels and have adverse effects (145).

Dittrich *et al.* (141) reported that monthly doses of the GnRH agonist goserelin acetate in combination with estrogen were effective in reducing testosterone levels with a low incidence of adverse reactions in 60 transgender females. Leuprolide and transdermal estrogen were as effective as cyproterone and transdermal estrogen in a comparative retrospective study (146).

Patients can take estrogen as oral conjugated estrogens, oral 17β-estradiol, or transdermal 17β-estradiol. Among estrogen options, the increased risk of thromboembolic events associated with estrogens in general seems most concerning with ethinyl estradiol specifically (134, 140, 141), which is why we specifically suggest that it not be used in any transgender treatment plan. Data distinguishing among other estrogen options are less well established although there is some thought that oral routes of administration are more thrombogenic due to the "first pass effect" than are transdermal and parenteral routes, and that the risk of thromboembolic events is dose-dependent. Injectable estrogen and sublingual

estrogen may benefit from avoiding the first pass effect, but they can result in more rapid peaks with greater overall periodicity and thus are more difficult to monitor (147, 148). However, there are no data demonstrating that increased periodicity is harmful otherwise.

Clinicians can use serum estradiol levels to monitor oral, transdermal, and intramuscular estradiol. Blood tests cannot monitor conjugated estrogens or synthetic estrogen use. Clinicians should measure serum estradiol and serum testosterone and maintain them at the level for premenopausal females (100 to 200 pg/mL and <50 ng/dL, respectively). The transdermal preparations and injectable estradiol cypionate or valerate preparations may confer an advantage in older transgender females who may be at higher risk for thromboembolic disease (149).

Values

Our recommendation to maintain levels of gender-affirming hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharmacologic doses. Those patients receiving endocrine treatment who have relative contraindications to hormones should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

Remarks

Clinicians should inform all endocrine-treated individuals of all risks and benefits of gender-affirming hormones prior to initiating therapy. Clinicians should strongly encourage tobacco use cessation in transgender females to avoid increased risk of VTE and cardiovascular complications. We strongly discourage the unsupervised use of hormone therapy (150).

Not all individuals with GD/gender incongruence seek treatment as described (*e.g.*, male-to-eunuchs and individuals seeking partial transition). Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach including mental health. No evidence-based protocols are available for these groups (151). We need prospective studies to better understand treatment options for these persons.

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕○○○)

Evidence

Transgender males

Physical changes that are expected to occur during the first 1 to 6 months of testosterone therapy include cessation of menses, increased sexual desire, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice (152, 153), clitoromegaly, and male pattern hair loss (in some cases) (114, 144, 154, 155) (Table 12).

Transgender females

Physical changes that may occur in transgender females in the first 3 to 12 months of estrogen and antiandrogen therapy include decreased sexual desire, decreased spontaneous erections, decreased facial and body hair (usually mild), decreased oiliness of skin, increased breast tissue growth, and redistribution of fat mass (114, 139, 149, 154, 155, 161) (Table 13). Breast development is generally maximal at 2 years after initiating hormones (114, 139, 149, 155). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in transgender females has been studied (150), precise information about other changes induced by sex hormones is lacking (141). There is a great deal of variability among individuals, as evidenced during pubertal development. We all know that a major concern for transgender females is breast development. If we work with estrogens, the result will be often not what the transgender female expects.

Alternatively, there are transgender females who report an anecdotal improved breast development, mood, or sexual desire with the use of progestogens. However, there have been no well-designed studies of the role of progestogens in feminizing hormone regimens, so the question is still open.

Our knowledge concerning the natural history and effects of different cross-sex hormone therapies on breast

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	—[a]
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	—[b]
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

[a] Prevention and treatment as recommended for biological men.

[b] Menorrhagia requires diagnosis and treatment by a gynecologist.

doi: 10.1210/jc.2017-01658

Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y[a]
Scalp hair	Variable	—[b]
Voice changes	None	—[c]

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

[a]Complete removal of male sexual hair requires electrolysis or laser treatment or both.

[b]Familial scalp hair loss may occur if estrogens are stopped.

[c]Treatment by speech pathologists for voice training is most effective.

development in transgender females is extremely sparse and based on the low quality of evidence. Current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect. This prevents us from drawing any firm conclusion at this moment and demonstrates the need for further research to clarify these important clinical questions (162).

Values and preferences

Transgender persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.*, breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone–induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse Outcome Prevention and Long-Term Care

Hormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons. The risks arise from and are worsened by inadvertent or intentional use of supraphysiologic doses of sex hormones, as well as use of inadequate doses of sex hormones to maintain normal physiology (131, 139).

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕◯◯)

Evidence

Pretreatment screening and appropriate regular medical monitoring are recommended for both transgender males and females during the endocrine transition and periodically thereafter (26, 155). Clinicians should monitor weight and blood pressure, conduct physical exams, and assess routine health questions, such as tobacco use, symptoms of depression, and risk of adverse events such as deep vein thrombosis/pulmonary embolism and other adverse effects of sex steroids.

Transgender males

Table 14 contains a standard monitoring plan for transgender males on testosterone therapy (154, 159). Key issues include maintaining testosterone levels in the physiologic normal male range and avoiding adverse events resulting from excess testosterone therapy, particularly erythrocytosis, sleep apnea, hypertension, excessive weight gain, salt retention, lipid changes, and excessive or cystic acne (135).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with parenteral or transdermal testosterone use (163, 164). Past concerns regarding liver toxicity with testosterone have been alleviated with subsequent reports that indicate the risk of serious liver disease is minimal (144, 165, 166).

Transgender females

Table 15 contains a standard monitoring plan for transgender females on estrogens, gonadotropin suppression, or antiandrogens (160). Key issues include avoiding supraphysiologic doses or blood levels of estrogen that may lead to increased risk for thromboembolic disease, liver dysfunction, and hypertension. Clinicians should monitor serum estradiol levels using laboratories participating in external quality control, as measurements of estradiol in blood can be very challenging (167).

VTE may be a serious complication. A study reported a 20-fold increase in venous thromboembolic disease in a large cohort of Dutch transgender subjects (161). This increase may have been associated with the use of the synthetic estrogen, ethinyl estradiol (149). The incidence decreased when clinicians stopped administering ethinyl estradiol (161). Thus, the use of synthetic estrogens and conjugated estrogens is undesirable because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease. In a German gender clinic, deep vein thrombosis occurred in 1 of 60 of transgender females treated with a GnRH analog and oral

Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:[a]
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

[a] Adapted from Lapauw *et al.* (154) and Ott *et al.* (159).

estradiol (141). The patient who developed a deep vein thrombosis was found to have a homozygous C677 T mutation in the methylenetetrahydrofolate reductase gene. In an Austrian gender clinic, administering gender-affirming hormones to 162 transgender females and 89 transgender males was not associated with VTE, despite an 8.0% and 5.6% incidence of thrombophilia (159). A more recent multinational study reported only 10 cases of VTE from a cohort of 1073 subjects (168). Thrombophilia screening of transgender persons initiating hormone treatment should be restricted to those with a personal or family history of VTE (159). Monitoring D-dimer levels during treatment is not recommended (169).

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 l⊕⊕◯◯)

Evidence

Estrogen therapy can increase the growth of pituitary lactrotroph cells. There have been several reports of prolactinomas occurring after long-term, high-dose estrogen therapy (170–173). Up to 20% of transgender females treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (156). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy or discontinuation of cyproterone acetate (157, 174, 175).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Clinicians should measure prolactin levels at baseline and then at least annually during the transition period and every 2 years thereafter. Given that only a few case studies reported prolactinomas, and prolactinomas were not reported in large cohorts of estrogen-treated persons, the risk is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in transgender females, clinicians may perform radiologic examinations of the pituitary in those patients whose prolactin levels persistently increase despite stable or reduced estrogen levels. Some transgender individuals receive psychotropic medications that can increase prolactin levels (174).

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
   a. Serum testosterone levels should be <50 ng/dL.
   b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

doi: 10.1210/jc.2017-01658

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 ⊕⊕◯◯)

Evidence

Transgender males

Administering testosterone to transgender males results in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride and low-density lipoprotein cholesterol values (176–179). Studies of the effect of testosterone on insulin sensitivity have mixed results (178, 180). A randomized, open-label uncontrolled safety study of transgender males treated with testosterone undecanoate demonstrated no insulin resistance after 1 year (181, 182). Numerous studies have demonstrated the effects of sex hormone treatment on the cardiovascular system (160, 179, 183, 184). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (161). Likewise, a meta-analysis of 19 randomized trials in nontransgender males on testosterone replacement showed no increased incidence of cardiovascular events (185). A systematic review of the literature found that data were insufficient (due to very low–quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or VTE in transgender males (176). Future research is needed to ascertain the potential harm of hormonal therapies (176). Clinicians should manage cardiovascular risk factors as they emerge according to established guidelines (186).

Transgender females

A prospective study of transgender females found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (178). However, increased weight, blood pressure, and markers of insulin resistance attenuated these favorable lipid changes. In a meta-analysis, only serum triglycerides were higher at ≥24 months without changes in other parameters (187). The largest cohort of transgender females (mean age 41 years, followed for a mean of 10 years) showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (161).

Thus, there is limited evidence to determine whether estrogen is protective or detrimental on lipid and glucose metabolism in transgender females (176). With aging, there is usually an increase of body weight. Therefore, as with nontransgender individuals, clinicians should monitor and manage glucose and lipid metabolism and blood pressure regularly according to established guidelines (186).

4.4. We recommend that clinicians obtain BMD measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 ⊕⊕◯◯)

Evidence

Transgender males

Baseline bone mineral measurements in transgender males are generally in the expected range for their pretreatment gender (188). However, adequate dosing of testosterone is important to maintain bone mass in transgender males (189, 190). In one study (190), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels in the normal range may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol, both systemically and locally in the bone.

Transgender females

A baseline study of BMD reported T scores less than −2.5 in 16% of transgender females (191). In aging males, studies suggest that serum estradiol more positively correlates with BMD than does testosterone (192, 193) and is more important for peak bone mass (194). Estrogen preserves BMD in transgender females who continue on estrogen and antiandrogen therapies (188, 190, 191, 195, 196).

Fracture data in transgender males and females are not available. Transgender persons who have undergone gonadectomy may choose not to continue consistent sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss. There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (*e.g.*, when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be

reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for those designated female at birth. (2 |⊕⊕◯◯)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕◯◯◯)

Evidence

Studies have reported a few cases of breast cancer in transgender females (197–200). A Dutch study of 1800 transgender females followed for a mean of 15 years (range of 1 30 years) found one case of breast cancer. The Women's Health Initiative study reported that females taking conjugated equine estrogen without progesterone for 7 years did not have an increased risk of breast cancer as compared with females taking placebo (137).

In transgender males, a large retrospective study conducted at the U.S. Veterans Affairs medical health system identified seven breast cancers (194). The authors reported that this was not above the expected rate of breast cancers in cisgender females in this cohort. Furthermore, they did report one breast cancer that developed in a transgender male patient after mastectomy, supporting the fact that breast cancer can occur even after mastectomy. Indeed, there have been case reports of breast cancer developing in subareolar tissue in transgender males, which occurred after mastectomy (201, 202).

Women with primary hypogonadism (Turner syndrome) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (203, 204). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short term (<20 to 30 years). We need long-term studies to determine the actual risk, as well as the role of screening mammograms. Regular examinations and gynecologic advice should determine monitoring for breast cancer.

Prostate cancer is very rare before the age of 40, especially with androgen deprivation therapy (205). Childhood or pubertal castration results in regression of the prostate and adult castration reverses benign prostate hypertrophy (206). Although van Kesteren *et al.* (207) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostates of transgender females, studies have reported cases of benign prostatic hyperplasia in transgender females treated with estrogens for 20 to 25 years (208, 209). Studies have also reported a few cases of prostate carcinoma in transgender females (210–214).

Transgender females may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for transgender females who transitioned after age 20 years to have annual screening digital rectal examinations after age 50 years and prostate-specific antigen tests consistent with U.S. Preventive Services Task Force Guidelines (215).

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Evidence

Although aromatization of testosterone to estradiol in transgender males has been suggested as a risk factor for endometrial cancer (216), no cases have been reported. When transgender males undergo hysterectomy, the uterus is small and there is endometrial atrophy (217, 218). Studies have reported cases of ovarian cancer (219, 220). Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender-affirming surgery to prevent reproductive tract cancer (221).

Values

Given the discomfort that transgender males experience accessing gynecologic care, our recommendation for the medical necessity of total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecologic care required following transition. Additionally, in certain countries, the approval required to change the sex in a birth certificate for transgender males may be dependent on having a complete hysterectomy. Clinicians should help patients research nonmedical administrative criteria and

doi: 10.1210/jc.2017-01658

provide counseling. If individuals decide not to undergo hysterectomy, screening for cervical cancer is the same as all other females.

5.0 Surgery for Sex Reassignment and Gender Confirmation

For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not. Those that change fertility (previously called sex reassignment surgery) include genital surgery to remove the penis and gonads in the male and removal of the uterus and gonads in the female. The surgeries that effect fertility are often governed by the legal system of the state or country in which they are performed. Other gender-conforming surgeries that do not directly affect fertility are not so tightly governed.

Gender-affirming surgical techniques have improved markedly during the past 10 years. Reconstructive genital surgery that preserves neurologic sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (187). Additionally, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender-affirming treatment that includes hormones and surgery (130, 144) (Table 16).

Surgery that affects fertility is irreversible. The World Professional Association for Transgender Health Standards of Care (222) emphasizes that the "threshold of 18 should not be seen as an indication in itself for active intervention." If the social transition has not been satisfactory, if the person is not satisfied with or is ambivalent about the effects of sex hormone treatment, or if the person is ambivalent about surgery then the individual should not be referred for surgery (223, 224).

Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina (225, 226). Surgeons often invert the skin of the penis to form the wall of the vagina, and several literatures reviews have reported on outcomes (227). Sometimes there is inadequate tissue to form a full neovagina, so clinicians have revisited using intestine and found it to be successful (87, 228, 229). Some newer vaginoplasty techniques may involve autologuous oral epithelial cells (230, 231).

The scrotum becomes the labia majora. Surgeons use reconstructive surgery to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Some surgeons are also creating a sensate pedicled-spot adding a G spot to the neovagina to increase sensation (232). Most recently, plastic surgeons have developed techniques to fashion labia minora. To further complete the feminization, uterine transplants have been proposed and even attempted (233).

Neovaginal prolapse, rectovaginal fistula, delayed healing, vaginal stenosis, and other complications do sometimes occur (234, 235). Clinicians should strongly remind the transgender person to use their dilators to maintain the depth and width of the vagina throughout the postoperative period. Genital sexual responsivity and other aspects of sexual function are usually preserved following genital gender-affirming surgery (236, 237).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. Voice therapy by a speech language pathologist is available to transform speech patterns to the affirmed gender (148). Spontaneous voice deepening occurs during testosterone treatment of transgender males (152, 238). No studies have compared the effectiveness of speech therapy, laryngeal surgery, or combined treatment.

Breast surgery is a good example of gender-confirming surgery that does not affect fertility. In all females, breast size exhibits a very broad spectrum. For transgender females to make the best informed decision, clinicians should delay breast augmentation surgery until the patient has completed at least 2 years of estrogen therapy, because the breasts continue to grow during that time (141, 155).

Another major procedure is the removal of facial and masculine-appearing body hair using either electrolysis or

Table 16. Criteria for Gender-Affirming Surgery, Which Affects Fertility

1. Persistent, well-documented gender dysphoria
2. Legal age of majority in the given country
3. Having continuously and responsibly used gender-affirming hormones for 12 mo (if there is no medical contraindication to receiving such therapy)
4. Successful continuous full-time living in the new gender role for 12 mo
5. If significant medical or mental health concerns are present, they must be well controlled
6. Demonstrable knowledge of all practical aspects of surgery (*e.g.*, cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation)

laser treatments. Other feminizing surgeries, such as that to feminize the face, are now becoming more popular (239–241).

In transgender males, clinicians usually delay gender-affirming genital surgeries until after a few years of androgen therapy. Those surgeries that affect fertility in this group include oophorectomy, vaginectomy, and complete hysterectomy. Surgeons can safely perform them vaginally with laparoscopy. These are sometimes done in conjunction with the creation of a neopenis. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (242, 243). Radial forearm flap seems to be the most satisfactory procedure (228, 244). Other flaps also exist (245). Surgeons can make neopenile erections possible by reinervation of the flap and subsequent contraction of the muscle, leading to stiffening of the neopenis (246, 247), but results are inconsistent (248). Surgeons can also stiffen the penis by imbedding some mechanical device (*e.g.*, a rod or some inflatable apparatus) (249, 250). Because of these limitations, the creation of a neopenis has often been less than satisfactory. Recently, penis transplants are being proposed (233).

In fact, most transgender males do not have any external genital surgery because of the lack of access, high cost, and significant potential complications. Some choose a metaoidioplasty that brings forward the clitoris, thereby allowing them to void in a standing position without wetting themselves (251, 252). Surgeons can create the scrotum from the labia majora with good cosmetic effect and can implant testicular prostheses (253).

The most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility. Breast size only partially regresses with androgen therapy (155). In adults, discussions about mastectomy usually take place after androgen therapy has started. Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual. There are now newer approaches to mastectomy with better outcomes (254, 255). These often involve chest contouring (256). Mastectomy is often necessary for living comfortably in the new gender (256).

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 |⊕⊕◯◯)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 |⊕◯◯◯)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 |⊕⊕◯◯).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 |⊕◯◯◯)

Evidence

Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult. However, one systematic review including a large numbers of studies reported satisfactory cosmetic and functional results for vaginoplasty/neovagina construction (257). For transgender males, the outcomes are less certain. However, the problems are now better understood (258). Several postoperative studies report significant long-term psychological and psychiatric pathology (259–261). One study showed satisfaction with breasts, genitals, and femininity increased significantly and showed the importance of surgical treatment as a key therapeutic option for transgender females (262). Another analysis demonstrated that, despite the young average age at death following surgery and the relatively larger number of individuals with somatic morbidity, the study does not allow for determination of

doi: 10.1210/jc.2017-01658

causal relationships between, for example, specific types of hormonal or surgical treatment received and somatic morbidity and mortality (263). Reversal surgery in regretful male-to-female transsexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcomes. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

When a transgender individual decides to have gender-affirming surgery, both the hormone prescribing clinician and the MHP must certify that the patient satisfies criteria for gender-affirming surgery (Table 16).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or following surgery (176). For this reason, the surgeon and the hormone-prescribing clinician should collaborate in making a decision about the use of hormones before and following surgery. One study suggests that preoperative factors (such as compliance) are less important for patient satisfaction than are the physical postoperative results (56). However, other studies and clinical experience dictate that individuals who do not follow medical instructions and do not work with their physicians toward a common goal do not achieve treatment goals (264) and experience higher rates of postoperative infections and other complications (265, 266). It is also important that the person requesting surgery feels comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (223).

An endocrinologist or experienced medical provider should monitor transgender individuals after surgery. Those who undergo gonadectomy will require hormone replacement therapy, surveillance, or both to prevent adverse effects of chronic hormone deficiency.

Financial Disclosures of the Task Force*

Wylie C. Hembree (chair)—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Peggy T. Cohen-Kettenis**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Louis Gooren**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Sabine E. Hannema**—financial or business/organizational interests: none declared, significant financial interest or leadership position: Ferring Pharmaceuticals Inc. (lecture/conference), Pfizer (lecture). **Walter J. Meyer**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **M. Hassan Murad****—financial or business/organizational interests: Mayo Clinic, Evidence-based Practice Center, significant financial interest or leadership position: none declared. **Stephen M. Rosenthal**—financial or business/organizational interests: AbbVie (consultant), National Institutes of Health (grantee), significant financial interest or leadership position: Pediatric Endocrine Society (immediate past president). **Joshua D. Safer, FACP**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Vin Tangpricha**—financial or business/organizational interests: Cystic Fibrosis Foundation (grantee), National Institutes of Health (grantee), significant financial interest or leadership position, Elsevier *Journal of Clinical and Translational Endocrinology* (editor). **Guy G. T'Sjoen**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared.* Financial, business, and organizational disclosures of the task force cover the year prior to publication. Disclosures prior to this time period are archived.**Evidence-based reviews for this guideline were prepared under contract with the Endocrine Society.

Acknowledgments

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Disclosure Summary: See Financial Disclosures.

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-54

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

GLOUCESTER COUNTY SCHOOL BOARD'S RULE 26(a)(2) DISCLOSURE

NOW COMES the Defendant Gloucester County School Board ("School Board"), by counsel, and hereby discloses the following expert in accordance with Rule 26(a)(2) of the Federal Rules of Civil Procedure.

The School Board submits this disclosure without conceding that expert testimony is appropriate or needed with regard to the claims against the School Board, and without prejudice to or waiving the School Board's right to summary judgment and/or a judgment as a matter of law at the conclusion of plaintiff's evidence.

The following information is offered only as a summary of the respective expert's opinions and the grounds underlying those opinions. The School Board reserves the right to supplement, modify and/or change this expert disclosure as the expert continues to review this matter on behalf of the School Board and as additional discovery is conducted. The expert opinion is based on the expert's training, education and experience, as well as his review of the documents and other relevant materials noted in the reports. All opinions expressed will be offered to a reasonable degree of certainty in the witness' field of expertise unless stated

otherwise. The expert witness may render additional opinions or expound on the opinions listed in the reports at his depositions. The report and opinion testimony of the expert is incorporated in this Disclosure by reference.

Quentin L. Van Meter, M.D.
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The School Board reserves the right to call as a witness, Dr. Quentin L. Van Meter, an expert in the field of pediatric endocrinology. Dr. Van Meter's expert report and CV are attached to this Disclosure and incorporated by reference as if fully set forth herein. (Exhibit 1).

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I hereby certify that a true copy of the foregoing was emailed and mailed this 26th day of February, 2019 to:

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26 February, 2019

1. I have been retained by counsel for the Gloucester County School Board as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this report. My professional background, experience, and publications are detailed in my curriculum vitae, which is attached as Exhibit A.

2. I received my B.A. in Science at the College of William and Mary, and my M.D. from the Medical College of Virginia, Virginia Commonwealth University.

3. I am currently a pediatric endocrinologist in private practice in Atlanta Georgia. I am the President of Van Meter Pediatric Endocrinology, P.C. I am on the clinical faculties of Emory University School of Medicine and Morehouse College of Medicine, in the role of adjunct Associate Professor of Pediatrics.

4. I am board certified in Pediatrics and Pediatric Endocrinology. I have been licensed to practice medicine in Georgia since 1991. I have been previously licensed to practice medicine in California, Louisiana, and Maryland.

5. I did my Pediatric Endocrine fellowship at Johns Hopkins Hospital from 1978-1980. The faculty present at that time had carried on the tradition of excellence established by Lawson Wilkins, M.D. Because of the reputation of the endocrine program as a center for exceptional care for children with disorders of sexual differentiation, I had well-above average exposure to such patients. As a Pediatric Fellow, I was also exposed to adults with Gender Identity Disorder, then called Trans-Sexuality, and received training from John Money, Ph.D., in his Psychohormonal Division.

6. I have maintained a continued interest in gender discordance since my fellowship years and have read extensively the literature in scientific peer-reviewed journals and have attended national and international pediatric endocrine conferences where this subject is presented and discussed. I am also familiar with the wide array of commentary on the subject.

7. My professional memberships include The Pediatric Endocrine Society, the Endocrine Society, the American Association of Clinical Endocrinologists where I held a position on the Pediatric Scientific Committee until it was disbanded one year ago, the American Diabetes Association, and I am a fellow of the American College of Pediatricians, currently serving on the Board of Directors as President. I am on the Advisory Board of Camp Kudzu, a non-profit organization which provides diabetes camp experience in Georgia.

8. My opinions expressed in this report are based upon my education, training, and experience in the subject matters discussed. The materials that I have relied upon are the same types of materials that

EXHIBIT
1

other experts in my field rely upon when forming opinions. Specific sources upon which I rely in this report are footnoted.

9. Over my career, I have served as an expert witness in medical malpractice cases for both plaintiff and defense. I have testified at Georgia State Legislative Committee hearings. In the past six years, I have testified by deposition in Harlen Schneider v. J. Enrique Lujan, M.D.et al., in the circuit court of the first judicial circuit of Okaloosa County, FL, Civil Division, on 7 Feb 2014; and in the case of plaintiff Kimora Gilmer, represented by attorneys at the Birmingham, AL, firm of Pittman Dutton on 22 May 2014.

10. I provided an expert declaration in the case of Carcano v McCorey and US vs North Carolina on 12 August 2016. I testified in Springfield. Illinois as a plaintiff's expert witness in the case of Cooley v. Paul for the firm of Kanoski Bresney, 3 Nov 2017. I testified in court in Hamilton County Ohio in February 2018 in regard to Jessica Siefert, a transgender teen who had been removed from the custody of her biologic parents. I testified via skype in Alberta Province, Canada on 14 June 2018 in regard to the matter of parents suing the school systems there for withholding information about transgender-promoting programs in the public schools from the parents. My publications include a textbook chapter, case studies, and articles generated by clinical research studies. I serve on the speaker's bureau of major pharmaceutical companies.

11. I am being compensated at an hourly rate for actual time devoted, at the rate of $350 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

Sexual Differentiation in the Fetus

12. From the moment of conception, a fetus is determined to be either a male (XY), female (XX), or in rare cases, to have a combination of sex-determining chromosomes, many of which are not compatible with life, and some of which are the cause of identifiable clinical syndromes. The presence of a Y chromosome in the developing fetus directs the developing gonadal tissue to develop as a testicle. The absence of a functional Y chromosome allows the gonadal tissue to develop as an ovary. Under the influence of the mother's placental hormones, the testicle will produce testosterone which directs the genital tissue to form a penis and a scrotum. Simultaneously, the testicle produces anti-Müllerian Hormone (AMH) which regresses development of the tissue that would otherwise develop into the uterus, fallopian tubes, and upper third of the vagina.

13. This combination of actions in early fetal development is responsible for what we subsequently see on fetal sonograms, and what we observe at birth as male or female genitalia. It is only when the genital structures are ambiguous in appearance that sex assignment is withheld until a thorough expert team evaluation has occurred.

14. For reasons most often occurring as random events, there are malfunctions of the normal differentiation. These aberrations of normal development are responsible for what we classify as Disorders of Sexual Differentiation (DSD) and they represent a very small fraction of the human population. The incidence of such circumstances occurs in 1:4500 to 1:5500 births[1]

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1 Lee PA et al, Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care, 2016 Horm Res Paediatr

15. Sex is binary, male or female, and is determined by chromosomal complement and corresponding reproductive role. The exceedingly rare DSDs are all medically identifiable deviations from the human binary sexual norm. The 2006 consensus statement of the Intersex Society of North America and the 2015 revision of the Statement does not endorse DSD as a third sex.[2]

16. DSD outcomes range from appearance of female external genitalia in an XY male (complete androgen insensitivity syndrome) to appearance of male external genitalia in an XX female (severe congenital adrenal hyperplasia). As one would expect, there are variations of the degree of hormonally driven changes that create ambiguous genital development that prevent assigning of a specific classification as either male or female at birth.

17. DSD patients are not "transgender"; they have an objective, physical, medically verifiable, physiologic condition. Transgender people generally do not have intersex conditions or any other verifiable physical anomaly. People who identify as "feeling like the opposite sex" or "somewhere in between" do not comprise a third sex. They remain biological men or biological women.

18. "Gender" is a term that refers to the psychological and cultural characteristics associated with biological sex. It is a psychological concept and sociological term, not a biological one. The term gender possessed solely a linguistic meaning prior to the 1950s. This changed when sexologists of the 1950s and 1960s manipulated the term to conceptualize cross-dressing and transsexualism in their psychological practice.

19. "Gender identity" is a term coined by my former endocrine faculty member John Money in the 1970s and has come to refer to an individual's mental and emotional sense of being male or female. The norm is for individuals to have a gender identity that aligns with one's biological sex.

20. Gender discordance (formerly Gender Identity Disorder) is used to describe a psychological condition in which a person experiences marked incongruence between his experienced gender and the gender associated with his biological sex. He will often express the belief that he is the opposite sex.

21 Gender discordance occurs in 0.001% of biological females and in 0.0033% of biological males.[3] Exact numbers are hard to document since reporting is often anecdotal. Gender discordance is not considered a normal developmental variation.

22. "Gender Dysphoria" is a diagnostic term to describe the emotional distress caused by gender incongruity.[4]

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2 Lee PA et al, Consensus Statement on Management of Intersex Disorders, Pediatrics 2006; 118 e488-e500.

3 Seaborg E, About Face, Endocrine News 2014 (May) 16-19.

4 American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed; 2013:451-459.

Etiology of Gender Disorders

23. Transgender affirming professionals claim transgender individuals have a "feminized brain" trapped in a male body at birth and vice versa based upon various brain studies. Diffusion-weighted MRI scans have demonstrated that the pubertal testosterone surge in boys increases white matter volume. A study by Rametti and colleagues found that the white matter microstructure of the brains of female-to-male (FtM) transsexual adults, who had not begun testosterone treatment, more closely resembled that of men than that of women.[5] Other diffusion-weighted MRI studies have concluded that the white matter microstructure in both FtM and male-to-female (MtF) transsexuals falls halfway between that of genetic females and males.[6] These studies, however, are of limited clinical significance due to the small number of subjects and failure to account for neuroplasticity.

24. Neuroplasticity is the well-established phenomenon in which long-term behavior alters brain microstructure. For example, the MRI scans of experienced cab drivers in London are distinctly different from those of non-cab drivers, and the changes noted are dependent on the years of experience.[7] There is no evidence that people are born with brain microstructures that are forever unalterable, but there is significant evidence that experience changes brain microstructure.[8,9] Therefore, any transgender brain differences would more likely be the result of transgender behavior than its cause.

25. Furthermore, infants' brains are imprinted prenatally by their own endogenous sex hormones, which are secreted from their gonads beginning at approximately eight weeks' gestation.[10,11,12] There are no published studies documenting MRI-verified differences in the brains of gender-disordered children or adolescents. The DSD guidelines also specifically state that current MRI technology cannot be used to identify those patients who should be raised as males or raised as females.[13]

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5 Rametti G, Carrillo B, Gomez-Gil E, et al. White matter microstructure in female to male transsexuals before cross-sex hormonal treatment. A diffusion tensor imaging study. J Psychiatr Res 2011;45:199-204.

6 Kranz GS, Hahn A, Kaufmann U, et al. White matter microstructure in transsexuals and controls investigated b diffusion tensor imaging. J Neurosci 2014;34(46):15466-15475.

7 Maguire EA et al, Navigation-related structural change in the hippocampi of taxi drivers, PNAS 2000;97:4398- 4403.

8 Gu J, Kanai R. What contributes to individual differences in brain structure? Front Hum Neurosci 2014;8:262.

9 Sale A, Berardi N, Maffei L, Environment and Brain Plasticity: Towards an Endogenous Pharmacotherapy, Physiol Rev 2014; 94: 189 –234.

10 Reyes FI, Winter JS, Faiman C. Studies on human sexual development fetal gonadal and adrena sex steroids. J Clin Endocrinol Metab 1973; 37(1):74-78.

11 Lombardo M. Fetal testosterone influences sexually dimorphic gray matter in the human brain. J Neurosci 2012; 32:674-680.

12 Campano A. [ed]. Geneva Foundation for Medical Education and Research. Human Sexual Differentiation;2016Availableat:www.gfmer.ch/Books/Reproductive_health/Human_sexual_differentiation.html. Accessed May 11, 2016.

13 Lee PA et al, Consensus Statement on Management of Intersex Disorders, Pediatrics 2006; 118 e488-e500.

26. Behavior geneticists have known for decades that while genes and hormones influence behavior, they do not hard-wire a person to think, feel, or behave in a particular way. The science of epigenetics has established that genes are not analogous to rigid "blueprints" for behavior. Rather, humans "develop traits through the dynamic process of gene-environment interaction. ... [genes alone] don't determine who we are." [14]

27. Regarding transgenderism, twin studies of adults prove definitively that prenatal genetic and hormone influence is minimal. The largest twin study of transgender adults found that only 10 percent of identical twins were both transgender-identified.[15] Since identical twins contain 100 percent of the same DNA from conception and develop in exactly the same prenatal environment exposed to the same prenatal hormones, if genes and/or prenatal hormones contributed to a significant degree to transgenderism, the concordance rates would be close to 100 percent. Instead, 80 percent of identical twin pairs were discordant. This would indicate that at least 80 percent of what contributes to transgenderism as an adult in one co-twin consists of one or more non-shared post-natal experiences including but not limited to non-shared family experiences.

28. These findings also mean that persistent GD is due predominately to the impact of nonshared environmental influences. These studies provide compelling evidence that discordant gender is not hard-wired genetically.

Gender Dysphoria vs. Gender Identity Disorder

29. Up until the recent revision of the DSM-IV criteria, the American Psychological Association (APA) held that Gender Identity Disorder (GID) was the mental disorder described as a discordance between the natal sex and the gender identity of the patient.

30. Dr. Kenneth Zucker, who is a highly respected clinician and researcher from Toronto carried on evaluation and treatment of GID patients for forty years. His works, widely published, found that the vast majority of boys and girls with GID identify with their biological sex by the time they emerge from puberty to adulthood, through either watchful waiting or family and individual counseling.[17] His results were mirrored in studies from Europe.[18,19] When the DSM-V revision of the diagnosis of GID was proposed by the APA committee responsible for revision, Dr. Zucker insisted that there be a medical term to replace Gender Identity Disorder, removing gender discordance as a mental disorder apart from the presence of significant emotional distress. With this revision, Gender Dysphoria describes the mental anguish which is experienced by the gender discordant patient.

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14 Shenk, D. The Genius in All of Us: Why everything you've been told about genetics, talent, and IQ is wrong. (2010) New York, NY: Doubleday; p. 18.

15 Diamond, M. "Transsexuality Among Twins: identity concordance, transition, rearing, and orientation." International Journal of Transgenderism, 14(1), 24–38.

17 Zucker KJ, Gender Identity Disorder, in Rutter M, Taylor EA, editors. Child and Adolescent psychiatry, 4th ed, Malden Mass: Blackwell, 2006: 737-753.

18 Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. J AM Academy Child Adolescent Psychiatry 2008; 47:1413-1423.

19 Schechner T. Gender Identity Disorder: A Literature Review from a Developmental Perspective. *Isr J PsychiatryRelated Sci* 2010; 47:42-48.

31. The theory that societal rejection is the root cause of Gender dysphoria was validly questioned by a study from Sweden which showed that the dysphoria was not eliminated by hormones and sex reassignment surgery even with widespread societal acceptance.[20]

Treatment of Gender Dysphoria

32. The treatment of the child and adolescent with gender discordance and accompanying gender dysphoria should include an in-depth evaluation of the child and family dynamics. This provides a basis on which to proceed with psychologic therapy. The entire biologic and social family should be involved in psychological therapy designed to assist the patient, if at all possible, to align gender identity with natal sex. Psychological support by competent counselors with an intent of resolving the gender conflict should be provided as long as the patient continues to suffer emotionally. Given the high degree of eventual desistance of gender discordance/dysphoria by the end of puberty, it would be ethical and logical to counsel the patient and family to rear the child in conformity with natal sex.

33. Erikson described the stage of adolescence as "Identity versus Role Confusion" during which the teen works at developing a sense of self by testing roles then integrating them into a single identity.[21] This process is often unpleasant regardless of the presence or absence of gender identity conflicts. The major benefit of enduring puberty in a GD patient is that it provides a strong likelihood of alignment of his gender identity with his natal sex. There is no doubt that these patients need compassionate care to get them through their innate pubertal changes. Scientific evidence shows that 80%-95% of pre-pubertal children with GD will come to identify with their biological sex by late adolescence. Some will require lifelong supportive counseling, and others will not.[22]

Science vs. Pseudoscience

34. The advent of "centers of excellence" for gender-disordered patients[23] combined with sociologic agenda in academia has created the impression that there is scientific validity to gender discordance as a variation of normal. There has been a flurry of non-peer-reviewed articles in journals and newsletters circulated to general pediatricians that promote the ideology of transgenderism without scientific support.[24,25,26,27] Mainstream clinicians and scientists who consider gender discordance to be a mental disorder have been deliberately excluded in the makeup of the steering committees of academic and medical professional societies which are promulgating guidelines that were previously unheard of.

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20 Dhejne, Cecilia et al. Long-term Follow- up of transsexual Persons Undergoing Sex Reassignment Surgery:Cohort Study in Sweden *PLoS One* February 2011 Vol 6 Issue 2, e16885

21 Erikson, E. H. (1993). *Childhood and society*. WW Norton & Company. Erikson, E. H. (1993). *Childhood and society*. WW Norton & Company.

22 Zucker KJ, Gender Identity Disorder, in Rutter M, Taylor EA, editors. *Child and Adolescent psychiatry*, 4th ed, Malden Mass: Blackwell, 2006: 737-753.

23 Hsieh S and Leninger J, Resource List: Clinical Care Programs for Gender-Nonconforming Children and Adolescents, *Pediatr Ann* 2014:43:238-244.

24 Prager, LM, A boy who wants to be a girl, *Contemporary Pediatrics 2008*; 25:56-58.

25 Garafolo R Tipping points in caring for the gender-non-conforming child and adolescent, *Pediatr Ann* 2014;43:227-229.

26 Steever J, Cross-gender Hormone therapy in adolescents, *Pediatr Ann* 2014;43: e-138-e-144.

27 Simons LK et al, Understanding gender variance in Children and Adolescents, *Pediatr Ann*2014;43:e-126-e131.

35. The Endocrine Society published such a document in 2009.[28] Its recommendations promoted the use of psychological evaluation, counseling, blocking of pubertal maturation at the onset of puberty, the subsequent use of cross- sex hormones, and possible surgical intervention at the age of consent. Of the 22 recommendations contained in the document, only three were supported by scientific proof. These three warned of potential adverse effects of hormonal manipulation. The remaining 19 recommendations were nearly evenly split into a group that was based on very limited scientific evidence and a group that was based on no scientific evidence at all. The response to these guidelines was a burgeoning of Gender Identity Clinics in the United States from three to over forty-five in a period of seven years. Subsequently, the Endocrine Society revised the guidelines and the modifications were more permissive with the younger ages at which cross-sex hormones and surgical treatment could be recommended. They did add a concern that counseling regarding induced infertility should be included.[29]

The Pediatric Endocrine Society created their own guidelines[30] as did the American Academy of Pediatrics.[31] Each of these subsequent guidelines were more lenient and the AAP actually suggested that initial evaluation for undercurrent psychological issues be abandoned altogether.

36. WPATH is an agenda-driven advocacy organization whose membership consists of anyone who has an interest in the transgender social and political agenda. There are no requirements for specialty training or certification. Its guidelines and standards of care are not scientifically supported.

37. WPATH promotes "expert witnesses" and provides them with a bibliography replete with self-confirming references to opinion pieces and anecdotal case reports along with clinical case reviews with inherent selection bias.

38. WPATH's "peer-reviewed" journal is not reviewed by anyone with an opinion that is not in keeping with the philosophy of the organization itself.

39. I reviewed the legal complaint filed on behalf of the plaintiff, Gavin Grimm as well as the deposition of Gavin Grimm and the declaration by expert witness, Dr. Melinda Penn. I direct my strongest criticism at the information that was presented to support the affirmation of the gender incongruence through counseling, medical and surgical intervention. Statements were made that such action is clearly the only scientifically valid way to proceed, when the breadth of medical literature does not support this concept.

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28 Hembree WC et al, Endocrine Treatment of Transsexual Persons: and Endocrine Society Clinical PracticeGuideline, *J Clin Endo Metab*2009; 94:3132-3154.

29. Hembree WC et al, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: an Endocrine Society Clinical Practice Guideline, J Clin Endo Metab 2017 ;102:3869-3903.

30. https//www.pedsendo.org.../TG_SIG_%20Statement_10_220_16.pdf

31. Rafferty J, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, Pediatrics 2018;142:320182161

40. There are no scientifically validated gender incongruence training programs at universities in the United States. Under the guise of compassion for the bullied, endocrinologists are promoting chemical treatment that forever creates medical suffering, introducing complications such as sterility, increased stroke and cancer risk all to supposedly save the gender-incongruent person from taking his/her life to end the suffering imposed upon them by society. The suicide risk is hyper-inflated to as high as 50% when in reality it is actually 5%, as reported by the Williams Institute.[32] The mantra of "insistent, persistent and consistent" as a means to diagnose the entity of gender incongruence is not scientifically supported. The Nuremburg Guidelines are an established framework that have been overlooked by WPATH, the Endocrine Society, the Pediatric Endocrine Society and the American Academy of Pediatrics.

41. The requirement that society at large, and school systems in particular, should grant special regulatory privileges to a gender-incongruent person which is intended to further a student's belief that they are born into the body of the wrong sex is an endorsement of a form of medical "treatment" which has no scientific basis. Allowing a biologic female to use a male-designated bathroom facility is one of several "gender affirming" care options, but it is creating harm to at least two parties. The harm to the gender incongruent person is that it promotes a pathway to inevitable long-term medical and psychological morbidity. The premise of gender affirming care can be managed through other methods without requiring school systems to permit transgender students to use the restroom associated with their new gender identity. The second party harmed is the student without gender incongruence who must suffer emotionally while being told they must tolerate the presence of an opposite sex individual in a sexually segregated space and embrace the regulation which gives the gender incongruent person special privileges as if they were based on a civil right founded on immutable biology.

Quentin L. Van Meter, M.D.
Pediatric Endocrinologist

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32. Wilson BDM et al, Characteristics and Mental Health of Gender Nonconforming Adolescents in California, Health Policy Fact Sheet, The Williams Institute UCLA School of Law December 2017

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updated 7 January 2019

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PERSONAL

Home Address:	1080 Peachtree St. NE #3507, Atlanta, GA 30309
Home Phone:	(404) 963-5618
Date of Birth:	September 13, 1947
Place of Birth:	Laramie, Wyoming
Citizenship:	USA

EDUCATION:

Undergraduate:	College of William & Mary, 1969 B.S. – 1969
Medical School:	Medical College of Virginia, 1973 M.D. – 1973

CLINICAL TRAINING:

Institution:	The University of California, San Francisco
Hospital:	Naval Regional Medical Center, Oakland
Position:	Pediatric Intern – 1973 – 1974 Pediatric Resident – 1974 – 1976
Institution:	Johns Hopkins University
Hospital:	Johns Hopkins Hospital
Position:	Fellow, Pediatric Endocrinology 1978 – 1980 Fellowship Program Director: Claude Migeon, M.D.
Current Position:	Pediatric Endocrinologist Van Meter Pediatric Endocrinology, P.C. 1800 Howell Mill Road, Suite 475 Atlanta, Georgia 30318

PROFESSIONAL CERTIFICATION & SOCIETIES:

Diplomate, National Board of Medical Examiners, 1974

American Board of Pediatrics, certified in general pediatrics, 1978, sub-board certified in Pediatric Endocrinology, 1983

EXHIBIT
A

Fellow:	American Academy of Pediatrics, Georgia Chapter 1975 -present President, Uniformed Services West Chapter, 1987 – 1990 District VIII member, AAP Committee on Awards for Excellence in Research, 1990-1994 Editor, The Georgia Pediatrician, 1994 – 1998
	Chairman, Georgia Chapter Legislative Committee, 1996 – 2006
Fellow:	The American College of Pediatricians, 2007 – present Member of the Board of Directors, 2008- present Vice President/President, 2015-present
Member:	Pediatric Endocrine Society, 1989 – present
Member:	American Diabetes Association Professional Section, 1988 – present
Member:	Endocrine Society, 1994-present
Member:	Southern Pediatric Endocrine Society, 1992 – Present
Member:	American Association of Clinical Endocrinologists, 2005 – present
Licensure:	Georgia, #34734

FACULTY POSITIONS:

Institution:	Morehouse School of Medicine
Position:	Associate Clinical Professor, Pediatrics, 2004 – present
Institution:	Emory University School of Medicine
Position:	Associate Clinical Professor, Pediatrics, 1991 – present
Institution:	University of California, San Francisco
Position:	Associate Clinical Professor, Pediatrics, 1989 – 1991
Institution:	University of California, San Diego, School of Medicine
Position:	Assistant Clinical Professor, Pediatrics, 1980 – 1986
Institution:	LSU School of Medicine, Clinical Instructor, Pediatrics, 1977 – 1978

MILITARY SERVICE:

Commission:	Medical Corps, United States Navy, August 1971
Rank:	Captain, retired
Duty Stations:	Health Professional Scholarship Student, 1971 – 1974
	Intern and Resident, Pediatrics, Naval Regional Medical Center, Oakland, 1973 – 1976
	Staff Pediatrician, Naval Regional Medical Center, Oakland, 1976

Staff Pediatrician, Naval Regional Medical Center,
New Orleans, 1976 – 1978

Full time out-service fellow in Pediatric Endocrinology,
Johns Hopkins Hospital, 1978 – 1980

Staff Pediatric Endocrinologist, Naval Hospital San Diego,
1980 – 1986

Chairman and Director, Residency Training, Department of Pediatrics
Naval Hospital Oakland, 1986 – 1991

OTHER PROFESSIONAL ACTIVITIES:

Consultant, Pediatric Endocrinology,
Nellis Air Force Base Hospital, Las Vegas, Nevada
1981 – 1991

Consultant, Pediatric Endocrinology,
Naval Hospital Lemoore, CA
1986 – 1991

Consultant, Pediatric Endocrinology,
Letterman Army Medical Center, Presidio of San Francisco, CA
1990 – 1991

Consulting Endocrinologist,
Columbus Regional Medical Center, Columbus, GA
1991 – 1994

Pediatrician and Pediatric Endocrinologist, partner
Fayette Medical Clinic
Peachtree City, Georgia 30269
September 1991 – October 2003

Pediatric Endocrinologist Peer Reviewer 2006 – present
MCMC, LLC, Boston, MA
IMEDECS, Lansdale PA

Speaker's Bureau
Novo Nordisk, Pfizer, Endo, Abbvie
AAP Eqipp course on Growth- development committee- 2012

PUBLICATIONS: (Articles in Peer Reviewed Journals)

Riddick, JR, Flora R., Van Meter, QL:
"Computerized Preparation of Two-Way Analysis of Variance Control Charts for Clinical Chemistry," Clinical Chemistry, 18:250, March 1972.

Van Meter, QL, Gareis FJ, Hayes, JW, Wilson, CB:
"Galactorrhea in a 12 Year Old Boy with Chromophobe Adenoma," J. Pediatrics 90:756, May 1977.

Plotnick, LP, Van Meter, QL, Kowarski, AA, "Human Growth Hormone Treatment of Children with Growth Failure and Normal Growth Hormone Levels by Immunoassay: Lack of Correlation with Somatomedin Generation: Pediatrics 71:324, March 1983.

Brawley, RW, Van Meter, QL, "Mebendazole Ascaris Migration," W.J. Med, 145:514015, October 1986.

Van Meter, QL, "The Role of the Primary Care Physician in Caring for Patients with Type-1 Diabetes," Comp Ther 1998; 24(2):93–101

Midyett LK, Rogol AD, Van Meter QL, Frane J, and Bright GM, "Recombinant Insulin-Like Growth factor (IGF)-I Treatment in Short Children with Low IGF-I Levels: First-Year Results from a Randomized Clinical Trial," J Clin Endocrinol Metab, 2010;95:611–619.

ABSTRACTS:

Van Meter,Q L, & Lee, PA: "Evaluation of Puberty in Male and Female Patients with Noonan Syndrome," Pediatric Research 14:485, 1980.

Van Meter, QL, et al: "Characterization of Pituitary Function in Double Bolus GnRH Infusion as a Diagnostic Tool," Pediatric Research 32:111, 1984.

Van Meter, QL, Felix, SD, Lin, FL: "Evaluation of the Pituitary-Adrenal Axis in Patients Treated with nasal Beclomethasone," (Presented at the 1991 Annual Meeting of the Endocrine Society and the 6th Annual Naval Academic Research Competition, Bethesda, MD, 17 May, 1991).

Rogol AD Midyett LK Van Meter Q, Frane J, Baily J, and Bright GM, Recombinant Human IGF-1 for Children with Primary IGF-1 Deficiency (IGFD): Safety Data from Ongoing Clinical Trials (presented at the PAS 2007, Toronto).

Van Meter Q, Midyett LK, Deeb L et al, Prevalence of primary IGFD among untreated children with short stature in a prospective, multicenter study (Poster POO715) ICE Rio de Janeiro, Brazil 2008.

G.M. Bright[1], W.V.Moore[2], J.Nguyen[3], G. Kletter[4], B. S. Miller[5], Q. L. Van Meter[6], E. Humphriss[1], J.A. Moore[7] and J.L. Cleland[1] Results of a Phase 1b Study of a new long-acting human growth hormone (VRS-317) in pediatric growth hormone deficiency (PGHD). PAS 2014 May 2014

Van Meter Q, Welstead B and Low J, Characteristics of a Population of Obese Children and Adolescents: Suggesting a New Paradigm, presented at ESPE meeting, Dublin 2014.

Wayne V. Moore[1], Patricia Y. Fechner[2], Huong Jil Nguyen[3], Quentin L. Van Meter[4], John S. Fuqua[5] , Bradley S. Miller[6], David Ng[7], Eric Humphriss[8], R. W. Charlton[8], George M. Bright[8], Safety and Efficacy of Somavaratan (VRS-317), a Long-Acting rhGH, in Children with Growth Hormone Deficiency (GHD): 3-Year Update of the VERTICAL & VISTA Trials, presented at the 2017 Endocrine Society meeting in Orlando FL

Bradley S. Miller[1], Wayne V. Moore[2], Patricia Y. Fechner[3], Huong Jil Nguyen[4], Quentin L. Van Meter[5], John S. Fuqua[6], David Ng[7], Eric Humphriss[8], R. W. Charlton[8], George M. Bright[8], 3-Year Update of the Phase 2a and Long-term Safety Studies (VERTICAL and VISTA) of Somavaratan (VRS-317), a Long-acting rhGH for the Treatment of Pediatric Growth Hormone Deficiency, presented at the 2017 IMPE meeting in Washington D.C.

Laidlaw MK, Van Meter QL, Hruz PW, Von Mol A, and Malone WJ, Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," J CLin Endo Metab 2019;104: 1-2.

ADDITIONAL PRESENTATIONS/LECTURES:

Pediatrics Update, CME Associates, San Diego – Orlando Annual Conferences: Lectures on Pediatric Endocrine Subjects – 1986 – 2001. Course Moderator, 1997, 1998, 1999, 2000, 2001

Endocrine and Gastroenterology Update, CME Associates, Maui HI Nov 2001, Lecturer and Course Moderator

Lecture on Panhypopitutarism, Pharmacia Conference, Nashville TN April 2002.

Family Medicine Review Course, Orlando, FL, 1992 – 2001

Pediatric Grand Rounds, Tanner Medical Center, October 1997

Pediatric Grand Rounds, Hughes Spaulding Children's Hospital, September, 2003

Pediatrics in the Park, Fall CME meeting for the Georgia Chapter of the American Academy of Pediatrics, November 2003

Pediatric Grand Rounds, Columbus Regional Medical Center, January 2004

Frontiers in Pediatrics CME Course, sponsored by the Atlanta Children's Health Network, Atlanta, March 2004.

Pediatric Grand Rounds, Eggleston Children's Hospital, May 2004.

Sue Schley Matthews Pediatric Conference, Columbus Regional Medical Center, September 2004

56th Annual Scientific Assembly and Exhibition of the Georgia Academy of Family Physicians, Nov 2004

Program Co-Chairman: Southern Pediatric Endocrine Society Annual meeting, Nov 2004, November 2014

Presentations on Diabetes, Growth Failure, and Thyroid Disease to the Postgraduate Pediatric Nurse Practitioner Program, Georgia State University, Nov 2005, June 2006, May 2007

Issues in Medicine, US Medical Congress Conference and Exhibition, Las Vegas, meeting planner and speaker, June, 2006

CME Presentations for the Georgia Chapter of the American Academy of Pediatrics Spring and Fall Meetings 2004-present

Pediatric Grand Rounds, Columbus Regional Medical Center, Columbus, GA, 2011-present

Human Growth Foundation Regional CME Conference, Atlanta GA March 2013, February 2014 Columbus Georgia

International Federation of Therapeutic Counseling Choice: Transgender Medicine, IFTCC Launch, October 15, 2018 London, Third International Congress, October 25 2018 Budapest.

Audio Digest Pediatrics - ① v. 41, no. 4; ② v. 41, no. 20; ③ v. 43, no. 17

Audio Digest Family Practice - ① v. 42, no. 5; ② v. 44, no. 11; ③ v. 44, no. 44; ④ v. 45, no 15

Audio Digest Otolaryngology - ① v. 32, no. 14

CURRENT HOSPITAL APPOINTMENTS:

Eggleston/Scottish Rite Children's Hospitals, active staff, Pediatric Endocrinology

PAST AND CURRENT CLINICAL RESEARCH:

2006	Sanofi-Aventis HMR1964D/3001	study completed 2007
2006	Tercica MS301-	study completed 2008
2007	Tercica MS310-	study completed 2008
2007	Tercica MS306-	study completed 2010
2007	Tercica MS316-	study completed 2012
2008	EMD Serono 28358	study completed 2009
2012	Versartis 12VR2	study completed 2014
2012	Debiopharm 8206-CPP-301	study started July 2012
2013	Versartis 13 VR3	study started Dec 2013
2014	Novo-Nordisk Elipse	study started 2014
2015	Versartis 14 VR4	study completed 2017
2017	Mannkind MKC-TI-155	study started 2017

LEGAL EXPERT WITNESS:

2017 North Carolina Legislature- transgender bathroom bill
2018 Jessica Siefert transgender case, Cincinnati, OH
2018 Alberta, Canada school system transgender case
2018 Decatur GA School Board transgender case

Customary charges for medical legal review, deposition and court testimony for
Quentin L. Van Meter, M.D.

Retainer- $1500

Record review- $350/h

Deposition and Testimony- $450/h

If testimony requires travel, lodging, and meals- reimbursement for full receipted cost

If testimony requires days away from the medical practice, flat fee of $3500 per day involved.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, Plaintiff, v. GLOUCESTER COUNTY SCHOOL BOARD, Defendant.	)	Civil No. 4:15-cv-00054-AWA-RJK

REBUTTAL EXPERT REPORT AND DECLARATION OF DR. MELINDA PENN, M.D.

1. I, Melinda Penn, M.D., have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have reviewed the expert disclosure report of Dr. Quentin Van Meter dated February 26, 2019, submitted by Defendant in the above-captioned matter.

3. I submit this rebuttal expert report and declaration in response.

REBUTTAL OPINIONS

4. As discussed in my initial expert declaration and report, I provide treatment to transgender adolescents in accordance with the World Professional Association for Transgender Health ("WPATH") Standards of Care and the Endocrine Society's Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons. The American Academy of Pediatrics recognizes that these reflect the accepted standards of care for the treatment of children and adolescents suffering from gender dysphoria.

5. Pediatricians and endocrinologists rely on the American Academy of Pediatrics and the Endocrine Society for guidance on the prevailing standards of care for practicing physicians. The AAP and the Pediatric Endocrine Society are highly regarded and respected medical societies. AAP is the largest organization of pediatric physicians in the United States, and is dedicated to promoting the physical, mental, and social health and well-being of children and adolescents.

6. Dr. Van Meter is the President of the Board of Directors of the American College of Pediatricians. Although that organization has an official-sounding name, it is a small, fringe organization with policy positions and medical recommendations that contradict the recommendations of the American Academy of Pediatrics and other mainstream medical organizations.

7. I first learned about the American College of Pediatricians in the last few years following their issuance of position statements against LGBT parenting, vaccination against the HPV virus, and affirming treatment of LGBT youth. These positions stand in stark contrast to the positions of the AAP and the major medical organizations in the United States, and often cause confusion among the public because of the official-sounding name about what are the accepted standards of care or prevailing views of the medical community.

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

Dated: 3/11/2019

Melinda Penn, M.D.

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Transcript of Nathan Collins

Date: September 21, 2018
Case: Grimm- v- Gloucester County School Board

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA

- x
GAVIN GRIMM :
Plaintiff : CASE NO.
v. : 4:15-CV-54
GLOUCESTER COUNTY SCHOOL BOARD :
Defendant :
- x

Deposition of NATHAN COLLINS
Glen Allen
Friday, September 21, 2018
9:32 a.m.

Job No.: 207622
Pages 1 - 177
Reported by: Lisa M. Blair, RMR

Deposition of NATHAN COLLINS, held at the offices of:

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4951 Lake Brook Drive
Suite 100
Glen Allen, Virginia 23060

Pursuant to agreement, before Lisa M. Blair, Notary Public in and for the Commonwealth of Virginia.

A P P E A R A N C E S

ON BEHALF OF PLAINTIFF:
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ALSO PRESENT:
Eden Heilman
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By Mr. Block 7

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P R O C E E D I N G S

Whereupon,

NATHAN COLLINS,

being first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE PLAINTIFF

BY MR. BLOCK:

Q. Good morning, Mr. Collins.

A. Good morning.

Q. My name is Josh Block. I'll be taking your deposition. I represent Gavin Grimm in the lawsuit against Gloucester County Public Schools.

Have you ever had your deposition taken before?

A. I have not.

Q. Great. First time. So a couple of ground rules for the deposition. The first is we have a court reporter who is writing down everything that we say. And it's important that

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all your answers, therefore, be oral and not just with head nods or saying uh-huh; does that sound okay to you?

A. Yes, it does.

Q. Great. Perfect. The second is that it's my job to ask questions in a way that you can understand. So if I say anything that's unclear, can I count on you to let me know, and I'll rephrase the question?

A. Absolutely.

Q. And if you answer the question, I'll assume that means you understand it; is that fair?

A. Yes, correct, fair.

Q. And then the third is that since the court reporter is writing down a dialogue, we have to be careful about not talking over each other. So I'll make sure to let you complete your answer before I say something, and you'll make sure for me to complete my question before answering?

A. Of course.

Q. Great. Okay. Let's get started. Could you say your name for the record?

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A. Thomas Nathan Collins.
Q. And what is your current job?
A. I am currently the principal of Robert E. Lee High School in Staunton, Virginia.
Q. And what job did you have immediately before that?
A. I was principal of Gloucester High School in Gloucester, Virginia.
Q. So the first exhibit I have here -- have you seen this document before?
A. I have, yes.
Q. What is it?
A. This was the press release issued by Staunton City Schools when I was named principal of Robert E. Lee High School.
MR. BLOCK: Great. I'll ask the court reporter to mark it as Exhibit 1.
(Collins Exhibit Number 1 was marked for identification)
Q. I'd just like to review some biographical information with you, okay?
A. Yes.

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Q. So it says here that you began your career as a U.S. and world history teacher at Buffalo Gap High School, right?
A. That's correct.
Q. And you were there for four years?
A. That's correct.
Q. Do you remember the dates?
A. 1997, so August of -- July of 1997 through June of 2001.
Q. And after that you were an assistant principal and principal at Stuarts Draft High School?
A. That's correct.
Q. How long were you an assistant principal?
A. Four years.
Q. What dates were those?
A. Let's see. July of 2001 -- well, four and-a-half years, July of 2001 until January of 2006.
Q. And how long were you principal?
A. Two years.

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Q. And that was from 2006 to 2008?
A. That's correct.
Q. And then you worked at New Kent County Public Schools as director of secondary instruction and executive director of curriculum and instruction?
A. That's correct.
Q. How long were you director of secondary instruction?
A. I don't recall when my position changed. I can't remember when I was promoted.
Q. Okay. So --
A. Approximately three years, I believe.
Q. Great. Which means -- I'm sorry, I'm not getting my math very good today -- how long were you executive director of curriculum and instruction?
A. Sorry, approximately four years.
Q. Okay. Great. So at any of the schools you worked at before Gloucester, were there any policies or practices regarding transgender students?

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A. Not that I recall specifically.
Q. Okay. Do you recall whether there were any out transgender students at any of those schools before Gloucester?
A. Yes.
Q. What schools?
A. At Stuarts Draft High School, I recall.
Q. And how many?
A. At least one.
Q. And to the best of your knowledge, did anyone -- did any transgender student there make a request to use a restroom or locker room that was different from their sex assigned at birth?
A. Not to my knowledge.
Q. Do you know whether that student used a single user restroom at all?
A. I don't know.
Q. You have no knowledge about what type of restroom the student used?
A. None.

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Q. And at any of your other schools do you have any knowledge about what types of restrooms students used?

MR. CORRIGAN: Object to the form. Go ahead.

BY MR. BLOCK:

Q. So at any of the schools -- at Buffalo Gap High School, Stuarts Draft High School, New Kent County Public Schools, do you have any knowledge of which restrooms transgender students in those schools used?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: Not specifically.

BY MR. BLOCK:

Q. Do you have generally?

A. No.

Q. So when you interviewed for your current position as principal of Robert E. Lee High School, did they ask you any questions about Gavin's case?

A. In the interview process?

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Q. Yes.

A. No.

Q. How about outside of the interview process?

A. No.

Q. In any context did they ask you questions about Gavin's case?

A. No.

Q. Did they -- did they ask you any questions about Gloucester's restroom policy for transgender students?

A. Not that I recall.

Q. Does Robert E. Lee High School have any policies or practices regarding transgender students?

A. None specifically.

Q. Do they have generally any policies or practices?

A. I'd have to refer to the division policy manual.

Q. Are you aware whether there are any transgender students attending Robert E. Lee High School?

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A. Yes, I believe there are.

Q. And do you know what restrooms those students use?

A. I do not.

Q. Is it possible that any of those students use restrooms consistent with their gender identity?

MR. CORRIGAN: Object to the form of the question. Go ahead.

THE WITNESS: It's possible.

BY MR. BLOCK:

Q. So you don't know either way whether they use restrooms consistent with their gender identity or some other restroom?

A. Correct.

Q. Have you ever spoken with anyone in the administration of Staunton City Schools about what to do if a student requested to use restrooms consistent with their gender identity?

A. I have not.

Q. At Robert E. Lee High School, are

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there any transgender students participating on sports teams?

A. I don't know.

Q. So going to your educational background on this press release, you had your undergrad education at William & Mary; is that right?

A. That's correct.

Q. And then a master's in K through 12 education from UVA?

A. Educational administration, correct.

Q. And you're currently pursuing a doctoral degree?

A. That's correct.

Q. What's that doctoral degree in?

A. Educational leadership.

Q. Now, while earning any of your degrees in education, did you ever learn about the treatment of transgender students as part of your coursework?

A. I don't recall specifically.

Q. In your current doctoral degree

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program, are you learning at all about treatment of transgender students?
A. I don't recall specifically.
Q. Have you ever received any trainings or continuing education about transgender students?
A. I don't believe so.
Q. Have you ever reached out to any professional organizations for technical assistance regarding transgender students?
MR. CORRIGAN: Object to the form of the question.
THE WITNESS: Could you tell me what you mean by technical assistance?
BY MR. BLOCK:
Q. Yeah, sure. Have you ever spoken with any professional organizations in general about the treatment of transgender students?
MR. CORRIGAN: Object to the form of the question.
THE WITNESS: Spoken to directly personally? I can't say that I have.

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BY MR. BLOCK:
Q. How about indirectly?
A. I would say beyond school counseling staff, perhaps a school psychologist, no.
Q. Are you familiar with the National Association of Secondary School Principals?
A. Yes, I am.
Q. How are you familiar with it?
A. I'm a member of the Virginia Association of Secondary School Principals.
Q. And they are an affiliate of the National Association of Secondary School Principals?
A. That's correct.
Q. And why are you a member?
MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: It's generally-accepted practice for my profession.
BY MR. BLOCK:
Q. To be a member of that organization?
A. To be a member, correct.

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Q. And is it an organization whose recommendations principals generally rely upon?
A. I can't say I necessarily do know.
Q. Why is it a generally-accepted practice to be a member of the organization?
A. Opportunities for professional development, opportunities for professional networking.
Q. Would you say it's a mainstream organization?
MR. CORRIGAN: Object to the form.
THE WITNESS: I can't answer that.
BY MR. BLOCK:
Q. And you subscribe to their newsletters; is that right?
A. I do.
Q. And are they a source that a principal would generally consult for guidance?
MR. CORRIGAN: Object to the form.
THE WITNESS: I can't speak for other principals. I occasionally read them for guidance.

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BY MR. BLOCK:
Q. And have you ever read their guidance regarding treatment of transgender students?
A. I believe I have.
Q. And when do you think you read it?
A. I can't recall.
Q. And have you ever spoken with any representative of the organization regarding transgender students?
A. Not that I recall.
Q. Or have you ever communicated in any form like e-mail or otherwise?
A. Regarding?
Q. Regarding transgender students?
A. No, not that I recall.
Q. Okay. So on the -- turn to the second page of Exhibit A. The last sentence of the first paragraph it says, "Collins has also demonstrated a commitment to cultivating a welcoming environment for all students, facilitating the formation of clubs and organizations for students of diverse

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backgrounds." Did I read that right?
A. I'm trying to find what you just read. Yes, you did.
Q. Great. What does -- what does cultivating a welcoming environment for all students mean?
MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: I didn't write this, so I can't speak to the writer's thoughts.
BY MR. BLOCK:
Q. Did you review it before it went out?
A. I did, uh-huh.
Q. Okay. So when you read it, you didn't object to it, right?
A. That's correct, no, I didn't.
Q. So what did you understand the term to mean when you read it?
A. I think generally speaking a commitment to developing a positive school climate, being welcoming and open to parents, being a strong communicator, offering

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opportunities for students within the school to explore their interests, and provide support for students as they need it.
Q. Do you think it's important as a principal to cultivate a welcoming environment for all students?
A. Absolutely.
Q. And why is that?
A. I think fundamentally students learn best when they feel safe and secure and comfortable in their environment.
Q. And does having a welcoming environment also have positive benefits for other students who are not members of a minority group?
MR. CORRIGAN: Object to the form.
THE WITNESS: I believe it has benefits for all students.
BY MR. BLOCK:
Q. What types of benefits?
A. Again, safety, security, comfort. I believe that it helps students develop connections within the school community. It helps them better

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understand students of different backgrounds.
Q. And that's an important part of the educational process, right?
MR. CORRIGAN: Object to the form.
THE WITNESS: I think it's generally accepted that that's correct, yes.
BY MR. BLOCK:
Q. You can put this one aside. I'm showing you a document marked at GCSB 04122. Do you recognize this document?
A. May I have a second to read it?
Q. Sure.
A. (Witness reviewing document). Yes, I do recognize it.
Q. What is it?
A. This is a memo that I prepared for my superintendent at the time, Dr. Walter Clemons, in October of 2014 providing background information regarding a student at my school.
MR. BLOCK: I'll have the court reporter mark it as Exhibit 2.

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(Collins Exhibit Number 2 was marked for identification)
Q. When was the first time you personally heard about Gavin Grimm?
A. In late August or September of 2014, sometime around the beginning of that school year.
Q. How did he come to your attention?
A. One of my school counselors told me about him.
Q. And was that Tiffany Durr?
A. I believe it was, yes.
Q. And what did she say?
A. Ms. Durr told me that we had a student who was transitioning from female to male, and that the family had provided some information to her regarding that transition.
Q. And did she say anything else?
A. I believe when Ms. Durr initially discussed Gavin with me, we discussed his desire to be referred to with male pronouns. I believe we discussed a plan for him to use an alternative restroom at Gloucester High School.

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Q. And at the time that she came to you, had you had any experience dealing with transgender students at all?
A. In what way?
Q. As a principal or as -- I'll take that back.
Had you had any experience in any of your roles as an educator or administrator over the course of your career at the time that she came to you?
A. In doing what?
Q. In working with transgender students?
A. Other than having transgender students in the schools I served, not directly.
Q. Were you familiar with the phenomenon of transgender students wanting to be referred to by their pronouns consistent with their gender identity?
A. Yes, I was.
MR. CORRIGAN: Object to the form. Go ahead.
BY MR. BLOCK:

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Q. In other schools in which you worked where transgender students attended, do you know if those students were referred to by pronouns consistent with their gender identity?
A. I can't recall.
Q. Do you know if you personally ever referred to a transgender student with pronouns consistent with their gender identity?
A. Prior to Gavin, I can't recall.
Q. So when Ms. Durr came to you, did she request your approval, or sign off on any of the accommodations being made for Gavin?
A. She wanted to know if I agreed with the plan she and Gavin had developed.
Q. So just to clarify, she and Gavin developed it together first, and then she presented it to you?
A. To my knowledge, yes, that's correct.
Q. And when she presented it to you, did she give any further explanation for why she thought this was an appropriate plan?
A. In the initial conversation I had with her, I believe -- I can't recall. Sorry.
Q. And so what did you say in response?
A. I agreed with the plan that they -- she presented to me.
Q. And did you consult with anyone else before telling her that you agreed with it?
A. At that time I talked with our director of school counseling, but beyond that, no.
Q. And the director of school counseling is Matt Lord?
A. Correct.
Q. And what did you say to him?
A. I can't recall specifically. We had a conversation about it.
Q. And he agreed with it as well?
A. Yes.
Q. Did you talk with anyone from the superintendent's office?
A. At that time I don't believe I did.
Q. So is -- as part of referring to him consistently with his new name, were you aware

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that he had had a formal name change at the time?
A. I believe I was made aware at that time, yes.
Q. And was part of the plan developed by Ms. Durr that his name would be changed in school records?
A. I believe at the time I talked with Ms. Durr, that had already occurred.
Q. What's the process for that occurring?
MR. CORRIGAN: Object to the form.
THE WITNESS: I can't say that I know that. That was a function more of school counseling staff and the student services office.
BY MR. BLOCK:
Q. Did Ms. Durr tell you whether Gavin made any requests about restroom use?
A. I believe Ms. Durr -- I can't recall if Gavin made a request. I recall Ms. Durr telling me that the plan that was developed was agreeable to Gavin.

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Q. Okay. So all your knowledge at this point about Gavin was based on what Ms. Durr relayed to you; is that right?
A. That's correct.
Q. Who is Stephanie Vermeire? Is that her name?
A. She was an assistant principal at Gloucester High School.
Q. Is she no longer there?
MR. CORRIGAN: For me and the court reporter, spell it, if you have it.
MR. BLOCK: V-E-R-M-E-I-R-E; is that the right spelling?
MR. CORRIGAN: I-E or E-I?
MR. BLOCK: E-I-R-E.
THE WITNESS: I think it was V-E-R-M-E-I-R-E.
BY MR. BLOCK:
Q. Do you recognize this document?
A. I don't recall this, no.
Q. Okay. But at the top is that Ms. Vermeire's e-mail address?

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A. It looks like it was her address, yes.
Q. And at the "to" line it looks like your address?
A. That's correct.
MR. BLOCK: I'm going to mark this, please, as Exhibit 3.
(Collins Exhibit Number 3 was marked for identification)
Q. And so I'll tell you what this appears to be to me, and you can tell me if it appears to be that to you, too. This appears to me to be an e-mail chain that Ms. Vermeire forwarded to you on April 2nd, 2015; is that right?
A. I would agree that's what it seems to be.
Q. It appears to be that in the e-mail chain she is exchanging e-mails with Ms. Durr on August 18th and August 19th; is that right?
A. Yes, I would agree with that.
Q. Of 2014?

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A. 2014, uh-huh.
Q. So my question is: Do you know if -- well, do you know what role Ms. Vermeire had in developing this plan for Gavin during this time period?
A. No, I don't.
Q. Okay. And do you know if she talked with Gavin at all?
A. No, I don't.
Q. And do you remember discussing the issue with her at all?
A. Gavin?
Q. Yes.
A. At this time?
Q. Yes.
A. I don't recall discussing it at this time, no. I had just begun at Gloucester High School in July of 2014. So no, I don't recall that.
Q. So can we go to the third big paragraph of Exhibit 2, which is your memo to Dr. Clemons?

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A. Okay.
Q. Actually, the fourth paragraph. So the first line of the fourth paragraph it says, "At the beginning of the school year, a plan was put in place to accommodate the student's bathroom use concerns. An administrative decision was made and the student was informed by his school counselor he may use the bathroom in the school clinic. In the case of an emergency the student was given permission to use the staff bathroom on the D wing of the school, in which the majority of his classes are located." Did I read that right?
A. Yes, you did.
Q. Okay. Great. I'm going to show you now another document for purposes of asking some questions.
A. Sure.
Q. Do you recognize that document?
A. I do, yes.
Q. And what is it?
A. This is a map of the floor plan of Gloucester High School, and it's labeled

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2009-2010.

Q. But does it accurately reflect what the map looked like during this time period, too?

A. It does, yes.

MR. BLOCK: Okay. If the court reporter could please mark it as Exhibit 4.

(Collins Exhibit Number 4 was marked for identification)

Q. Now, the D wing of the school, is that the rectangle at the top of the map marked as D-Hall?

A. That's correct, yes.

Q. And the staff faculty restroom that Gavin could use in cases of emergency, is that the little tiny yellow dot between D-2 and D-4?

A. That's correct, yes.

Q. And do you know what the capacity is in that staff restroom?

A. Those were single user restrooms. I believe there are more than one, but I cannot recall how many there may have been.

Q. Let me show you yet another document.

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Have you seen this document before?

A. I don't recall seeing this, no.

Q. This is a document, for the record, marked GCSB 03942. And if you turn to the third page of the document, there is a heading that says, "Gloucester High;" is that correct?

A. That's correct.

Q. And this appears to me to be a list of the different restrooms in Gloucester High School and a brief description of those restrooms; is that right?

A. I would agree.

MR. BLOCK: Let's mark this as Exhibit 5.

(Collins Exhibit Number 5 was marked for identification)

Q. And so if you go down, it has two entries that say D-Hall, one for boys and one for girls; is that right?

A. Correct, yes.

Q. And then it says teacher's lounge men and teacher's lounge women. Is this -- is this

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yellow square that we had talked about before between D-2 and D-4, is that the teacher's lounge?

A. D-2 would have been considered the teacher's lounge or teacher's workroom, yes.

Q. Got it. So it looks like -- so in there, there was -- you say there was two -- so based on this, it appears that there's two single user restrooms available in the teacher's lounge; is that accurate?

A. I didn't produce this document, but I would read it that way, yes.

Q. Okay. Great. And so these are the ones that Gavin was able to use in the event of an emergency?

A. Yes.

Q. And what type of emergency were you referring to in the memo?

A. In case he needed to go to the restroom more immediately, and could not go to the other restroom in the clinic.

Q. And the clinic, is that the blue rectangle that's marked as nurse's office on the

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map?

A. That's correct, yes.

Q. Do you know how many feet away the D-Hall is from the clinic?

A. No, I don't.

Q. Now, you say that most of his classes are on the D-Hall. Is that a function of him being a sophomore that year?

A. I would say it would have been a function of his class schedule at the time I wrote this memo.

Q. Okay. Do students in different grades generally have classes in different wings of the school?

A. It really depends on the courses they're taking more than the grade -- or depended, past tense.

Q. Do you know if Gavin ever used the faculty restroom?

A. I don't have direct knowledge of that, no.

Q. Were there any objections from

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teachers about him using the faculty restroom?

A. Not expressed to me.

Q. Were there any objections expressed to other people that you heard of?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: That I heard of later on, yes.

BY MR. BLOCK:

Q. And what were those objections?

A. I can't recall specifically.

Q. Well, in general?

A. In general I would say the concern that I heard was that a student was using a faculty restroom.

Q. And when did you hear about that concern?

A. I can't recall.

Q. Can you recall whether it was before or after you decided that Gavin could use the boys restrooms?

A. It was after.

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MR. BLOCK: It was after. Okay. If I could get this one marked as Exhibit 6.

(Collins Exhibit Number 6 was marked for identification)

Q. Focusing on the middle section of an e-mail that's marked -- that's dated November 11th, you haven't seen this e-mail before, have you?

A. No, I have not.

Q. So it appears to me to be an e-mail from Kimberly Hensley to a couple of addresses where the names are redacted; is that right?

A. I would agree.

Q. And who is Kimberly Hensley?

A. There was a Kimberly Hensley who was a member of the Gloucester School Board.

Q. And in this e-mail she says at GHS, which is Gloucester High School, right?

A. I would assume so.

Q. "At GHS, there was a system in place that the student would use the bathroom in the clinic or a faculty bathroom. However, there were

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some problems that arose out of that. I'm not sure what exactly, but it was something about faculty not wanting a student in the bathroom" -- and then in parentheses -- "I'm hoping not to the level of a hostile environment because that was supposed to be the agreed-upon accommodation, closed parentheses. So the child and parents talked to the school and said that the child was not going to go all the way to the clinic anymore, but was going to use the gender identified bathroom." Did I read that accurately?

A. You did.

Q. Great. Is -- do you agree with Ms. Hensley's description of events there?

MR. CORRIGAN: Object to the form of the question.

THE WITNESS: Give me a second to read through it.

I can't say this is accurate with my recollection -- or is consistent with any recollection.

BY MR. BLOCK:

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Q. You can't say?

A. I can't say that it is.

Q. Is it inconsistent with your recollection?

MR. CORRIGAN: Object to the form of the question.

THE WITNESS: In what way?

BY MR. BLOCK:

Q. Well, do you know whether or not -- let me phrase this differently. Do you know whether faculty objections to Gavin using the faculty restroom was one of the factors that prompted Gavin to say that he wanted to start using the boys room instead?

A. I don't know.

Q. You don't know either way?

A. I don't know either way.

Q. Okay. But your recollection is that at the time that you made the decision to let Gavin use the boys room, you were not aware of faculty objections to him using the faculty restroom?

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A. I was not, no.
Q. But after the fact you did become aware that faculty had not liked the fact that he was using a faculty restroom?
MR. CORRIGAN: Object to the form of the question. Go ahead.
THE WITNESS: That's correct.
BY MR. BLOCK:
Q. And do you know -- is it your understanding that those faculty expressed their opinions to Gavin ever?
MR. CORRIGAN: Object to the form.
THE WITNESS: I don't know.
BY MR. BLOCK:
Q. And is your understanding that those faculty expressed their objections to anyone else in the administration besides you?
MR. CORRIGAN: Object to the form.
THE WITNESS: I don't know.
BY MR. BLOCK:
Q. All right. So you can put this one aside.

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Going back to your memo in Exhibit 2, this is picking up where we left off before, so the middle of the fourth paragraph. It says, at the beginning of the school year -- no, I'm sorry, the next sentence. "In early October, prior to the anticipated date of the student beginning hormone therapy, the student met with his school counselor and requested permission to use male student bathrooms either before or once he begins hormone therapy. This request was brought to my attention." Did I read that right?
A. You did.
Q. I just want to make sure that I get the dates here correct. So I'm going to show you another e-mail. Do you recognize this e-mail?
A. I don't recall it specifically, no.
Q. Is it -- it appears to me to be an e-mail chain in which Ms. Durr e-mailed you on September 25th, and you replied also on September 25th; is that right?
A. I would agree, yes.
MR. BLOCK: Okay. Let's mark this,

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before I forget, as the next exhibit. This would be Exhibit 7.
(Collins Exhibit Number 7 was marked for identification)
Q. In the original e-mail Ms. Durr writes, "I would like to speak to your briefly regarding a session I had with this Gavin yesterday. What is a good day and time for you?" It appears that the subject of the e-mail is Gavin Grimm; is that right?
A. I agree, yes.
Q. So is it possible that if Ms. Durr is writing this e-mail to you on September 25th talking about a meeting she had with Gavin yesterday, that Gavin's meeting with Ms. Durr happened on September 24th?
MR. CORRIGAN: Object to the form.
THE WITNESS: Based on what she's written, I would agree, yes.
BY MR. BLOCK:
Q. So does that refresh your recollection at all on whether, when you wrote in

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the memo that Gavin made a request in early October, that could have occurred on September 24th and not early October?
A. I can't recall what the content of the September 24th e-mail was specifically.
Q. Okay. But is it possible that it could have been the meeting with Gavin?
MR. CORRIGAN: Object to the form.
THE WITNESS: It's possible.
BY MR. BLOCK:
Q. Okay. But sitting here today, do you think that Gavin's meeting with his school counselor in which he requested to use the male restroom occurred in early October?
A. That's what I wrote on the October 23rd memo. To my recollection, that's what occurred.
Q. Okay. Who is Beverly Sabourin?
A. She was the school nurse.
Q. Was she consulted at all in your discussions with Ms. Durr about Gavin's request?
A. I did not talk to Ms. Sabourin, no.

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Q. So when Ms. Durr brought Gavin's request to your attention, what did she say?

MR. CORRIGAN: Object to the form. Which request are we talking about?

MR. BLOCK: Request to use the boys restroom.

THE WITNESS: Ms. Durr expressed to me that Gavin was no longer comfortable using the clinic restroom, and that he desired to use -- to be allowed to use male restrooms at Gloucester High School.

BY MR. BLOCK:

Q. And did she have a recommendation as a counselor about what would be in Gavin's best interest?

A. I don't recall if she expressed that to me.

Q. Did she give any opinion on whether Gavin's request should be granted?

A. I can't recall.

Q. So after she made this -- after she passed on information about this request to you,

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what did you say?

A. To who?

Q. To her.

A. I can't recall specifically what I said.

Q. Okay. So back on Exhibit 2, the next sentence -- and it's actually the last sentence in that paragraph before the redaction say, "I consulted with Dr. Clemons and with school counseling staff members to review available legal references." Did I read that right?

A. You did, yes.

Q. And what school counseling staff did you consult with?

A. I talked to Matt Lord, our director of school counseling specifically.

Q. Anyone else?

A. I talked to Dr. Clemons, the superintendent.

Q. But he's not school counseling staff?

A. Correct. Yes.

Q. So what did Matt Lord recommend?

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A. Mr. Lord provided me a couple of documents with recommendations for transgender students using the restrooms, and he recommended that Gavin be allowed to use the male restrooms.

Q. Which documents did he provide you?

A. I can't recall specifically.

Q. What was the basis for his recommendation that Gavin be allowed to use male restrooms?

MR. CORRIGAN: Object to the form of the question.

THE WITNESS: I can't speak to that. I don't recall.

BY MR. BLOCK:

Q. Was he saying it in his capacity as a school counselor?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: Yes.

BY MR. BLOCK:

Q. And you were asking for his opinion as a school counselor, right?

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A. Absolutely. Correct.

Q. Okay. And did he say anything indicating that he thought as a school counselor that using the male restrooms would be in Gavin's best interest?

A. Yes, he did express that.

Q. And did -- what did you say in response?

A. I can't recall specifically at that time. I asked him to probably explain the reason for his opinion. I asked him what information, what guidance, what research informed his opinion, probably.

Q. And what did he say in response?

A. Again, he shared with me at least two guidance recommendation documents that he referred to as a professional, and the specific issue with the transgender use of restrooms as the basis for his professional opinion.

Q. You also talked to Dr. Clemons; is that right?

A. That's correct.

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Q. Did you talk with anyone else from the superintendent's office?
A. I don't recall that, no.
Q. Any of the assistant superintendents?
A. At that time, I don't believe so.
Q. And what did Dr. Clemons say?
A. Dr. Clemons and I had a conversation in which we wanted to gather more information to make sure we understood any existing policy, regulations, laws, and then make the best decision -- to help me make the best decision I could regarding the request.
Q. And was it ultimately your decision to make in this conversation with Dr. Clemons?
A. It was, yes.
Q. So it was -- during this conversation with Dr. Clemons it was your understanding that you were empowered as the principal to make this decision?
MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: I would say I understood

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it was my decision to make, yes.
BY MR. BLOCK:
Q. And it was your understanding that there weren't any existing school policies that prohibited you from allowing Gavin to use the boys restrooms, correct?
MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: Correct.
BY MR. BLOCK:
Q. Now, did you talk to any administrators in other school districts?
A. Not that I recall, no.
Q. Did you review any medical literature?
A. I can't say specifically.
Q. During this time that you were making your decision, did you speak with anyone who advised you not to let Gavin use the boys restrooms?
A. No.
Q. And so, after this consultation

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process, what did you decide to do?
A. I ultimately decided after this consultation process and after meeting with Gavin directly that Gavin should be allowed to use male restrooms at Gloucester High School.
Q. Why?
A. I felt it was in his best interest, and it seemed to be in line with the guidance I had received.
Q. So even if the law didn't require that you let Gavin use the boys restroom, you still thought it was in his best interest?
A. Yes.
MR. CORRIGAN: Object to the form. Go ahead.
BY MR. BLOCK:
Q. And do you think permitting him to use the boys restroom was the best decision for his ability to succeed in school?
MR. CORRIGAN: Object to form. Go ahead.
THE WITNESS: I don't know if it was the

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best decision, but I believe it was a decision that made him more comfortable at my school.
BY MR. BLOCK:
Q. Did you have any concerns that Gavin using the restroom would be an invasion of other students' privacy?
MR. CORRIGAN: Object to the form.
THE WITNESS: At that time, no.
BY MR. BLOCK:
Q. Why not?
A. I would have to say I just didn't consider that. I was focused mainly on Gavin and what was best for him.
Q. Did you have any concerns that Gavin using the restrooms would lead to violence or disruption?
A. I would say I had concern that he could be subject to mistreatment by other students.
Q. And did you have any concerns that a student could pretend to be transgender to use the restroom for an improper purpose?

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A. I did not have that concern, no.
Q. By allowing Gavin to use the boys restroom, did you think you were setting a new policy that all transgender students could always use restrooms to match their gender identity under all circumstances?
MR. CORRIGAN: Object to form. Go ahead.
THE WITNESS: I think I understood that in my professional practice I made this decision for Gavin. I would make the same decision for other students in my school.
BY MR. BLOCK:
Q. Did you think you would still be assessing what to do on an individualized basis?
MR. CORRIGAN: Object to the form.
THE WITNESS: Could you clarify that?
BY MR. BLOCK:
Q. Yeah. Did you -- in the event that other students made similar requests, did you anticipate that you would be assessing those requests on an individualized basis?

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MR. CORRIGAN: Object to the form of the question.
THE WITNESS: I would say I would always make an individualized decision, yes, as long as it was consistent with the policy.
BY MR. BLOCK:
Q. By allowing Gavin to use the boys room, did you think you were making a commitment to allow transgender students to use locker rooms consistent with their gender identity?
MR. CORRIGAN: Object to the form.
THE WITNESS: No, we were focused -- I was focused on the restroom specifically, not necessarily the locker room.
BY MR. BLOCK:
Q. Going back to your memo, Exhibit 2, after the redacted portion it says, During a meeting with the school principal, school counselor and the student -- sorry, I'll say that again so it's correct. "During a meeting with the school principal, school counselor, the student and the student's mother, the student was informed

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by the school principal he may begin using student male bathrooms at Gloucester High School on October 20th, 2014, and a written plan for doing so was developed;" is that right?
A. That's correct, yes.
Q. So I'll show you another document. This document is marked GCSB 894. Is this the written plan referenced in your memo?
A. It is, yes.
MR. BLOCK: Great. I'd like to have this marked as Exhibit 8.
(Collins Exhibit Number 8 was marked for identification)
Q. So if we go to the bullet point that says restroom use, it says, "Gavin may go to any male student restroom at Gloucester High School. He will need a restroom stall with a door, one which will be selected by Gavin. Gavin will notify Ms. Durr if and when this need changes; is that right?
A. That's correct.
Q. Now, question about the sentence that

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says he will need a restroom stall with a door, one which will be selected by Gavin. What does that sentence -- why did you write that sentence?
A. To my recollection, that was Gavin's request at that time.
Q. That --
A. That he have a stall with a door.
Q. Okay. One which will be selected by Gavin would mean that Gavin would be selecting which restroom he uses?
A. Correct.
Q. So I just want to be clear on the interaction between the first sentence and the second sentence.
A. Sure.
Q. So the first sentence says Gavin may go to any male student restroom. And the second sentence indicates that he'll need a restroom with a door, one that will be selected by Gavin?
A. Uh-huh.
Q. So does that mean that Gavin would be selecting a particular restroom and then just be

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using that restroom, or does it mean that Gavin could continue to use whatever men's restroom he wants to?

A. Gavin was free to use any men's restroom he wanted to. If I recall correctly, there were some restrooms that did not have stall doors, and Gavin had made it clear that he wanted a stall with a door, I believe. So I wanted to make it clear that he could use any male restroom, but he would have to select based on where doors were available. Does that make sense?

Q. Yes, it does.

A. Thanks.

Q. Are there restrooms in Gloucester High School where doors aren't available?

A. Are there currently or were there?

Q. Were there?

A. I believe so, yes.

Q. Okay. Do you remember which ones those were?

A. I can't recall, sorry.

Q. So it's your understanding that Gavin

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would not be using the urinals at any of these restrooms; is that right?

MR. CORRIGAN: Object to the form.

THE WITNESS: I can't say that I had that understanding necessarily.

BY MR. BLOCK:

Q. Okay. The second bullet point says responding to verbal harassment, threatening behavior and other conflicts, is this an issue that you specifically discussed with Gavin at the meeting?

A. It is, yes.

Q. What did Gavin say during the meeting?

A. To my recollection, Gavin did not express any concern about that occurring at the meeting.

Q. Were you concerned at all about Gavin being a danger to others?

A. No.

Q. Then this other bullet point says, "Other needs: No other needs are needed at this

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time." What does this refer to?

A. I think that was a general -- we asked generally in the meeting did Gavin have any other needs regarding this issue or others in using male restrooms at Gloucester High School. So I just wanted to reflect that we had discussed that, and there were no other needs.

Q. Did you discuss locker rooms during your meeting with him?

A. No.

Q. Did you discuss sports teams?

A. Not that I recall.

Q. Did you make any promises about how any other request related to him being transgender would be resolved?

A. Not that I recall.

Q. Why does the memo say the decision doesn't go into effect until October 20th?

A. That was agreed upon with Gavin's mother and Gavin and I. I can't remember the days of the week. I believe -- I can't recall why that date was specifically selected.

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Q. Now, Gloucester Public Schools has a generally applicable policy prohibiting assault and battery, right?

A. Correct.

Q. And it has a generally applicable policy prohibiting bullying, right?

A. Correct.

Q. And it has a generally applicable policy prohibiting harassment, right?

A. Correct.

Q. And it also has a generally applicable policy prohibiting sexual offenses, right?

A. I believe that's correct.

Q. And by granting Gavin's request, were you suspending operation of any of these other generally applicable policies as applied to him?

A. No.

MR. CORRIGAN: Object to the form. Go ahead.

BY MR. BLOCK:

Q. So if Gavin committed any sexual

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offense or harassment using the restroom, he would still be punishable just like any other student under the generally applicable policies, right?

A. Yes.

MR. BLOCK: Do you need a break?

MR. CORRIGAN: I think it would be a great idea. We've been here almost exactly an hour, and I think it's generally a good idea to take a break every hour.

MR. BLOCK: Perfect.

(Whereupon, a recess was taken).

BY MR. BLOCK:

Q. So this meeting that you had with Gavin that's referenced in the plan, was that the first time you met Gavin personally?

A. I don't believe so. I think I had spoken to him before this meeting.

Q. In what context?

A. I believe I spoke to Gavin to let him know that I wanted to meet with him and his mother regarding his request to use the male restrooms.

Q. Okay.

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A. That was probably just maybe a few days before this meeting occurred.

Q. So in your meeting with Gavin, what did Gavin say about why he wanted to use boys restrooms?

A. In the October 14th -- in this meeting?

Q. Yeah, in person.

A. Gavin expressed that he was not comfortable with the alternative bathroom plan. He felt that he should be able to use restrooms of his identified gender. I believe he expressed that the alternative restroom plan was not always convenient for him as well.

Q. Did he give any other reasons?

A. I can't recall specifically.

Q. Did his mom say anything?

A. His mother expressed support for Gavin. That's my recollection of her discussion of the meeting.

Q. And were you aware at the time this meeting took place that Gavin had a treatment

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documentation letter from psychologists?

A. I can't recall when I became aware of that letter.

Q. Your memo to Dr. Clemons says that Gavin's request was to use the restroom either before or after he started hormone therapy; is that right?

A. Yes.

Q. So did -- was the timing of him being on hormone therapy a factor in any of your considerations?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: In terms of his use of the restroom?

BY MR. BLOCK:

Q. Well, in any context.

A. Could you ask that again?

Q. Yeah, sure. So was him being on therapy or not being on therapy a variable when you were deciding what to do?

A. I don't know that it was a variable.

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I think it was just a part of understanding his situation and his transition.

Q. And is there a reason why you thought it was -- you decided that he shouldn't have to wait until after he actually began hormone therapy?

MR. CORRIGAN: Object to the form.

THE WITNESS: I'm sorry, ask that again.

BY MR. BLOCK:

Q. Sure. So is there -- why did you agree that he could use the restroom before actually initiating hormone therapy?

MR. CORRIGAN: Object to the form.

THE WITNESS: Because I believe the decision should be made based on his identified gender, and not necessarily any medical procedure or therapy.

BY MR. BLOCK:

Q. And on what basis did you make that decision?

A. Research and guidance provided.

Q. But you did know at the time that he

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was intending to initiate hormone therapy, right?
A. Yes.
Q. And you did know at the time that he had been diagnosed with gender dysphoria; is that right?
A. I don't know when I knew that.
Q. Okay.
A. I believe that was all provided in the same documentation from the family, and I cannot recall when I was aware of that.
Q. I'm showing you a document marked GCSB 4120. Do you recognize this document?
A. I don't recall it specifically.
Q. Okay. Is that -- does it appear to be an e-mail from you to Dr. Clemons dated October 22nd, 2014?
A. It does.
MR. BLOCK: Let's mark this as Exhibit 9.
(Collins Exhibit Number 9 was marked for identification)
Q. So at the bottom of the chain there

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appears to be an e-mail from a redacted person to you with the subject line, "bathroom usage;" is that right?
A. Yes.
Q. Do you remember this e-mail?
A. Not specifically, I'm sorry.
Q. Okay. So in an e-mail it says, "Mr. Collins, I hope you're having a good day. I want to address a story I heard with you to verify if it's true or not. I was told today that a female student has requested to use the boys bathroom, and that request has been approved by GHS administration. Apparently this female is considering herself a transgender student," exclamation point.
And then you forward that to Dr. Clemons saying, "FYI, this is the second inquiry about this I've had today."
MR. CORRIGAN: That's a question mark, not an exclamation point.
MR. BLOCK: Oh, yeah, sorry.
MR. CORRIGAN: That's all right.

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BY MR. BLOCK:
Q. So when I was reading the earlier quote, it was a question mark, not an exclamation point.
So do you recall receiving an e-mail like this and forwarding it to Dr. Clemons?
A. I do recall that, yes.
Q. Now, had you received any complaints before Wednesday, October 22nd?
A. I don't recall the chronology. I remember at least two parent concerns expressed to me. In the e-mail I wrote to Dr. Clemons I said "the second one today." So I don't recall that I had any prior to that day necessarily.
Q. Now, did you personally receive any complaints from anyone that wasn't a parent?
A. From a student.
Q. Okay. So a student personally complained to you?
A. A student requested to meet with me in my office regarding transgender use of the restroom, yes.

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Q. Was that before you met with the School Board about it?
A. I can't recall when it was.
Q. And so it could have been -- do you know if it was before or after the public School Board meeting?
A. I can't recall. I'm sorry.
Q. But -- so it's possible it could have been after the public School Board meeting?
MR. CORRIGAN: Object to the form.
THE WITNESS: It's possible.
BY MR. BLOCK:
Q. And what did the student say to you?
A. The student who requested to meet with me?
Q. Uh-huh.
A. Expressed concern about a female student in the boys bathroom and lack of privacy.
Q. And was this student male?
A. Yes, it was a male student.
Q. And did the student indicate whether they had actually used the same restroom as Gavin?

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A. I don't recall that.
Q. Do you recall whether the student was taking classes in the D-Hall?
A. No, I don't recall.
Q. And what did you say to the student?
A. I can't recall my specific words. I believe I said to the student, Thank you for your opinion and for sharing with me your concern. That's the extent of it, I would imagine.
Q. Did you offer the student any privacy accommodations?
A. I can't recall.
Q. So after you forwarded this e-mail to Dr. Clemons, what did he say in response?
A. I don't recall.
Q. You don't recall at all?
A. No, I don't.
Q. Did he talk to you about bringing the issue to the Board?
A. I can't recall. I can't recall specifically.
Q. Did any faculty or staff object to Gavin using the boys restroom?
A. At this time?
Q. Yes, before it was brought to the School Board's attention?
A. To Gavin using male restrooms?
Q. Well, yes.
A. No, I don't recall that.
Q. Who is Ralph VanNess?
A. Ralph VanNess was a security staff member at Gloucester High School.
Q. Is he also the head of the Bible club?
A. There was a Bible club he was a sponsor of, yes.
Q. Did he have any other role at Gloucester High School?
A. Not to my recollection, no.
Q. And did Ralph VanNess ever complain to you about Gavin using the boys restrooms?
A. No, he did not.
Q. Do you know if he complained to anyone else about Gavin using the boys restrooms?

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A. I know he addressed the School Board during public comment, but I don't know of any other conversations he had.
Q. Do you know if he talked to other students about Gavin using the boys restrooms?
A. No, I don't know.
Q. Do you know how information about Gavin's restroom use was disseminated to the community?
A. No, I don't know.
Q. Do you know if Ralph VanNess had any role in telling other people Gavin was using the boys restrooms?
A. No.
MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: I don't know.
BY MR. BLOCK:
Q. Do you know if any other school administrators had a role in telling people that Gavin was using the boys restrooms?
MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: No, I don't know.
BY MR. BLOCK:
Q. Do you know if any School Board members had a role in informing the community that Gavin was using boys restrooms?
MR. CORRIGAN: Object to the form of the question.
THE WITNESS: No, I don't know.
BY MR. BLOCK:
Q. Did any -- did any student or parent complain that Gavin committed any sort of misconduct while using the restrooms?
A. While using the restrooms, not to my recollection.
Q. Did any student or parent describe any actual instances in which someone used the restroom with Gavin and felt that their privacy was violated?
A. Not to my recollection.
Q. Did any students -- let me start over.

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Did any students or parents report incidents of anyone pretending to be transgender to use the restroom?

A. No.

Q. Did any student make a request to use a different restroom once they found out that Gavin was?

MR. CORRIGAN: Object to the form.

THE WITNESS: Other than Gavin, you mean?

BY MR. BLOCK:

Q. Yes.

A. Not to me, no.

Q. Any student come up to you and say that they were gender fluid?

A. No.

Q. Any student say, Well, you know, today I feel like a girl, so I should use the girls restroom?

A. No.

Q. To the best of your knowledge, has that type of request occurred at any school that

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you've worked at?

A. Which request?

Q. Someone saying, Today I feel like a girl, so I should be able to use the girls restroom today?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: Request made to me directly?

BY MR. BLOCK:

Q. No. Well, first start with you directly.

A. No.

Q. To the best of your knowledge, has that request been made to anyone at the school?

A. No.

MR. CORRIGAN: Object to the form. Go ahead.

BY MR. BLOCK:

Q. Have you ever -- you've said before that you were aware that -- of transgender students at other schools you worked at, right?

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A. Correct.

Q. Are you aware of any student ever saying that they're gender fluid and want to use different restrooms on different days?

A. In a school in which I've worked?

Q. Yes.

A. Other than Gavin?

Q. Well, so I'm talking about -- so I'm not talking about someone that says, I want to use --

A. Gender fluid specifically?

Q. Yes.

A. No.

Q. Let me just say that again to clean up the transcript.

So at any of the schools that you've worked at, are you aware of any student ever saying that they're gender fluid, and want to use one restroom one day and a different restroom a different day?

A. No.

Q. Did Gavin ever indicate that he

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wanted to switch back and forth between boys restrooms and girls restrooms?

A. Not to me, no.

Q. Do you know if he indicated that to anyone else?

A. I'm not aware, no.

Q. I'll show you -- this is marked as WAVY TV FOIA response 007. And have you seen this document before?

A. No, I don't believe so.

Q. It appears to be an e-mail from Dr. Clemons to the School Board; is that right?

A. Yes.

MR. BLOCK: I'd like to have this one marked as Exhibit 10.

(Collins Exhibit Number 10 was marked for identification)

BY MR. BLOCK:

Q. And it's dated October 22nd, right?

A. Yes, it is.

Q. And so that's the same day that you forwarded your e-mail to Dr. Clemons; is that

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right?

A. Yes, that's right.

Q. So going down to the fourth line from the bottom -- well, let's start at the top, I'm sorry. The beginning he says, "Just FYI, two issues that I would like to discuss with you tomorrow in closed session including a transgender issue at GHS."

Did Dr. Clemons tell you he intended to raise this issue to the Board?

A. Not that I recall. I can't recall if he did or not.

Q. Okay. And then at the bottom of the e-mail like the third sentence from the end he says, "Finally, I will forward you some literature on the transgender issue that Elizabeth Ewing (VSBA) sent to me when we had a discussion on this issue previously."

Are you aware of what information he's referring to?

A. Dr. Clemons shared information with me that he had been provided. I can't remember

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specifically what that was.

Q. But this is information he had been provided by Elizabeth Ewing at the VSBA?

A. I can't say I knew that at the time what the source was.

Q. Okay. Do you remember whether the literature was in favor of allowing transgender students to use restrooms consistent with their gender identity?

MR. CORRIGAN: I'm going to object. This is a line that we're at. Elizabeth Ewing is a lawyer. She works at VSBA. It was legal counsel that Dr. Clemons was seeking with her, and I'm going to take the position that what she provided him and what he then provided is all protected. So if you're going to get into the substance of what was said or didn't say, then I'm going to object to it because it's attorney-client privilege. The fact of the consultation, arguably I could have objected to that, but I don't think I can because there it is. It's something that's already been

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provided. It's what you and I talked about.

MR. BLOCK: Right. Right.

MR. CORRIGAN: So there's going to be a line here. And I'm not trying to be disruptive in the deposition or anything like that, but I have obligations to my client to respect attorney-client privilege.

MR. BLOCK: Sure. And to clarify, she is an attorney at the VSBA that provides legal counsel to school boards?

MR. CORRIGAN: Correct. That is my understanding. I don't know Elizabeth Ewing, but that is my understanding. I'll just leave it there.

BY MR. BLOCK:

Q. Then the sentence says, "Furthermore, I will have Mr. Collins present tomorrow evening so he can fill you in on his actions thus far related to these issues."

Did you present to the School Board the following evening?

A. I would read that as I will have

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Mr. Collins present tomorrow evening.

Q. Oh, thank you. Were you present the following evening at the School Board?

A. I was present at a School Board meeting. I can't remember the date, but I would assume this is the meeting at which I was present, yes.

Q. Okay. And did Dr. Clemons ask you to be present at that meeting?

A. He did, yes.

Q. And what did he say the reason was that he wanted you to be present?

A. The reason was simply to share with School Board members information regarding what he referred to as the transgender issue.

Q. And is the memo that you prepared to Dr. Clemons that was marked as Exhibit 2, that's dated October 23rd; is that right?

A. Correct.

Q. And so what was your purpose in writing that memo?

A. I believe Dr. Clemons requested

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background information regarding the issue, and I provided it for him.

Q. But did he request it for the specific purpose of forwarding it to the Board?

A. I can't recall.

Q. But you had already had several conversations with Dr. Clemons before he wrote that memo; is that right?

A. Correct.

Q. Do you know whether this memo was shared with the Board?

A. I can't recall. Actually, I don't know.

Q. So at the Board meeting -- actually, let me -- at the Board meeting, what did you say?

MR. CORRIGAN: I'm going to draw the line there. I'm going to instruct him not to answer. The closed session of the Board meeting is not just attorney-client privilege. There's also a legislative privilege that attaches. I think that the results of what happened after the closed session is something

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he can talk about. I think he can talk about -- if you have something that shows that I have waived something like that, please show it to me, because I don't want to fight a battle I'm not going to win, but I don't think that we have.

MR. BLOCK: I'm going to have this marked -- this is a document marked GCSB 826. I'd like to get this marked as Exhibit 11, please.

(Collins Exhibit Number 11 was marked for identification)

BY MR. BLOCK:

Q. You haven't seen this document before, have you?

A. No, I have not.

Q. So you can tell -- I'll tell you what it appears to be to me, and you can tell me if you agree. This appears to me to be an e-mail from Kimberly Hensley to Dr. Clemons and to Chuck Wagner dated Friday, October 24th, 2014; is that right?

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A. That's right.

Q. And who is Chuck Wagner?

A. Chuck was -- is the assistant superintendent of Gloucester County Public Schools.

Q. And had you spoken with Chuck Wagner at all about Gavin's situation?

A. Prior to October 24th?

Q. Yes.

A. I don't recall.

Q. So in this e-mail Ms. Hensley says, "Dear Dr. Clemons and Dr. Wagner, I know I complain a lot, so I wanted to make sure I told you how glad I am today after the work session last night. I was worried that the situation at GHS with our transgendered student might be controversial, which it was, but I am happy that things worked out as they did."

And then in the next paragraph she says, "It's thanks to you both that the vote came out as it did. Thank you for your guidance and your ability to lead the Board into a good

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decision."

Did I read that correctly?

A. You did.

Q. So do you know -- do you agree with the assessment here that it's thanks to Dr. Clemons and Mr. Wagner that the vote came out as it did?

MR. CORRIGAN: Object to the form of the question. Object to asking him to speculate and lack of foundation.

THE WITNESS: I know that Dr. Wagner and Dr. Clemons were both present at the school meeting I attended. I was not present for a vote, to my recollection.

BY MR. BLOCK:

Q. And just to make a record of any objections, and so do you know what Dr. Clemons and Dr. Wagner recommended to the Board?

MR. CORRIGAN: Object, and instruct the witness not to answer because it's I believe privileged.

BY MR. BLOCK:

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Q. Then if you go down to the bottom of the e-mail it appears to be a response from Dr. Wagner to Ms. Hensley that says, "Whoever said that doing right was easy? Thanks for your kind words and concern for the student."

Did Dr. Wagner ever express to you that he thought that allowing Gavin to use the boys room was the right thing to do?

A. Yes, he did.

Q. When did he express that to you?

A. I can't recall.

Q. Did Dr. Clemons ever express to you that he thought that allowing Gavin to use the boys restroom was the right thing to do?

MR. CORRIGAN: Object to the form of the question. Go ahead.

THE WITNESS: Dr. Clemons did not say that to me in those words. I believe we both agreed on the guidance that we had read that suggested that would be the appropriate course of action.

BY MR. BLOCK:

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Q. And by the guidance, do you mean just legal guidance, or do you mean other types of guidance, too?

A. I would say legal and professional, characterize it.

Q. Legal and professional?

A. Yes. For example, information provided by the school counselor.

Q. So after your -- the meeting at which you attended, did you have any further meetings with the School Board about Gavin or transgender students?

A. I did not, other than attendance at open School Board meetings.

Q. Did you have any further discussions with Gavin or his parents between your meeting with him and the public November 11th Board meeting?

A. I know I met with Gavin. I do not recall meeting with his parents.

Q. What was your meeting with Gavin?

A. I would characterize it as a check-in to see how he was doing, what his experience had been, if there had been any issues, any concerns directly from him.

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Q. And when did this check-in occur?

A. I don't recall specifically when that was. Sometime probably October, early November of 2014.

Q. And what did Gavin say?

A. He did not express any concerns to me.

Q. Was Gavin ever informed that anyone had complained about the fact that he was able to use the restrooms?

A. Not by me.

Q. So before the November 11th meeting, did Gavin -- was Gavin ever informed that any members of the School Board had concerns about him being allowed to use the boys restrooms?

A. Not by me.

Q. Do you know if he was informed by anyone else?

A. I don't know.

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Q. And for the previous question, too, about parents or students having concerns, do you know whether anyone else informed Gavin that parents or students had concerns?

A. I don't know.

Q. So -- and then again between the November meeting and the December School Board meeting, did you meet with Gavin at all?

A. I can't recall specifically. I am positive I interacted with him as a student in my school. I can't recall if I met with him specifically regarding his bathroom usage.

Q. So you can't recall whether you had any other check-ins?

A. I can't recall.

Q. So did anyone, to the best of your knowledge, have a conversation with Gavin saying there has been some complaints; can we have a meeting to see if there's a way to adjust the accommodation somehow?

A. I don't know.

Q. So do you know if anyone had a

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meeting with Gavin where they could discuss the possibility of maybe him using a subset of restrooms or something like that?

A. I don't recall that. I don't know.

Q. So to the best of your knowledge, was Gavin ever given an opportunity to have a dialogue with the administration or the board in working out a solution to the problem?

MR. CORRIGAN: Object to the form.

THE WITNESS: The administration other than me?

BY MR. BLOCK:

Q. Yes.

A. I don't know. I'm not aware.

Q. Okay. When did school administrators begin discussing the possibility of creating new single user student restrooms?

A. I believe that followed the November School Board meeting.

Q. And what prompted those discussions?

A. I can't say that I know what prompted that.

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Q. Do you know who brought the idea up?

A. No, I don't.

Q. So how did you first hear of those discussions?

A. Either Dr. Clemons or Assistant Superintendent John Hutchinson had a discussion with me about the possibility, and areas in our school where it might be possible to create additional restrooms, along with -- along with modifying restrooms to provide greater privacy for all students.

Q. And why did they say this was being discussed?

MR. CORRIGAN: Object to the form. Object to speculation and foundation. Go ahead.

THE WITNESS: I think -- I can't say. I can't say what motivated that conversation.

BY MR. BLOCK:

Q. So when they talked to you about the issue, did they indicate that it was in connection with controversy of Gavin's restroom use?

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A. I would say that Gavin's restroom use raised the larger issue of bathroom privacy at Gloucester High School. I would also say that it was related to providing Gavin a comfortable space to use the restroom, if he desired.

Q. Did anyone ever ask Gavin what he thought about the idea?

A. I don't know.

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: I don't know.

BY MR. BLOCK:

Q. Did anyone consult with Gavin about what sort of facility would be most convenient for him?

A. I don't know. I did not.

Q. So to the best of your knowledge, Gavin didn't have any role in the process?

MR. CORRIGAN: Object to the form.

THE WITNESS: I don't know.

MR. BLOCK: I have a couple of documents I'd like to mark here as Exhibits 12, 13 and 14.

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(Collins Exhibit Numbers 12, 13 and 14 were marked for identification)

Q. Take your time and review the three documents.

A. (Witness perusing document).

Q. So just going through them in order, so Exhibit 12 is an e-mail from Amy Bergh to you dated November 19th; is that right?

A. Correct.

Q. And the title is "restrooms," right?

A. Correct.

Q. Do you remember receiving this e-mail?

A. Now that I've read it, I do, yes.

Q. Okay. And then Exhibit 13 is an e-mail from Catrona Hill-Charity to you that's also dated November 19th, correct?

A. Correct.

Q. And the title is "C-Hall teacher's restroom," correct?

A. Correct.

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Q. And do you remember receiving this e-mail?

A. I don't remember that.

Q. And Exhibit 14 at the bottom, it's an e-mail from Patricia Rilee to you that's also dated November 19th, right?

A. Correct.

Q. And then on top of that is your response to her dated the same day, right?

A. That's correct.

Q. And do you recall this e-mail?

A. Now that I've read it, I do recall, yes.

Q. So if you turn to Exhibit 13 it says, "I'm a bit concerned about the upcoming changes to the C-Hall restrooms. As stated in the meeting yesterday, there has often been times when I arrive to the restrooms to be the fourth person in line," and then the sentence goes on.

But what meeting yesterday do you understand the e-mail to be referring to?

A. I believe that referred to Gloucester

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High School faculty meeting.

Q. And what happened?

A. At that meeting I shared a plan that was being developed to convert some restrooms in the school to single user restrooms for students.

Q. And what were the original plans for the C-Hall restrooms?

A. On C-Hall there were I believe two faculty restrooms, and I believe the original plan was to convert one of those two to a student single user restroom.

Q. Did the ultimate plan follow through on that?

A. Not -- no. The plan was changed.

Q. What was changed?

A. Two other areas on C-Hall were identified that could become student single user restrooms so as not to reduce the availability of faculty restrooms for teachers.

Q. So can we look at the map on Exhibit 4. Can you tell me where the teacher restrooms that -- one of which was going to be

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converted -- are located?

A. That were going to be converted are located in the areas marked by yellow directly two spaces below C-156 in C-Hall, so near what's labeled "wood shop."

Q. I see. And so there is -- are those -- there are faculty restrooms and then student restrooms right next to it?

A. There were two student gang restrooms, a male and a female, and then I believe two faculty restrooms, a male and a female directly adjoining.

Q. So if one of those faculty restrooms had been changed to a single user restroom, it would have been right next to the other student restrooms that other boys and girls use, right?

A. Yes, correct.

Q. And no one would have had to walk away from where other students were using the restroom in order to get to that single user facility, right?

MR. CORRIGAN: Object to the form.

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THE WITNESS: Could you clarify?

BY MR. BLOCK:

Q. I'll withdraw it.

And so where were those single user restrooms ultimately installed in C-Hall?

A. Ultimately they were -- and I can't identify exactly which spaces, but they were in proximity to the cafeteria, senior cafeteria, I believe the two yellow spaces directly above the space labeled "cafeteria."

Q. And why weren't faculty restrooms moved to that spot instead?

A. I don't know.

Q. Now, did you have any role in presenting the original plans?

I'll take that back. Did you have any role in developing the original plans?

A. I believe John Hutchinson and I walked around Gloucester High School to identify possible locations.

Q. So in Exhibit 14 you write back to Patricia Rilee. You say, "Hi, Tricia, I think

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it's safe to say that everyone realizes it might not be a good idea to convert the C-Hall restrooms. There is a new plan in the works that should spare them;" is that right?

A. That's right.

Q. Why did -- so is it accurate that you agreed that it wasn't a good idea to convert the C-Hall restrooms as originally planned?

A. I would agree, yes.

Q. And why wasn't it a good idea?

A. Because of the number of adults -- staff members who used those two restrooms.

Q. And those staff members raised concerns that it would be difficult to get to another restroom and back between classes?

A. Those are the concerns they shared, yes.

Q. You agree that it would be difficult for a faculty member to get to a different restroom and back between classes?

MR. CORRIGAN: Object to the form.

THE WITNESS: With what bathroom

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configuration?

BY MR. BLOCK:

Q. So do you agree that if the teacher's restroom were removed and a faculty member had to walk to a different faculty restroom, it would have been difficult to do so between classes and make it back to class on time?

MR. CORRIGAN: Object to the form.

THE WITNESS: I can't speak for every teacher. It would depend on their specific location, but generally speaking it would have made it much more difficult, yes.

BY MR. BLOCK:

Q. And where is the nearest other faculty restroom?

A. Prior to the changes being made?

Q. Well, how about this: At the time you were considering what changes to make --

A. Sure.

Q. -- if the -- if, as originally planned, the faculty restroom had been eliminated in the original location, what would have been the

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next closest?

A. The next closest faculty restrooms to C-Hall?

Q. Yes.

A. To C-Hall would have been the restrooms as I'm looking at the layout in the main office, or on A-Hall there were faculty restrooms.

Q. Can you tell me on -- above C-154, there appears to be a little yellow marker for a restroom. Is that another restroom there?

A. That's how it's labeled. I can't recall what that was.

Q. Let's look at Exhibit 5. So I just want to make sure that I know what all the entries here refer to. It says C-Hall boys, C-Hall girls. And those are the big yellow squares above C-160?

A. I believe so, yes.

Q. Then it says C-Hall staff women, C-Hall staff men. Those are the tiny yellow squares next to the student restrooms, right?

A. I believe so, yes.

Q. And then C-Hall new unisex and C-Hall

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new unisex, those are the new ones that were created in front of the cafeteria; is that right?

A. Correct, I believe, yes.

Q. And what used to be in that location where the new ones were created?

A. Those were locker rooms for custodial staff.

Q. Could you tell me a little bit more? What is a locker room for custodial staff?

A. So those were two rooms with lockers and with restroom facilities for custodial staff to use before or after their shift, during their shift theoretically.

Q. So there already were toilets in those restrooms, right?

A. Yes. Yes.

Q. And was it also a storage area for custodians?

A. A storage area for?

Q. Well, did any -- yeah, sorry, like cleaning equipment and things like that?

A. I don't know. I don't recall.

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Q. Where did custodians have to go to use the restrooms once those were changed?
A. They would have used other staff restrooms.
Q. And so there is no other entry on this list under Gloucester High School that would match up to this tiny little yellow thing above C-154; is that right?
MR. CORRIGAN: Object to the form.
THE WITNESS: I don't see anything on the list, and I don't recall -- I cannot recall.
BY MR. BLOCK:
Q. If you turn to Exhibit 12 in Ms. Bergh's letter there's some bullet points with asterisks --
A. Okay.
Q. -- where she has some other suggestions?
A. Uh-huh.
Q. So the third one says, "I don't know if anyone is currently using the old childcare

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restroom, C-162. Perhaps that could be converted as a long-term solution."
Do you know what she's referring to as an old childcare restroom?
A. No, I don't. Oh, I'm sorry, I can see 162 on the map, but I don't know what the old childcare was, no.
Q. Okay. She says, "The B-Hall restrooms are not even used during the day. Perhaps the doors could be adjusted to accommodate this problem."
Where are the B-Hall restrooms?
A. I believe the restrooms she was referring to are the two yellow spaces directly below B-141.
Q. See. What are those restrooms used for?
A. Those were typically used as public restrooms for events and games. They were multi-user restrooms.
Q. So going back to this issue of a faculty member having to use the restrooms between

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classes, do you think it would also be difficult for a student to have to walk the same distance to use the restroom between classes?
MR. CORRIGAN: Object to the form.
THE WITNESS: Between classes?
BY MR. BLOCK:
Q. Uh-huh.
A. It would make it more difficult to be in class on time, yes.
Q. If you go to Ms. Bergh's e-mail again near the bottom -- actually, two-thirds of the way down a sentence starting, "Most of C-Hall teachers;" do you see that near the right-hand side?
A. Okay. Uh-huh. Yes.
Q. "Most of C-Hall teachers have at least one day that we have no opportunities to use the restroom, other than the five minutes during class changes from before 8:00 with school until our lunch at 12:30. That is a very long time for anyone to wait, but pretty impossible for faculty on diuretics."

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Do you agree that waiting from 8 a.m. to 12 p.m. is a long time for someone to have to wait to use the restroom?
MR. CORRIGAN: Object to the form.
THE WITNESS: For me, it would be.
BY MR. BLOCK:
Q. How long do students have between classes?
A. I can't recall the bell schedule that year. Five minutes, I believe.
Q. And that's the same amount of time the faculty have between classes, correct?
A. Correct. I would say the difference between students and teachers, students can be excused during classes, whereas teachers generally do not have the ability to leave class to go to the restroom.
Q. But if a student is excused during class, they miss class time, right?
A. That's correct.
Q. Let's go to -- I'm showing you a document marked GCSB 893. Do you recognize that

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document?

A. I do, yes.

Q. What is it?

A. It's a letter that I wrote to David and Deirdre Grimm -- they were Gavin's parents -- regarding actions taken by the Gloucester School Board, and the resulting impact on Gavin.

MR. BLOCK: I'd like to have this marked as Exhibit 15.

(Collins Exhibit Number 15 was marked for identification)

Q. So in this letter it says, Gavin will no longer be able to use the male restrooms at Gloucester High School effective immediately; is that right?

A. That's correct.

Q. Now, at the time this letter was sent, had the new unisex restrooms been installed yet?

A. I can't recall the timeline.

Q. It's your understanding that Gavin was prohibited from using all mens restrooms at

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the school, correct?

A. That was my understanding, yes.

Q. Okay. I'd like to turn back to the -- to Exhibit 4 and 5 again.

A. Okay.

Q. If you look on the list of restrooms on Exhibit 5 under Gloucester High School, and you go down past locker room to auditorium.

A. Uh-huh.

Q. It says auditorium boys, one non-ADA restroom with single commode and sink; and auditorium girls one non-ADA restroom with single commode and sink; is that right?

A. Correct. Yes.

Q. So are those the two yellow squares near -- in the room marked auditorium on the map?

A. Yes.

Q. So those are both single user restrooms, right?

A. I can't recall, but based on the description in Exhibit 5, yes.

Q. And was Gavin allowed to use the boys

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single user restroom in the auditorium?

A. That specific restroom?

Q. Yeah.

A. I don't recall.

Q. There wouldn't have been any risk to anyone else's privacy from Gavin using that restroom, right?

MR. CORRIGAN: Object to the form.

THE WITNESS: That would have been a single user restroom. So typically no one else would have been in the restroom with him.

BY MR. BLOCK:

Q. Did anyone consider making those two single user restrooms, restrooms for any gender?

A. I can't recall specifically, but I believe those restrooms were located in dressing rooms, and those typically were kept locked during the day. They were not regularly used by students during the day, unless, for example, part of our theater program -- our band program perhaps.

Q. So were they in enclosed spaces where a student had to be in a boys dressing room or a

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girls dressing room in order to access the restroom?

A. I can't recall the layout specifically, and I can't tell from the map.

Q. Where is the third restroom that was created as a single user restroom?

A. In addition to the two on C-Hall?

Q. Yes.

A. The third was located on the A-Hall. So directly below the nurse's office labeled in blue, there are two yellow areas that were male and female student gang restrooms. To the right of those there's a small single user restroom that was a faculty restroom that was converted.

Q. So they're very close to the clinic; is that right?

A. That's correct, yes.

Q. So if the clinic was difficult to get to, presumably these would be equally difficult to get to, right?

MR. CORRIGAN: Object to the form.

THE WITNESS: From where?

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BY MR. BLOCK:
Q. From another part in the school?
MR. CORRIGAN: Same objection.
THE WITNESS: They would have been the same distance, roughly, from some parts of the building.
BY MR. BLOCK:
Q. To the best of your knowledge, did any students actually use any of the new single user restrooms that were created?
A. Yes, some students did.
Q. How many?
A. I can't say.
Q. How frequently?
A. I can't say.
Q. So what are you basing your answer on?
A. I certainly saw students coming out of those restrooms at times, and other signs of usage of those restrooms.
Q. And did you see those signs of usage during the first year in which those restrooms

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were installed?
A. Yes.
Q. Do you have a ballpark of how many students you think would have used them?
A. No, I don't know.
Q. So do you know how --
MR. BLOCK: I'd like to have this marked as Exhibit 16.
(Collins Exhibit Number 16 was marked for identification)
Q. This was produced as GCSB 502, and it's "Guidelines for School Facilities in Virginia's Public Schools." Are you familiar with these guidelines?
A. Familiar, no.
Q. So if you turn to the second page, it says, "13.4 General Use Instructional Toilets." It says, "General toilet rooms for each gender should be provided on each floor of every building where toilets are not provided in classrooms, and should be located within 200 feet of the most remotely located instructional space."

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Do you know if there was a single user student restroom located within 200 feet of the most remotely located instructional space?
A. No, I don't know that.
Q. Do you know whether Gloucester County Public Schools generally follows the guidelines for school facilities?
A. I don't know.
MR. CORRIGAN: Object to the form.
BY MR. BLOCK:
Q. In the student locker rooms, do the showers work in both of the student locker rooms or in all the student locker rooms?
A. Currently?
Q. In 2014?
A. To my knowledge, yes.
Q. They all worked?
A. I can't say that I know that they all worked.
Q. Okay. If you look at Exhibit 5 on this list of facilities it says, Locker room main boys one gang shower. And then it says, Locker

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room JV boys no shower. And then it says, Locker room main girls 26-stall shower not used. Do you know what that "not used" indicates?
A. I believe that simply indicated that girls typically did not use the showers.
Q. Not that the water in the shower didn't work?
A. Not to my knowledge, no.
Q. At any point in time did the water in any of the student showers not work?
A. I don't know.
Q. Do you know whether students showered for gym during gym class?
A. I don't know that every student did. I don't know who showered and who didn't.
Q. Do you know if any students did?
A. I don't know.
Q. Do you know if students got fully undressed when changing for gym class?
A. I know it was generally -- it was the general expectations for students to change clothes for gym class.

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Q. Do you know if they would remove underwear as part of that?

A. I don't know.

Q. So at the football stadium there was no single user restroom at the football stadium, right?

A. No, there was not.

Q. And when there's a nighttime football game, are the restrooms in the school accessible?

A. To the general public?

Q. To students?

A. Some students -- for example, band students might go into the band room. So I would say that perhaps they could use restrooms in the building, but to general attendees at events, no, they were not.

Q. So if Gavin was attending a football game, did he have any restroom that he was able to use?

MR. CORRIGAN: Object to the form.

THE WITNESS: I don't know.

BY MR. BLOCK:

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Q. Was there any single user restroom that he was able to use?

A. Not to my knowledge, no.

Q. The additional privacy protections, were they installed only in boys restrooms?

A. I don't recall where they were installed. Do you mean boys as opposed to girls?

Q. Yes.

A. I can't recall specifically what modifications were made where.

Q. Do you recall any discussions about the issue of whether modifications would be made in both the boys rooms and the girls rooms?

A. I remember discussions about making modifications for the privacy of all students, but I don't recall a specific conversation about male versus female.

Q. Did you think at any time that Gavin would be using one of the girls restrooms?

MR. CORRIGAN: Object to the form.

THE WITNESS: Did I think that he would?

BY MR. BLOCK:

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Q. At school?

A. Using a girls restroom?

Q. Yes.

A. I can't say that I would have expected that, no.

Q. Why not?

A. He had expressed a desire to use male restrooms.

Q. And would you have -- how do you think students would have reacted if he had used a girls restroom?

MR. CORRIGAN: Object to the form.

THE WITNESS: I can't speak to that. I don't know.

BY MR. BLOCK:

Q. Did any student say to you they were uncomfortable with Gavin using a girls restroom?

A. A girls restroom? I can't recall.

Q. To the best of your knowledge, did the Board ever ask for information about whether the new restroom policy was having a negative effect on Gavin?

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MR. CORRIGAN: Object to the form.

THE WITNESS: I don't know.

BY MR. BLOCK:

Q. So to the best of your knowledge, did they ask for updates on how he was doing academically?

A. I don't know, no.

Q. You were never asked for updates, were you?

A. I was never asked by the School Board, no.

Q. Were you ever asked by the superintendent for updates?

A. I would say Dr. Clemons expected me to let him know if there were issues or concerns that need to be addressed.

Q. What sort of issues or concerns?

A. For example -- I can't say what he might have had in mind.

Q. Well, under what circumstances did you think you should give Dr. Clemons additional information?

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MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: If I had concerns about Gavin's welfare or safety, if I had concerns about potential for conflict in the school, if I had concerns that the issue -- the larger issue was detrimental to anyone at school.
BY MR. BLOCK:
Q. To the best of your knowledge, did the School Board ever indicate it would reassess the policy if it was harming Gavin?
MR. CORRIGAN: Object to the form.
THE WITNESS: I don't know. I wasn't involved in discussions with the School Board generally.
BY MR. BLOCK:
Q. Did Gavin come back to Gloucester High School in September 2015 for his junior year?
A. I'd have to refer to the record. I know he was in an alternative program for part of that year. I don't recall if he returned the beginning of the year and then changed, or if

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he began the year in the alternative program. I can't remember.
Q. What was the alternative program?
A. There was an alternative program located in another Gloucester County Public Schools facility for students who needed an alternative setting, and those students typically engaged in virtual coursework.
Q. What was your understanding for why Gavin was enrolling in that program?
MR. CORRIGAN: Object to the form.
THE WITNESS: I believe my understanding was that Gavin preferred a different location in a smaller setting. I can't recall specifics beyond that.
BY MR. BLOCK:
Q. Did -- do you recall whether the restroom policy played any role in him using an alternative program?
MR. CORRIGAN: Object to the form, foundation.
THE WITNESS: I can't recall

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specifically.
MR. BLOCK: I'd like to have this marked as Exhibit 17.
(Collins Exhibit Number 17 was marked for identification)
Q. Do you recognize this document?
A. Yes, I do.
Q. What is it?
A. This is a form letter that was sent to students who had exceeded the number of absences allowed by Gloucester County Public Schools policy to earn credit for coursework.
Q. And so you said it was a form letter. Did you personally review it?
A. Personally meaning this specific letter to Gavin?
Q. Yeah, did you know that letter was being sent to Gavin?
A. I signed it, so I assume I did, yes.
Q. Did that cause any concerns for you about whether the school policy was negatively affecting him?

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MR. CORRIGAN: Object to the form.
THE WITNESS: I can't say.
BY MR. BLOCK:
Q. Did you tell anyone from the superintendent's office that Gavin was having a lot of absences?
A. I can't recall that specifically, no.
MR. BLOCK: I'll have this marked as Exhibit 18.
(Collins Exhibit Number 18 was marked for identification)
Q. This is a document produced and marked as GCSB 4278, and it's a letter to whom it may concern dated April 26, 2016. Have you seen this letter before?
A. I can't recall it specifically, no.
Q. Did you -- do you recall receiving any letter from a doctor regarding the reasons for Gavin's absences?
MR. CORRIGAN: Object to the form.
THE WITNESS: I can't recall a specific letter, no.

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BY MR. BLOCK:

Q. So were you aware that the absences were due to symptoms of depression and anxiety impacting his functioning?

A. When?

Q. Well, at any time?

A. I would say yes, I became aware of that.

Q. When did you become aware of that?

A. I can't remember.

Q. Was it -- was it at some point during his junior year?

A. Most likely. So during the 2015-'16 school year it appears the Gloucester County Public Schools policy allowed for students to earn credit if they had more than ten absences due to extenuating circumstances. So what most likely occurred is that documentation was provided, reasons for Gavin's absences as part of a review process for extenuating circumstances. Most likely I became aware of it during that process.

Q. And did you discuss this with the

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counseling department at all?

A. I don't recall, other than -- I can't recall.

Q. You started to say "other than." Were there any conversations with the counseling department about Gavin after the restroom policy was put into place?

A. Yes. I had conversations with Ms. Durr, his counselor, and also Matt Lord periodically. We had -- regarding Gavin specifically and his well-being and any needs. And I believe Ms. Durr generally had -- attempted to have weekly check-ins with Gavin. And then I had asked her to please let me know if he had any concerns that I need to be aware of. I believe I talked to Gavin directly on occasion. I can't recall how many times during that year.

Q. What did Gavin say during those check-ins?

A. With me?

Q. Yeah.

A. Gavin did not express concerns regarding restroom usage. Gavin expressed disappointment that he could not use the male restrooms. I can't recall other specifics that he might have discussed.

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Q. Did Gavin talk about the school feeling unwelcoming and unsafe?

A. He did not express that directly to me, no.

Q. Did he express it to the counseling department?

A. I don't know.

Q. Did Gavin indicate to you that he would use the single user facilities?

A. When -- in December of -- when the Gloucester County Public School Board passed a resolution, I talked with Gavin directly, in addition to sending a letter to his parents to make sure he knew what action I was taking. At that time he told me that he understood and would comply with the School Board's wishes. I don't know that I had further conversation with him after that time specifically about restroom usage.

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Q. Did you know whether or not Gavin was using the single user restrooms?

A. It's not something I kept tabs on.

Q. Did anyone at the counseling department express concerns about the effect that the policy was having on Gavin?

A. Not that I recall to me.

Q. So during these check-ins, what would counselors say?

A. To Gavin?

Q. To you.

A. To me?

Q. You said you talked with Matt Lord and Ms. Durr about how Gavin was doing. What did they say to you?

A. I see. I'm sorry, I see. I'm trying to recall. I would say the substance of those -- I don't recall specifically discussing his restroom usage. I'm not sure if that's something they were specifically aware of. It was more about his academic progress in school, talked generally about his well-being at some point. I

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recall talking about an alternative placement for him, those types of things. I would say generally expressing concern, as we would for any student experiencing what the student would consider adverse conditions.

Q. What were the adverse conditions in this case?

MR. CORRIGAN: Object to the form.

THE WITNESS: I can't speculate to Gavin's thought process. My assumption would be that he was not able to use male restrooms at Gloucester High School.

BY MR. BLOCK:

Q. How was his academic performance?

A. I can't recall specifically. Average. I know he graduated on time, but I can't recall specific grades or specific progress.

Q. So were you aware that after this letter from the doctor, Gavin was offered the chance for at-home education?

MR. CORRIGAN: Object to the form.

MR. BLOCK: I'll show it to you.

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(Collins Exhibit Number 19 was marked for identification)

Q. So this is a document produced at GCSB 4280, and it's a letter dated May 4th, 2016 from Bryan Hartley, director of student services to Deirdre Grimm. Have you seen this document before?

A. I don't recall seeing this, no.

Q. In this it says, "Based upon the information provided, Ms. Page Call homebound coordinator, contacted you to offer Gavin an opportunity to continue his academics via homebound services."

Were you aware that Gavin was offered this?

A. Yes, I believe I was aware.

Q. And so do you think it was a good idea to offer him homebound educational services?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: I can't make that judgment. I would say it would have been

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fairly consistent practice for students who provided medical documentation that that be offered, if they're unable to attend school due to medical issues. That was a function, again, of school counseling and student services. I wasn't generally involved in those kinds of decisions.

BY MR. BLOCK:

Q. As a general matter, just in terms of -- as a general matter in terms of educational practice, is having a homebound program as optimal an environment as being able to go to school?

MR. CORRIGAN: Object to the form.

THE WITNESS: I think it depends on the student, and the way homebound services are provided, and the coursework.

BY MR. BLOCK:

Q. Is in general, as a general educational matter, being able to be at school with other students and interacting with other people a positive aspect of the educational experience?

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MR. CORRIGAN: Object to the form and foundation. Go ahead.

THE WITNESS: In my experience generally that's the hope we have for all of our students, but also in my experience I find some students are more comfortable at school and some students are more comfortable not at school. I can't speak to specific students.

MR. BLOCK: Can we go off the record for a second.

(Whereupon, a recess was taken).

BY MR. BLOCK:

Q. To the best of your knowledge, before you became principal at Gloucester High School, had any transgender students attended Gloucester High School?

A. I don't have personal experience, obviously, but I've been told that yes, they have.

Q. Who told you?

A. I don't recall. Other division employees, I believe.

Q. And did they say what restrooms those

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students used?
A. No, I don't believe so.
Q. Did they say what locker rooms those students used?
A. No.
Q. What division employees told you?
A. I can't recall specifically, so I don't know if it was more than hearsay.
Q. But you heard; you just don't know who told you?
A. I can't recall who told me. I would say it's a general recollection on my part that it's information that was shared with me.
Q. Besides Gavin, did any transgender students attend Gloucester High School while you were principal?
A. I'm not sure that I know specifically who they were. So I can't say yes or no, because I don't know specifically who they might have been.
Q. But you know -- do you know whether some unnamed people did?

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A. I would -- yeah, I believe so. I was told that there are other students who are transgender in our school. I think I was told that by the students, actually.
Q. And were you told anything about what restrooms they wanted to use?
A. No, I don't recall that.
Q. Do you know if any of them decided to use those single user restrooms?
A. No, I don't know.
Q. You had said before that you had seen people use the single user restrooms. About how frequently were students using it?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: I can't recall how frequently.
BY MR. BLOCK:
Q. Like about every day do you think you saw someone?
MR. CORRIGAN: Same objection.
THE WITNESS: Well, I can't say that I

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observed it, because I wasn't in the same place every day. I would say typically I saw students using the C-Hall single user restrooms at lunchtime because they were in close proximity, but I can't give you a frequency.
BY MR. BLOCK:
Q. Did you see anyone use the restrooms between classes, the single user restrooms between classes?
MR. CORRIGAN: Object to the form, foundation. Go ahead.
THE WITNESS: I can't recall. I can't recall when I might have seen that.
BY MR. BLOCK:
Q. Okay. So you can't recall whether or not you've seen students use the single user restrooms between classes?
A. No, I can't recall.
Q. So if someone said that no other students used the single user restrooms between classes, you wouldn't have any basis to say that's not true?

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MR. CORRIGAN: Object to the form, foundation.
THE WITNESS: Between classes specifically?
BY MR. BLOCK:
Q. Yes.
A. I can't recall an instance specifically during class when I saw a student exit a single user restroom.
Q. Now, have you had any other information, or inferences, or, you know, news come to you that would lead you to believe that students use the single stall restrooms between classes?
MR. CORRIGAN: Object to the form.
THE WITNESS: I know they were used, because they were dirty. They had to be cleaned. They clearly had been used, but I don't know -- I can't say specifically when during the day they were used.
MR. BLOCK: We can mark this as 20.
(Collins Exhibit Number 20 was marked for

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identification)
Q. I'm showing you a document produced as GCSB 1349 and marked as Exhibit 20. At the bottom of this e-mail thread is an e-mail from you to Dr. Clemons dated November 16th, 2015; is that right?
A. That's correct.
Q. And do you recall sending this e-mail?
A. I do, yes.
Q. Okay. So I'll just read the first paragraph with you. Before our discussion -- I'll start that over and I'll read it correctly. "Per our discussion last Friday, I would like to provide you with some information regarding one of our students who has requested to participate in a VHSL sport as a transgender student."
What does VHSL stand for?
A. Virginia High School League.
Q. And is Gloucester High School a member of the Virginia High School League?
A. It was at that time.

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Q. Is it no longer?
A. I don't know.
Q. And then it says, "The student is a tenth grade student who is biologically female and who is identified at GHS as a female, but who is apparently in the process of transitioning to a male gender identity publicly."
So do you recall who this student is?
A. I do.
Q. So when you previously said you weren't aware of -- specifically of transgender students at Gloucester High School, and you just knew information based on what students had told you, does this, you know, refresh your recollection?
A. It does, yes.
Q. Does it refresh your recollection about whether there might be any other students that you were aware were transgender, other than hearing it from the student body?
A. No, I believe this is the only other one I knew of specifically.

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Q. Okay. The next sentence is, "The student met with their school counselor in September and informed her school counselor at that time that she had come out as transgender to her family, was not ready to do so publicly."
Do you know whether that student ultimately did come out as transgender publicly?
A. If coming out publicly includes formally requesting to compete as a different gender athletically, then yes. And to my knowledge, at least the student's friends were aware of the transition, yes. And I know that at least two of the student's instructors were aware of the transition.
Q. And did the student adopt a name consistent with his gender identity?
A. The student adopted a different name, a preferred name, yes.
Q. And was the student's name changed in school records?
A. As of the time I left Gloucester -- I can't recall. I don't believe it had been as of

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the time I left Gloucester High School.
Q. And do you know whether the student had any medical treatment as part of the transition?
A. To my knowledge, no.
Q. Do you know whether the student made any request with respect to using restrooms?
A. Not to my knowledge, no.
Q. Do you know what restrooms the student did use?
A. I do not know.
Q. Let's read -- continuing with the e-mail it says, "The student and her parent inquired as to the process necessary to allow her to compete as a male member of our swim team through our swim coach, and Kristy Hunter, GHS Activities Director, met with the student and her parent last week and shared with them the VHSL policy regarding eligibility of transgender student athletes."
How did you become aware of these conversations and meetings?

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A. I believe the activities director, Ms. Hunter, who I referred to. I can't recall who told me. I know I had a discussion with Ms. Hunter regarding the meeting she had with the student and parent. I cannot recall if the counselor had also talked to me about it or not.

Q. And what is the VHSL policy regarding the eligibility of transgender student athletes?

A. I can't say that I can quote it, but I believe at that time the Virginia High School League required a medical change before they would approve a student competing as a transgender individual.

Q. And was it your understanding -- what was your understanding of whether this student had had the appropriate treatment to qualify for competing on --

A. Right.

Q. -- the team consistent with their gender identity?

A. I don't believe it had occurred.

Q. If you would turn the page, you say,

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"At this point, I have notified the Peninsula District chairperson of the possibility of this appeal being submitted for review by a District Committee."

What is the Peninsula District?

A. The Peninsula District was the district in which Gloucester High School competed in Virginia High School League-sanctioned competitions.

Q. Do you know whether the student ultimately did file an appeal?

A. Yes.

Q. And what was the outcome?

A. At the district level the district committee upheld the student's appeal, meaning that the district agreed that the student could compete as a male.

Q. And so, the student was allowed to compete as a male on the Gloucester swim team?

A. Ultimately, no.

Q. Why not?

A. Because that decision also required

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affirmation by the Virginia High School League, who denied the appeal, to my recollection.

Q. All right. So there was an immediate appeal to the District Committee?

A. Right. Correct.

Q. And the District Committee granted it?

A. Correct.

Q. And then the VHSL had to review that decision?

A. Correct.

Q. Now, does that review happen automatically, or does someone have to request that review?

A. I believe the district chairperson would have submitted that to the Virginia High School League for review.

Q. Meaning that happens automatically?

A. I believe it was part of the appeal procedures for the Virginia High School League, so yes.

Q. So to the best of your knowledge,

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Gloucester County Public Schools didn't request that appeal?

A. No. To the Virginia High School League?

Q. Yes.

A. No. Yes, it was a part of the procedure that was required.

Q. And if the appeal had -- if the Virginia High School League had upheld the decision of the District Committee, would that student have been allowed to participate on the male swim team --

A. Yes.

Q. -- at Gloucester High School?

A. Yes, correct.

Q. Did you confirm that that is something that the superintendent's office agreed with?

A. I don't recall that specifically, no.

Q. Was it your understanding that the School Board would have to sign off on allowing the student to compete if the VHSL said they

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could?

A. I don't recall ever having that discussion.

Q. So you don't know one way or another whether the School Board would have allowed it to go forward?

A. No, I don't know.

Q. In response to your e-mail to Dr. Clemons, what did he say back to you?

A. I don't recall anything more specifically than: Please keep me informed regarding the situation.

Q. It says -- it indicates at the beginning of this e-mail you say, "Per our discussion last Friday."

So did you have a conversation with him in person about it?

A. Either in person or on the phone. I don't recall.

Q. Okay. And what was the content of that conversation?

A. Probably nearly identical to what is

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in the e-mail. I don't recall if when I spoke to him previously if the -- if I had yet notified the Peninsula District chairperson. So I'm not sure where in the process I was.

Q. Going back to the second page of this e-mail, you write, "Coincidently, the student is also a member of our NJROTC program, and recently requested to wear a male uniform as a member of that program."

A. Uh-huh.

Q. Was that request granted?

A. I believe the instructors granted that request, yes.

Q. So who were the instructors of the NJROTC program?

A. At that time, commander Justin LeWitt and Alvin Grant. I cannot recall.

Q. Does Gloucester County Public Schools have any role in deciding whether those types of requests are granted?

A. Within the NJROTC program?

Q. Yes.

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A. I don't know if Gloucester County Public Schools does, but that decision was by me deferred to the instructors as part of the NJROTC program regulations.

Q. And did you think you had to get approval from Dr. Clemons to allow that to happen?

A. No.

Q. And did you think you had to get approval from the School Board to allow that to happen?

A. I can't say I considered it.

Q. Why not?

A. Because I think NJROTC regulations would have been the deciding information in that decision.

Q. So has any student while you've been principal at Gloucester High School been able to compete on the team consistent with their gender identity instead of the sex assigned to them at birth?

A. Not to my knowledge, no.

Q. When you've had this communication

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with Dr. Clemons, was he already aware of the VHSL policy?

A. I can't say. I don't know.

MR. BLOCK: Mark this as Exhibit 21.

(Collins Exhibit Number 21 was marked for identification)

Q. So this was produced as GCSB 606. It's an e-mail from Chuck Wagner to you and Kristy Hunter dated December 5th, 2014. So that's the previous school year; is that right?

MR. CORRIGAN: Object to the form.

THE WITNESS: That was the previous school year. I would say it was sent to the School Board, and copied to Ms. Hunter and myself.

BY MR. BLOCK:

Q. I see. Do you recall receiving this e-mail?

A. I do not, no.

Q. So in the e-mail Dr. Wagner says -- I'm looking at the second sentence -- well, I'll just read the whole thing for context. "I saw the

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very recent news article below and thought it might provide additional context, especially considering our recent discussion regarding the likelihood that VHSL soon may be considering this issue. If and when it does, and for whichever position it takes, it will be critical that the VHSL and local school divisions have aligned policies/practices in place that otherwise do not place schools, administrators, coaches, athletic directors, and VHSL itself in situations of noncompliance."

Did you hear any other information from Dr. Wagner about the VHSL policy?

A. Not that I recall.

Q. And do you agree that it's critical that local school divisions have aligned policies/practices in place with the VHSL policy?

MR. CORRIGAN: Object to the form.

THE WITNESS: I would say I would expect my school to be in compliance with Virginia High School League regulations.

BY MR. BLOCK:

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Q. When Gloucester High School competes against other schools, those other schools are also in the Virginia High School League, right?

A. In most situations, yes.

Q. And so eligibility for positions on those other schools' teams are also governed by the same VHSL rules regarding transgender students competition, right?

A. Yes.

MR. CORRIGAN: Object to the form. Go ahead.

BY MR. BLOCK:

Q. So under those rules, it's already possible that boys on Gloucester High School's boys sports teams will be competing against boys teams that have transgender boys on them, right?

MR. CORRIGAN: Object to the form.

THE WITNESS: I don't know.

BY MR. BLOCK:

Q. Well, I'm just asking, the teams that the boys teams compete against, those teams under VHSL rules could have transgender boys competing on them?

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MR. CORRIGAN: Object to the form.

THE WITNESS: If other schools have students who are found eligible to compete under Virginia High School League's regulations as transgender students, then yes.

BY MR. BLOCK:

Q. And the same is true for Gloucester High School's girls teams, that the schools they compete against may also have transgender girls on their girls teams?

MR. CORRIGAN: Object to the form.

THE WITNESS: If eligible, yes.

BY MR. BLOCK:

Q. And do you know one way or the other whether any transgender students within the VHSL have been approved as eligible?

A. No, I don't know.

Q. You don't know either way?

A. Either way.

Q. If a student at Gloucester High School who is a transgender boy was allowed to

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compete on the boys swim team, what locker rooms would that student use?

MR. CORRIGAN: Object to the form.

THE WITNESS: I can't speculate. It wasn't discussed.

BY MR. BLOCK:

Q. Do you know of any other requests by transgender students to compete on sports teams consistent with their identity?

A. At Gloucester High School?

Q. Yes.

A. I'm not aware of others, no.

Q. How about at your current school?

A. In the time I've been employed there?

Q. Yes.

A. No.

Q. How about before you were employed there?

A. No, I don't have knowledge of that, no.

Q. So have you at any time spoken to other school administrators in other districts

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about their experiences with transgender students using facilities consistent with their gender identity?

A. Could you repeat that? I'm sorry.

Q. Yeah. Have you at any time spoken with administrators in other districts about their experiences with transgender students using facilities consistent with their identity?

A. I don't recall specific conversations. It's generally a topic of discussion within the profession, but I don't recall specific conversations that I've had, no.

Q. Have you -- so you've read about school administrators in other districts that have policies that allowed trans students to use the restrooms consistent with their identity?

A. I recall reviewing other cases pending throughout the country, but I can't recall specifics.

Q. Did you read the Amicus brief submitted in this case from school administrators from other districts?

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A. I don't believe I have.

Q. In all of your reading or in all the conversations that you've participated in, have you ever heard of a transgender student at a school using the restroom facility for an improper purpose?

MR. CORRIGAN: Object to the form. Foundation. Go ahead.

THE WITNESS: Can you clarify that?

BY MR. BLOCK:

Q. Sure. Well, maybe I'll change it. Have you ever heard, in your reading on the topic or your discussions on the topic, of someone pretending to be transgender in order to use a restroom?

A. I don't recall that I have, no.

Q. Have -- in all of your reading on the topic and discussions on topic, have you ever heard of a transgender student using the restroom consistent with their identity invading other students' privacy?

MR. CORRIGAN: Object to the form, foundation.

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THE WITNESS: I would say I recall reading where it has been asserted that that's occurred, but I can't say I've read that that has occurred.

BY MR. BLOCK:

Q. In your reading and in your conversations on the topic, have you ever heard of a situation in which a transgender student was using facilities consistent with their identity, and that student saw someone else's genitals or their genitals were exposed to another student?

A. No, I have not.

Q. You're aware that Gavin has obtained a birth certificate reflecting that his sex is male, right?

A. Yes.

Q. And you're aware that he has also obtained a court order to that effect?

MR. CORRIGAN: Object to the form.

BY MR. BLOCK:

Q. Is that right?

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A. I believe vital records require a court order to be changed in Virginia. So yes, I would say I'm aware of that.

Q. So how are you aware of that?

A. I can't recall.

Q. Did Gavin request that his school records be updated to reflect the gender marker on his birth certificate?

A. I don't recall if he made a specific request, or if he or his parents provided the information. I can't recall.

Q. And then what happened afterwards?

A. I can remember a discussion with Matt Lord, with our director of student services, regarding when records should be changed, and what is necessary to change a student's gender in their school record. I can't recall the outcome of those discussions and whether it was changed or not before leaving Gloucester.

Q. Who would be the one to make the decision about whether it's changed?

A. I'm not sure.

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Q. What did Matt Lord say in those discussions?
A. I believe it was Mr. Lord's opinion that the vital record change would be sufficient to change a student's school record -- gender in the school record.
Q. And how about the other person in the conversation?
A. I don't know that I ever heard that opinion.
Q. Can you tell me the name of the other person in the conversation?
A. That would have been Bryan Hartley. I'm not sure it was one specific conversation, but communication regarding it.
Q. Does Gloucester Public Schools have a specific policy for changing gender markers in students' records?
A. At the time I don't believe we did, no.
Q. Do you know if they do now?
A. I don't know.

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Q. Now, does Gloucester County Public Schools keep records of whether the birth certificate on file is the student's original birth certificate or an amended one?
A. I don't know.
Q. And in general when a student enrolls in Gloucester County Public Schools, the gender marker on their student records is the same as the marker on the birth certificate they present at that time; is that right?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: Yeah, I don't have firsthand knowledge.
BY MR. BLOCK:
Q. Does -- can you think of any other situation in which a student's gender marker on school records is different from the gender marker on the student's birth certificate?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: Yeah, I don't have any knowledge of that.
BY MR. BLOCK:
Q. Does Gloucester County Public Schools keep records on the chromosomes of each student?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: Not to my knowledge.
BY MR. BLOCK:
Q. Does Gloucester County Public Schools keep records on what the students' genitals look like?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: Not to my knowledge.
BY MR. BLOCK:
Q. So if a transgender student had already transitioned at a different school district and had a birth certificate reflecting their gender as consistent with their gender identity and then transferred to Gloucester County Public Schools, would Gloucester County Public Schools have any way of -- well, let me rephrase this. I'll go back and start from the beginning.
If a student from another school district had already transitioned and had a birth certificate reflecting their gender marker consistent with their gender identity and then came to Gloucester County Public Schools, what's your understanding of which restroom that student would be required to use?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: I think it would be expected the student would use the restroom of the gender we received in their student record.
BY MR. BLOCK:
Q. So even if the gender in their student record is different from the sex they were assigned at birth?
MR. CORRIGAN: Object to the form, foundation.
THE WITNESS: Yes.
BY MR. BLOCK:
Q. And why is that?

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A. Could you be more specific?
Q. Yeah, why would -- if that student's sex assigned at birth let's say was female, and they had two X chromosomes, then -- but they had transitioned and had a male birth certificate, why do you think that student would use the male restrooms instead of the female ones?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: Because we would accept that as their gender.
BY MR. BLOCK:
Q. And you would accept that as their biological gender for purposes of the policy?
MR. CORRIGAN: Object to the form and foundation. Calls for a legal conclusion.
THE WITNESS: I don't know that I can speak to that specifically. We would accept that as their gender assignment.
BY MR. BLOCK:
Q. Were you ever given any training on how the policy applies to that sort of situation?

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A. Which policy?
Q. How the restroom policy applies to that sort of situation?
A. No.
Q. Were you ever given training on how the policy applies to a student with intersex conditions?
A. With, I'm sorry, what conditions?
Q. Intersex conditions. So they have either genitals that are ambiguous or have other parts of the anatomy that are typically not aligned with their sex?
A. Was I given training?
Q. Yes.
A. No.
Q. Were you given any training on how the policy would apply to a student who has had transition-related surgery?
A. Training, no.
Q. So going back on all those questions, had you had any informal conversations about how the policy would apply in the context of a student who had already transitioned and came to the school?
A. I can't say there was any conversation about speculative cases, no.
Q. And that's also true for students with intersex conditions, you didn't have any conversations about that?
A. Not that I recall.
Q. And that's also true for students who might have had transition-related surgery, right?
A. Not that I recall, no.
Q. Is it your understanding that under the policy a transgender girl who has had puberty blockers, and so never went through puberty as a boy, and had cross-sex hormones so she went through puberty as a girl, and had breasts and other anatomical characteristics that developed during puberty, was it your understanding that that student would have to use the boys restrooms at Gloucester High School?
MR. CORRIGAN: Object to the form and foundation.

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THE WITNESS: I wouldn't say I ever considered that scenario.
BY MR. BLOCK:
Q. So even though this was passed as a policy, did you ever consider how it would apply to anyone except Gavin?
MR. CORRIGAN: Object to the form, foundation, legal conclusion.
THE WITNESS: Privately, yes.
BY MR. BLOCK:
Q. How so?
A. What do you mean?
Q. Well, you said privately you considered how it would apply to someone besides Gavin. So in what context?
A. How we would come to know that a student was transgender, is this an enforceable policy. Those two questions primarily.
Q. And what did you -- did you sort of privately think it was an enforceable policy?
MR. CORRIGAN: Object to the form and foundation.

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THE WITNESS: I don't know that I drew a conclusion.
BY MR. BLOCK:
Q. Did you have doubts?
A. I would say it would be difficult to enforce, yes.
Q. And as a factual matter, to the best of your knowledge, has the policy been applied to anyone besides Gavin?
MR. CORRIGAN: Object to the form.
THE WITNESS: As of the time I left Gloucester?
BY MR. BLOCK:
Q. Yes.
A. Not to my knowledge.
Q. Could the School Board have just directed you to not let Gavin use the boys room without creating a formal policy about it?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: I don't know if they can, or could have.

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MR. CORRIGAN: Legal conclusion. Go ahead.
BY MR. BLOCK:
Q. Have any administrative decisions that you've made been over turned by the Board without a formal policy?
MR. CORRIGAN: Object to the form.
THE WITNESS: In Gloucester?
BY MR. BLOCK:
Q. Yes.
A. I can't recall specifically. Perhaps in a student discipline issue, but I cannot recall specifically.
Q. How about in other schools?
A. In other schools, not to my knowledge.
Q. Every time a school board disagrees with a decision of a principal or superintendent, they don't have to pass a formal policy about it, do they?
MR. CORRIGAN: Object to the form and foundation. Legal conclusion.

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THE WITNESS: I don't think they have to, no.
BY MR. BLOCK:
Q. Sitting here today, do you think that allowing Gavin to use the boys facilities was the decision that was in his best interest?
MR. CORRIGAN: Object to the form, foundation, legal conclusion.
THE WITNESS: Yes.
BY MR. BLOCK:
Q. Sitting here today, do you think that the decision to allow him to use the boys facilities was the right decision?
MR. CORRIGAN: Object to form, foundation, legal conclusion.
THE WITNESS: It was the right decision for Gavin.
BY MR. BLOCK:
Q. Do you think that Gloucester's restroom policy can cause harm to the well-being of trans students?
MR. CORRIGAN: Object to the form and

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foundation. Calls for speculation.
THE WITNESS: I don't know if I'm qualified to answer that.
BY MR. BLOCK:
Q. Do you think it sends a message that indicates they're not welcome?
MR. CORRIGAN: Object to the form, foundation, legal conclusion.
THE WITNESS: I can't speak for other students.
BY MR. BLOCK:
Q. Do you think it sent a message to Gavin that Gavin wasn't welcome?
MR. CORRIGAN: Object to the form, foundation, legal conclusion.
THE WITNESS: I believe he felt that, yes.
BY MR. BLOCK:
Q. Do you think that was a reasonable feeling?
MR. CORRIGAN: Object to the form, foundation.

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THE WITNESS: Reasonable in what way?
BY MR. BLOCK:
Q. Do you think Gavin was reasonable in feeling that way?
MR. CORRIGAN: Object to the form, foundation.
THE WITNESS: I can say I understood his perception.
MR. BLOCK: I'll get this marked as Exhibit 22.
(Collins Exhibit Number 22 was marked for identification)
Q. This was produced as GCSB 4283, and it appears to me to be the final transcript for Gavin at Gloucester High School; is that right?
A. Final transcript? Yes.
Q. So is this the document that is sent to colleges when a student applies?
A. It is required by the college for admission, yes.
Q. And so under the top left box it says student, and then it says, State ID, birth date,

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gender, and then grade level. And next to gender it says female, right?
A. It does, yes.
Q. Okay. So any time Gavin applies to a school that required a copy of his transcript, they would receive a document that looks like this; is that right?
A. Yes.
MR. CORRIGAN: Object to the form and foundation. Go ahead.
BY MR. BLOCK:
Q. And that document would list Gavin's gender as being female; is that right?
A. I don't know if that record has been amended since the time this document was produced, but as of the time this document was produced, that's correct.
Q. So do you think that -- can you think of any way that listing Gavin as female on this document protects the privacy of any other student?
MR. CORRIGAN: Object to the form,

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foundation, legal conclusion.
THE WITNESS: Could you repeat the question, please?
BY MR. BLOCK:
Q. Can you think of any way that listing Gavin as female on this document protects the privacy of any other student?
MR. CORRIGAN: Same objections.
THE WITNESS: No.
BY MR. BLOCK:
Q. And so if a college didn't already know that Gavin is trans, transmitting a school record identifying him as female could reveal that he's transgender, right?
MR. CORRIGAN: Object to the form, foundation.
THE WITNESS: I'm not sure that it would necessarily.
BY MR. BLOCK:
Q. Some more mundane questions. At Gavin's -- I want to talk about Gavin's classes senior year, and I want to talk about at what

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areas of the school those classes would have been held.
A. Okay.
Q. So English 12, where on the school map would that class have been?
A. Could have been either A-Hall or D-Hall, depending on the teacher. I don't believe it would have been on the C-Hall.
Q. And if the class was on D-Hall, there is no restroom available for him to use on D-Hall; is that right?
MR. CORRIGAN: Object to the form.
A. No single user restroom, correct.
Q. And where would algebra fundamental data have been?
A. Algebra Functions and Data Analysis, that would have been on A-Hall.
Q. And where would U.S. Government have been?
A. U.S. Government could have been on any of the three halls, depending on the teacher.
Q. And Economics and Personal Finance?

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A. Economics and Personal Finance could have been on either A or C, depending on the teacher.

Q. Do you know the names of the teachers? Are you able to tell me if they had teacher X they would have been on A-Hall, and teacher Y they would have been on C-Hall, so I could figure it out from records?

A. I would have to -- I don't know that I could necessarily for each year.

Q. How about for his senior year?

A. No, I don't -- yes, I could probably do that.

Q. Okay. So for English, what teacher would he have had to have had for it to be on A-Hall?

A. Oh, no, I'm sorry, I can't do that.

Q. Okay.

A. If you could tell me the teacher, I could tell you where they were located, but I can't go the other way.

Q. And do you think someone else at

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Gloucester High School would be able to put two and two together?

A. I don't know if the master schedule document for that year still exists. As you know, teacher names are not included on the transcript. So I don't know.

Q. And would there be any other record about where Gavin's classrooms were located at different points in time?

A. Not to my knowledge, no.

MR. CORRIGAN: I'm going to interrupt a second. What did you say about algebra? Where was algebra?

THE WITNESS: Algebra Functions and Data Analysis would have been on A-Hall.

MR. CORRIGAN: Thanks. Sorry.

BY MR. BLOCK:

Q. And for his junior year, what does DL mean under attributes? Do you see there's course title?

A. The DL corresponds to virtual courses. So where you see DLC in the course

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title -- I don't know what DL means specifically. Those attributes are assigned to virtual courses.

Q. I see. So all of his -- with the exception of creative writing, all of Gavin's credits in his junior year were from virtual courses?

A. Correct, yes.

Q. And his PE credit from tenth grade was from virtual courses, right?

A. Correct. Yes.

Q. Now, looking at his transcript, just as an educator, when do you think was -- in terms of Gavin's performance, when do you think was his most successful time in high school?

MR. CORRIGAN: Object to the form and foundation.

THE WITNESS: Based on grades?

BY MR. BLOCK:

Q. Yes.

A. Well, without actually calculating his GPA, it would appear either his sophomore year or his senior year.

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Q. How about based on just other attributes, in your observations, when do you think Gavin's most successful time in high school was?

A. And let me qualify this. I was not there when Gloucester was in 9th grade -- or when Gavin was in 9th grade. So I can only speak to 10th, 11th and 12th. And I can't speak for him specifically. I don't know that I can make a judgment about that.

Q. Did you notice a change in Gavin at all after the school passed its restroom policy?

A. What kind of change?

Q. Just a change in his enthusiasm?

MR. CORRIGAN: Object to the form and foundation.

THE WITNESS: I can't say I can answer that simply because I knew Gavin for a very short time prior to that policy being enacted.

BY MR. BLOCK:

Q. How about just a change in his affect?

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MR. CORRIGAN: Same objections.
THE WITNESS: Yeah, I don't believe I interacted with Gavin personally enough to be able to determine whether there was a change in his affect.
BY MR. BLOCK:
Q. What were Gavin's -- what was Gavin like in his interaction with other students?
A. When he was at Gloucester High School I saw Gavin with a small, close group of friends typically. I did not personally witness any negative interactions between Gavin and other students. That's the best I can say.
Q. From your vantage point, could you tell whether Gavin was accepted as a boy by his peers?
A. I can't speak for all of his peers. Certainly from his friend group he was accepted as a boy.
Q. And in terms of his, you know -- the clothes he wore and and how he acted, from your vantage point was it consistent with how a boy

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would typically dress and look and act?
MR. CORRIGAN: Objection to the form, foundation, legal conclusions.
THE WITNESS: I don't know that there's a consistent behavior for a boy, but I would say I recognized him as a boy based on appearance.
BY MR. BLOCK:
Q. If you had seen Gavin outside of school like in a public setting, would you have recognized him as a boy in that setting?
MR. CORRIGAN: Object to form, foundation.
THE WITNESS: By his senior year, yes.
BY MR. BLOCK:
Q. Was Gavin ever inconsistent in asserting his gender identity and acting in accordance with his male gender identity?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: In my experience?
BY MR. BLOCK:

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Q. Yes.
A. In my interactions with him, no.
Q. At any time in Gloucester High School did anyone raise any doubts about the fact that Gavin was, in fact, a transgender boy?
MR. CORRIGAN: Object to the form and foundation. Legal conclusion.
THE WITNESS: To me directly, no.
BY MR. BLOCK:
Q. Indirectly?
MR. CORRIGAN: Same objections.
THE WITNESS: I don't have firsthand knowledge of it, no.
MR. BLOCK: If you give me just a couple of minutes, I'll see if we can wrap up.
THE WITNESS: Okay.
(Whereupon, a recess was taken).
MR. BLOCK: So that's all of my questions for you. Do you have any, Dave?
MR. CORRIGAN: No questions, and he will read.
(Off the record at 1:43 p.m.)

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ACKNOWLEDGMENT OF DEPONENT

I,

NATHAN COLLINS, do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct, and complete transcription of the testimony given by me; and any corrections appear on the attached Errata sheet signed by me.

_____ _____

(DATE) (SIGNATURE)

CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC

I,

LISA BLAIR, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my direction; that reading and signing was requested; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 22nd day of September 2018.

My commission expires October 31, 2020.

Lisa Blair, RMR

Transcript of Walter Clemons, PhD

Date: September 21, 2018
Case: Grimm- v- Gloucester County School Board

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
CIVIL CASE NO. 4:15-CV-54

GAVIN GRIMM : Plaintiff
v. :
GLOUCESTER COUNTY SCHOOL BOARD : Defendant

Deposition of WALTER CLEMONS, PhD
Glen Allen
Friday, September 21, 2018
2:08 p.m.

Job No.: 207622
Pages 1 - 116
Reported by: Lisa M. Blair, RMR

Deposition of WALTER CLEMONS, PhD, held at the offices of:

HARMAN, CLAYTOR, CORRIGAN & WELLMAN, P.C.
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Pursuant to agreement, before Lisa M. Blair, Notary Public in and for the Commonwealth of Virginia.

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C O N T E N T S

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By Mr. Block 6

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P R O C E E D I N G S

Whereupon,

WALTER CLEMONS, PhD,

being first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE PLAINTIFF

BY MR. BLOCK:

Q. Good morning, Dr. Clemons. My name is Josh Block. I will be taking your deposition today. I represent Gavin Grimm in Grimm versus Gloucester County Public Schools.

Have you ever had your deposition taken before?

A. I have not.

Q. Okay. First time for everything. So I want to just review with you a couple of ground rules for the deposition. The first is that a transcript is being made of everything we say. So it's important that all your answers also be verbal so the reporter can write them down; does

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1 that sound okay to you?
2 A. Yes.
3 Q. Perfect. Second is because this is a
4 transcript, she can't write down crosstalk if
5 we're both talking at the same time. So it's
6 important that I wait for you to finish answering
7 before I ask my next question, and you wait for me
8 to finish asking questions before you answer; is
9 that okay?
10 A. That's fine.
11 Q. Great. And finally, it's my job to
12 ask questions that you can understand. So if
13 anything I say is unclear, I'm going to count on
14 you to let me know, so I can fix it; is that fair?
15 A. That's fair.
16 Q. And if you answer a question, I'm
17 going to take that to mean that you understand it,
18 okay?
19 A. Correct.
20 Q. Great. And is there any reason why
21 you wouldn't be able to give your full and
22 complete and truthful testimony today?

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1 A. No.
2 Q. Okay. So can you say your name and
3 your title for the record?
4 A. I'm Dr. Walter Clemons,
5 superintendent of schools for Gloucester County
6 Public Schools.
7 Q. And how long have you been
8 superintendent there?
9 A. I started there July 1, 2014 till the
10 present.
11 MR. BLOCK: I'm going to mark this as
12 Exhibit 1.
13 (Clemons Exhibit Number 1 was marked for
14 identification)
15 Q. Just reviewing your impressive
16 resumé; do you recognize this document at all?
17 A. Yes.
18 Q. Okay. What is it?
19 A. It's a document from Frances Hubbard
20 of the -- one of the local reporting, you know,
21 agencies that talked about my arrival, you know,
22 coming to Gloucester.

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Q. Great. So I just want to use this to go over some background information with you. Before being superintendent at Gloucester, you were superintendent for Northampton County; is that right?

A. That's correct.

Q. How big a district is Northampton County?

A. At that point in time Northampton County had four schools roughly consisting of about 1,700, 1,800 kids.

Q. And how long were you a superintendent there?

A. I was superintendent there for three years.

Q. And what did you do before that?

A. I was assistant superintendent for six and-a-half years in Franklin City Public Schools.

Q. And what did you do before that?

A. Before that, I was principal at Franklin High School for five and-a-half years.

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Q. And before that?

A. Assistant principal at West Charlotte Senior High School in Charlotte, North Carolina for two years.

Q. And before that?

A. I was an assistant administrator at Gildersleeve Middle School in Newport News.

Q. And before that?

A. I was a teacher in Newport News for six years.

Q. And before that?

A. Before that, I was a teacher in Isle of Wight County, Smithfield High School, starting back in 1987.

Q. And before that?

A. Okay. I was a student at Norfolk State University.

Q. So starting from your first job as a teacher till the time that you came to Gloucester, did any of the schools where you were working have any policies regarding transgender students?

A. Not that I can recall.

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Q. And to the best of your knowledge, were there any students at any of those schools who were transgender?

A. Not to my knowledge.

Q. So to the best of your knowledge, did any transgender student at any of those schools request to use restroom or locker room facilities that were different from the sex assigned to them at birth?

A. Not to my knowledge.

Q. I'd like to just review your educational background, too. You got a PhD in educational leadership and policy from Virginia Tech?

A. That's correct.

Q. And you also got a certificate of advanced study in educational administration from Old Dominion University?

A. That's correct.

Q. And MA in music education and BA in instrumental music from Norfolk State University?

A. That's correct.

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Q. While earning any of your degrees in education, did you ever learn about the treatment of transgender students in schools?

A. Not to my recollection.

Q. Have you ever received any training or continuing education about the treatment of transgender students in schools?

A. Could you repeat that question?

Q. Have you ever received any trainings or continuing education about transgender students in school?

A. No training or education, to my knowledge.

Q. Have you been to any conferences or seminars about it?

A. I have.

Q. Which ones?

A. Back in I believe two thousand and -- it may have been '15, VSBA and some of the law conferences we have, they will have law firms come and speak on various topics. So I recall being at a session regarding discussion of, you know,

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transgender students at that point in time.

Q. Have you at any time had conversations with administrators from other school districts about their experience with transgender students at their school?

A. Not that I can recall.

Q. Have you ever had any communications with administrators at other school districts about policies that -- or practices that allow trans students to use restrooms consistent with their gender identity?

A. Not that I can recall.

Q. Have you ever heard or read indirectly about experiences of school administrators in other districts that allow trans students to use restrooms consistent with their identity?

A. Not that I can recall.

Q. Now, Nate Collins started as principal the same year you started as superintendent at Gloucester; is that correct?

A. That is correct.

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Q. Was he a good principal?

A. I feel he was a good principal.

Q. You feel he had a successful tenure at Gloucester High School?

A. Yes.

Q. And you could trust him to act in the best interest of students?

MR. CORRIGAN: Object to form.

THE WITNESS: Yes.

BY MR. BLOCK:

Q. And you trusted him to be able to handle day-to-day questions and concerns that might come up at Gloucester High School?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: Yes.

BY MR. BLOCK:

Q. And you respect his judgment?

A. Yes.

Q. And the school did well under his tenure, right?

A. Yes.

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Q. Is it true that before he started, Gloucester High School was just accredited on a probationary basis?

A. It was accredited with warning.

Q. And what is that?

A. That means that as it relates to the academic disciplines of English, mathematics, history and science, you have to attain a certain percentage of passing grades on the Standards of Learning assessments that's prescribed by the state. And if you fall short in any one of those areas, you may have a distinction other than being fully accredited. And at that time Gloucester High School was not meeting the benchmark in mathematics, so it was accredited with warning.

Q. And during the years that he was principal, did Gloucester High School meet the necessary benchmarks?

A. Yes.

Q. All four years?

A. No. He was there three years. Two of the years, yes; and one year, no.

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Q. And the one year that didn't, which year was that?

A. That was 2015-'16.

Q. Okay. When did you first learn about Gavin Grimm?

A. To the best of my recollection, that would have been at the end of September of 2014, right at the beginning of October of 2014.

Q. And how did you come to learn about him?

A. I learned about Gavin from a conversation with Mr. Collins.

Q. And what did Mr. Collins say?

A. He indicated to me that there was a student at the high school that he had been working with throughout the course of the first couple of months with using a restroom that was in the clinic, and that there was a student that was working through getting a name change, and was working in being classified as transgender.

MR. BLOCK: I'm going to ask for this document to be marked as Exhibit 2.

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(Clemons Exhibit Number 2 was marked for identification)

Q. This document was produced as GCSB 4121, and it's an e-mail from Mr. Collins to you dated October 23rd. Do you recognize this document?

A. Yes.

Q. So if you turn to the second page, this is a memo from Mr. Collins to you; is that right?

A. Yes.

Q. And do you recall receiving this memo?

A. Yes.

Q. So this memo just recounts some background about Gavin's interactions with the school, right?

A. Yes.

Q. So I just want to use this as a frame of reference to talk about the events that occurred before the date of this memo. So if you go to the fourth paragraph here where it says, "At

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the beginning of the school year, a plan was put in place to accommodate the student's bathroom use concerns. An administrative decision was made, and the student was informed by his school counselor he may use the bathroom in the school clinic. In the case of an emergency, the student was given permission to use a staff bathroom on the D wing of the school, in which the majority of his classes are located."

At the time that this administrative decision was made to let Gavin use the school clinic, did Mr. Collins contact you in connection with that administrative decision?

A. No.

Q. Then continuing to read this paragraph, "At the beginning of the school year, the student and his mother reported the student will begin hormone therapy during the month of October. In early October, prior to the anticipated date of the student beginning hormone therapy, the student met with his school counselor and requested permission to use male student

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bathrooms either before or once he begins hormone therapy. This request was brought to my attention. I consulted with Dr. Clemons and with school counseling staff members to review available legal references."

And so is this -- is this conversation in which Principal Collins said he consulted with you and with school counseling staff members the time when you first became aware of Gavin Grimm?

A. To the best of my recollection, the time that I first became aware of Gavin was when Mr. Collins contacted me again at -- like I said, at the latter part of September, the first part of October to give me some preliminary background about, you know, what had transpired with the student earlier.

Q. So you had a conversation with him -- with Mr. Collins before the conversation in which he discussed Gavin using the boys restroom?

A. Correct.

Q. And so why was Mr. Collins bringing

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the issue to your attention at that time?

A. Again, to the best of my recollection, Mr. Collins was bringing it to my attention because he had been made aware by his staff that the student now was asking permission to use the restroom consistent with his gender identity. And so then that's the first that actually I'm aware of the situation. And so that's when he then gave me some background, you know, information on what had transpired leading up to that.

Q. Okay. And so when he contacted you about this request, what did he say?

A. He gave me the background information about the student and requesting to have the name change, and, you know, discussing the information about using the restroom that was in the nurse's designated area. And then from that standpoint he asked me -- he let me know that the student -- you know, there was a request for the student to use the restroom consistent with gender identity.

Q. Did he ask for your advice on that

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request?
A. I shared with him at that point in time that that was, you know, an area that I was unfamiliar with. So I would have to try to garner some information to even have a discussion about it.
Q. And what steps did you take to garner that information?
A. From that point in time I contacted the Virginia School Board Association and spoke with Elizabeth Ewing.
Q. Is there any other source of information you consulted?
A. Not at that point in time, no.
Q. Did you consult with material -- consult with any other professional organization like organizations of school superintendents or any other sort of professional resource?
A. No, I did not.
Q. And after -- did you consult at all with either of the assistant superintendents?
A. No, I did not. Not at that point.

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Q. Were they involved in this discussion in any way?
A. Not to my knowledge.
Q. And so after -- did you talk with any of the counseling staff?
A. No, I did not.
Q. So after you consulted with Ms. Ewing from the Virginia School Board Association, what did you tell Principal Collins?
A. I received some literature that Ms. Ewing had sent, and then I just shared that information with Mr. Collins that it was just some literature about transgender students so that we both could start to familiarize ourself with the topic.
Q. After you sent him that information, did you continue discussing whether or not Gavin's request should be granted?
A. To my recollection, what we talked about at that point in time, because Gavin -- Mr. Collins had not met actually with Gavin or his mother at that point in time. And so our

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discussion was more so based around the premise of Mr. Collins would meet with Gavin and his mother. And as principal, principals have the authority to work with students on a case-by-case basis to try to do what's in the best interest of the student, regardless of what the issue is. And so the conversation that we had was he would determine, you know, what the avenues would be as it relates to Gavin. And he would treat it as an individual student matter and confidential, as we would do with any student.
Q. And at the time did you think there was any School Board policy that precluded Mr. Collins from allowing Gavin to use the boys restrooms?
MR. CORRIGAN: Objection to the form, foundation, legal conclusion. Go ahead.
THE WITNESS: Not to my knowledge.
BY MR. BLOCK:
Q. And did you think that you were giving Mr. Collins, you know, permission to decide what the policy should always be for all

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transgender students under all circumstances?
MR. CORRIGAN: Objection to the form and foundation.
THE WITNESS: To my recollection, I was allowing the principal to just have autonomy to make decisions as, you know, he or she would on any confidential student matter.
BY MR. BLOCK:
Q. And it would be determined on an individualized basis; is that right?
A. That is correct.
Q. And did you tell Principal Collins that you would support whatever decision he makes?
A. I support any principals on decisions that they make after we've had discussion regarding, you know, whatever the topics are. They have autonomy to work and do what they see is best, you know, based on their review of the information and deciding what they feel is in the best interest of moving students forward.
Q. Why is that? Why do you give principals that autonomy?

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A. They're the leader of the buildings. So that's their right. I was a building principal.

Q. Do you think they are in a better position to make those types of decisions than you are?

MR. CORRIGAN: Object to the form and foundation.

THE WITNESS: I think they are an appropriate decision-maker because they are working with students on a day-to-day basis, and I'm not, from the position that I hold.

BY MR. BLOCK:

Q. In your studies about education, is there anything in the literature about the most effective ways to allocate decision-making between principals and superintendents?

MR. CORRIGAN: Object to the form and foundation, legal conclusion. Go ahead.

THE WITNESS: Shared base leadership and giving principals the authority within reason to, you know, run their buildings as they deem

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necessary.

BY MR. BLOCK:

Q. Is there any situation you can think of in which you've overruled a principal's decision about how to run their building?

A. I cannot recall anything specifically at the moment, but probably during my tenure, probably at some point.

Q. Can you recall another situation besides this one in which a School Board reversed the decision of a principal?

MR. CORRIGAN: Object to the form and foundation.

A. Not to my recollection.

Q. So after Principal Collins met with Gavin, did he check in with you again to let you know that he met with Gavin, and his plan was to allow Gavin to use the boys restrooms?

A. Not to my recollection.

Q. But did you expect him to check in with you?

A. The last communication that we had

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had before that was before he had actually met with Gavin and his parents. And, you know, like I said, that conversation just consisted of, you know, you meet with the parent and, you know, you have the discretion to make a decision that you feel is in the best interest of moving forward.

Q. Did you form your own personal opinion about what the best decision would have been?

MR. CORRIGAN: Object to the form and foundation. Legal conclusion.

A. I have not had a personal opinion.

Q. Is that -- as a general matter, do you not develop personal opinions on these issues that are delegated to principals?

MR. CORRIGAN: Object to the form.

A. I can't recall on all matters, but for this one I just didn't formulate an opinion, you know, pro or con.

Q. Is that because you hadn't studied the issue enough to form an opinion?

A. Yeah, I think of course --

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MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: At that point in time that was a relatively new subject. You know, I feel that when you are looking at things that are, you know, out of your realm, so to speak, it's best to, you know, not really form an opinion either way.

BY MR. BLOCK:

Q. When you told Mr. Collins that he could make the decision he thought was appropriate, did you think you were setting a new policy about how transgender students should be allowed to use locker rooms?

MR. CORRIGAN: Object to the form and foundation, legal conclusion. Go ahead.

THE WITNESS: Not to my recollection.

BY MR. BLOCK:

Q. Did you consult with the Board at this time before Mr. Collins made the decision to allow Gavin to use the boys restrooms?

A. No, I did not.

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Q. To the best of your knowledge, did any transgender students at Gloucester High School before Gavin ever request to use restrooms that were different from their sex assigned at birth?

A. Not to my recollection.

Q. Now, Gloucester County Public Schools has generally applicable policies prohibiting assault and battery, right?

A. Yes.

Q. And it has generally applicable policies prohibiting harassment, right?

A. Yes.

Q. And it has generally applicable policies prohibiting sexual offenses, right?

A. Yes.

Q. And those policies apply to students when they use the restrooms; is that right?

A. Well, the code of conduct would outline all of the rules and regulations for students.

Q. And did you -- and so the fact that Gavin could use the boys restrooms didn't give him

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permission to engage in activity that would otherwise have been prohibited by one of those generally applicable disciplinary policies, rights?

A. All students are expected to abide by the student code of conduct.

MR. BLOCK: Let's mark this as Exhibit 3.

(Clemons Exhibit Number 3 was marked for identification)

Q. I'm showing you a document marked as GCSB 4120. Do you recognize this document?

A. I do.

Q. What is it?

A. It's an e-mail that Mr. Collins had made me aware of regarding inquiries about the student and restroom usage.

Q. And what did you -- well, are these -- is this e-mail the first time that you were made aware of any complaints regarding Gavin's use of the restrooms?

A. Yes.

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Q. What did you do when you received this e-mail?

A. I just -- you know, like I said, I reviewed the e-mail, and I, you know, then had an upcoming meeting the following evening, as a matter of fact, with the Gloucester County Board of Education and just tried to give them some insight from what had been shared with me.

MR. CORRIGAN: You said Board of Education.

THE WITNESS: School Board.

MR. CORRIGAN: I wanted to make sure we weren't delving into something else. I don't mean to testify.

THE WITNESS: School Board.

BY MR. BLOCK:

Q. And that memo that we looked at a second ago in Exhibit 2 that Mr. Collins wrote to you, did you ask him to prepare that memo for the purpose of sharing that information with the School Board?

A. I don't recall the exact details of

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the discussion about the preparation of the memo.

Q. Do you know why that memo was prepared on that day?

A. I don't have a recollection at this point in time.

MR. BLOCK: Let's mark this as Exhibit 4.

(Clemons Exhibit Number 4 was marked for identification)

Q. I'm showing you a document produced as GCSB 801, and it's an e-mail from a redacted person. Do you recognize this document?

A. (Witness perusing document). Yes.

Q. What is it?

A. It's an e-mail that came to School Board members and myself from a concerned member of the community.

Q. And do you -- at this time, had you received any other e-mails directly?

A. Not to my recollection.

Q. Okay. And what was your reaction

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when you received this e-mail?
A. In thinking back, similar to what he had shared with me, you know, previously about the other concern that he had got was just, you know, some concern that's been generated by the student's use of the restroom.
Q. And you wanted to brief the School Board in response to these concerns?
A. Yes, and share it, because I, you know, had an idea that, you know, if concerns are beginning to be expressed, that at some point in time the Board members would probably get some -- you know, some concerns shared with them as well.
MR. BLOCK: Mark this as Number 5.
(Clemons Exhibit Number 5 was marked for identification)
Q. This is a document produced as WAVY TV FOIA response 007. Do you recognize this document?
A. Yes.
Q. And what is it?
A. It's an e-mail that I had sent to the

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School Board that was on the evening of Wednesday, October 22nd.
Q. So near the bottom, the third line from the bottom you write, "Finally, I will forward you some literature on the transgender issue that Elizabeth Ewing (VSBA) sent to me when we had a discussion on this issue previously."
Is that the information that you previously talked about in this deposition?
A. That's correct.
Q. And you say, "Furthermore, I will have Mr. Collins present tomorrow evening so he can fill you in on his actions thus far relating to these issues."
Did you mean to say that he will present or he will be present?
A. I can't recall at this point.
Q. Okay. I don't know how you write that on the transcript.
Now, at the time you wrote this, had any School Board members contacted you about the issue?

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A. I can't recall at this point in time, and I'll just say that to the best of my recollection.
MR. BLOCK: This is Number 6.
(Clemons Exhibit Number 6 was marked for identification)
Q. This is a document produced as GCSB 826, and at the top of the chain is an e-mail from Kimberly Hensley to you and Chuck Wagner; is that right?
A. That's correct.
Q. Do you recognize this document?
A. Yes, I do.
Q. So this appears to me to be a document that Board Member Hensley sent to you and Dr. Wagner the day after you had the School Board meeting briefing them on Gavin's issue; is that right?
MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: That is correct.
BY MR. BLOCK:

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Q. So in here she writes, "Dear Dr. Clemons and Dr. Wagner: I know I complain a lot, so I wanted to make sure I told you how glad I am today after the work session last night."
And the work session, you understand her to be referring to the meeting; is that right?
A. Correct.
Q. She goes on, "I was worried that this situation at GHS with our transgendered student might be controversial, which it was, but I am happy that things worked out as they did."
Then I'll skip to the next paragraph: "It is thanks to both of you that the vote came out as it did. Thank you for your guidance and your ability to lead the Board into a good decision."
So do you -- what did you understand Ms. Hensley to be referring to when she said, "It's thanks to you both that the vote came out as it did?"
MR. CORRIGAN: Object to the form and foundation. Go ahead.

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THE WITNESS: Repeat the question again.
BY MR. BLOCK:
Q. What did you understand Ms. Hensley to be referring to when she said, "It's thanks to you both that the vote came out as it did?"
A. To the best of my recollection, it's just sharing information, you know, as we stated earlier -- as I stated earlier about what I had found out and what the communication had been thus far with the Board, and, you, just having discussion with them about, you know, the information that had been discussed so far.
Q. And did you -- did you agree with the vote that came out during that meeting?
MR. CORRIGAN: Object to the form and foundation, legal conclusion. And I'm going to -- this is a touchy area with the legislative privilege of what the Board talked about within his meeting. And I understand that Ms. Hensley has said whatever it is she said, but I don't think the Board has waived its privileges. And so what the Board decided

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I think is something I'm going to instruct him not to answer.
MR. BLOCK: So I'm not asking for the content. I'm just asking if he agreed with the result.
MR. CORRIGAN: Okay. Object to the form and foundation. Legal conclusion. Go ahead.
THE WITNESS: To the best of my recollection, there wasn't a vote.
BY MR. BLOCK:
Q. So putting aside the issue of whether there's a vote, did you agree with the ultimate outcome of the meeting?
MR. CORRIGAN: Same objection.
THE WITNESS: I can't recall the outcome, so to speak, other than there being no outcome.
BY MR. BLOCK:
Q. So further down in that e-mail chain at the bottom Dr. Wagner writes back and says, "Whoever said that doing right was easy? Thanks for your kind words and concern for the student."

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Do you recall him writing that response?
A. To my recollection, I can't recall at this point in time.
Q. Did Dr. Wagner ever express to you that he thought that allowing Gavin to use the boys restroom was the right thing to do?
MR. CORRIGAN: Objection to the form and foundation.
THE WITNESS: I'm not certain at this point in time.
BY MR. BLOCK:
Q. So at this point in time -- well, when you say you're not certain at this point in time, do you mean that you're not certain that as of October 24th he had expressed that opinion to you, or are you saying sitting here today at this time you're not certain?
A. At that point in time, I'm not certain.
Q. At any time, did Dr. Wagner express to you that letting Gavin use the boys restroom

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was the right thing to do?
A. I can't recall, honestly.
Q. Did Dr. Wagner ever express to you an opinion on whether adopting the restroom policy that the Board ultimately adopted was the right thing to do?
MR. CORRIGAN: Object to the form and foundation, legal conclusion. Go ahead.
THE WITNESS: Not to my recollection, to the best of my knowledge.
BY MR. BLOCK:
Q. Did he express any opinion on it either way?
MR. CORRIGAN: Same objections.
THE WITNESS: To the best of my recollection, not to my knowledge.
BY MR. BLOCK:
Q. Quick question: At the time that you told Dr. Collins that he could decide how to handle Gavin's request, did you think that the law compelled him to make one decision or another?
MR. CORRIGAN: Object to the form and

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foundation. Legal conclusion. Go ahead.
THE WITNESS: Could you repeat the question again for me?
BY MR. BLOCK:
Q. Yeah. When you authorized Dr. Collins to decide how to handle Gavin's request to use the boys room, did you think that the law compelled him to decide the issue one way or another?
MR. CORRIGAN: Same objections. Go ahead.
THE WITNESS: Not to my knowledge.
MR. BLOCK: We can mark this as Number 7.
(Clemons Exhibit Number 7 was marked for identification)
Q. This is a document produced as GCSB 835. Do you recognize this document?
A. Yes, I do.
Q. And what is it?
A. That is a response from me to a concerned parent regarding the issue at Gloucester

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High School.
Q. And in that response I'm looking at the third sentence. You say, "The school division respects the rights of all students, and will consider any request for a specific accommodation within the contours of relevant federal and state laws and guidance."
So in writing that sentence, did you -- when you say the school will consider any request for a specific accommodation, what were you referring to?
A. I was referring to the matter of being kept as a confidential student matter, that I wasn't going to discuss with a parent and that more so than anything the school division looks at trying to follow guidelines of student privacy. I wasn't going to get into that type of conversation.
Q. And that any future requests would also be addressed on an individualized basis; is that right?
MR. CORRIGAN: Object to the form.

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THE WITNESS: Principals had their authority -- again, as we said earlier -- to, you know, look at student matters on a case-by-case basis.
BY MR. BLOCK:
Q. Did you hear any complaints from faculty members about Gavin using the boys restroom?
A. I'm trying to think back. There was one faculty member or one staff member that had requested to have a meeting with me at an upcoming date who wanted to have some discussion about restroom usage.
Q. And which faculty member was that?
A. It was a member, to the best of my recollection, of the security team there.
Q. Would that be Ralph VanNess?
A. That's correct, to the best of my knowledge.
Q. Do you know if Mr. VanNess spoke with any students about Gavin using the restroom?
A. Not that I'm aware of.

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Q. Do you know if Mr. VanNess had any role in disclosing to the public that Gavin was using the boys restroom?
A. Not that I'm aware of.
Q. When parents or other individuals complained about Gavin using the restroom, did they ever indicate how they learned about this fact?
A. Not to my recollection at the moment.
Q. Did you ever tell any parent that the topic of a student using the restroom consistent with their identity was going to be discussed at this closed School Board meeting?
A. Not to my recollection.
Q. So as a general matter would you tell parents the topics that are discussed at these School Board meetings?
A. School Board meetings, of course they have an agenda, and there are certain things that happen with the agenda topics that will be open or closed.
Q. Yes. I'm sorry. Would you generally

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tell parents the topics that are discussed at these closed work session meetings?
MR. CORRIGAN: Object to the form.
THE WITNESS: Not to my recollection.
BY MR. BLOCK:
Q. So if any parent, you know, was aware or became aware of the fact that the topic was going to be discussed at that meeting, they didn't learn that from you; is that right?
MR. CORRIGAN: Object to the form.
THE WITNESS: Not to my recollection.
BY MR. BLOCK:
Q. And if any parent after the School Board meeting, the closed work session, became aware that the topic was discussed, they wouldn't have heard that from you, either, after the meeting took place?
A. To the best of my recollection, that would be correct.
Q. So you never at any time told anyone about whether or not some sort of vote did or did not happen at the meeting, right?

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A. Not to the best of my knowledge, no.
Q. Do you know how information about Gavin's restroom use was disseminated to the community?
A. I don't have firsthand knowledge, no.
Q. Do you have secondhand knowledge?
MR. CORRIGAN: Object to the form. Go ahead. Foundation.
THE WITNESS: Possibly hearsay.
BY MR. BLOCK:
Q. What hearsay did you hear?
MR. CORRIGAN: Same objections. Go ahead.
THE WITNESS: I said possible hearsay. I don't have firsthand, but possible hearsay about restroom usage.
BY MR. BLOCK:
Q. Right. So I mean, I -- there are objections to whether that can be admitted in court, but for purposes of this, you can answer my question, even if it's based on hearsay.
A. I'm not aware of any specific

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discussions of, you know, how the community may have become aware of the restroom situation.
Q. Have you heard any hearsay about whether any members of the School Board disclosed the information to the community?
MR. CORRIGAN: Object to the foundation. Go ahead.
THE WITNESS: Not to my recollection.
BY MR. BLOCK:
Q. Have you heard any hearsay that any people working at the school disclosed the information to the community?
A. Not to my recollection.
Q. How do you think the information was disseminated to the community?
MR. CORRIGAN: Object to the form and foundation. Calls for speculation. Go ahead.
THE WITNESS: You saw a previous e-mail that I responded to from the parent of one of the kids. So there could be a multitude of ways that, you know, that could have been, you know, the basis for starting conversation.

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BY MR. BLOCK:
Q. Did you ever receive any complaints from a student or the parent of a student who had actually used the restrooms at the same time as Gavin?
A. Not to my recollection.
Q. During this closed meeting work session, could -- as you understand it, could the School Board have overruled your administrative decision about allowing Mr. Collins to allow Gavin to use the boys restroom?
MR. CORRIGAN: Object to the form and foundation. Legal conclusion. Go ahead.
THE WITNESS: The School Board is responsible for adopting policy and approving budgets and things of that nature. So it's within their purview to address any issue that I would think that's related to some form of a policy.
BY MR. BLOCK:
Q. But could they -- in general, the School Board could reverse an administrative

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decision without passing a new broader policy to do it, right?
MR. CORRIGAN: Objection to the form. Legal conclusion. Foundation.
THE WITNESS: I would surmise in the grand scheme of things maybe they could, but normally school boards, you know, acquire, you know, additional information, or they become versed in a topic before making any final decisions regarding regulation or policy.
BY MR. BLOCK:
Q. If there is no policy specifically addressing a question and it's just a matter of discretion, the School Board can't weigh in on that about how they think the discretion should be exercised?
MR. CORRIGAN: Objection to the form. Foundation, legal conclusion, speculation. Go ahead.
THE WITNESS: I think they could provide, you know, some conversation.
BY MR. BLOCK:

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Q. So let's say that a student has been disciplined for some reason and a School Board disagrees with the severity of the discipline. And in your experience do they have to have a public meeting with a formal policy in order to overrule the decision of the administrators?
MR. CORRIGAN: Object to the form and foundation. Legal conclusion. Go ahead.
THE WITNESS: There are different regulations as it relates to school discipline. School discipline is handled at the building level with certain parameters for amounts of times that students can be out of school. If a parent doesn't agree with the decision of a building level administrator, they can appeal it to the School Board office, whoever that designee is, which is the director of student services, and ultimately a disciplinary committee of the School Board, which consists of a three-member panel. Those things come to play when you deal with long-term suspensions or expulsions. Other things that relate to

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short-term suspensions School Board members don't interject, to the best of my recollection.
BY MR. BLOCK:
Q. One difference between the work sessions and a full School Board meeting is that the agenda is public, right?
MR. CORRIGAN: Objection to the form, foundation, characterization. Go ahead.
THE WITNESS: Yeah, agendas are public.
BY MR. BLOCK:
Q. And for closed School Board work sessions, the agendas are not public; is that right?
MR. CORRIGAN: Object to the form, foundation, legal conclusion.
THE WITNESS: Based on the code talking about specific areas of School Board closed sessions, they are public; i.e., personnel, etc.
BY MR. BLOCK:
Q. So I'm not talking about the closed

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session at a public board meeting. The meetings where -- like the meeting in which you briefed the School Board about Mr. Collins's decision, those type of meetings do not have a public agenda, right?
MR. CORRIGAN: Objection to the form, foundation, legal conclusion.
THE WITNESS: I can't recall, to the best of my knowledge, at this time.
BY MR. BLOCK:
Q. What, there's a public agenda at those meetings?
MR. CORRIGAN: Same objections. Go ahead.
THE WITNESS: For a closed, meaning work sessions do have agendas. A closed work session on any matter the specifics are not going to be outlined, to the best of my recollection.
BY MR. BLOCK:
Q. So are decisions ever made in a closed work session on a specific matter?

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MR. CORRIGAN: Object to the form and foundation, legal conclusion. Go ahead.

THE WITNESS: All decisions have to be voted on in open session. A closed session provides opportunity for a discussion, but any final decisions on any matter that is a closed session topic that has to have -- a vote has to be done in open session.

BY MR. BLOCK:

Q. And what protections are in place for students' privacy in those contexts when a vote has to be done in open session, but the underlying topic is a matter concerning the privacy of an individual student?

MR. CORRIGAN: Object to the form. Go ahead. And legal conclusions.

THE WITNESS: Could you repeat that question so I can fully understand it?

BY MR. BLOCK:

Q. So if there is a decision that needs to be made based on -- that concerns an individual student and concerns a matter of sensitive

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information, if decisions can only be made by the Board in the context of an open session, what sort of protections are in place to protect the privacy of the student in those contexts?

A. The student --

MR. CORRIGAN: Object to the form, foundation, legal conclusion. Go ahead.

THE WITNESS: The name of the student wouldn't be disclosed. It would be Student A or a student matter, but not giving the specifics about the student for protection of identity.

BY MR. BLOCK:

Q. Between the night of your closed work session with the School Board and the November 11th School Board meeting, did you have any discussion with Mr. Collins about Gavin's use of the restroom?

A. I can't remember if I did or if I didn't.

Q. Did you ever have any conversations with Gavin or his parents directly?

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A. Only once in the three years.

Q. And when was that?

A. That was in the 2016, '17 school year when we were addressing a matter of a communication that had come to the school in the form of a letter that we sat down around a table and I had some conversation, you know, at that time. But other than that, not that I can recall.

Q. Did anyone -- did anyone ever suggest to Dr. -- to Mr. Collins that he reconsider his decision to allow Gavin to use the boys room?

A. Not that I'm aware of.

Q. Well, if people -- if people were concerned -- if School Board members were concerned about Mr. Collins's decision to allow Gavin to use the boys restrooms, do you think there are other ways they could have encouraged him to change course without holding a public School Board meeting?

MR. CORRIGAN: Object to the form, foundation, legal conclusions. Go ahead.

THE WITNESS: Not that I'm aware of.

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BY MR. BLOCK:

Q. Was -- to the best of your knowledge, was Gavin ever given an opportunity to work out a compromise solution in light of concerns that had come up?

MR. CORRIGAN: Object to the form, foundation, legal conclusion. Go ahead.

THE WITNESS: Not to my knowledge.

BY MR. BLOCK:

Q. To the best of your knowledge, was Gavin notified by anyone at the school that the topic of transgender students' restroom use was going to be discussed at the November 11th meeting?

A. Not to my knowledge.

Q. Did anyone outside the context of protected legislative deliberation express any concerns about the negative impact that a public School Board meeting could have on Gavin?

MR. CORRIGAN: Object to the form.

THE WITNESS: Not to my recollection.

BY MR. BLOCK:

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Q. So I know that you and the School Board received a variety of letters from a variety of groups, some of which, like the ACLU, are advocacy groups. To the best of your knowledge, has any educational organization, as opposed to an advocacy group like ACLU or Alliance Defending Freedom, recommended against allowing Gavin to use the boys restrooms?

A. Not to my recollection.

Q. And just -- you generally keep up on, you know, literature issued by professional organizations, right?

MR. CORRIGAN: Object to the form.

THE WITNESS: Yes, there's a variety of literature that I will research and look at from various points in times.

BY MR. BLOCK:

Q. And have you ever read any literature from an educational organization that advised against allowing transgender students to use restrooms to match their gender identity?

MR. CORRIGAN: Object to a legal

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conclusion. Go ahead.

THE WITNESS: Not to my recollection.

BY MR. BLOCK:

Q. When did administrators begin discussing the possibility of creating new single user student restrooms?

A. To the best of my recollection, that would have been in between November and December of 2014.

Q. And who raised the idea?

A. To the best of my recollection, I was the one who raised that. I can't recall if there were others.

Q. And who came up with the initial plans for what privacy improvements would be made or what new restrooms would be created?

A. To the best of my recollection, that was me in having discussion with my assistant superintendent who has oversight of facilities.

Q. Is that Dr. Hutchinson?

A. Mr. Hutchinson, that is correct.

Q. Did anyone ask Gavin what he thought

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of the idea?

A. Not to my knowledge.

Q. Did anyone ask Gavin for his input on, like, ways to make any improvements the most welcoming?

A. Not to my knowledge.

MR. BLOCK: Let's get this marked as Exhibit 8.

(Clemons Exhibit Number 8 was marked for identification)

BY MR. BLOCK:

Q. I'm showing you a document that's been marked as GCSB 4232, and it appears to be an invoice from Tidewater Stalls and Specialties. Is that -- do you know whether this is the vendor that installed improvements in the restrooms, or do you know what this document is?

A. Yes, I know what the document is.

Q. What is it?

A. It describes the work as it relates to improvements for restrooms at Gloucester High School.

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Q. Now, under this invoice the only restrooms I see are boys restrooms. Are boys restrooms the only restrooms in which these improvements were made?

A. To the best of my recollection, it was boys restrooms and the creation of single stall restrooms. I can't recall at this point in time if we made accommodations for female restrooms as well.

Q. Do you know if girls restrooms have an extended height of the toilet stall that are comparable to how the boys restrooms now have an extended height?

A. I'm not certain at this point.

Q. And do you know whether they have a privacy strip on the stall door?

A. To the best of my knowledge when we were discussing, you know, making upgrades, I -- I believe that we talked about, you know, privacy strips and partitions for all of our restrooms.

Q. But you don't know one way or the other whether those privacy strips are actually

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included in the girls restrooms, right?
A. Yes, I can't recall at this point in time.
Q. So is one reason why this invoice just lists boys restrooms because those were the restrooms that people were concerned about Gavin using?
MR. CORRIGAN: Object to the form. Foundation.
THE WITNESS: Not that I'm aware of.
BY MR. BLOCK:
Q. Were any contingencies in place in the event that Gavin used the girls restroom?
A. Not that I'm aware of.
Q. Did -- in your conversations -- people anticipate that as a possibility, him using the girls restroom?
MR. CORRIGAN: Object to the form. Foundation. Go ahead.
THE WITNESS: Not that I can recall.
MR. BLOCK: Mark this as Exhibit 9.

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(Clemons Exhibit Number 9 was marked for identification)
Q. Do you recognize this document?
A. I do.
Q. What is it?
A. This is a document that to the best of my recollection we received at our VSBA conference back in November of 2014.
MR. BLOCK: I have another document to show you marked as Exhibit 10.
(Clemons Exhibit Number 10 was marked for identification)
Q. So the second-to-last paragraph on this first -- well, first of all, do you recognize this document?
A. I do.
Q. What is it?
A. It's a press release.
Q. And it's a press release dated December 3rd, 2014?
A. Correct.
Q. And it is -- the title of the press

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release is, "Gloucester School Board prepares to discuss likely vote at December 9 meeting on restroom/locker room use for transgender students"?
A. Yes.
Q. Did you have any role in reviewing this press release?
A. The press release was being done by an outside resource, to the best of my knowledge. And I can't recall whether I saw it before it actually went out. That person's name was Beth Gibson.
Q. So in the second-to-last paragraph it says, "The Board has received a great deal of input from the local public through e-mails, phone calls, comments at the November 11 School Board meeting, and community meetings. Several Board members and Superintendent Walter Clemons recently attended the Virginia School Board Association's annual conference in Williamsburg, which had an entire working session, quote, 'Transgender Protections in Public Schools: Recent

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Developments,' presented by a law firm."
Now, is this Exhibit 9 the presentation referenced in that press release?
A. To the best of my recollection, that would be yes.
Q. Do you remember who from the School Board meeting attended that presentation?
A. Not that I can recall exact members.
Q. So if you turn to page 9 of Exhibit 9 under the slide that says "best practices," it says -- it has four squares as bullet points and it says -- the first one is, "Respond immediately to claims of harassment/bullying." The second square is, "Permit use of facilities based on gender identification;" is that right?
A. That's what it says, yes, sir.
Q. And do you recall that being a slide shown at the presentation?
A. Not to my recollection specifically, but I know this was the presentation, but I couldn't, you know, pinpoint each and every slide on the presentation was actually shown or

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discussed.
Q. Okay. Does the policy that Gloucester County School Board ultimately adopted conflict with what this presentation identifies as a best practice?
MR. CORRIGAN: Object to the form, foundation, legal conclusion. Go ahead.
THE WITNESS: The information in the presentation is just that, in my opinion. It's information shared by a legal firm. That's what I took it for.
BY MR. BLOCK:
Q. And you don't know why this presentation in particular was singled out to be mentioned in the press release?
MR. CORRIGAN: Object to the form.
THE WITNESS: Not to my knowledge.
MR. BLOCK: I have another document to mark as Exhibit 11.
(Clemons Exhibit Number 11 was marked for identification)
BY MR. BLOCK:

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Q. This was produced as WAVY TV FOIA response 33, and it's an e-mail from Carla Hook dated November 14th, 2014. Do you recognize this document?
A. Yes, I do.
Q. What is it?
A. It's an e-mail that Mrs. Hook, who was one of the former Board members, sent to members of the Board and myself at that time regarding some information that had been shared with her by the School Board attorney in Hampton.
Q. And did you read this information when it was sent?
A. I can't recall at this point in time.
Q. Do you mean sitting here today you can't recall whether --
A. Yeah.
Q. -- you read it or not?
A. Four years ago, yeah, I don't recall.
Q. And just if you turn to the third page of the document, which appears to be the attachment, do you -- can you tell me what this attachment is?
A. From the title of it, it is a document that speaks to looking at, you know, accommodations for transgender students.
Q. And to the best of your recollection, is this the information that the assistant -- former assistant county attorney passed on to Ms. Hook, and that she was then forwarding to you and the Board?
A. From the communication, that would appear to be correct.
MR. BLOCK: Do you need a break?
MR. CORRIGAN: I think it's a good idea to take a minute.
(Whereupon, a recess was taken).
BY MR. BLOCK:
Q. After the School Board passed its new policy limiting students to -- transgender students using the restroom based on their, quote, biological gender, unquote, has any administrator in the school system asked for guidance on how to apply the policy?

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A. Not to my -- not to my knowledge.
Q. To your knowledge is there any other student in the school system who is transgender and has -- we'll leave it at that. Is there any other student in the school system who is transgender?
A. At the present time, not that I'm aware of.
Q. How about during your tenure there?
A. To my recollection, I think there have been or there has been an incidence where one student has declared or spoke about transgender status.
Q. And do you know what restroom that student uses?
A. I wouldn't have firsthand knowledge. I do recall the student has graduated also.
Q. Now, what's your understanding of how to determine what a student's biological gender is?
A. Male/female.
Q. That's the term the policy uses. So

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was that your answer?
A. Yes.
Q. Male or female. So what's your understanding of how to determine whether a student is male or female for purposes of the biological gender policy?
MR. CORRIGAN: Object to form.
THE WITNESS: Genitalia.
BY MR. BLOCK:
Q. So does Gloucester County Public Schools have a record of what each student's genitals look like?
A. Not that I'm aware of.
Q. And is it your understanding that if a student has had genital surgery, that that would alter their biological gender?
MR. CORRIGAN: Object to the form and foundation, legal conclusion.
THE WITNESS: I would speculate.
BY MR. BLOCK:
Q. So, then, do you want to change your answer that you understand you would determine

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biological gender by a student's genitalia?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: No. I mean, I meant male or female organs when I said genitalia.
BY MR. BLOCK:
Q. Internal organs?
A. Well, just organs.
Q. Well, so what is your understanding of the biological gender of someone who has androgen insensitivity disorder where they don't develop external genitals consistently with their chromosomes and internal anatomy?
MR. CORRIGAN: Object to the form and foundation, legal conclusion. Go ahead.
THE WITNESS: I really haven't given that thought.
BY MR. BLOCK:
Q. To the best of your knowledge, has anyone in the school district given that thought?
A. I would not have knowledge of that.
Q. Certainly no one has spoken to you

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about it?
A. Not that I'm aware of.
Q. And if administrators did have a question about the policy, you'd be the source that they would ask, right?
MR. CORRIGAN: Object to the form, foundation.
THE WITNESS: I could be a source.
BY MR. BLOCK:
Q. What other sources would someone ask?
MR. CORRIGAN: Object to the form, foundation.
THE WITNESS: Possibly other administrators.
BY MR. BLOCK:
Q. But you were the most -- you were at the top of the pyramid for administrators, right?
A. As far as Gloucester County Public Schools is concerned?
Q. Yes.
A. Yes, I would say yes.
Q. So is there any other person besides

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you that an administrator within Gloucester County Public Schools would ask for guidance on how to apply the biological gender policy?
MR. CORRIGAN: Object to the form and foundation. Legal conclusion.
THE WITNESS: I don't know the answer to that question.
BY MR. BLOCK:
Q. Is it your understanding that if a transgender girl, someone who is assigned a male sex at birth, but has a female gender identity, is it your understanding that if she has puberty blockers so she never goes through puberty as a boy, and has cross-sex hormones so that she goes through puberty as a girl and develops breasts and other features consistent with other girls who go through puberty, that she would, under the school's policy, have to use the boys restrooms?
MR. CORRIGAN: Object to the form and foundation, legal conclusion.
THE WITNESS: I'd like you to repeat that question.

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BY MR. BLOCK:
Q. Yeah. So a transgender girl has had puberty blockers, so never goes through puberty as a boy, and has cross-sex hormones so that she develops breasts and hips and fat disposition -- distribution consistent with other girls, that that transgender girl with breasts should be using the boys restroom?
MR. CORRIGAN: Object to the form and foundation, legal conclusion.
THE WITNESS: I don't know the answer to that question.
BY MR. BLOCK:
Q. Do you have any knowledge of what sort of physiological effects hormone treatments can have on transgender youth?
A. Not that I'm aware of, no.
Q. And to the best of your knowledge, have you been in any discussions in which that sort of information was provided to School Board members?
MR. CORRIGAN: Object to the form,

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foundation.
THE WITNESS: Not that I'm aware of.
BY MR. BLOCK:
Q. So during your deliberations or during the School Board's deliberations around the policy, did they ever consult with any medical authorities?
MR. CORRIGAN: Object to the form.
THE WITNESS: Not to my recollection.
BY MR. BLOCK:
Q. If a student were to transfer to Gloucester High School and that student had previously transitioned at a different school district and had a birth certificate reflecting a gender that matched their gender identity, and then post transition they transitioned to Gloucester High School, what's your understanding of what restroom that student should use?
MR. CORRIGAN: Object to the form and foundation. Legal conclusion.
THE WITNESS: Can you repeat the question again?

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BY MR. BLOCK:
Q. Yeah, so if a student -- let's say a student is a transgender girl from a different school district who has transitioned from an early age, gotten their birth certificate amended, and transfers to Gloucester County Public Schools, and the first time she enrolls she presents her birth certificate that lists her as being female, what's your understanding of which restroom she should use under the biological gender policy?
MR. CORRIGAN: Same objections.
THE WITNESS: I don't know the answer to that question.
BY MR. BLOCK:
Q. Why not?
MR. CORRIGAN: Same objections.
THE WITNESS: I just don't know.
BY MR. BLOCK:
Q. Have you ever had any discussions about what the answer would be with anyone else at the school?
A. Not that I can recall.

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Q. To the best of your knowledge, did the School Board ever ask you to keep them updated on how Gavin was doing after the policy passed?
A. When I pause, it's four years to think back on.
Q. Take your time.
A. Not that I can specifically recall.
Q. Did anyone from the School Board ask to -- did anyone from the School Board ask you to let them know if the policy was having an effect on Gavin's academic performance?
A. Not that I can recall.
Q. Did anyone from the School Board ask you to let them know if the policy was having an effect on Gavin's psychological well-being?
A. Not to my recollection.
Q. To the best of your knowledge, did the School Board ever indicate that it would reassess the policy if it was, in fact, harming Gavin?
MR. CORRIGAN: Object to the form.
THE WITNESS: Not to my recollection.

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BY MR. BLOCK:
Q. Now, is it your understanding that under the policy a principal now has no discretion to let any transgender student use any restroom that is inconsistent with the sex assigned to them at birth?
MR. CORRIGAN: Object to the form.
THE WITNESS: Repeat that question for me, please.
BY MR. BLOCK:
Q. Is it your understanding that the school prevents principals from making case-by-case judgments about whether a transgender student should be able to use a restroom consistent with their identity?
MR. CORRIGAN: Object to the form.
THE WITNESS: The policy as I know it is that students who have gender identity issues are prescribed to use restrooms alternate facilities.
BY MR. BLOCK:
Q. And the principal doesn't have any

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discretion to say, well, in this case I think it's appropriate to let this transgender student use this particular facility that aligns with their gender identity?
A. Right. That's prescribed by the policy.
Q. So the autonomy we're talking about that principals have, the policy takes that away, right?
MR. CORRIGAN: Object to the form.
THE WITNESS: (No verbal response).
BY MR. BLOCK:
Q. Could you answer verbally?
A. From that perspective, yes.
Q. And so even if under the facts of a particular situation everybody in the school comes up to you and says -- I'll start over.
Let's say everyone in the school comes up to the principal and says, we have no problem with this transgender student using a restroom consistent with their identity, your understanding is the principal still has no

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authority to let them use that restroom consistent with their identity under the policy?
A. That would be to the best of my knowledge, yes, but that's also in relationship to any policy that we have where the policy of the school division itself govern the actions of, you know, the administrators.
Q. And so in order to change the policy, if the School Board were ever to change its mind, it would have to do so by taking a public vote and having a formal policy change; is that right?
MR. CORRIGAN: Object to form and foundation, legal conclusion.
THE WITNESS: To the best of my knowledge --
MR. CORRIGAN: Let me just say this: You're welcome to ask him any of these questions you want. To me, this is the 30(b)(6) questions. These are not his decisions, whether these things are the law or not, whether that's how they operate or not.
MR. BLOCK: No. No. I understand. I

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want to know as the superintendent what his understanding --
THE WITNESS: To the best of my knowledge when it regards policy, any policy, that if the School Board has adopted a policy, then they would be the entity that would have to, you know, make whatever changes or modifications to policy.
BY MR. BLOCK:
Q. And it's your understanding that the only way policy can be changed is in an open School Board meeting, right?
MR. CORRIGAN: Object to the form, foundation, legal conclusion.
THE WITNESS: To the best of my knowledge, that would be yes for something that they have officially voted on in an open session.
MR. BLOCK: I'll have this one marked as 12.
(Clemons Exhibit Number 12 was marked for identification)

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Q. Before we look at this, I'm sorry, all my previous questions about how the biological gender policy would apply to different situations, you've never been given any guidance from the School Board on how the policy would apply to those situations, have you?

A. Not to my knowledge.

Q. Okay. So I'm showing you a document marked GCSB 502. Do you recognize this document?

A. I don't recall previously seeing this document.

Q. Do you know if Gloucester County Public Schools generally follows the guidelines for school facilities in Virginia's public schools?

A. Since I haven't seen this document that I can recall, I don't believe I could give, you know, an answer.

MR. BLOCK: Mark this one as 13.

(Clemons Exhibit Number 13 was marked for identification)

Q. This is a document produced as GCSB 1349. Do you recognize this document?

A. Yes.

Q. Now, is the transgender student mentioned in this document the same transgender student you were mentioning before?

A. Yes.

Q. And so, when you -- from reading the beginning of the e-mail at the bottom, which is the e-mail from Principal Collins to you dated November 16, 2015, Mr. Collins says, Per our discussion last Friday, I would like to provide you with some information regarding one of our students who has requested to participate in a VHSL sport as a transgender student. Can you tell me about the conversation you had with Mr. Collins on this topic?

A. I cannot remember. Yeah, I couldn't recall the nature of that conversation.

Q. And do you -- can you recall whether either at -- can you recall the first time that you became aware of the fact that under VHSL rules transgender students were allowed under some

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circumstances to participate on the sports team consistent with their gender identity?

A. I can't recall.

Q. Do you know if you knew that information before you received this e-mail from Mr. Collins?

A. Not that I can recall.

Q. Okay. You might have known it and you might not have known it?

A. Yeah, I just don't remember.

Q. And then you took this information and you forwarded it to the members of the School Board; is that right?

A. Yes.

Q. And you wrote, FYI, keeping you in the loop; is that right?

A. Yes.

Q. Why did you send that e-mail?

A. I sent it just as an awareness that of course because of the situation that the Board has been involved in over the past year with, you know, Gavin, that, you know, there's another

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student that, you know, regarding transgender that has come to the knowledge, and I just wanted to make sure that they were aware.

Q. Now, were you concerned that the School Board might disagree with how Principal Collins was handling the matter?

A. No, not that I can recall. It was just making them aware.

Q. And did anyone respond to your e-mail?

A. Not that I can -- not that I can recall.

Q. So at least as of November 19th, 2015 when you forwarded this e-mail, the School Board was aware of the fact that VHSL regulations allow transgender students to compete on teams consistent with their gender identity; isn't that right?

MR. CORRIGAN: Objection to the form and foundation, legal conclusion.

THE WITNESS: I can't recall what they were aware of.

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BY MR. BLOCK:
Q. Well, at least on that date you sent them an e-mail referring to that fact?
MR. CORRIGAN: Object to the form and foundation, legal conclusion.
THE WITNESS: Yeah, I sent them this e-mail just as a courtesy involving that there was a potential -- another transgender student that we had in the school.
BY MR. BLOCK:
Q. And does the school district comply with VHSL regulations?
MR. CORRIGAN: Object to the form and foundation, legal conclusion.
THE WITNESS: To the best of my knowledge, I would say yes.
BY MR. BLOCK:
Q. Are you allowed to participate in the VHSL as a school if you don't comply with their rules about who can participate?
MR. CORRIGAN: Objection to the form, foundation.

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THE WITNESS: To the best of my knowledge, you would, you know, work within the confines of the VHSL.
BY MR. BLOCK:
Q. Has anyone expressed to you concerns that under the VHSL policy the girls sports teams at Gloucester High School will be playing against other girls sports teams that might include girls that are transgender?
A. Not that I can recall.
Q. Has anyone expressed concerns that under the VHSL policy boys sports teams at Gloucester High School could be playing against boys sports teams at other schools that include boys who are transgender?
A. Not to my knowledge.
Q. So if the student had won his appeal at VHSL, is it your understanding that the student would have been allowed to swim as a boy on the Gloucester swim team?
A. I don't know the answer to that question.

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Q. Is that something that would have had to have been approved by the Board?
MR. CORRIGAN: Object to the form and foundation, legal conclusion. Go ahead.
THE WITNESS: I don't know.
BY MR. BLOCK:
Q. Do you have any knowledge of what schools Gavin attended during his junior year?
A. What schools? Junior year, that was '15-'16, to the best of my knowledge, outside of Gloucester High School, the only thing that I can remember is a time that may have been spent in Riverside.
Q. And what's Riverside?
A. It's like at VCU. It may have been he was there for a medical reason. I think he was out of school for maybe a week, but I just don't recall the detail surrounding that. But as far as a public school, not that I'm aware of.
Q. Are you aware of Gavin attending the Gloucester Online Academy of Learning?
A. The GOAL program, that's in

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Gloucester.
Q. Yes.
A. That's at Gloucester High School.
Q. It's located at Gloucester High School?
A. Yeah.
Q. So where is it located?
A. There have been two locations in my tenure since I've been in Gloucester. It's either been at the high school, or it's been at T.C. Walker Education Center.
Q. Where is the T.C. --
A. That's the School Board office.
Q. Is the T.C. Walker Education Center?
A. Yes.
Q. What are the restrooms available to students when they were attending the GOAL program at the T.C. Walker Education Center?
A. Male/female restrooms as a former elementary school consistent with that of an elementary school. There would be faculty restrooms or a staff restroom. That's what I

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think of.
Q. And so, do you have any knowledge of whether Gavin attended the GOAL program at the T.C. Walker location?
A. I don't ever recall seeing Gavin, because it's in a different location than where my office is located, but I would -- to the best of my knowledge, I would think that he was there at some point in time.
Q. What restrooms would be available for him to use there?
A. To the best of your knowledge, I think there are male/female restrooms that are on that hall where those classrooms were.
Q. Any single user restrooms?
A. I can't recall.
Q. Do you have any knowledge of whether the showers work in Gloucester High School locker rooms?
A. I can't recall.
MR. BLOCK: I'd like to have this marked as 14.

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MR. CORRIGAN: It was 5 in the first deposition.
(Clemons Exhibit Number 14 was marked for identification)
Q. I want to turn to the last page. For reference, this is GCSB 03945, and on the last page this appears to me to be a list of the restroom facilities available at the T.C. Walker Education Center; is that your understanding from looking at this list as well?
A. Yes, to the best of my knowledge, I would say yes.
Q. So under the places where the classrooms would be for students attending class there, would that be in -- if you look down these lists, would that be the thing that's labeled classrooms, or would it be a different part of the building?
A. To the best of my knowledge, I'm just trying to think about the location of where they would be. I would say yes in terms of that's in a different part of the building from where my

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office is, but from what I recall from where the GOAL program was located, it was located on that hall or near the cafeteria where there were some classrooms.
Q. And so then according to this document it appears -- it says, Classrooms four, and it says unisex one non-ADA restroom with single commode only each.
I read that to mean that in that classroom section there were four single stall unisex restrooms for students to use; is that your understanding too?
A. No. My interpretation of that is they're for classrooms with one unisex restroom --
Q. I see.
A. -- that's located.
Q. Okay. Well, I mean, I guess we can just confirm it because --
A. Yeah.
Q. -- it's --
A. I think there are four classrooms.
Q. In each --

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A. In that particular area where there would be one restroom in that particular area that had the unisex capability, or was a unisex restroom or single stall restroom.
Q. That serviced all four --
A. Yeah.
Q. -- of those classrooms?
And that would be the restroom that is meant for students taking classes in those classrooms, right?
A. I would have to verify that by actually looking at the --
Q. Right.
A. -- going there and seeing it. I wouldn't want to give you an incorrect answer.
Q. But no unisex restrooms were installed in T.C. Walker Education Center in connection with the School Board's biological gender restroom policy?
A. No, not to my recollection.
Q. So those restrooms already --
A. Yeah.

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Q. -- existed?
MR. BLOCK: Did you get that?
THE REPORTER: Yes.
BY MR. BLOCK:
Q. So you're aware that Gavin has a birth certificate now reflecting that his sex on the birth certificate is male; is that right?
A. Yes.
Q. And how did you become aware of that?
A. That information was shared with me by the building principal.
Q. By?
A. Mr. Collins.
Q. And why did he share that information with you?
A. To keep me informed.
Q. And were you aware that Gavin requested that his school records be updated to reflect the gender marker on his birth certificate?
A. I can't recall.
Q. Are you aware of any discussion or

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deliberation with respect to whether Gavin's school records should reflect the gender marker on his birth certificate?
A. I don't remember.
Q. Do you know whether Gavin's school records currently do reflect the gender marker on his birth certificate?
A. I don't remember.
Q. Does Gloucester County Public Schools have any policies for determining what gender marker should be listed on a student's education records?
MR. CORRIGAN: Object to the form and legal conclusion. Go ahead.
THE WITNESS: Not that I can recall.
BY MR. BLOCK:
Q. Does Gloucester County Public Schools keep records on whether the birth certificate on file is the birth certificate issued at birth or an amended one?
MR. CORRIGAN: Same objection.
THE WITNESS: I don't know the answer to

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that question.
BY MR. BLOCK:
Q. Does Gloucester County Public Schools keep records of what chromosomes the student has?
A. I don't know the answer to that question.
Q. Were you ever consulted about whether Gavin's school records should be changed so that they reflect the gender on his birth certificate?
MR. CORRIGAN: I'm going to frame an objection in the form of an instruction. Anything that has been talked about -- I'm not saying it was or wasn't -- with me or with anything relating specifically to attorney-client privilege, you're not allowed to talk about; but anything that's outside of that, you would be.
THE WITNESS: Not that I'm aware of.
BY MR. BLOCK:
Q. So if I -- if someone had -- if Principal Collins had come to you with a question: Gavin's birth certificate has been changed. He

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wants to know if his -- the gender marker on his school records can be changed to reflect that. What would you have done?
A. Sought legal counsel.
Q. Can you think of any way that listing Gavin's sex on his transcript as female helps protect the privacy of other students?
MR. CORRIGAN: Object to the form and foundation. Go ahead.
THE WITNESS: I don't know the answer to that question.
BY MR. BLOCK:
Q. Can you think of any educational reason for why it would make sense to list Gavin's sex on his transcript as female instead of male?
MR. CORRIGAN: Object to the form of the question.
THE WITNESS: I don't know the answer to that question.
BY MR. BLOCK:
Q. Can you think of any instance that you're aware of in which students' sex on their

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school records was different from the sex on their birth certificate?
MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: Not to my recollection.
BY MR. BLOCK:
Q. Is it your understanding under the school's biological gender policy that it applies even if the boy or girl restroom is itself a single user facility?
MR. CORRIGAN: Object to the form.
BY MR. BLOCK:
Q. So let's say you have a restroom for boys that's just one stall, and a restroom for girls that's just one stall. Is it your understanding that a transgender boy is precluded from using the boys restroom under that policy, even though it only contains one stall?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: Yeah, I don't know --
MR. CORRIGAN: Legal conclusion. Go

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ahead.
THE WITNESS: -- the answer to that question.
BY MR. BLOCK:
Q. You don't know the answer to that question?
A. Yeah.
Q. So do you -- you said at the time that you authorized Principal Collins to make a decision about what restroom Gavin should be able to use, that at that time you hadn't formed an independent opinion on the issue; is that right?
A. Correct.
Q. So at any future point in time after that did you form an opinion about which restroom Gavin should be able to use?
MR. CORRIGAN: Object to the form, foundation, legal conclusion.
THE WITNESS: Not that I can recall.
BY MR. BLOCK:
Q. So sitting here today, from, you know, the standpoint as an educator, do you think

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that it's in Gavin's best interest to be able to use boys restrooms?
MR. CORRIGAN: Object to the form and foundation, legal conclusion. Go ahead.
THE WITNESS: I don't know the answer to that question.
BY MR. BLOCK:
Q. Sitting here today as an educator, do you think that the School Board's decision to take this issue away from principals and decide it at the policy level was the right thing to do?
MR. CORRIGAN: Object to the form and foundation, legal conclusion.
THE WITNESS: I would say the School Board had the executive authority to regulate policy as they see fit.
BY MR. BLOCK:
Q. I understand they have the power to do it, but --
A. I wouldn't speculate on what I would think is right or wrong. I don't know the answer to that question. So I wouldn't give an answer to

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that.
Q. But as a general matter you think it's best for the principal to be able to have authority to make decisions about how the building is used, right?
A. I believe, yes, that principals have the ability to have site-based management of their schools, but also recognizing that that is subject to policies and regulations set forth by a school division.
Q. And you're obviously still employed by the Gloucester County School Board, right?
A. Yes, sir, that's correct.
Q. And you don't have any plans to have another job next year, or anything like that, do you?
A. That's a loaded question. I would say at this point in time the answer is no. They haven't told me anything. No, no, no. I'm still going to be there for a while.
Q. Right. If you had one foot out the door, then maybe --

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A. Oh, no, absolutely not.
Q. So is the idea of principals having authority over on-site management, is that a topic that comes up in educational literature or literature around education management?
MR. CORRIGAN: Object to the form.
THE WITNESS: I believe you will find literature that talks about roles and responsibilities of building-level administrators and what some of the scope of those responsibilities are.
BY MR. BLOCK:
Q. And what does the literature say about the scope and responsibilities of building-level administrators.
A. I mean generally speaking it's a matter of principals, they are like the chief executive officer of a school, and, you know, they -- you know, they have the ability to make decisions regarding their specific schools.
Q. And is there like a -- in the literature, is that connected at all to the

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success of the school in providing a good education to students?
MR. CORRIGAN: Object to the form.
THE WITNESS: There's so much literature. I mean, principals, they do contribute to the success of a school in many ways, but there are many factors that contribute to the success or non-success of a school that goes beyond a principal.
BY MR. BLOCK:
Q. Do you think that Gloucester County Public Schools policy regarding transgender students' use of restrooms can cause harm to the well-being of transgender students?
A. I don't know the answer.
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: I don't know the answer to that.
BY MR. BLOCK:
Q. And over the past four years have you taken any steps to educate yourself about what the

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answer would be?
A. Not that I can recall.
Q. Did you read the Amicus brief filed in this case by school administrators from other school districts that have policies allowing trans students to use restrooms that are consistent with their identity?
A. I can't remember at this point in time. There's been so much over four years.
Q. Have you ever spoken with any administrators from other school districts that allow trans students to use restrooms consistent with their identities?
A. Not that I can recall.
Q. If the School Board asked for your advice on whether they should change the policy, what advice would you give them?
A. To seek legal counsel.
Q. You wouldn't have any advice from your perspective as an educator?
A. No.
Q. So let's say the School Board says,

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we've talked to our lawyers. We want to know what you think is the best thing to do for the students, regardless of what the law says.
MR. CORRIGAN: Object to the form.
BY MR. BLOCK:
Q. You would say?
A. I don't know what I would say.
Q. If a student was allowed to use restrooms consistent with their gender identity, do you think that the principals would be equipped to administer that policy?
MR. CORRIGAN: Object to the form. Legal conclusion. Go ahead.
THE WITNESS: It would be my expectation that building level administrators try to uphold whatever policies that are in place by the school division.
BY MR. BLOCK:
Q. And so do you think that -- do you have any concerns that the building level administrators would not, as a practical matter, be able to implement a policy that allowed

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transgender students to use restrooms consistent with their identity?

A. I had not given that any thought, so I don't truly know an answer to that question.

MR. BLOCK: Give me a couple of minutes. I'll be back.

(Whereupon, a recess was taken).

BY MR. BLOCK:

Q. To the best of your knowledge, has the biological restroom policy been applied to anyone else besides Gavin?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: I couldn't speak to specific students. I would just expect that whatever policies are in place are applied for all students.

BY MR. BLOCK:

Q. But just to the best of your knowledge, do you know whether --

A. Not to my knowledge.

Q. And just to make sure I'm not missing

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something, no one -- no one in Gloucester County Public Schools has asked you how the policy would apply to any particular student?

A. Not to my knowledge.

Q. The complaints that you heard about transgender students using restrooms, did any of those complaints base their objections on religious disapproval of being transgender?

A. Not that I can recall.

Q. If a group of students were upset that gay and lesbian students were using the same restrooms as them, is there any school policy that would govern how you respond to those complaints?

MR. CORRIGAN: Object to the form and foundation. Legal conclusion.

THE WITNESS: Not that I'm aware.

BY MR. BLOCK:

Q. How would you respond to those complaints?

MR. CORRIGAN: Object to the form and foundation. Go ahead.

THE WITNESS: I would speak with

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building level administration and make sure that, you know, appropriate conduct is governed by, you know, whatever policies we have in place.

BY MR. BLOCK:

Q. And so, what would that be?

A. Well, from what I would say, you know, gay and lesbian are not around the policy itself based on gender. So I would just expect students to adhere to whatever policies we have in place.

Q. And so, under your understanding of what the policies we have in place would be that, you know, every boy is allowed to use the boys restroom, even if that boy is gay, right?

MR. CORRIGAN: Object to the form. Legal conclusion. Go ahead.

THE WITNESS: To the best of my thought, yes.

BY MR. BLOCK:

Q. And also in terms of showering in the locker rooms, if a student was uncomfortable with

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the fact that there was a gay teammate who showered in the locker rooms, to the best of your knowledge, there wouldn't be any basis for excluding the gay teammate from the locker rooms based on the other student's discomfort, right?

A. To the best of my knowledge, yes.

Q. Now, have you ever in your career had a situation where students were uncomfortable being in proximity to gay students?

A. Not that I can recall.

Q. Did you ever have an experience where students were uncomfortable being in proximity to students of a different race?

A. Not that I can recall.

Q. How about any experience where students were uncomfortable being around students of a different religion?

A. Not that I'm aware of.

Q. In the event that students were uncomfortable with gays and lesbians, bisexual people using the locker rooms, do principals have tools at their disposal to address that

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discomfort?
MR. CORRIGAN: Object to the form and foundation. Legal conclusion. Go ahead.
THE WITNESS: I don't know.
BY MR. BLOCK:
Q. What are -- do administrators at the school receive any training on building inclusive communities or teaching tolerance?
A. I can't recall specifically, but I believe at some point in time we've had discussions with building administrators about trying to make sure that all students feel comfortable with being in your facility, you know, treating everybody decently and equitable.
Q. And why is that important?
MR. CORRIGAN: Object to the form.
THE WITNESS: Well, you want all students to feel welcome and comfortable in the places where they go to school.
BY MR. BLOCK:
Q. Well, why don't you just want most students to feel welcome and comfortable?

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MR. CORRIGAN: Object to the form. Foundation.
THE WITNESS: You're asking me why would I want most students to feel comfortable?
BY MR. BLOCK:
Q. No. I'm asking why is it -- why is it that you want every student to feel welcome and comfortable, as opposed to just prioritizing the comfort of the majority of students?
A. I think you should try to, you know, help all students be successful when they come through your doors.
Q. And the feeling welcome and comfortable is generally an ingredient in whether a school -- a student is successful?
MR. CORRIGAN: Object to the form.
THE WITNESS: Feeling comfortable?
BY MR. BLOCK:
Q. Yes.
A. Feeling that it's someplace where they're welcome I think is important.
Q. And just as a general matter, it's

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generally true that any student, if they don't feel that they're welcome at a school, is going to have that interfere with their ability to thrive there, right?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: I don't know the answer to that question.
BY MR. BLOCK:
Q. Well, it can't help their ability to thrive, can it?
MR. CORRIGAN: Same objections.
THE WITNESS: I don't know.
BY MR. BLOCK:
Q. Has there been any incidences of, you know, bullying based on race or religion or sexual orientation at Gloucester High School while you've been there?
A. Not that I have specific knowledge of.
Q. Do you know if there's like a gay/straight alliance or other LGBT affinity group

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at any of the schools?
A. I don't know.
Q. If a request were made to have one, who would have responsibility for approving that request?
A. The initial request would go to the building level administrator.
Q. And then would you review it after the building level administrator made a decision?
A. If it pertains to a policy type of question, more than likely.
Q. And can you see any reason why a gay straight alliance or other LGBT affinity group wouldn't be allowed?
MR. CORRIGAN: Object to the form. Calls for a legal conclusion.
THE WITNESS: I don't know.
BY MR. BLOCK:
Q. So sitting here today, you don't have any opinion one way or the other with respect to whether the School Board's restroom policy should be changed?

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MR. CORRIGAN: Object to the form, foundation, legal conclusion.
THE WITNESS: No.
BY MR. BLOCK:
Q. So from your vantage point, you would be equally okay with either outcome?
MR. CORRIGAN: Object to the form and foundation, legal conclusion.
THE WITNESS: My responsibility has always been to just try to give information. Ultimately the School Board has the ability to determine as it relates to policy. And when they do, I try to make that policy work, you know, and it's applied equitably regardless of which way the policy is voted on by the school.
BY MR. BLOCK:
Q. So whichever policy the School Board decides on, you'll be able to make it work?
A. I would follow the guidance that the School Board has set as it relates to the policy, yes, sir.
Q. And you wouldn't have any doubts

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about your practicable ability to follow --
A. Absolutely not, no.
Q. Let me just say I want to just get that exchange, the full sentence.
So you don't have any doubts about your practical ability to implement whichever policy the School Board chooses, right?
A. No.
MR. BLOCK: I think that's all my questions.
MR. CORRIGAN: All right. He will read also. No questions.

(Off the record at 5:04 p.m.)

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ACKNOWLEDGMENT OF DEPONENT

I,

WALTER CLEMONS, PhD, do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct, and complete transcription of the testimony given by me; and any corrections appear on the attached Errata sheet signed by me.

_____ _____

(DATE) (SIGNATURE)

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CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC

I,

LISA BLAIR, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my direction; that reading and signing was requested; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 23rd day of September 2018.

My commission expires October 31, 2020.

Lisa M Blair

_____

Lisa Blair, RMR

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Transcript of Tiffany Durr

Date: October 10, 2018
Case: Grimm- v- Gloucester County School Board

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
CIVIL CASE NO. 4:15-CV-54

GAVIN GRIMM : Plaintiff
v. :
GLOUCESTER COUNTY SCHOOL BOARD : Defendant

Deposition of TIFFANY DURR
Glen Allen
Wednesday, October 10, 2018
9:36 a.m.

Job No.: 207625
Pages 1 - 58
Reported by: Lisa M. Blair, RMR

Deposition of TIFFANY DURR, held at the offices of:

HARMAN, CLAYTOR, CORRIGAN & WELLMAN, P.C.
4951 Lake Brook Drive
Suite 100
Glen Allen, Virginia 23060

Pursuant to agreement, before Lisa M. Blair, Notary Public in and for the Commonwealth of Virginia.

A P P E A R A N C E S

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C O N T E N T S

EXAMINATION OF TIFFANY DURR PAGE
By Mr. Block 5

E X H I B I T S

1 E-mail from Stephanie Vermeire to Nate Collins, 4-2-15 21

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P R O C E E D I N G S

Whereupon,

TIFFANY DURR,

being first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE PLAINTIFF

BY MR. BLOCK:

Q. Good morning, Ms. Durr.

A. Good morning.

Q. My name is Josh Block. I represent Gavin Grimm in this case against Gloucester County School Board, and I'll be asking you questions today. Have you ever had a deposition before?

A. No.

Q. So here are some ground rules. The first is that the reporter is typing down everything we say. So it's important that all of our communication be orally and with words. So no uh-huh, no nodding. Just make sure everything that you say is oral. Does that sound okay?

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A. Yes.

Q. Perfect. Second is because there is a transcript, we have to make sure we're not talking over each other. So make sure that I'm done talking before you answer, and I'll make sure that you're done talking before I ask the next question, okay?

A. Okay.

Q. Perfect. And the third is that it's my job to ask questions in a way that you can understand. So if anything I say is unclear, I'm counting on you to let me know so I can rephrase it in a way that you can answer; is that okay?

A. Yes.

Q. And if you do answer my question, I'm going to assume that that means you understand it; is that okay?

A. Yes.

Q. Okay. Are you ready?

A. Yes.

Q. Great. Could you say your name for the record?

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A. Tiffany Durr.

Q. And what was your job at Gloucester High School?

A. I was a school counselor, ninth through 12th grade -- or sorry, at the time, 10th through 12th grade school counselor.

Q. How many years were you at Gloucester High School?

A. Ten years.

Q. Ten years. So why don't you take me through that. Did your job position change at different points in time?

A. No.

Q. Okay. So the whole time you did -- what grades did you counsel for the whole time that you were there?

A. I did at times ninth through 12th, but then at one point we had a freshman counselor, and I did 10th through 12th grade because the freshman counselor worked solely with ninth grade students. And so that was for a few years that I had done solely 10th through 12th. And then we

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went back to everyone taking ninth through 12th graders.

Q. So at the time that Gavin Grimm was in ninth grade, that was a time when you were working just with 10th through 12th?

A. I do not remember.

Q. Okay. And what's your -- where do you work now?

A. I am currently not working.

Q. Okay. And when was your last day working at Gloucester High School?

A. It was the end of June. I don't remember the exact date. It was around the 28th, I believe, of 2018.

Q. And when you were at Gloucester, who was your supervisor?

A. Matt Lord.

Q. And he was your supervisor the whole time you were there?

A. No. When I first started working at Gloucester there was a different supervisor, and Matt became my supervisor after maybe three or

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four years. I'm not sure exactly how many years had passed when he became my direct supervisor.

Q. But he was your direct supervisor at the time that Gavin Grimm was at --

A. Yes.

Q. -- Gloucester?

A. That is correct.

Q. Great. When did you first become aware of Gavin Grimm?

A. I first became aware of Gavin Grimm the summer prior to his sophomore year. He and his mother came to the high school, and he introduced himself to me.

Q. And did he or his mother contact you in advance to set up a meeting?

A. No. They actually just happened to come in and do a walk-in, and ask if they could speak with his counselor for the upcoming school year regarding some concerns they had.

Q. And you had already been assigned to be his counselor for the upcoming school year?

A. Yes, by then I had.

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Q. What did they say when they met with you?

A. When they came in they shared that Gavin had recently had a name change, a legal name change, and they were wanting to -- they were inquiring about the process to change his name on the school documents.

Q. And did -- well, did they ask anything else?

A. At that time, I don't recall. I think that was the main purpose of their -- of them visiting, and to also just I guess kind of inquire about support and resources within the school.

Q. Now, at the time that they came to you for this meeting, had you had any experience before working with transgender students?

A. Yes.

Q. What experience was that?

A. I had a few students in the past who, you know, they identified not with their birth-assigned gender, yes.

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Q. And did they -- how did you know that?

A. The students had, you know, told me that, and I had counseled them through various different things or issues that arose regarding that.

Q. In general, how did those students describe the atmosphere at Gloucester High School? Was it -- did they describe it as a welcoming atmosphere for transgender students?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: No.

BY MR. BLOCK:

Q. How did they describe it?

A. Well, I guess mainly the students would, you know, just state due to the location, the area of Gloucester, that they didn't feel like -- that they didn't always feel as though they had support in the school community.

Q. Did they indicate whether they felt they were supported by teachers at the school?

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A. I can't remember.

Q. About how many students would you say you had counseled before Gavin that were transgender?

A. I can remember one for sure.

Q. And you think possibly it was more than one?

A. I don't recall.

Q. So the student that you do remember, did that student identify as a boy or a girl?

A. The student was born a girl, but identified as a male.

Q. And do you know what restrooms that student used?

A. I'm assuming the student used restrooms for their birth-assigned gender.

Q. But that's -- you didn't discuss that explicitly --

A. No. No. No.

Q. -- with him?

A. And I'm sorry, now that I recall, I actually had -- there were two students I worked

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with. I'm sorry.

Q. Okay. And so the second student, was that student -- did that student identify as male or female?

A. The student was born female and identified as male.

Q. Do you know what restrooms that student used?

A. Restrooms for females.

Q. And did you ever discuss that topic explicitly with either of those two students?

A. No.

Q. So do you know either way whether either of those students avoided using the restroom to avoid having to go into a restroom that conflicted with their gender identity?

A. I do not know.

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: I do not know.

BY MR. BLOCK:

Q. And so you don't -- so you don't have

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any knowledge either way about whether either of those students experienced any distress as a result of not being able to use facilities that were consistent with their gender identity?

A. I do not recall.

Q. So when Gavin and his mom came to you at this meeting in the summer before his sophomore year, did they bring with them his name change order?

A. I don't remember. Usually our registrar handles that. They wouldn't have given that to me, and I can't recall if they brought that in. It really wasn't like an official meeting. It was kind of a drop in. They wanted to speak with me. So they were just kind of I guess briefing me on what had occurred. So I cannot recall if they brought in documentation.

Q. And can you recall if they brought in a letter from his treating mental health provider?

A. I do not remember.

Q. So after they came in and described the situation to you, what did you say to them?

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A. Well, I expressed, you know, that I was a resource in the school that the student could utilize, and the counseling office as a whole, and that if there were any concerns, to make sure to alert us.

Q. Did you -- had you received any training on how to counsel transgender students?

A. No.

Q. Were you aware of any policies that the school had with respect to transgender students?

A. No.

Q. Did they express any concern about whether Gavin would be addressed by male pronouns?

A. Yes.

Q. What did they say?

A. Well, Gavin stated that he, in addition to wanting everybody to identify him by his new name -- or the name change, that he also, of course, wanted to be identified by male pronouns.

Q. And what did you say in response to

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that?

A. I acknowledged everything he said and agreed, and told him I would, you know, honor his wishes.

Q. So after you had this meeting with Gavin -- actually, before we go to that, did Gavin or his mother talk at all about his use of restrooms during this first meeting?

A. I do not recall.

Q. And do you know whether he or his mom talked about his enrollment in physical education class during this first meeting?

A. Actually, I don't remember anything regarding physical education, but I do remember that we did speak about using the restroom, and we came up with a plan for him to use the restroom, the nurse's restroom in the nurse's office. And then also the majority of his classes were down in a hall called D-hall. And so, there is a teacher's lounge there that had individual stalls, and we said because most of the majority of his classes were in that hall, or that section of the

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school, that he was welcome to use restrooms in that -- in the teacher's lounge.

Q. So who proposed that solution?

A. I do not remember.

Q. Did Gavin indicate what his preference was?

A. At the time I believe he was -- you know, he was fine. He never really stated a preference, but I think he was okay with that plan.

Q. So did Gavin say to you during that conversation anything to indicate that he would have been uncomfortable using the boys restroom?

A. Not during that conversation.

Q. During a later conversation did he say anything to indicate he would be uncomfortable using the boys restroom?

A. Using the boys restroom?

Q. Yeah.

A. Oh, no.

Q. So would it be -- I'm going to give you two characterizations, and you tell me which

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one is more accurate, or tell me if neither is accurate.

Would it be more accurate to say that Gavin -- well, I'll scratch that, because David will object to it.

MR. CORRIGAN: I was getting ready.

MR. BLOCK: I know.

BY MR. BLOCK:

Q. So my question is, you know, Gavin agreed to the solution, but you don't know whether that actually would have been his preferred preference at the time; is that right?

MR. CORRIGAN: Object to the form of the question. Go ahead.

BY MR. BLOCK:

Q. Go ahead.

A. He agreed to -- can you go into more detail? He agreed to using the restrooms.

Q. Sure. What I want to -- this solution of him using the nurse's restroom and the faculty restroom, that was not something that Gavin had proposed himself; is that right?

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MR. CORRIGAN: Object to the form.

THE WITNESS: I do not recall.

BY MR. BLOCK:

Q. Okay. So did anyone else have to give approval of this plan for him to use the nurse's restroom and the faculty restroom?

A. I do not recall, but I remember speaking with my direct supervisor and the principal, Nate Collins, at the time. And I do not remember who -- if there was official approval.

Q. And you spoke with them at the time in August before school started?

A. Yes.

Q. And what did you say to them?

A. Well, I went to -- I think, if I recall correctly, I went to Matt Lord, my director, and explained to him what was going on. And then I remember Nate Collins was also involved, but I don't remember particulars and how we came to the final decision.

Q. Okay. And do you remember what

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Mr. Lord said to you when you brought it to his attention?

A. No.

Q. Do you know who made the decision to change Gavin's name in school records?

A. No.

Q. You said you think that's something that's done at the registrar's office?

A. Well, typically, yes, the registrar is the one that would change any information in the system for a student. The school counselor does not change personal information in the system for students.

MR. BLOCK: So I'm going to show you a document that I'm going to ask the court reporter to mark as Exhibit A.

MR. CORRIGAN: Why are we going with letters? Didn't we have numbers?

MR. BLOCK: We can do --

MR. CORRIGAN: It doesn't make any difference to me, but sometimes it can be confusing. I don't care.

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MR. BLOCK: We can change it to numbers. So the court reporter will remark it as Exhibit 1.

(Durr Exhibit Number 1 was marked for identification)

BY MR. BLOCK:

Q. So this appears to me to be an e-mail chain that Stephanie Vermeire forwarded that involves e-mails between you and her.

A. Right.

Q. Does that appear correct to you?

A. Yes.

Q. And so, I want to go at -- just the bottom of the e-mail chain for just these e-mails between you and Ms. Vermeire; is that okay?

A. Yeah, that's fine.

Q. So if we go to the bottom of the chain on GCSB2379, there is an e-mail from Ms. Vermeire to you on August 18th that says, Tiffany, are you familiar with Gavin Grimm; is that right?

A. Yes.

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Q. Do you remember receiving the e-mail from Ms. Vermeire?

A. No.

Q. And then you write back the next day -- on Tuesday, August 19th you write back saying, Yes, he and I had a long convo yesterday. I instructed him to speak with you to give him a heads-up on his situation.

Do you remember at all what you said to Gavin about speaking with Ms. Vermeire?

A. No.

Q. And then the chain from that, she responds again on Tuesday, August 19th saying, Did he discuss bathroom use at all? And you reply later that day, Yes, let's get together later after 12:30 and discuss, if you'd like. I believe he plans to use the nurse's office.

Do you remember having this follow-up discussion with Ms. Vermeire at all?

A. No.

Q. Okay.

A. It's been a while.

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Q. Of course.

So when is the next time you spoke with Gavin Grimm after your meeting with him in August?

A. I don't recall.

Q. Okay. Did there come a point in time when Gavin or his mother asked you about whether he could start using the boys restrooms?

A. Yes, later, not in August, but it was later. He came in and met with me. When he came in, in August he had also informed us that he was getting ready to start hormone therapy. And so he came in and he, you know, shared with me that he was going to start hormone therapy at some point soon, and wanted to know, when he began his therapy, if he could start using the male restrooms.

Q. Now, did you have any other interactions with him between your first meeting with him in August and this meeting?

A. I can't recall specifics. I believe so, but I can't recall anything specific.

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Q. And so, when he made that request about using the male restrooms, what did you say?

A. Well, I told him that I would have to, you know, consult with administration, and that I would get back with him.

Q. And what did you do after the conversation?

A. I believe I spoke with Mr. -- with Matt Lord, who then instructed me to speak with administration regarding the issue.

Q. And what did you do next?

A. I believe I got with administration and informed them of the student's intent.

Q. And by administration, do you mean Principal Collins?

A. Mr. Collins, yes, and I cannot remember if I involved an assistant principal.

Q. And what did they say in response?

A. Mr. Collins said he would have to check with -- you know, he would have to do some investigating himself, and, you know, go from there.

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Q. Did you have any further discussions about what the response to Gavin's request should be?

A. I'm sorry, I'm not sure if I'm understanding your question.

Q. Sure. Did Mr. Collins then get back to you with his decision, or did he also have further discussions with you about what his decision should be?

A. I don't remember.

Q. Did you provide any input on what you thought Mr. Collins should decide?

A. I don't recall.

Q. Did you have any recommendation about whether Gavin should be allowed to use the boys restrooms?

A. I don't recall.

Q. Do you recall if Mr. Lord had any recommendation about whether Gavin should be able to use the restrooms?

A. I don't recall.

Q. So do you recall having any

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discussions at all about whether Gavin should be allowed to use the restrooms?

A. I'm sorry, I don't recall.

Q. It's okay. So when -- when did you find out what Mr. Collins' decision was?

A. I don't remember the order, but I remember Mr. Collins informing me that -- sorry. Let me think. I just have to remember. Mr. Collins didn't -- he did not necessarily give me a -- let's see. I remember -- what I do remember is that Mr. Collins had consulted with the superintendent, and I do remember that we were told that, you know, Gavin would be allowed to use the male restroom; however, we would have to meet with Gavin and his mother and develop a safety plan and find out Gavin's needs.

Q. And during this meeting with Gavin, was Principal Collins there for this meeting where you developed a safety plan?

A. Yes. It was myself, Mr. Collins, Gavin, and his mother.

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Q. And did you speak at all during that meeting?

A. Yes. Mr. Collins and I both, you know, explained to Gavin what had been decided and the reason for the meeting, which was to find out his needs and to come up with a safety plan, yes.

Q. And did you think that allowing Gavin to use the boys restrooms was the right decision?

MR. CORRIGAN: Object to the form, foundation. Go ahead.

THE WITNESS: Yes.

BY MR. BLOCK:

Q. Why did you think that?

MR. CORRIGAN: Object to the form, foundation.

THE WITNESS: Well, I felt like this is how the student was identifying. And, you know, in order for him to feel comfortable at school, I felt like, you know, there needed to be some consideration into what would make him feel comfortable.

BY MR. BLOCK:

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Q. Did you have any doubts about whether Gavin really was transgender, or was just pretending?

A. No.

Q. Did you -- sorry?

A. Did I?

Q. I thought you were going to say something.

Did you have any concerns about what the impact on other students would be if Gavin were allowed to use the boys restroom?

A. No, I don't recall.

Q. After Gavin started using the boys restroom, did any students ever complain to you about it?

A. No.

Q. Has any student described being uncomfortable around Gavin?

A. Not to me.

Q. Do you know whether anyone has described being uncomfortable around Gavin to someone else?

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A. I was told there was one student, but I don't know that student. I never had a conversation with that student.

Q. And do you know who that student spoke to?

A. Their counselor, I believe.

Q. And are you aware of what the outcome of that conversation was?

A. No.

Q. So after this meeting with you and Mr. Collins and Gavin and his mother, did you have any other conversations with Principal Collins about Gavin's use of the restrooms?

A. We just, you know, spoke with each other as far as being aware and making sure the student felt comfortable, but also that the student and other students were safe -- you know, felt safe and comfortable. I don't recall any other conversations.

Q. And at any point did you think that Gavin wasn't safe or comfortable?

A. No.

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Q. Did Gavin ever report any problems with his use of the boys restrooms?

A. No.

Q. So did there come a time when you became aware of the School Board wanting to speak with Mr. Collins about the situation?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: I don't recall specifics, but I do recall hearing that they were going to have a closed meeting regarding the issue.

BY MR. BLOCK:

Q. And did Mr. Collins speak with you about helping him prepare for the meeting?

A. I don't recall.

Q. Did you provide any input about what should be discussed at the meeting?

A. No.

Q. Were you asked for any input about what should be discussed?

A. No.

Q. When did you first become aware that

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the School Board was considering a policy that would prohibit transgender students from using the facilities that matched their gender identity?

MR. CORRIGAN: Object to the form, foundation. Go ahead.

THE WITNESS: If I recall correctly, it was around the time of the second meeting.

BY MR. BLOCK:

Q. And when was the second meeting?

A. I don't recall.

Q. Is the second meeting that you're referencing a closed meeting or an open meeting?

A. That meeting was an open meeting, if I recall, I believe.

Q. So were you given any advance notice that the School Board was considering this policy before the School Board held its public meeting on the issue?

A. I don't recall.

Q. Did anyone at the School Board or the administration ask for your input on whether the proposed new policy was a good idea?

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MR. CORRIGAN: Object to the form.

THE WITNESS: No.

BY MR. BLOCK:

Q. Did anyone from the School Board or administration ask for your input on the topic of transgender students using the restrooms at all?

A. No.

Q. Did anyone from the School Board or administration ask your input on whether adopting their new policy would be harmful to Gavin?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: No.

BY MR. BLOCK:

Q. Did anyone from the School Board or administration ask for your input on whether the new policy was consistent with the welfare of transgender students?

MR. CORRIGAN: Object to the form.

THE WITNESS: I'm sorry, can you repeat that?

BY MR. BLOCK:

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Q. Yeah, I'm sorry. Did anyone at the School Board or administration ask for your input on whether the proposed new policy was consistent with the welfare of transgender students?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: No.
BY MR. BLOCK:
Q. To the best of your knowledge, was anyone else from the counseling department consulted by the School Board or the administration when they were considering adopting the new restroom policy?
A. I don't recall.
Q. Were you surprised to hear that the School Board was considering adopting this new policy?
MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: No.
BY MR. BLOCK:
Q. Why not?

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A. Gloucester is a very conservative community.
Q. Can you elaborate on that at all?
MR. CORRIGAN: Object to the form. Go ahead.
THE WITNESS: Just from my experience, Gloucester appeared to be conservative.
BY MR. BLOCK:
Q. And has anyone at the School Board or administration ever said anything to you indicating disapproval of transgender students?
A. No.
Q. And has anyone at the School Board or administration said anything to you indicating disapproval of lesbian, gay or bisexual students?
MR. CORRIGAN: Object to the form and foundation. Go ahead.
THE WITNESS: No.
BY MR. BLOCK:
Q. When you say that Gloucester is a conservative community, how would being a conservative community impact their view on

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whether Gavin should be allowed to use the boys restroom?
MR. CORRIGAN: Object to form and foundation.
THE WITNESS: Can you restate the question?
BY MR. BLOCK:
Q. Yeah, sure. I'm just trying to connect when you say that Gloucester is a conservative community, what's the connection between being a conservative community and having a particular view on whether Gavin should be allowed to use the boys restrooms?
MR. CORRIGAN: Object to form and foundation of the question. Go ahead.
THE WITNESS: If I don't feel comfortable answering a question, I don't -- I don't wish to elaborate.
BY MR. BLOCK:
Q. Okay. Can you think of another instance during your time at Gloucester High School in which the School Board intervened to

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overrule a decision from the administration about what was in a student's best interest?
MR. CORRIGAN: Object to form and foundation. Go ahead.
THE WITNESS: No, I can't recall any other instances during my tenure there.
BY MR. BLOCK:
Q. Do you personally disagree with the School Board's decision to enact their new policy?
MR. CORRIGAN: Object to form.
THE WITNESS: Can you repeat the question?
BY MR. BLOCK:
Q. Did you personally disagree with the School Board's decision to enact the new restroom policy?
A. I tried not to act from my personal views, but for the best interest of the student. As a school counselor, my job is to advocate for my student. And so for me, it wasn't about my personal views. It was more so about what was right for the student in my role as the student's

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school counselor to advocate for their needs.

Q. And so in your capacity as the student's counselor, did you disagree with the School Board's decision to enact the new policy?

MR. CORRIGAN: Object to form.

THE WITNESS: Again, I chose to assist my student based on the student's needs, and not my personal views.

BY MR. BLOCK:

Q. And your understanding of the student's needs was that using the boys restroom was in his best interest; is that right?

MR. CORRIGAN: Object to form. Go ahead.

THE WITNESS: Yes.

BY MR. BLOCK:

Q. Did you speak with Gavin at all about his use of the restrooms after the School Board enacted its policy?

A. I'm sorry, can you repeat that?

Q. After the School Board passed its new policy, did you have further discussions with

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Gavin about his use of restrooms?

A. Yes.

Q. What were those discussions?

A. Well, I actually met with Gavin once a week. That was another part of setting up a plan for Gavin after he was allowed to use the restroom. And so it was mainly just to check up with him just to make sure he was safe. And so, mainly that was to make sure he was safe, but then there was a discussion where he stated he did not want to use the restrooms that were identified by the School Board because he felt like it singled him out.

Q. Did he explain why he felt that it singled him out?

A. I do not recall.

Q. And so during this discussion, which restroom did Gavin say he would be using?

A. I don't recall.

Q. Did you continue to meet with him once a week throughout the rest of the year?

A. Yes.

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Q. And during these meetings, did Gavin give any indication of how the new policy was impacting him?

A. I do not recall.

Q. Do you recall whether Gavin indicated he was experiencing any distress as a result of the new policy?

A. I remember in the same conversation where he stated that he felt as though the new policy singled him out, that he expressed that it was disappointing. I don't recall specifically distressing, but he was disappointed with the decision.

Q. Did Gavin talk to you at all about how the policy was impacting his ability to study or to be in class on time?

A. Well, initially before -- well, not necessarily the policy, but prior to the policy I know he had stated sometimes, you know, using the restroom down in D-Hall, or having to go to the nurse's office at times, you know, was a bit much for him, you know, having to go to one of the

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extremes, which was then, if I recall correctly, what brought him to ask me the question regarding once he started the hormone therapy, if he could use the male restrooms so he could have more flexibility.

Q. So during these weekly check-in meetings, what did you talk about?

A. Mainly just checked in with him to see if he was okay. You know, the goal every week was to make sure that he wasn't being harassed, if there was anything that he needed as it related to support within the school, within myself as a school counselor in the school counseling department.

Q. And what did he say at these meetings?

A. With most of the meetings he was -- you know, he was -- he stated he wasn't -- hadn't been harassed by any students, and things were going fine.

Q. Now, in the context of these meetings, did you ever specifically ask him about

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how the new policy was impacting him?

A. No. I did not want to ask any probing questions. So I would, you know, kind of just remind him, this is our weekly check-in, and I would leave the floor open for him to share. I would ask specific questions regarding his safety, of course, and if he was being harassed, but then from there I would allow him to share what he wanted to share.

Q. So the meetings weren't necessarily a forum for him to complain about the restroom policy in particular; is that right?

MR. CORRIGAN: Object to the form of the question. I think it mischaracterizes her testimony.

THE WITNESS: The meetings were for him to share anything that he wanted to share, whether it related to policy, or academics, just being a teenager -- you know, living under a roof with two parents and having to follow rules. It was just a way to give him an outlet, and to know that he had support within

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the school.

BY MR. BLOCK:

Q. Well, if he was having problems with the restroom policy, what support would he have actually had from the school?

MR. CORRIGAN: Object to form. Go ahead.

THE WITNESS: I'm not aware. If there was anything that I could recall that he brought up specifically, I would have gone through the proper protocol, and then, you know, we would go from there.

BY MR. BLOCK:

Q. But changing the restroom policy wasn't an option that could have been under consideration?

MR. CORRIGAN: Object to form, foundation.

THE WITNESS: Not to my knowledge.

BY MR. BLOCK:

Q. And you said before that the primary purpose of the check-ins was to make sure that he

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wasn't being harassed; is that right?

A. Yes, by other students.

Q. And did he ever report harassment by other students?

A. Not that I recall.

Q. Did you, as part of these check-in meetings, monitor at all how Gavin was doing academically?

A. We at times would discuss grades.

Q. And how were Gavin's grades that semester?

A. Honestly, I don't recall.

Q. Do you remember whether his grades were worse after the policy went into effect than they were before?

A. I don't recall.

Q. So there is a lot from these check-ins that you don't recall the specifics of what was said; is that right?

A. Mainly at the check-ins Gavin stated he was okay. Like I said, at one point we did briefly discuss, you know, the policy, and which

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he discussed he felt like it singled him out. But, you know, not every check-in was about that.

Q. You didn't say: Do you still feel that this policy singles you out each week, right?

A. No.

Q. And when Gavin said that he's okay, did you understand him to be saying that he was okay with respect to how other students were treating him?

MR. CORRIGAN: Object to form. Go ahead.

THE WITNESS: I'm sorry, can you repeat that question?

BY MR. BLOCK:

Q. Yeah. When Gavin would say that he's okay, did you understand him to be referring to not experiencing harassment?

MR. CORRIGAN: Object to form.

THE WITNESS: I would specifically ask him, and he would say no.

BY MR. BLOCK:

Q. So you would say, Are you facing any

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harassment from other students?

A. Nothing is going on, how are things going, how are you, yeah. And he would -- he never reported that he was -- at least not to me -- that there was any harassment from any other students.

Q. Did anyone from the School Board or the administration check in with you to ask how Gavin was doing?

A. I don't remember.

Q. Did you remain Gavin's counselor after his sophomore year?

A. No.

Q. Why not?

A. We changed alphabets. Our alphabets -- because we typically do counselor assignments based on a student's last name. So we had a shift in the alphabet assignment, so he was assigned to someone else the following year.

Q. Do you know who that was?

A. I believe it was Jon Neblett.

Q. Did you ever discuss Gavin with

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anyone else from the counseling department during the rest of his time at high school?

A. I believe Jon Neblett and I had some discussion. There was some concerns that teachers had brought to me, thinking I was still Jon -- excuse me, Gavin's counselor. Then I would obviously have to redirect them to Jon. I kind of made Jon aware so he, you know, could move forward having knowledge in working with Gavin. And like I said, sometimes there were things that were brought to me because there was a mistake that someone thought, okay, you're his counselor; but then bring Jon into the loop and merge the teacher with the counselor.

Q. What concerns from teachers were brought to you?

A. Sometimes -- I don't remember specifics, but I remember maybe grades or just maybe observations regarding him in class. You know, so then I would -- I directed Jon. It was only like maybe once, maybe twice I directed them to speak with Jon, but I don't recall specifics.

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Q. Were the concerns that he wasn't engaged in class?

A. I don't remember.

Q. Were they behavior concerns about him misbehaving?

A. I don't recall.

Q. Can you recall what teacher brought concerns to you?

A. I remember one time his -- I think it was an English teacher, if I'm not mistaken, but I don't remember the details.

Q. Do you remember if any teachers expressed concerns that his grades were suffering?

A. You're saying the following year?

Q. At any time.

A. Oh, I remember there being concerns about grades, not necessarily that they were -- I remember there being concerns about grades, but, you know, more so kind of how can I help this student. But he wasn't like failing significantly, if I recall correctly. I really don't remember how his grades were that year, but

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I remember there were e-mails regarding, you know, teacher concerns about various -- like regarding bathroom and him being in the halls. I do specifically remember that.

Q. When did that concern come in?

A. That was maybe earlier in the school year his sophomore year.

Q. And what was the complaint?

A. Just there were various complaints that he was seen in different parts of the school during class, and so there was just some concern as far as him being in class.

Q. And what did you do when you got those complaints?

A. I believe he and I had a conversation, but I honestly do not remember details.

Q. Was the reason why he was not in class because he had to travel to use a restroom?

MR. CORRIGAN: Object to form. Foundation.

THE WITNESS: Honestly, I can't

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remember.
BY MR. BLOCK:
Q. So you don't remember what Gavin might have said when you talked to him about the complaint?
A. I don't remember. I'm sorry.
Q. Would there be e-mails of this complaint?
A. There were a few e-mails, yes.
Q. To the best of your recollection, you think this was earlier on in his sophomore year?
A. Yes, if I recall correctly. I don't remember specifics, but I remember at one point it was -- you know, I just received some heads up, and I think it was toward the first -- at least within the first semester. I don't recall.
Q. Can you recall whether it was before he was allowed to start using boys restrooms?
A. I can't recall.
Q. And did you have any discussions with Jon Neblett about how Gavin was doing?
A. You're saying during his junior year?

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Q. Yeah.
A. I don't recall.
Q. Did you have any discussions with Matt Lord about how Gavin was doing?
A. You're saying when he was no longer on my caseload, or just in general?
Q. Well, let's first talk about sophomore year.
A. Okay.
Q. Sophomore year, did you have conversations with Matt Lord about how Gavin was doing?
A. I remember checking in with him as my supervisor, but I don't remember specifics.
Q. And then how about for Gavin's junior and senior year, did you ever have any conversations with Matt Lord about how Gavin was doing?
A. I don't recall.
Q. Did you ever have any additional interactions with Gavin yourself after his sophomore year?

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A. I believe there was a couple of times he came in to speak with his counselor, and his counselor was unavailable. So then being so that I had a rapport with him, he spoke with me.
Q. And what did he say?
A. I don't remember specifically what those conversations were, but I remember he needed to speak with a counselor, and I do remember seeing him just a few times, maybe once or twice the following year when I was no longer assigned as his counselor.
Q. Do you know if Jon Neblett remained his counselor for his junior and senior year?
A. Yes, he did.
Q. Did you become aware at any time during his sophomore year that -- excuse me, did you become aware at any time during his junior year that Gavin was attending a different school?
A. Attending a different school? I don't believe I knew anything about that.
Q. We talked about students that you had worked with who were transgender before you

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started working with Gavin. After you started working with Gavin, did you then work with any additional students who were transgender?
A. Yes.
Q. About how many?
A. There's only one that I'm thinking of at the moment -- that I can think of at the moment.
Q. And did that student talk to you at all about the impact that the school's new restroom policy was having on them?
A. No.
Q. Did that student describe any difficulties they were having at school with respect to being transgender?
A. No, not that I recall.
Q. Do you know what restrooms that student used?
A. I do not recall, but the student never brought up -- to my knowledge, never questioned what restroom they could use or access. So I'm not sure.

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Q. So to the best of your knowledge, at the time that the School Board made their decision to adopt their new restroom policy, the only student you're aware of, to the best of your knowledge, that had ever requested to use a restroom consistent with their gender identity is Gavin?

A. To my knowledge, yes.

MR. CORRIGAN: Do you have a lot more, a little more?

MR. BLOCK: I don't have a lot more.

MR. CORRIGAN: Let's keep going, then.

MR. BLOCK: Yeah, it will be under ten minutes.

MR. CORRIGAN: Clock's on.

BY MR. BLOCK:

Q. Did you talk with anyone else in the counseling department or the teacher's lounge about their views on the School Board's new restroom policy?

A. No.

Q. Why not?

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A. Well, I just felt as a school counselor it was inappropriate to speak with the teachers regarding that. And to protect the confidentiality of the student, I never wanted to get into any conversations with anyone outside of the counseling office regarding that.

Q. Did you ever overhear other teachers talk about their views on the school's new restroom policy?

A. No, not that I recall.

MR. BLOCK: If you could just give me one minute, I just want to talk outside for a second. We'll be right back.

(Whereupon, a recess was taken).

MR. BLOCK: Okay. I don't have any other questions.

MR. CORRIGAN: No questions. And she -- is it okay if she wants to read it?

THE WITNESS: I also had one more thing. I do remember having one conversation with Jon additional. I think there was an incident. He was informing me of Gavin -- there was an

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incident I think where he had attempted to hurt himself. And so, because I had spoken to the student at -- you know, just a few handful of times -- I totally just thought about this -- Jon had, you know, communicated with me just, you know, kind of hey, heads up, you know, working with the student. But other than that, I don't recall having many conversations with him regarding Gavin.

BY MR. BLOCK:

Q. Do you remember when this conversation was?

A. I can't remember when it occurred. And honestly, he didn't really go into detail about it. He just let me know that there was something that had happened with the student.

Q. Do you recall whether it could have been his junior year or his senior year?

A. I can't remember, sorry.

MR. BLOCK: No, that's okay. Thanks. No further questions.

MR. CORRIGAN: No further questions, and

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she'll read.

(Off the record at 10:37 a.m.)

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ACKNOWLEDGMENT OF DEPONENT

I,

TIFFANY DURR, do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct, and complete transcription of the testimony given by me; and any corrections appear on the attached Errata sheet signed by me.

_____ _____

(DATE) (SIGNATURE)

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CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC

I,

LISA BLAIR, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my direction; that reading and signing was requested; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 16th day of October 2018.

My commission expires October 31, 2020.

_____

Lisa Blair, RMR

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Transcript of Matthew R. Lord

Date: October 10, 2018
Case: Grimm- v- Gloucester County School Board

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
CIVIL CASE NO. 4:15-CV-54

GAVIN GRIMM :
Plaintiff :
v. :
GLOUCESTER COUNTY SCHOOL BOARD :
Defendant :

Deposition of MATTHEW R. LORD
Glen Allen
Wednesday, October 10, 2018
11:14 a.m.

Job No.: 207625
Pages 1 - 64
Reported by: Lisa M. Blair, RMR

Deposition of MATTHEW R. LORD, held at the offices of:

HARMAN, CLAYTOR, CORRIGAN & WELLMAN, P.C.
4951 Lake Brook Drive
Suite 100
Glen Allen, Virginia 23060

Pursuant to agreement, before Lisa M. Blair, Notary Public in and for the Commonwealth of Virginia.

A P P E A R A N C E S

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C O N T E N T S

EXAMINATION OF MATTHEW R. LORD PAGE
By Mr. Block 5

E X H I B I T S

1 Speech by Matthew Lord 7
2 ASCA document entitled, "The School Counselor and Transgender/Gender nonconforming youth" 12
3 School transcript of Gavin Grimm 41

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P R O C E E D I N G S

Whereupon,

MATTHEW R. LORD,

being first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE PLAINTIFF

BY MR. BLOCK:

Q. Good morning, Mr. Lord.

A. Good morning.

Q. My name is Josh Block. I'll be representing Gavin Grimm in his lawsuit against Gloucester County School Board, and I'll be taking your deposition. Have you ever had your deposition taken before?

A. I don't believe so, no.

Q. Okay. So I'll go over some ground rules. The first is that we have a court reporter writing down everything I say and everything you say. So it's important that all your responses be oral so she can write down the answer. No nodding

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your head or saying uh-huh; does that sound fair?

A. Yes.

Q. Great. The second is that she's writing down what we're saying, and she can't write down what two people are saying at the same time. So unlike normal conversations, we need to be sure that you wait till I'm completely done before you answer, and I wait that you're completely done before I ask the next question. Sound good?

A. Yep.

Q. And finally, it's my job to ask questions in a way that you can understand. So if anything I say is unclear, I'm counting on you to let me know so I could rephrase it; agreed?

A. Makes sense, yes.

Q. And if you do answer a question, I'm going to assume that means you understood it; does that sound good?

A. Yes.

Q. Okay. Let's begin. Could you say your name for the record, please?

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A. Matthew Robert Lord.

Q. Great. And what is your position at Gloucester High School?

A. I'm the director of school counseling at the high school.

Q. How long have you been director of school counseling?

A. I believe this is my sixth year.

MR. BLOCK: So I am going to show you something that I'm going to have the reporter mark as Exhibit 1.

(Lord Exhibit Number 1 was marked for identification)

BY MR. BLOCK:

Q. This is something we found Googling on the Web. I think it's a speech from you when running for treasurer or a different position. Do you recognize this document?

A. Yes.

Q. What is it?

A. It was the Virginia Counseling Association, the Executive Board, and I was

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running for treasurer. And so this is what I sent them that they could publish for the elections.

Q. Great. And is everything on this document true and accurate?

A. Yes.

Q. Great. So according to this -- I'm just going to review some of your key credentials -- you received your bachelor's in 1987; is that right?

A. Yes.

Q. And you got a master's of education in counselor education in 1991 from VCU; is that right?

A. Yes.

Q. You've been a member of the American Counseling Association since 1991?

A. Yes.

Q. What does -- what is the American Counseling Association?

A. The American Counseling Association is the professional organization for counselors, for professional counselors, LPCs, school

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counselors, folks that have that credential.
Q. And why are you a member?
A. Because in my graduate program, professional membership was explained as an important thing to be the advocate for the profession.
Q. And what is the ACAC division?
A. That's one of the divisions within the ACA. ACAC is the Association of Childhood and Adolescent Counseling.
Q. And you've been a VCA member since 1996; is that right?
A. Correct.
Q. What does VCA stand for?
A. It is the state division or the state member from the ACAC, the Virginia Counselors Association.
Q. And why are you a member of the VCA?
A. For the same reasons I am of the ACA.
Q. It says you're a founding member of the VA Alliance for School Counseling; is that right?

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A. Correct.
Q. What is the VA Alliance for School Counseling?
A. That is the division within the VCA that represents school counselors.
Q. Now, are you familiar with an organization called the American School Counselors Association?
A. I am.
Q. What does ASCA do?
A. They are actually still a division of the ACA, but there was a huge split between the ACA and ASCA many years ago. Some people have chosen to go one way or the other. Some still belong to both.
Q. Do you belong to the ASCA?
A. No.
Q. Why not?
A. Because I was one of the people that went the other way.
Q. Okay. What was the reason for the split?

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A. Professional identity issues. That's my opinion.
Q. Could you explain a little more?
A. Well, there are some people in the counseling world that see themselves as they are niche, you know, like addictions counselors, mental health counselors. And so they more identify with that narrow segment. Then there's folks that see themselves as a bigger picture of all counselors. And so, that's what happened there, in my opinion, many years ago, was the people that identified solely as school counselors, and not as an overall membership of a larger group. I didn't see it that way.
Q. Do you ever review guidance or position statements from the ASCA?
A. Yeah. Yeah, because I'm still in the profession.
Q. Is it viewed as a credible source within the profession?
MR. CORRIGAN: Object to form. Go ahead. I may occasionally --

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THE WITNESS: Yeah.
MR. CORRIGAN: -- make a statement. Just wait for me to finish, then talk.
THE WITNESS: Uh-huh.
MR. CORRIGAN: All right. Thanks.
THE WITNESS: If you're a member of that organization, then you should abide by it. I am not a member of that organization. So not necessarily do I have to do that.
MR. BLOCK: Okay. I'm going to show you another document marked -- I'm going to have marked as Exhibit 2.
(Lord Exhibit Number 2 was marked for identification)
BY MR. BLOCK:
Q. This is a document on the letterhead of the ASCA titled, "The School Counselor and Transgender and Gender Nonconforming Youth;" is that right?
A. It is.
Q. Have you seen this document before?
A. No.

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Q. Okay. Are you familiar with the American School Counselor Association's recommendations on treatment of transgender and gender nonconforming youth?

A. I see this came out of 2016. I am not.

Q. Has the American Counselor Association issued any official guidance on school counselors and transgender students?

A. Not to my knowledge.

Q. Does the ACA issue these sort of position statements the same way that the ASCA does?

A. Not to my knowledge.

Q. And do you know if there's a reason for that?

A. No, I don't.

Q. Does the ACA or the VCA provide any professional training or resources on counseling LGBT students?

A. At conferences and at workshops, yes.

Q. What sort of training?

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A. Training directed toward following ethical guidelines and standard of practice, and ones that would also discuss just kind of an awareness of how to not offend clients, working with diversity type training, this being one of the many groups that counselors need to be aware of and know how to work with those students -- or in this case, students -- but those clients.

Q. Have you attended any of those trainings?

A. Yes.

Q. What trainings do you remember that you've attended?

MR. CORRIGAN: Are you asking all trainings he's ever attended?

MR. BLOCK: On the topic of transgender.

THE WITNESS: On the specific topic of transgender?

BY MR. BLOCK:

Q. Of transgender clients, yes.

A. Nothing specific to transgender clients.

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Q. So I'm going to just point out just a few of the recommendations from the ASCA statement. I'd just like your opinion on whether you agree with them.

MR. CORRIGAN: Do you think it's fair to give him a minute to read it over --

MR. BLOCK: Yeah, sure.

MR. CORRIGAN: -- in fairness to him.

MR. BLOCK: No, of course.

MR. CORRIGAN: I have no idea what it says.

BY MR. BLOCK:

Q. All done?

A. Sure.

Q. Is there anything about this document's description of what the role of a school counselor should be with respect to trans students that you disagree with?

MR. CORRIGAN: Object to form and foundation. Calls for a legal conclusion. Go ahead.

THE WITNESS: No, not practically.

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BY MR. BLOCK:

Q. So -- well, anything impractically?

MR. CORRIGAN: Object to form and foundation, legal conclusion. Go ahead.

THE WITNESS: Again, it says things like, subject to state and federal civil rights laws. You know, counseling gets into that weird place where we have a code of ethics that sometimes is in conflict with those things.

BY MR. BLOCK:

Q. Okay. So focusing on your understanding of code of ethics and the proper role of a school counselor, I just want to review the following statements to just confirm that you agree that this falls within the proper role of a school counselor.

So just look at the very first paragraph. It says, School counselors recognize all students have the right to be treated equally and fairly with dignity and respect as unique individuals, free from discrimination, harassment and bullying based on their real or perceived

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gender identity and expression; and school counselors work to safeguard the well-being of transgender and gender nonconforming youth.

Do you agree with that statement?

A. Yes.

MR. CORRIGAN: I'm going to object to the form, foundation, legal conclusion. Can I have a standing objection --

MR. BLOCK: Yes.

MR. CORRIGAN: -- rather than having to state that over and over again?

MR. BLOCK: Yes, absolutely.

MR. CORRIGAN: Okay. Thank you. So for all these questions, I have a standing objection of that nature. Thank you. Go ahead.

BY MR. BLOCK:

Q. If you go to the next paragraph that's titled the rationale, I just want to look at that last sentence: School counselors recognize the overall goal is to ensure the safety, comfort and healthy development of all

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students, maximizing inclusion and social integration while minimizing exclusion and stigmatization.

Do you agree with that statement?

A. Yes.

Q. Why is it important to maximize inclusion and social integration?

A. Well, it really says that beforehand: To ensure safety, comfort and healthy development of all students.

Q. Okay. And in your opinion and professional experience, is being included and socially integrated with the rest of the school community an important factor in the healthy development of students?

MR. CORRIGAN: I have a new objection. The effort to make him an expert witness for the plaintiff in the case is inappropriate. He is to testify to facts, and his opinions professionally are not something to me that is appropriate questioning for this witness. What happened in this case, things of that nature,

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but I don't agree that it's appropriate for him to answer these questions. I'm not going to instruct him not to answer, but that's another objection that I would ask be a standing objection, if this is the road we're going down --

MR. BLOCK: Sure.

MR. CORRIGAN: -- rather than me having to restate that.

MR. BLOCK: Sure.

BY MR. BLOCK:

Q. So could you just answer that question: In your professional experience, is being included and socially integrated generally important to the welfare and development of students?

A. Yes.

Q. And is being excluded and stigmatized generally harmful to the welfare and development of students?

MR. CORRIGAN: Object to form and foundation. Go ahead.

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THE WITNESS: Could you say that again?

BY MR. BLOCK:

Q. Yeah. Is being excluded or stigmatized generally harmful to the welfare and healthy development of students?

A. Generally, yes.

Q. So when did you first become aware of Gavin Grimm?

A. This is all just memory. Sometime during his ninth grade year.

Q. And in what context did you become familiar with him?

A. I don't remember exactly. I don't know if it was through, you know, just meeting him through coming into the counseling office, or whether it was through working with the Gay Straight Alliance at the school, but somewhere in that year.

Q. Now, before you met Gavin, to the best of your knowledge, were you aware of other students at Gloucester High School who were transgender?

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A. By their definition, yes, and/or questioning.
Q. About how many students?
A. At that point, less than five.
Q. Are you -- were you aware of any students ever requesting to use a restroom or locker room that was consistent with their gender identity instead of the sex assigned to them at birth?
A. Not to my knowledge.
Q. Were you aware of any students who requested to use single user or alternate restroom or locker room instead of this locker room or restroom for their sex assigned at birth?
A. Not to my knowledge.
Q. So going back to Gavin, did -- are you aware that -- of the meeting that Gavin and his mother had with Tiffany Durr before school started?
A. Am I aware of it now, or was I aware of it when it happened?
Q. Well, were you aware of it when it

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happened?
A. I don't remember. You know, shortly thereafter I was aware of it.
Q. So did -- after she met with Gavin, did she talk to you at all about the meeting?
A. That whole chunk of time is kind of fuzzy about what happened when for me, in all honesty. So did she talk to me immediately after that meeting? I don't remember.
Q. Were you consulted with respect to what the plan would be for Gavin using restrooms like when he started school?
A. I don't remember that.
Q. And --
A. You're talking about the plan of the nurse's room, and then later adding like the D-Hall bathroom?
Q. Yes, I'm talking about that plan.
A. I don't remember me knowing that as it happened. I was aware of it shortly afterwards.
Q. Okay. Well, when do you recall being

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made aware of it?
A. When Gavin asked to be able to use male bathrooms throughout the building.
Q. And how did you become aware of it?
A. I believe that was shared with me by Ms. Durr.
Q. And can you elaborate more on what Ms. Durr said to you?
A. From what I remember, just that Gavin wanted to start using the male bathrooms.
Q. And what did you say to her?
A. I probably said we needed to talk to Mr. Collins and do a little bit of research on the situation to see what was to be suggested.
Q. And so, did you do any research on the situation?
A. Yes, I did.
Q. What research is that?
A. I looked on the Lambda Legal site, which I'm already aware of, and I looked at the GLSEN site to see if there was anything on those that would help people that had to make this

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decision, make this decision.
Q. And you think -- in your experience is the guidance on those sites generally consistent with good practice for school counselors?
MR. CORRIGAN: Object to the form, foundation, legal conclusion.
THE WITNESS: Just like with other things that are put up by professional organizations, they're one source to look at to see if there's anything that's already known in certain cases.
BY MR. BLOCK:
Q. And so do you recall who you shared these resources with?
A. From what I remember, I sent an e-mail to all the administrators, which would be Mr. Collins and the APs, Ms. Durr, and one of the nurses. I'm just saying here's two sources to look at.
Q. Did you have any other conversations with any of those people?

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A. I mean, I spoke with Ms. Durr, you know, more about it, and I spoke with Mr. Collins more about it.

Q. And did you give Mr. Collins a recommendation about what he should do?

A. From what I remember, was to read that stuff over and talk to the superintendent. When you say recommendation, like did I read it all and did I come up with what I thought should be done?

Q. Or did you recommend to him whether Gavin should be allowed to use the boys restrooms?

A. My reading of those documents suggested that that would be a decision that they should make on that end, but not my decision to make.

Q. But did they ask for your input at all on whether allowing him to use the boys restrooms would be something important to his well-being?

A. I don't know specifically about his well-being, but -- I don't know about that as a

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specific reason for it.

Q. Well, I guess what is the role of a school counselor in this -- in this context when a student comes to you and makes that sort of request? What is the role of a school counselor in handling that?

A. Well, since we're looking at this document, it's to make sure that the student is safe, and that their, you know, mental and physical health is not negatively impacted as best as possible.

Q. And so, do you -- did you have a recommendation to Principal Collins about how to do that?

A. Again, my reading of the two sites and the documents on them made me suggest to them that what appeared to have already been decided in other cases was that he should be able to use the restroom.

Q. But you didn't have an independent opinion, besides just what those two sites said?

MR. CORRIGAN: Object to form and

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foundation, legal conclusion. Go ahead.

THE WITNESS: I don't understand. I mean --

BY MR. BLOCK:

Q. I'm just --

A. My personal opinion?

Q. Well --

A. My professional opinion?

Q. Well, I'm just saying the principal says, you know -- well, did Principal Collins say, What do you think I should do?

MR. CORRIGAN: Object to form and foundation.

THE WITNESS: If he did -- and I'm sure that was somehow in the conversations, but it's a long conversation ago -- is read the documents; I think they say this.

BY MR. BLOCK:

Q. I guess what I'm missing in the link is whether you say: And I think that -- is that you say, I think they say this, and I think that's correct or not. I want to know whether you --

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whether you give an opinion on whether following what the documents say was the right thing to do?

MR. CORRIGAN: Object to form, foundation, legal conclusion.

THE WITNESS: And I suggested they follow them. That is me saying that that's the right thing to do, because that would be following what has already been, in my opinion in reading through the stuff, what had already been decided in courts.

BY MR. BLOCK:

Q. Well, I want to put aside the issue of what the law requires and just focus only on what a school counselor looks for in terms of well-being of a student. Did you express any opinion at the time, putting aside what the legal requirements were, and just focusing on your opinion about what would have been in the best interest of Gavin?

MR. CORRIGAN: Object to form, foundation, legal conclusion. Go ahead.

THE WITNESS: I don't remember at that

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time doing that, because my role in that was more as an administrator. Ms. Durr was his counselor. And so I perceived myself as more being as the director kind of working with these two people to help them navigate through the situation that was going on.

BY MR. BLOCK:

Q. So was there ever a time when you were asked for your opinion about whether being allowed to use the boys restroom was in the best interest of Gavin?

A. By whom?

Q. Well, let's start with by anyone in the administration.

A. If Mr. Collins had asked, I would have said yes. You know, in all the conversations that went on during that period, I am sure that that came up. And if it had, I would have said yes.

Q. And were you ever asked for your opinion about whether it was in Gavin's best interest by anyone from the School Board ever?

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A. No.

Q. Were you ever asked for your opinion about whether it was in Gavin's best interest by anyone in the superintendent's office?

A. Not that I remember.

Q. Were you ever asked for your opinion about whether using the boys restrooms was in Gavin's best interest by anyone else in the counseling department?

A. Yes.

Q. By whom?

A. By Ms. Durr.

Q. And what did you tell her?

MR. CORRIGAN: Object to form, foundation, legal conclusion. Go ahead.

THE WITNESS: Again, as the director, we discuss all kinds of stuff, whether it's cases about what students should apply to colleges and get them to do that in that direction, or whether it's more, you know, social/emotional issues. And so, counselors consult with me as a director often. I'm sure she did, and I'm

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sure that we discussed that would be in his best interest.

BY MR. BLOCK:

Q. To the best of your knowledge, did any students complain to counselors about beings uncomfortable with Gavin using the boys restrooms?

A. Not to my recollection.

Q. To the best of your knowledge, did any students speak with counselors at all about the topic of Gavin using the restrooms?

A. I really don't know. It was a topic around the school. It may have been discussed, but not in a counseling way.

Q. When did you become aware that the School Board was going to be reviewing whether Gavin should be allowed to continue using the boys restrooms?

A. Very shortly in that time frame. My recollection is that October -- late October, early November, I think. It was just in that -- in that time frame.

Q. And were you asked to give any input

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as part of that review process?

A. No, not that I remember.

Q. Did Gavin ever speak with you directly about his use of restrooms?

A. Yes.

Q. When was that?

A. Off and on throughout the whole process.

Q. But in the time period of his sophomore year?

A. Yes.

Q. And to the best of your recollection, what did Gavin say when he spoke with you?

A. That he wanted to use -- you know, because I started talking to him afterward -- that he wanted to use the male restroom.

Q. Did he say why that was important to him?

A. I believe -- kind of back to the letter that came from one of the doctors or the psychologist he was working with, that it would just be in his best interest, since he was

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transitioning to male, that he use the restroom that he identified with and that he was transitioning to.

Q. And did he ever talk about the impact that the new restroom policy that the School Board passed was having on him?

A. Strangely for me in all the conversations I had with him, no. We quite often talked about other things. One of my -- because I had somewhat of a relationship, not as much as Ms. Durr had counseling-wise -- was checking in, just wellness checking in to be sure: Where are you today, and how are you doing, for various reasons.

Q. What were those various reasons?

A. Well, we just know that transgender students and transgender people have more risk of all kinds of mental health issues. And so, we -- we care enough about the healthy development of students to be checking on ones that we know may be going through something that may put that in jeopardy.

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Q. And when you checked in with him, what did he say?

A. Some days things were going well, and some days things were more difficult.

Q. During these check-in meetings, was the restroom policy ever anything you specifically asked about?

A. Not necessarily, because it kind of was unfolding on its own anyways. It was more probably: Where are you and how are you doing today type stuff. What are you thinking? Anything going on with you we need to know about? That sort of stuff.

Q. And did Gavin ever report feeling stigmatized?

MR. CORRIGAN: Object to form. Go ahead.

THE WITNESS: By other students?

BY MR. BLOCK:

Q. Sure.

A. I don't really think so. It's a school of pretty nice kids. I don't remember

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there ever being an issue with other students.

Q. Did you -- well, following up on you saying it's a school of nice kids --

A. In general.

Q. In general.

Did you ever have any concerns that Gavin using the boys restroom would lead to physical disruption or violence?

MR. CORRIGAN: Object to form. Go ahead.

THE WITNESS: I mean, that's an impossible -- I mean, any student that goes in the restroom always -- you know, there's bad kids in the school that do stuff to people when no one is looking. Did I have any extra concerns? I mean, it would be impossible to say. I'm sure they were slightly elevated, but that quickly passed, because that wasn't something he was bringing up in our discussions as being an issue. He wasn't getting harassed by other students about this.

BY MR. BLOCK:

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Q. Were you in a position to form an opinion on whether Gavin was treated as a boy by his peers?

MR. CORRIGAN: Objection to the form, foundation, legal conclusion, expert witness testimony. Go ahead.

THE WITNESS: No. In the GSA meetings he attended, that was always done out in the school population. You know, I didn't observe one way or the other, and he never reported there being a problem with it.

BY MR. BLOCK:

Q. Did you ever see Gavin switch back and forth between what gender he identified as?

A. I don't know about ninth grade, but as of 10th grade, no.

Q. So as of 10th grade, he was consistently identifying as a boy?

A. Uh-huh.

Q. Can you just say it orally?

A. Yes.

Q. At GSA meetings, did students talk

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about what effect the School Board's policy was having just on the climate of the school?

A. No. My recollection is that they -- that there wasn't anything really happening with the climate within the school, and that they kind of knew that. They talked about whether they should go and speak at that board meeting or not. They were told that was up to them. As being citizens of the county, they could do what they wanted. I don't remember a GSA meeting where this came up again as a negative issue.

Q. Did any other transgender students after Gavin, to the best of your knowledge, ask to use restrooms that were different from the restrooms of their sex assigned at birth?

A. Can you say that again?

Q. Yeah, I'm sorry. Besides Gavin, did any other students ask to use restrooms, other than the restrooms based on their sex assigned at birth?

A. Not that I remember.

Q. So over the course of Gavin's

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sophomore year, were you able to observe any impact that the restroom policy was having on him?

MR. CORRIGAN: Object to form, foundation, legal conclusion. Go ahead.

THE WITNESS: So with the amount of things that were going on, I could not say that anything was directly related to the restroom policy any more than it was related to going through the medical procedures, to going through the mental health part of it, to going through family issues. To have assigned any of it to any one thing would have been to miss what was going on. So the whole thing had to be looked at as, you know, like any counseling human being that you're working with, is what's the whole picture going on.

BY MR. BLOCK:

Q. And all parts of that picture could be having an impact, right?

A. Yes.

MR. CORRIGAN: Object to form, foundation.

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BY MR. BLOCK:

Q. And so it's hard to isolate, you know, the specific effect that any one specific part was having; is that right?

MR. CORRIGAN: Object to the form. Go ahead.

THE WITNESS: (No verbal response).

BY MR. BLOCK:

Q. Could you say that out loud?

A. Yes.

Q. Did Gavin ever talk to you about feeling stigmatized under the policy?

A. And when you say stigmatized, what do you --

Q. Stigmatized by the school, that it was stigmatizing for him to use one of these new restrooms that were created?

MR. CORRIGAN: Object to form.

THE WITNESS: I don't remember in our conversations that coming up. Again, there was so much going on. And Ms. Durr was his main counselor. So in my discussions with him, I

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don't remember that being specifically said.

BY MR. BLOCK:

Q. Did there come a time in which you were concerned about -- well, let me start over again. Sorry.

So during Gavin's junior year, WHO was his counselor then?

A. Ms. Durr still, I believe.

Q. Was there some --

A. There may have been a change in our alphabet, but Ms. Durr continued to work with him. So our policy is that you're assigned to a counselor by alphabet, and that person will keep track of your academic record marching toward graduation, but that for personal issues and even for college and career issues, you can go to anyone you want to. Sometimes we have a shift in counselors because of somebody leaving, or the population of the students growing, or one year we had an extra counselor, that you can still choose to continue on working with someone you did. And I believe that Ms. Durr and Gavin continued to

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work together.
Q. Do you know if Jon Neblett worked with Gavin at all?
A. I don't remember. It was probably more on the academic, because once that person -- I mean, once that person is assigned to you, now you pick up their academic stuff. So I don't know that Jon did much more than keeping track of graduation requirements, talking about college and career stuff. I don't remember any conversations that would lead me to believe that there was a lot of social and emotional type services going on there.
Q. I'm going to show you a document I'm going to ask the reporter to mark as Exhibit 3.
(Lord Exhibit Number 3 was marked for identification)
BY MR. BLOCK:
Q. So does this appear to be Gavin's final transcript?
A. It is, yes.
Q. And the counseling office plays a

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role in compiling a student's transcript?
A. Yes.
Q. If you look at Gavin's 10th grade classes, if you see there's something that says VLC PE10; do you see that?
A. Yes. Yes.
Q. And under a column that says attributes, it says DL; do you see that?
A. Uh-huh. Yes.
Q. And what does DL stand for?
A. It's the online class. It probably meant distance learning. Not a good acronym, but it's the online classes. The VLC is the virtual learning.
Q. Now, if we look at Gavin's grades for his junior year, it looks like there is a DL next to his classes for English, geometry, oceanography, U.S. History and psychology; is that right?
A. Yes.
Q. So for all those classes, he got his credits through online learning; is that right?

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A. He got them through online learning, but at school. He wasn't at home doing those completely. So he was at -- I believe that year the virtual program was at -- partly at the high school and partly at another school. The creative writing class was done at Gloucester High School. So he was kind of going between the two, from what I remember, mainly at the virtual learning center.
Q. And do you know why he was taking so many classes at the virtual learning center?
A. From what I remember, he and his mother requested that, that year.
Q. Did they give a reason why?
A. I wouldn't have known what the reason why was. I wasn't involved in that decision.
Q. Do you know who would have been involved in that decision?
A. At that point, probably the student's administrator, Ms. Durr, because she was working with that side of things. Maybe Mr. Neblett and the online administrator, who was at that point a woman named Wendy Wyatt.

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Q. And did you have any check-ins with Gavin about his emotional well-being during his junior year?
A. I can't recall anything specific, but I would guarantee that we spoke at least in passing a few times. And I say that because I always kind of knew where Gavin was with himself.
Q. Well, so how was Gavin with himself during his junior year?
A. In our discussions?
Q. Yes.
A. Some days okay, some days struggling with everything that was -- you know, the whole totality of what was being dealt with.
Q. Well, what are some of the things that Gavin said he was struggling with?
A. From what I remember, there were a lot of issues outside of school, you know, mail, all kinds of people attempting to contact on both sides of things. I don't know what year it is, but I know one time he and I spoke about that, how people are very passionate on both sides of

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issues, and quite often people that are very passionate on both sides of issues do not have the best interest of the person who is going through it at heart. And so -- but that was something to always be aware of, that this group that's pro and this group that's con are quite often not really -- they don't really care about the person that is in the center of what's going on.

Q. And what did he say?

A. He was starting to understand that.

Q. And you think, just to the best of your recollection, do you know if that conversation in particular was during 11th grade or 12th grade?

A. No, I don't.

Q. And during these check-ins did you -- it sounds like you talked about the overall effect that the legal case might be having on him; is that right?

A. The overall effect of everything that was happening to him, was having on him.

Q. But did you talk about the effect

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that the bathroom policy in particular was having on him?

A. I don't think so, no.

Q. Do you know why Gavin, during his senior year, wasn't taking as many classes through distance learning?

A. He didn't take any in his 12th grade year, because he and his mother, from what I remember, decided that he was coming back to school, to the high school full time to finish. In fact, I believe at the end of his 11th grade year they were back at the high school anyway. That program had been moved back to the high school. And so, he -- this is from what I remember -- felt that he could go back into classes and finish his school year that way.

Q. If you look at the top left corner of the transcript, under gender it says female; is that right?

A. That's what it says.

Q. Now, are you aware of Gavin's efforts to have the school change his gender marker on his

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student records?

A. Yes.

Q. How are you -- what do you know about that?

A. I know that at one point Gavin had asked about it, was told that he would need a legal document, asked for it repeatedly, never producing one, did then produce one and turned it in to me, and I then gave it to Mr. Collins.

Q. So the legal document that he gave you, was that -- what was that legal document?

A. I believe it was a birth certificate.

Q. And when you said he was asked before about it and was told he needed a legal document, who is the person that told him he would need a legal document?

A. From what I remember, I had asked Mr. Collins, and probably Mr. Collins, but definitely I said it, because a lot of that information comes through the counseling office. That's where the registrar is, who is the records person.

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Q. So when Gavin gave you the legal document and then you gave it to Mr. Collins, what did Mr. Collins say?

A. He said he would have to call the School Board office, and for us to not change anything until we heard back.

Q. And were you surprised that that was his response?

A. No.

Q. Why not?

A. Because it was a legal issue that the School Board was fighting within the court system. And so it wouldn't surprise me for people to say stop, don't do anything.

Q. And what's the -- was there any discussion within Gloucester High School, the administration of Gloucester High School about whether his gender marker should be updated?

MR. CORRIGAN: Objection to the form, foundation, legal conclusion, expert opinion. Go ahead.

THE WITNESS: There was discussion about

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it, but that wasn't our decision to make.
BY MR. BLOCK:
Q. Understanding it wasn't your decision to make, did Principal Collins consult with you or anyone else about what should be done?
A. We could have discussed it, but the decision wasn't ours to make. So we gave opinions about it, but that was not a decision for us to make.
Q. Was there any conversation you had about changing the gender marker involving you, Mr. Collins, and Brian Hartley?
A. Probably, because Brian Hartley is the director of student services, so he's in charge of registrars. He's the overseer of student records also. So probably, yes.
Q. And would that conversation have been a forum in which you or Mr. Hartley would offer an opinion on what should be done?
A. An opinion, yes.
Q. And do you recall the opinion that Mr. Hartley offered?

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MR. CORRIGAN: Object to form and foundation, hearsay. Go ahead.
THE WITNESS: No. I mean, I really don't. I know what my opinion is, but I can't remember what his was.
BY MR. BLOCK:
Q. What was yours?
A. My opinion was --
MR. CORRIGAN: Hold on. Objection, form, foundation, hearsay, expert witness and legal conclusion. Go ahead.
THE WITNESS: My opinion was that if a transfer student comes in with a birth certificate, we don't question it. And somebody had produced a birth certificate that was a legal document. So that was my opinion.
BY MR. BLOCK:
Q. So what was the basis for your knowledge that if a transfer student comes in with a birth certificate, you don't question it?
A. Working there for many, many years prior to being the director when students produce

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birth certificates when they register, we look at the birth certificate and put the information into the computer from that.
Q. So there's never an occasion that you know of in which a student has been asked to provide, you know, their original birth certificate?
MR. CORRIGAN: Object to form and foundation. Go ahead.
THE WITNESS: To my knowledge, no.
BY MR. BLOCK:
Q. To the best of your knowledge, is there any record at Gloucester High School about what type of genitals a student has?
MR. CORRIGAN: Object to form.
THE WITNESS: I don't --
BY MR. BLOCK:
Q. Does Gloucester High School keep track of what students' genitals look like?
A. Not that I know of.
Q. And does Gloucester High School have a record of what their chromosomes are?

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A. Not that I know of.
Q. So when -- did there come a point in time in which Mr. Collins told you what the decision would be with respect to whether Gavin's gender marker would be changed on his transcript?
A. Yeah, there was a point somewhere in that process where we were told not to change it.
Q. And were you given a reason why?
A. That the director from the School Board office was to not change it.
Q. But no reason why was given?
A. No. I mean, just don't change it.
Q. Are there any other school documents in which the student's gender is listed?
A. Everything is electronic. So anything that would -- that would have that, you know, box, would. I don't know what those all are, but there's only one gender box in a student's academic record online. And so, any place that would ask for that, it would say that.
Q. Where does a student's transcript get sent by the school?

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MR. CORRIGAN: Object to form, foundation. Go ahead.
THE WITNESS: To wherever the student requested it be sent -- colleges, employers, that sort of thing.
BY MR. BLOCK:
Q. So any college that requires a student's transcript would be given this document; is that right?
MR. CORRIGAN: Objection to the form and foundation. Go ahead.
THE WITNESS: Correct.
BY MR. BLOCK:
Q. So any employer who asks for Gavin's high school transcript will be given this document; is that right?
MR. CORRIGAN: Objection to the form and foundation. Go ahead.
THE WITNESS: Correct.
BY MR. BLOCK:
Q. When a student applies for financial aid, do you know whether the student's records

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from the school are given to the FAFSA entity or not?
A. They are not.
Q. They are not.
Do you know any other context in which matches are done between the information in the student's school records and information that the state of Virginia keeps, or that the federal government keeps on a student?
MR. CORRIGAN: Objection to the form and foundation. Go ahead.
THE WITNESS: Give me an example. I don't understand.
BY MR. BLOCK:
Q. Yeah, well, I'm thinking of -- so when a student fills out a financial aid application, there's a marker there for what their gender is. And is there -- so that would have been one context in which another organization is keeping track of their gender. But you already testified that you don't -- to the best of your knowledge, this is not a document that's given as

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part of that process; is that right?
A. Correct. Anything that a student fills out or a family fills out on their own, this doesn't connect to it at all. This connects to our school system, and those other things are separate entities that have no connection to it at all.
Q. To the best of your knowledge, has any other student ever asked for their gender marker to be altered on their student records?
A. Not to -- while they were in school, not to my knowledge.
Q. How about after they graduated?
A. I believe there was a request made this year by a student who had already graduated.
Q. And was that request granted?
A. No.
Q. And how was the decision made to deny that request?
MR. CORRIGAN: Objection to the form and foundation. Go ahead.
THE WITNESS: Just as if a student gets

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married later in life and changes their last name, we don't go back and change the record of what was their name and other data when they were in school. So that was the reasoning. But that didn't come from me. That was the reasoning, though.
BY MR. BLOCK:
Q. Did the person requesting the marker be changed explain why they wanted it changed?
A. And let me say this. I'm not sure they asked their marker to be changed. They ask their name to be changed. I don't know that they asked their gender to be changed.
Q. Thanks for clarifying.
A. They asked for their name to be changed.
Q. And did they explain why they were making that request?
A. They had had -- they legally had their name changed.
Q. And was this person transgender?
A. Yes.

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Q. And did they express a concern about what would happen if they had to present a transcript that had a name -- their old name listed on it?

A. No.

Q. You had previously said the rationale for not changing the name, and you said that didn't come from me. Who did it come from?

A. That would come from Mr. Hartley, who is still the director of student services. Again, that's a records issue. Just like if somebody gets married and says, Can I please have my transcript changed to my new last name? No was the rationale, because he and I did discuss it, but the rationale was no.

Q. I just want to get clarity on it. Do you agree with that rationale?

MR. CORRIGAN: Object to form, foundation, legal conclusion, expert opinion.

THE WITNESS: For that, yes.

MR. BLOCK: Just give me a moment.

BY MR. BLOCK:

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Q. So you're also advisor to the school GSA; is that right?

A. Yes.

Q. And how long has the GSA been in existence?

A. Roughly 14, 15 years.

Q. And what would you say the environment at Gloucester High School is like for LGBT students?

MR. CORRIGAN: Let me make my objection. Sorry, I was daydreaming. Form, foundation, expert, legal conclusion. Go ahead.

THE WITNESS: We do not get a lot of complaint from sexual minority youth that they are being harassed because of that. So overall, it is not -- it does not, in my opinion, appear to be an issue amongst the students or the staff.

BY MR. BLOCK:

Q. And that's true both for LGB students and for trans students; is that right?

A. To my knowledge, yes.

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Q. You had said that there doesn't seem to be complaints that students are harassed because of that. Do, in your experience, LGBT students have complaints about being harassed for other reasons?

A. No more than any other student for any other reason.

Q. And have you had any communications with Gavin after he graduated at all?

A. Yes.

Q. What were those communications?

A. He came in to visit a few times. One time recently he just came in to check in and let me know how things were going. We had a nice talk.

Q. What did he say?

A. He's in California, you know, speaking, flying around, doing stuff. We talked again about how people on both sides of the extreme, you know, use people for their own end, and how he was doing with that, and where he was in a whole host of issues that are a lifetime

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worth of working out. It was a very pleasant conversation.

Q. Did Gavin ever talk to you about why he's pursuing the lawsuit?

A. I don't believe that we've ever talked about that like as a specific topic, or even as a kind of -- I don't think we've ever talked about that like as a topic.

Q. In terms of now that he's graduated, has he ever talked to you about what he hopes to accomplish by continuing with the lawsuit?

A. No. When I talk to Gavin, I try to talk to Gavin about how he's doing and what's going on in his life. And he has given me some education on some things, like chromosomes and things. You know, he's -- just like many students, somebody in ninth grade and somebody in 12th grade, it's amazing to watch the difference. He's just like one of those.

Q. It is.

If the School Board asked for your opinion on whether the policy should be changed,

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what opinion would you give them?
MR. CORRIGAN: Object to form, foundation, legal conclusion, and expert witness. Go ahead.
THE WITNESS: I would tell them to read what had been in law, what I perceived had been decided beforehand, and make a decision from there. I mean, I'm thinking of the well-being and safety of students as individuals and as a collective.
BY MR. BLOCK:
Q. But just putting aside what the law says, if they asked your opinion on what would be the best policy for students at Gloucester High School, what would -- what opinion would you give them?
MR. CORRIGAN: Same four objections. Go ahead.
THE WITNESS: It would be once the student has made the transition, they should be able to use the restroom of the gender they are transitioning to, if that is what is suggested

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by their medical and mental health professionals that are working with them, if that's what's suggested.
MR. BLOCK: Okay. I don't have any other questions.
MR. CORRIGAN: No questions. And he'll read.

(Off the record at 12:25 p.m.)

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ACKNOWLEDGMENT OF DEPONENT

I,

MATTHEW R. LORD, do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct, and complete transcription of the testimony given by me; and any corrections appear on the attached Errata sheet signed by me.

_____ _____

(DATE) (SIGNATURE)

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CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC

I,

LISA BLAIR, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my direction; that reading and signing was requested; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 17th day of October 2018.

My commission expires October 31, 2020.

Lisa M Blair

Lisa Blair, RMR

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Transcript of Troy Andersen

Date: March 12, 2019
Case: Grimm -v- Gloucester County School Board

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

- - - - - - - - - - - - - x
GAVIN GRIMM, :
Plaintiff, :
v. : Civil Action No.
GLOUCESTER COUNTY : 4:15-cv-00054-AWA-DEM
SCHOOL BOARD, :
Defendant. :
- - - - - - - - - - - - - x

Deposition of TROY ANDERSEN
Glen Allen, Virginia
Tuesday, March 12, 2019
10:00 a.m.

Job No.: 232148
Pages: 1 - 98
Reported By: Scott D. Gregg, RPR

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Deposition of TROY ANDERSEN, held at the offices of:

Harman Claytor Corrigan & Wellman, PC
4951 Lake Brook Drive, Suite 100
Glen Allen, Virginia 23060
(804) 747-5200

Pursuant to notice, before Scott D. Gregg, RPR, Notary Public in and for the City of Norfolk.

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P R O C E E D I N G S

TROY ANDERSEN, called as a witness, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. BLOCK:

Q Good morning, Mr. Andersen. How are you?

A I'm good. How about yourself?

Q I'm good. My name is Joshua Block. I'm an attorney for the plaintiff, Gavin Grimm, and I'll be taking your deposition today.

Have you ever had your deposition taken before?

A I have not.

Q Excellent. So this is -- since it's your first time, I'll just go over some ground rules.

The first is that, as you know, the court reporter is writing down everything that we're saying, so it's important that all of your responses be verbal, so full words, no nodding your head, no saying uh-huh.

So can we agree that you'll try to have

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all your responses be verbal?

A Yes, sounds good.

Q Terrific.

The second is that the court reporter needs to write down what we're saying, one person at a time, so it's important that we don't have cross-talk. So to make that run more smoothly, please wait until I finish asking the question before you answer, and I will wait until you're finished answering before I ask the next question.

Does that sound fair?

A Indeed, yes.

Q Great.

And the third is that it's my job to ask questions that you understand and can answer. So if there's anything unclear about my question, please let me know and I will try to clarify it.

But if I ask a question and you answer it, I'm going to take that to mean that you understood the question, okay?

A Sounds fair.

Q Great.

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Now, you are appearing today as the 30(b)(6) witness on behalf of Gloucester County School Board; is that right?

A Yes, sir.

Q Great. And so did you do any preparation in advance of this deposition to inform your testimony as a 30(b)(6) witness?

A I did.

Q What -- did you review any documents to prepare for this deposition?

MR. CORRIGAN: Josh, this is David. I'm not sure where the line is on this, but when he sits down with his lawyer and reviews documents, I think all that is attorney-client privileged. But the answer to the question, of course he reviewed documents and he's prepared. But in terms of what he reviewed -- but I don't want to answer for the witness or impede the deposition.

MR. BLOCK: Yeah. My question is basically what is the source of his knowledge as a 30(b)(6) witness.

BY MR. BLOCK:

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Q So I'm not looking for information about what your attorney specifically, you know, provided you or prepared you for, but I want to know when you're providing testimony as a 30(b)(6) witness, did you -- what sources of information did you consult?

MR. BLOCK: Is that a fair question, David?

MR. CORRIGAN: To the extent you're not asking for privileged information, it's a fair question, yeah, so I'll let him answer the things that are nonprivileged that he consulted.

THE WITNESS: Sure. So it was mainly just a review of records previously submitted, and those related to the Grimm case. And I reached back into my files and made sure I was familiar with our internal policies that form the crux of a lot of discussion based on the information that you seem interested in, and that probably would be the bulk of it.

BY MR. BLOCK:

Q Great.

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So were there any documents you've reviewed that -- nonprivileged documents you've reviewed that have not yet been produced in this case?

A Not to my knowledge.

Q Okay. And did you speak with anyone else besides your attorneys to prepare yourself for this deposition?

A Yes, our superintendent, Dr. Walter Clemons; our director of student services, Bryan Hartley; those would be the two.

Q So you're a member of the Gloucester County School Board; is that right?

A That's correct.

Q When did you first become a member of the Gloucester County School Board?

A I think I was appointed in 2012 to begin a term in 2013.

Q Did you have any other position at Gloucester County Public Schools before becoming a school board member?

A A student, kindergarten through 12th grade

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there, that was it.

Q What year did you graduate?

A 1995.

Q And do you have any volunteer roles with the schools at all before becoming a school board member?

A No, sir.

Q And you've been a school board member continuously since you were first elected?

A Correct.

Q When does your term expire?

A December 31st of this year, 2019.

Q Are you running for reelection?

A I have not decided yet.

Q All right. So during this deposition, I'm going to use the phrase the "restroom policy" or "the policy," and I want to make sure that, you know, if I use that shorthand, that we're talking about the same thing.

So when I refer to the phrase "the restroom policy" or "the policy," I am referring to the policy that was adopted by the Gloucester

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County School Board on December 9th, 2014.

Are you familiar with that policy?

A I am, yes, sir.

Q And so can we agree that if I use the phrase "the restroom policy" or "the policy" that you understood that is the particular policy I'm referring to; is that fair?

A Sounds good.

Q Great.

First thing I'd like to show you is --

MR. BLOCK: Jennifer, can you hand...

MS. SAFSTROM: Second amended complaint?

MR. BLOCK: No. The supplemental answer to interrogatory number one.

MS. SAFSTROM: Supplemental answers to interrogatory number one.

BY MR. BLOCK:

Q Have you seen this document before?

A I have, yes, sir.

Q What is it?

A This is the response back to the first interrogatory. This looks like -- yep, the

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supplemental one, so this is where it sounds like you-all came back with some additional questions to which our counsel provided some additional answers.

Q And you have reviewed this document previously?

A I have.

MR. BLOCK: So I'd like to mark this as Exhibit A to the deposition.

(Exhibit A was marked for identification.)

BY MR. BLOCK:

Q All right. So if you turn to page two --

A Okay.

Q -- the paragraph that begins with the number one, I'd like you to just follow along as I read it.

It says, identify all complaints received by Gloucester County School Board, quote, the Board, or its employees related to transgender students' use of the restrooms during 2014 to 2015 school year, and for each complaint identify the date of the complaint, the recipient of the

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complaint, the content of the complaint, how the complaint was communicated or transmitted, whether the complainant was from the Gloucester High School student or parent of a Gloucester High School student, and whether the complaint related to any incident in which a student reported being in the restroom at the same time as plaintiff.

Did I read that correctly?

A. You did.

Q. So I want to focus on the very end of that paragraph, whether the complaint related to any incident in which a student reported being in the restroom at the same time as plaintiff.

Now, in reviewing the answers to the interrogatories, I didn't see any reference specifically to whether any of the complaints related to any incident in which a student reported being in the restroom at the same time as the plaintiff.

So I'd like to know whether there were any complaints in which the complaint related to an incident in which a student reported being in the

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restroom at the same time as plaintiff.

A. No. My recollection is that there were no complaints that stemmed from a particular student being in the restroom at the same time as the plaintiff.

Q. Thank you. Now, I have a couple of questions about the policy.

How does the school determine what a student's biological gender is for purposes of the policy?

A. So we don't have any sort of process or procedure for that. We rely and continue to rely on social norms and binary sexes and people using the restroom that corresponds with their physiological sex.

Q. Could you explain that, how those three things interrelate? You identified social norms, binary sexes, and people using the restroom associated with their physiological sex.

Is there ever any conflict between, for example, what the social norms are and what the Board thinks someone's physiological sex is?

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MR. CORRIGAN: Object to the form of the question.

Go ahead. That will happen occasionally, I'll object to the form of a question, but just go ahead and answer.

THE WITNESS: Okay. Are you talking about outside of this case? Because this would be the only example I can think of where those three things are at odds or in conflict.

BY MR. BLOCK:

Q. I'm only talking for purposes of the Board's policy.

MR. CORRIGAN: Same objection.

Go ahead.

THE WITNESS: Can you ask the question one more time?

BY MR. BLOCK:

Q. Sure. So I asked, how does the school determine what a student's biological gender is under the policy?

And you in your response said social norms and you also said people using the restroom

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associated with their physiological sex.

And so my question is whether there's ever any conflict between those two things under the Board's policy?

A. With the exception of this particular case, no, there's no conflict that I'm aware of.

Q. And so can you explain how there's a conflict in this particular case?

A. In this case, we have a transgender student -- or had a transgender student at Gloucester County Public Schools who wished to use the bathroom of the gender they identified with instead of the gender corresponding to their physiological sex.

Q. So these conflicts between social norms and what you describe as someone's physiological sex only occurred in the context of transgender students?

A. I only have a sample size of one, but that's the only time I've been involved with any sort of conflict.

Q. How does the Board determine what a

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student's physiological sex is under the policy?
A I would say that's tied back to just their student records. So the when you sign up for schools in Gloucester County Public Schools, you have to provide a birth certificate and what's on that birth certificate about the marking on your student records. Anything other than that, there's no policy or procedure.
Q So for purposes of the policy, a student's physiological sex is whatever the gender marker was on their birth certificate at the time they enrolled in the school?
A Yes, sir.
Q So if a student, let's say, moved to the school from a different state and that state allowed people to change the gender markers on their birth certificates without having any medical procedure, so at the time that the student moved to Gloucester County, they had already had an amended birth certificate from another state that listed their sex as being the one consistent with their identity instead of their sex assigned

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at birth, Gloucester County Public Schools would follow the sex listed on their birth certificate as their biological gender for purposes of the policy?
MR. CORRIGAN: I would object to form, foundation, and calls for a legal conclusion.
He can answer.
THE WITNESS: Yes, that birth certificate provided to the schools, that marking would serve as our baseline for our student records. We don't do any sort of background checks or anything like that to figure out how they got to that, but whatever is on that birth certificate would serve as the baseline.
BY MR. BLOCK:
Q And they would be able to use whichever restroom matches the gender marker on their birth certificate at the time of registration?
A Correct.
Q All right. So let's -- I'm going to pose a question, understanding this is a hypothetical, so imagine two identical twins are put up for

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adoption to different families; both twins are assigned male sex at birth but both are transgender and identify as women as they begin to be able to articulate what their gender is; one of the students is raised in California and one of the students is raised in Gloucester County; the one that's in California is able to amend her birth certificate so that she is a female gender marker on her birth certificate; she then moves to Gloucester County where her identical twin has lived; so at the time that she lined up to enroll in Gloucester County Schools, everything about her body is identical to her identical twin's body; but unlike her identical twin, she has a female gender marker on her birth certificate.
Under that hypothetical, the transgender girl who moved from California, her biological gender for purposes of the school policy is female; is that right?
MR. CORRIGAN: Object to the form of the question, object to foundation, object to calls for speculation, legal conclusion, incomplete

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hypothetical.
Go ahead.
THE WITNESS: If I understood all the words you said, yes, provided that that was the marker on the birth certificate, that would be their associated gender in our student records.
BY MR. BLOCK:
Q So -- and she would be able to use the girls restroom; is that right?
A Correct.
Q So even though she and her twin have identical physiology, her -- she would have a different biological gender than her twin for purposes of the policy?
MR. CORRIGAN: Same objections as previously stated.
Go ahead.
THE WITNESS: Yes.
BY MR. BLOCK:
Q So a student's biological gender for purposes of using the restroom is based on what the birth certificate said at the time of

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registration, not based on any assessment of the student's current physiology; is that right?
MR. CORRIGAN: Object to form -- go ahead -- and the other bases as well.
THE WITNESS: Can you restate that one more time, please?
BY MR. BLOCK:
Q Yeah. So a student's biological gender for purposes of the school's policy is determined by what is on the student's birth certificate at the time of registration and not based on any assessment of the student's current physiology; is that right?
A Correct.
Q And Gloucester County Public Schools doesn't keep track of what chromosomes each student has; is that right?
A Correct, we don't.
Q And Gloucester County Public Schools doesn't keep track of what each student's genitals look like; is that correct?
A That's correct, certainly don't.

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Q So what are the government -- what are the governmental interests served by the Board's restroom policy?
A So that would be entirely focused on the privacy of all students in Gloucester County Public Schools system.
Q So privacy is the only governmental interest the Board is relying on; is that correct?
A That's what our policy is focused on, privacy of all students in the Gloucester County Public Schools system.
Q And is there any other governmental interest that the policy advances?
A No.
Q Does the policy -- is the policy designed to serve a governmental interest in student safety?
A I would say there's a secondary -- potentially secondary depending on how you look at it. That's more of a subjective thing that each individual board member may feel differently about. But from a policy perspective, it was

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focused on privacy.
Q And does the policy serve a governmental interest in listening to the views of constituents? Is that a governmental interest that the policy serves?
MR. CORRIGAN: Object to the form and foundation.
THE WITNESS: Answer still?
MR. CORRIGAN: If you can.
THE WITNESS: I would say it's not an interest, but it's a -- say the question one more time. I'm not sure I heard it.
BY MR. BLOCK:
Q Sure. Is listening to the views of constituents a governmental interest that the policy is designed to serve?
MR. CORRIGAN: Object to form, foundation, legal conclusion.
Go ahead.
THE WITNESS: I wouldn't use the term "interest," but I would say that it's part of the process of how policy is created and adopted.

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BY MR. BLOCK:
Q Can you explain how it's part of the process the policies are adopted?
A Sure. So whenever we have -- as a school system, whenever we have policies, we rely and solicit input from the citizens of Gloucester as we've done in the cases of this and others.
Q And are the Board's policies always in line with the views of a majority of the constituents?
MR. CORRIGAN: Object to the form, foundation, and speculation.
Go ahead.
THE WITNESS: I could never say with any mathematical certainty whether it's the majority or not, but there's been plenty of policies that are very unpopular and don't fall in line with what most speakers reflect at any sort of public hearing or school board meeting.
BY MR. BLOCK:
Q What are some examples?
A Our recently passed cell phone policy and

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our updated attendance policy.
Q What is your updated attendance policy?
A I mean, that's a long -- I would have to get out my policy manual, but this changed the number of days a person can be absent before they are not able to pass the class regardless of what their grade is.
Q So let's talk about the governmental interest in protecting student privacy.
So what are they being protected from? Is it from being seen naked?
MR. CORRIGAN: Object to form.
Go ahead.
THE WITNESS: It's -- in short, it's to ensure their privacy of not having to share a restroom with someone from an opposite physiological sex.
BY MR. BLOCK:
Q So it doesn't matter whether or not there's any risk of anyone being in a state of undress; is that right?
MR. CORRIGAN: Object to form.

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THE WITNESS: I would say that's a part of it.
BY MR. BLOCK:
Q Okay. So in terms of protecting their privacy, is it privacy from being seen naked? Is that one of the things the policy is supposed to protect?
A Correct.
Q And is it privacy from seeing someone else naked? Is that something else that the policy is supposed to protect?
A Correct, maintain privacy of all involved.
Q Okay. So if everyone is fully clothed at all times and there's no risk of anyone being naked, are there any other privacy interests that the policy is designed to protect?
MR. CORRIGAN: Object to form, foundation, legal conclusion.
Go ahead.
THE WITNESS: No. What I described and what we described together was the primary focus of the privacy.

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BY MR. BLOCK:
Q So it's exclusively privacy interest related to either being seen naked or seeing someone else naked?
A Correct.
Q So if there's no state of undress involved, then there's no privacy interest for the policy to serve; is that right?
MR. CORRIGAN: Object to form.
THE WITNESS: If that were to be true, yes, but I don't -- using the restroom while not -- I guess depends on how you define the word "undress." There's partial undress when you use a restroom.
BY MR. BLOCK:
Q So is simply being in the same restroom with someone of a different biological gender an invasion of someone's privacy?
A It could be viewed that way. And, again, I say it, the policy is protecting the privacy of all students.
Q So the privacy that the policy is designed

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to protect, is that a privacy from being in the same restroom as someone with a different biological gender?
A Yes, it's from having to share a restroom with someone from the opposite physiological sex.
Q So when you said that in the restrooms there's a state of partial undress, are you talking about in front of a urinal or in front of a toilet? Is that the partial state of undress you're referring to?
A Correct, both.
Q Is there any other partial state of undress that you're referring to?
A I would say I tuck my shirt in a weird way when I was a kid, so outside of the stall I was in a state of partial undress, so that would be another one that popped into my head.
Q You would -- you would open your pants in order to tuck in your shirt and then button up your pants?
A You got it.
Q Is that what you're --

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A Yes, sir.
Q Okay. So in terms of did you always do that in the restroom or did you ever do it, you know, in other places that were more public?
A No. It was always in a restroom.
Q So if we're focused on the privacy of someone when they are on the toilet or in front of a urinal, what additional protection does the biological gender policy provide when there are already dividers between the urinal stalls and locked stall doors in front of the toilets?
A So at the time the policy was passed, I don't believe the majority of the urinals had dividers between them. That was some improvements that we made for the privacy of all students in conjunction which the three single-stall restrooms.
Q So now that those additional privacy improvements have been installed, does the policy continue to serve an interest to protecting student privacy related to nudity?
A I believe, yes.

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Q How so?
A By affording them -- choose my words.
It continues to maintain privacy by ensuring that a student does not have to share a restroom with a person of the opposite physiological sex.
Q But how does it serve an interest in privacy related to nudity or being in a state of undress?
A By accounting for any situations other than the limited three that we've discussed, which would be standing at a urinal, sitting on a toilet, or tucking their shirt in away from a stall.
So I'm sure there's others that we haven't discussed, so it continues to remain the privacy on that front.
Q Well, what others?
A I can't think of any other off the top of my head.
Q So in terms of who -- who they are being protected from, you said that the policy provides

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privacy from being in a restroom with a member of the opposite physiological sex; is that right?
A Correct.
Q So why does that pose a greater invasion of privacy than being in the room with someone of the same physiological sex, to use your term?
A I would say that it just goes back to us relying on the social norms of binary sexes and people using the restroom associated with the physiological sex.
Q So the policy doesn't provide any additional privacy protection for someone that doesn't want to be seen in a state of undress around members of the same sex; is that right?
MR. CORRIGAN: Object to form.
Go ahead.
THE WITNESS: I would agree to that.
BY MR. BLOCK:
Q So if -- let me start over.
So if a transgender person has the birth certificate at the time of registration that is consistent with their gender identity and not with

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their sex assigned at birth, does it invade another student's privacy to have to share the restroom with that student consistent with the student's gender marker on their birth certificate?
MR. CORRIGAN: Object to form, foundation, hypothetical.
Go ahead.
THE WITNESS: Can you say that one more time, please?
BY MR. BLOCK:
Q Sure. So is it an invasion of someone's privacy to be sharing the same restroom with someone who had a different sex assigned to them at birth if that person has had gender marker changed on their birth certificate before enrolling in Gloucester County Public Schools?
MR. CORRIGAN: Object to form, foundation, speculation.
THE WITNESS: So from a policy perspective, it has to be tied to something, and we've already discussed that it's tied to the

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gender marker on the birth certificate and their student records. Whether it causes an additional invasion of privacy is a subjective thing that everybody is going to answer differently on. But we have to have something as a baseline, and as we discussed in the previous questions, that gender marker on the birth certificate serves that purpose.

BY MR. BLOCK:

Q So if, let's say, a student moves from California and even though the student had a female sex assigned to them at birth, they have a male gender marker on their birth certificate and they move to Gloucester and start going to school and using the restroom, and so that student can use the boys restroom even if that student has two X chromosomes and has uterus and a vagina; is that right?

MR. CORRIGAN: Object to form, foundation, legal conclusion, incomplete hypothetical.

Go ahead.

THE WITNESS: Since we previously

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established that we don't keep records or have any information about chromosomes or physiological traits, the basis would be based on that birth certificate that they provide when they sign up for schools in Gloucester County.

BY MR. BLOCK:

Q But does that student using the boys restroom infringe on the privacy interests of other boys using the boys restroom?

MR. CORRIGAN: Object to form -- same objections.

Go ahead.

THE WITNESS: I can't answer that from a policy perspective because it's a hypothetical that you'd never know about because it's based on their birth certificate.

BY MR. BLOCK:

Q So if the policy isn't designed to protect any sort of privacy interests, that might arise in that situation?

MR. CORRIGAN: Object to form.

THE WITNESS: Say the question again,

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please.

BY MR. BLOCK:

Q So the policy isn't designed to protect any privacy interest that might be involved in sharing the restroom with someone who has, you know -- let me start over.

So the policy isn't designed to protect the privacy interest of a boy from using the same restroom as a transgender boy who has a vagina and uterus and two X chromosomes but has a male gender marker on his birth certificate; is that right?

MR. CORRIGAN: Object to form, foundation --

THE WITNESS: I would say --

MR. CORRIGAN: -- legal conclusion.

Go ahead.

THE WITNESS: -- it's designed to provide the most amount of privacy as possible based upon the limited information we have as a school system.

BY MR. BLOCK:

Q So let's say there's a transgender girl at

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Gloucester High School who at the time of enrolling had a male gender marker on her birth certificate, but she has had hormone blockers and estrogen hormone therapy and is now 16 years old and has fully developed breasts.

Does it invade the privacy interests of boys for her to use the boys restroom?

MR. CORRIGAN: Object to form, foundation, legal conclusion, incomplete hypothetical.

THE WITNESS: So when you say "transgender girl," you mean that this person is -- their birth certificate says male?

BY MR. BLOCK:

Q Correct.

A And your question was does that -- her being in the boys restroom present privacy concerns?

Q Right.

A So it would, again, be tied to their gender marker on their student records.

Q So it doesn't violate boys' privacy to have her in the boys -- to have him -- excuse

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me -- it doesn't violate the boys' privacy to have her in the boys restroom?
MR. CORRIGAN: Object to form, foundation, legal conclusion, incomplete hypothetical.
Go ahead.
THE WITNESS: I'm struggling. I just want to make sure I understand what you're saying.
Again, so since the focus of the policy is to prevent people of physiological sexes from having to share a restroom, that would still present privacy issues because you have a difference -- or you don't in this case. It's a male using a males bathroom, correct? That's the scenario you just presented?
BY MR. BLOCK:
Q The scenario I'm presenting is someone who is assigned a male sex at birth but has gone through puberty with estrogen and has fully developed female breasts.
And is there privacy interest for the boys using the boys restroom to not have to have her in the restroom with them?

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A The scenario I hear is still having a boy in the boys restroom, so that policy is not focused on that.
Q So if -- so if this transgender student needs to change her shirt or something like that, she can do that in the boys restroom without -- and expose her breasts, she can do that in the boys restroom without it creating any infringement on boys' privacy?
MR. CORRIGAN: Object to form, foundation, speculation, incomplete hypothetical.
THE WITNESS: That's a scenario that our -- that I've never considered. There were a lot -- you know, you mentioned several of them earlier, different scenarios, and changing clothes was not a scenario we considered. Using a restroom was the focus of the policy.
BY MR. BLOCK:
Q Well, so what if she wants to tuck in her shirt and undoes like her pants in order to tuck in her shirt better, would that violate the privacy rights of boys in the restroom?

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MR. CORRIGAN: Object to -- same objections.
Go ahead.
THE WITNESS: Under the scenario you just presented, which I heard a male in a males bathroom tucking in their shirt, no, there's no privacy there or no privacy issues.
BY MR. BLOCK:
Q How about in the locker room, if she's using the boys' locker room and has to change clothes, you know, and expose her breasts in the process, does that violate the privacy of boys in the boys' locker room?
MR. CORRIGAN: Let me object further on this one that this case is not about locker rooms. In fact, it's expressly not about locker rooms, so I'm not going to have him answer any locker room questions. He's not prepared, it's not part of the 30(b)(6) designation, and he's not going to answer questions about locker rooms.
MR. BLOCK: David, the policy applies to restrooms and locker rooms, and locker rooms have

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been repeatedly brought up in legal briefs.
So if there is a relevancy objection, I don't think that's grounds for instructing the witness not to answer.
MR. CORRIGAN: Did you put it in your 30(b)(6) designation that we were going to talk about locker rooms?
MR. BLOCK: I asked about the biological gender under the policy, and the policy applies to locker --
MR. CORRIGAN: I understand. But you have made a vivid point of not including locker rooms in the case. It's not part of the case. You've said so, talk about on brief and every other way, so I don't think we should talk about locker rooms.
MR. BLOCK: So are we stipulating here that the Board will not rely on implications for locker rooms as part of its defense of the policy?
MR. CORRIGAN: Yeah, I think the case is about -- this is a case, a specific case about Gavin Grimm and this policy and restrooms. And

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you've made it that, and I don't think we have any choice but to say that's what the case is about.

MR. BLOCK: Okay. So, yes, you're stipulating that the Board is not relying on implications that this case would have for locker rooms as one of the bases for defending its policy?

MR. CORRIGAN: I'm stipulating that this case is only about restrooms, that's what I'm stipulating.

BY MR. BLOCK:

Q Is it an invasion of the privacy rights of girls or a transgender boy with facial hair and lots of muscles to be in the girls restroom with them?

MR. CORRIGAN: Object to the form, foundation, calls for speculation, legal conclusion.

Go ahead.

THE WITNESS: This seems like the inverse of the last question, so now we have a girl in a girls restroom, so, no, there's no -- not what the

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policy is focused on.

BY MR. BLOCK:

Q So it's not an invasion of their privacy?

A If it's a girl in a girls restroom, no.

Q What if this transgender boy, he wanted to undue his pants to tuck in his shirt, is that an invasion of their privacy?

A Focused on a girl in a girls restroom, no.

Q How -- so what if the girls in the girls restroom don't know that this transgender boy had a female gender marker on his birth certificate at the time he enrolled?

MR. CORRIGAN: Object to form, foundation, legal conclusion, speculation, incomplete hypothetical.

Go ahead.

THE WITNESS: Are you saying -- so what if the girls didn't know that was a girl, they could tell a teacher their concerns. But from -- that's not covered under the policy.

BY MR. BLOCK:

Q And so under the policy, the teacher would

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have to say to those girls, sorry, this is the restroom that that person should be using?

MR. CORRIGAN: Object to form, foundation.

THE WITNESS: That would be handled at the administrative level. And there's been no scenarios I've been involved in other than this one.

BY MR. BLOCK:

Q So what if the girls say, I really am uncomfortable using this restroom with this person who, you know, has facial hair and a ton of muscles, I feel this is an invasion of my privacy, what options are available for that girl?

A That's not something I can answer as a board member because that would be handled at the administrative level. The policy would serve as the basis for that future discussion.

Q But under the policy, there's no protection from -- the policy doesn't provide any protection for a girl who feels that her privacy is being violated by having to share the restroom with someone with facial hair and a lot of muscles

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because that person is a transgender boy; is that right?

MR. CORRIGAN: Object to form, foundation, speculation, inadequate opinion testimony.

Go ahead.

THE WITNESS: I'm not sure -- the hypotheticals are kind of getting me a little flustered.

BY MR. BLOCK:

Q Sorry. So the policy doesn't provide any protection for a girl who does not want to share a restroom with someone who is a transgender boy, meaning that they were assigned a female sex at birth but live as a boy and have facial hair and a lot of muscles?

MR. CORRIGAN: Object to form, foundation.

Go ahead.

THE WITNESS: Let's take it back since the focus of this is at the high school. Yes, the policy -- well, the implications of the policy do allow an alternate which is the single-stall restrooms we added, so that's the relief there.

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So they can be used by anybody. Those single-stall unisex restrooms are available for all students use.
BY MR. BLOCK:
Q So the girl who is uncomfortable using the girls restroom with a transgender boy has the option of using one of those single-stall restrooms instead; is that right?
A Absolutely.
Q And so a boy who is uncomfortable using the boys restroom with a transgender girl who has fully developed breasts can use the single-user restrooms instead; is that right?
A Correct.
Q And those single-user restrooms provide, you know, adequate protection for students in that situation; is that right?
MR. CORRIGAN: Object to form, foundation, vague.
Go ahead.
THE WITNESS: Can you further define "adequate protection"? You walk in, you're the

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only person in the room, and the door is locked.
BY MR. BLOCK:
Q So the privacy objections of a boy who doesn't want to share a restroom with a transgender girl are fully addressed by having the option of using a single-user restroom instead; is that right?
MR. CORRIGAN: Object to form, foundation, and inadequate speculation.
Go ahead.
THE WITNESS: So I still want to make sure I understand what you're saying. So a boy at the high school who doesn't want to use the restroom with another boy with female characteristics and traits, if they have a concern with that, they can use the single-stall unisex restroom.
BY MR. BLOCK:
Q And that fully addressed whatever privacy concerns that boy would have; is that right?
MR. CORRIGAN: Object to form, foundation, and incomplete hypothetical.
Go ahead.

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THE WITNESS: Under the scenario you described, yes.
BY MR. BLOCK:
Q So what if someone is attending Gloucester High School and doesn't want anyone to know they are transgender? So under this hypothetical, they previously went to a different school, they transitioned, moved to Gloucester, have not had their birth certificate amended, but appear externally, you know, with their clothes on as having all the same physiological characteristics as anyone with their gender identity, so -- let me rephrase that.
So a transgender girl transitions in another school district, they then move to Gloucester, registers for high school, and still has a male birth certificate but, you know, dresses and appears as a woman and has been on hormone therapy and she wants to start school without people knowing she's transgender, under the policy what restrooms should she be using?
MR. CORRIGAN: Object to form, foundation,

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incomplete hypothetical, and legal conclusion.
Go ahead.
THE WITNESS: Either the one associated with their physiological sex or the single-stall unisex restroom.
BY MR. BLOCK:
Q So if she uses the restroom that's based on her birth certificate, that would be the boys restroom, right?
A Correct.
Q And so by using the boys restroom, she would have to be identifying herself as transgender; is that right?
MR. CORRIGAN: Object to form, foundation, calls for speculation.
Go ahead.
THE WITNESS: They would be making a decision to do that instead of using the single-stall unisex restroom.
BY MR. BLOCK:
Q And so her own -- but if she used the single-stall restroom, she would then have to --

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let me rephrase that question.
So what if she says that she doesn't want to use the single-stall restroom because that just draws attention to her and it's going to raise questions in people's minds about why she is using a different restroom than everyone else?
MR. CORRIGAN: Object to form, foundation, incomplete hypothetical, calls for speculation.
Go ahead.
THE WITNESS: I don't understand the question. The single-stall restrooms are open to any student at Gloucester High School who wants to use them. It's not just for transgender students.
BY MR. BLOCK:
Q What restroom is she supposed to use if she's attending a football game and there aren't any single-user restrooms available?
A Not a scenario I've considered or we considered as a board.
Q So now that you're considering it now under the policy, what restroom should she be using at a football game?

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A The one that corresponds with their physiological sex.
Q So just to be clear, so this student who has gone through puberty with estrogen and has fully developed breasts and looks indistinguishable from any other girl and is not out to anyone else as being transgender should be using the boys restroom at the football game if she has to use the restroom; is that right?
MR. CORRIGAN: Object to form, foundation, incomplete hypothetical, calls for speculation.
Go ahead.
THE WITNESS: I just want to repeat back to you what I heard you say.
Now, we have the same scenario, the male is still on the birth certificate and now the scenario is at a football game?
BY MR. BLOCK:
Q Yes.
A So the three single-stall restrooms are for purposes of this question not available, so, yes, they would be using the restroom associated

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with their physiological sex if they chose to use the restroom.
Q And if the boys think that that's an invasion of their privacy in the restroom, what options do they have?
MR. CORRIGAN: Again, object to form, foundation, incomplete hypothetical, calls for speculation.
Go ahead.
THE WITNESS: What options do they have? Wait, use an off-premises facility, same as any person would have the same options.
BY MR. BLOCK:
Q What governmental interests are served by having this be an official school board policy as opposed to a one-off decision without a formal policy being adopted?
MR. CORRIGAN: Object to form, foundation, calls for legal conclusion.
THE WITNESS: Can you define what "one-off decision" would translate into?
BY MR. BLOCK:

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Q So for -- you know, when Gavin started using the boys restroom, why did the Board adopt a formal policy in response as opposed to just directing the administration to stop letting Gavin use the boys restroom?
A So we could capture it once and not have to discuss it each individual time it came up.
Q So you wanted a policy that would be comprehensive and addressing the situation if it came up again with a different student?
A Correct.
Q So you weren't -- in passing the policy, the goal was to go beyond the specific situation with Gavin and have a generally applicable rule; is that right?
A Correct. Because at the time this was going around, the initial stages of it, no one on the school board knew who Gavin was. So there was no Gavin, there was only a student at Gloucester High School.
Q All right. And so the policy was designed to apply to future situations in which future

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students that the Board didn't yet know about would be attending Gloucester High School; is that right?

A. Correct. If it ever happened again, here's the go-to policy.

Q. So in these various scenarios I have been asking that have been described as hypothetical scenarios, was the policy drafted, you know, to apply to those future hypothetical situations?

MR. CORRIGAN: Object to form, foundation, calls for speculation.

Go ahead.

THE WITNESS: There weren't a lot of hypo -- there weren't any hypothetical situations considered, to my knowledge. It was focused on dealing with students who wanted to use a restroom of the gender they identified with instead of the one associated with their physiological sex.

BY MR. BLOCK:

Q. But can you explain to me why the privacy interests in not sharing a restroom with someone of a different sex turn on what's on a piece of

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paper that's presented to the school at the time the student registers and not based on what the student's current physiology is?

A. Explain that -- say that one more time, please.

Q. Yeah. So, you know, we discussed before that for -- as you use the term "physiological sex" is being determined by what is on their birth certificate at the time they register; is that right?

A. Correct.

Q. All right. It's not determined based on what their current physiology actually is, correct?

A. Correct, because we have no procedures in place for determining physiological features.

Q. But the privacy interests you're protecting is in the interest related to physiological features; isn't that right?

MR. CORRIGAN: Object to form, foundation, speculation.

Go ahead.

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THE WITNESS: Correct.

BY MR. BLOCK:

Q. So you're using what's on their birth certificate at the time of registration as a proxy for what their physiological features are likely to be?

MR. CORRIGAN: Object to form.

Go ahead.

THE WITNESS: We're using the only piece of information that's available to us when they register.

BY MR. BLOCK:

Q. But there might be times when what's on their birth certificate doesn't actually match up to what their current physiological features are; is that right?

MR. CORRIGAN: Object to form, foundation, speculation.

Go ahead.

THE WITNESS: I don't know about physiological features. I'm talking about sex, male or female, so I guess someone could go

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through conversion and haven't had their birth certificate amended yet, so there could be a time when those two are technically out of sync.

BY MR. BLOCK:

Q. So the confusion I have here is you're using physiology and saying physiological sex, but then you're referring to the birth certificate, not to any current physiological feature; is that right?

A. The gender marking on the birth certificate is how we define that because we have nothing else.

Q. Let's say a transgender 18-year-old girl who has had hormone therapy and genital surgery and is a senior at Gloucester High School, if her birth certificate at the time that she registered was female -- was male -- let me state the question so the transcript is clean.

So if there's a transgender girl at Gloucester High School who is 18 years old and has had had hormone therapy and genital surgery, if the birth certificate at the time that she

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registered at Gloucester County Public Schools was male, she is viewed as a biological male for purposes of the school's policy; is that right?

MR. CORRIGAN: Object to form, foundation, calls for speculation, incomplete hypothetical.

Go ahead.

THE WITNESS: Until when and if that person would choose to append their gender marker on their student records.

BY MR. BLOCK:

Q So the policy is determined by their current birth certificate, not the birth certificate that they had at the time they registered?

MR. CORRIGAN: Object to form.

THE WITNESS: We wouldn't know what their current birth certificate said unless it was presented to us. So it's based on the birth certificate they provided when they registered for Gloucester County Public Schools.

BY MR. BLOCK:

Q But I'm talking about a student who

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registered with a male birth certificate, then had a transition process that included genital surgery, and then got an amended birth certificate or an updated birth certificate that listed her gender marker as being female and she gives that updated birth certificate to the school, does that change what her biological gender is for purposes of the school's policy?

MR. CORRIGAN: Object to form, foundation, speculation, incomplete hypothetical.

Go ahead.

THE WITNESS: I just want to make sure I heard the whole scenario right.

So they have had their birth certificate amended, they have presented it to the school system, and the school system has made the change to the gender marker in their educational records; is that the right scenario?

BY MR. BLOCK:

Q Well, everything except the last one. I don't know what the school -- we can talk later about what the school system does with the

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information once they receive the amended birth certificate.

But this is a situation where she's had genital surgery, gets an amended birth certificate, she gives it to the school.

Is her biological gender then whatever is on her updated birth certificate?

A Her gender for the purposes of school decisions are still tied to whatever record is on file.

Q So if she gives the updated birth certificate, does that birth certificate then become on file or not?

MR. CORRIGAN: Object to form, foundation, speculation.

Go ahead.

THE WITNESS: If she goes through policy JO correction of educational records and there's no issues found with the process used to obtain that amended birth certificate, then, yeah, in theory -- we haven't gone through one of these -- then it would change.

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BY MR. BLOCK:

Q So does the school's policy for updating educational records allow educational records to be updated based on a changed birth certificate with respect to the gender marker?

MR. CORRIGAN: Josh, I'll let him answer this question, then I want to take a short break, if that's all right?

MR. BLOCK: Sure.

THE WITNESS: Policy JO applies to all educational records and wouldn't preclude any changes based on an amended birth certificate.

BY MR. BLOCK:

Q But -- hold on one sec.

I'm confused about whether policy JO allows someone to change the gender marker on their school record ever.

Is that something covered by JO?

MR. CORRIGAN: We're kind of moving to a new topic. Can we take a break just for a few minutes and come back?

MR. BLOCK: Can we just get an answer to

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the pending question and then we can take the break?
MR. CORRIGAN: I tried to get it out before the last pending question was, which I allowed him to answer, so...
MR. BLOCK: Yeah.
MR. CORRIGAN: I don't think it's a big deal.
Go ahead.
THE WITNESS: Your question is does policy JO allow for a student's birth certificate to be changed? Yes.
BY MR. BLOCK:
Q No. School records to be changed, the gender marker on school records to be changed --
A Yeah.
Q -- based on a new birth certificate?
A Yeah.
MR. BLOCK: Okay. Thanks.
MR. CORRIGAN: All right. Be back in a minute.
(A recess was taken.)

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BY MR. BLOCK:
Q So apologies if this goes over some old ground, but I'll try to keep it brief.
So you testified before that Gloucester County Public Schools gives students a gender marker on their school records based on the birth certificate that the student gets at the time of registration; is that right?
A Correct.
Q And does the school do any investigation at that time to see if the gender marker on the birth certificate is accurate?
A No.
Q So if Gavin had attended school in a different school district, got in his amended birth certificate before his senior year, transferred to Gloucester County Public Schools for his senior year, and presented them with his updated birth certificate that listed his sex as male, what would Gavin's school records have listed his gender marker as being?
MR. CORRIGAN: Object to the form, foundation, inaccurate, and incomplete hypothetical.
Go ahead.
THE WITNESS: So I just want to make sure again I heard what you said.
So when he transferred to Gloucester County Public Schools, he provided a birth certificate that said male, and the question is what gender marker would he have on his Gloucester County Public Schools' records?
BY MR. BLOCK:
Q Yes.
A Male.
Q And he would be allowed to use the boys restrooms; is that right?
A Correct.
Q So does Gloucester County Public Schools have any policies, practices, or procedures for amending the gender marker on a student's school records?
A Specifically focused on gender markers, no. But policy JO deals with correction of educational records in general, and that could be anything to which a parent or student wants -- finds either to be inaccurate or wants changed.
Q So under policy JO, in order to have a record changed, the student has to show that the current record is inaccurate, misleading, or in violation of the student privacy rights; is that correct?
A I don't have that in front of me. It looks like you're reading right off policy JO, but that sounds correct.
Q So how would the school board determine whether someone's gender marker is inaccurate or misleading?
A By utilizing whatever information that student provided to the administrative staff as a part of the process outlined in JO.
Q What is the process by which the Board in Gloucester County Public Schools officials decided whether to update the gender marker in Gavin's school records?
A So the superintendent, as the lead

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administrative person for the school, consulted with legal counsel, reviewed the documentation provided, and made the decision.

Q But the superintendent had authority on behalf of the Board to make that decision; is that right?

A Correct.

Q So why did Gloucester County Public Schools not update the gender marker on Gavin's school records to update his birth certificate?

MR. CORRIGAN: To the extent the question has anything to do with anything not provided as legal counsel, he can answer.

THE WITNESS: Sure. So that was going to be my first one, input from legal counsel. The second was the information provided seemed to be at odds with the process and procedures outlined in Virginia law and the Virginia Administrative Code as far as what an amended birth certificate looks like. And also because the birth certificate provided as part of the request was stamped void, so it was those three reasons that

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resulted in the denial of the change.

BY MR. BLOCK:

Q How was the process apparently at odds with Virginia Code and regulations?

A I would have to pull out the Code, but my recollection is if you look in the Code, it says that amended birth certificates will have the issue scratched out with the correct one written next to it. And also somewhere on the document the word "amended" is added to it.

Q So the Board -- so the concern is that this could not -- could be a non authentic birth certificate?

A Correct.

Q Have you seen the copy of the birth certificate that was filed in this litigation?

A I've seen a version in a packet somewhere, yes.

Q And does that copy have the same features that you think call into question its authenticity?

A I would have to look at it again. It's

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not something I've looked at recently.

Q Did the Board or anyone from Gloucester County Public Schools take any action to verify the authenticity with the Department of Health?

A Not to my knowledge.

Q If -- I'd like to hand you a document marked -- with the heading answer to second amended complaint.

MS. SAFSTROM: One second. I'm getting it.

MR. CORRIGAN: Do we need the second amended complaint, too?

MS. SAFSTROM: Josh, would you like me to give them both the second amended complaint and the answers?

MR. BLOCK: Just the answer to the second -- answer to second amended complaint. I'm sorry if I said that incorrectly.

MS. SAFSTROM: And would you like that labeled Exhibit B?

MR. BLOCK: Yeah, we can label it B now.

(Exhibit B was marked for identification.)

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MR. BLOCK: Does the witness have the document?

MS. SAFSTROM: Yes.

MR. BLOCK: Great.

BY MR. BLOCK:

Q Have you seen this document before?

A This one doesn't look familiar.

Q So if you turn to page 14, paragraph 80, it says in response to paragraph 80 of Grimm's second amended complaint the school board admits in November of 2016 Grimm provided a different Virginia birth certificate listing Grimm's sex as male; however, the school board denies that the birth certificate was issued in conformity with Virginia law based upon the school board's understanding of the Code of Virginia and applicable administrative regulations.

Did I read that correctly?

A Yes, you did.

Q Okay. So without disclosing any information from discussions with your attorney, can you, please, identify all the ways that the

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school board believes that the birth certificate was not issued in conformity with Virginia law?

A That goes back to the -- my answer to the previous question. The presence of the word "void," the lack of the word "amended," and no strike-through, and I believe there was a third one. Without pulling out the Code or the VAC, it said that the background information leading to the change would also be amended to the updated document.

Q I'm sorry. Can you say that again?

A Sorry. Without pulling out the particular section of the Code of Virginia, in addition to the three things I previously mentioned, the fourth one was that I believe somewhere in there it says that the background data or court orders associated with the change would also be attached to the amended document, so nothing -- there was nothing attached to the amended document.

Q Are there any other ways that the school board contends that the birth certificate was not issued in conformity with Virginia law?

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A No, sir.

Q Has the -- are you aware that there was an order of the Circuit Court of Virginia in Gloucester County declaring Gavin's sex to be male and ordering the Department of Health to issue an updated birth certificate?

A I am aware of that order, yes.

Q When did you become aware of it?

A I'm not sure. Late 2018.

Q And so why does the school board in light of that order still take the position that the birth certificate was not issued in conformity with Virginia law?

MR. CORRIGAN: Object to form, foundation, legal conclusion.

Go ahead.

THE WITNESS: Input from legal -- well, your question is directly related to the validity of the amended record. I personally haven't seen one that addresses the three other things I mentioned.

BY MR. BLOCK:

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Q Have you -- you've taken no steps to verify the authenticity within the Department of Health?

A Correct.

Q And are you aware of the distinction between long form birth certificates and short form birth certificates?

A I'm not.

Q Okay. Are you aware that -- okay.

So you haven't taken any steps to determine whether or not there is a long form birth certificate in the custody of the Virginia Department of Health that has those features?

A Correct, I have not --

Q Okay. Why have you not taken those steps?

A It's not my role as a board member. That's an administrative -- if that's what needs to take place, that's an administrative duty. And then the second part would be input from legal counsel.

Q Where are the specific defects that you're identifying now recorded to Gavin or his family as

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the basis for not updating his school records?

A There was a letter that went back to the Grimm family. And I would have to look back at the letter to find -- I recall there were four -- I think four bullets as to why the request was denied. I'm not sure if one of those four was what we just talked about. In the letter, I actually might have misspoke. It went to you, not the Grimms.

Q So that was the only response sent by the school to explain why it did not update the birth certificate; is that right?

A To my knowledge, correct.

Q And have you viewed the copy of the birth certificate that was filed as an attachment to a declaration that Gavin filed in this case?

A I would have to see it to see if I've ever seen it prior to this question.

Q We'll get a copy e-mailed to --

MR. CORRIGAN: E-mail it to me and I'll get it printed.

MR. BLOCK: Great. So Shayna will e-mail

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it to you.
BY MR. BLOCK:
Q So is one of the bases that the school board is relying on -- let me rephrase that.
So does the school board contend that the medical procedures that Gavin has undergone are insufficient to change the gender marker on his birth certificate under Virginia law?
A No, that's not one of our arguments.
Q Okay. So you're not contending that his chest surgery did not qualify as surgery that warrants changing a birth certificate under Virginia law?
A No, not one of our arguments and not within our purview as a school board to determine.
Q So if you were presented today with a birth certificate that did not have those markings on it that you say that the initial birth certificate that was filed with the school had, would you update Gavin's gender marker on his school records to match that birth certificate?
MR. CORRIGAN: Object to form, foundation,

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calls for legal conclusion, and, frankly, I think it's something that would be consulted with counsel. I don't know what his answer is, but that's my objection or concern.
Go ahead.
THE WITNESS: That's my answer, I would take the information provided and give it to Dr. Clemons, as the head administrative superintendent for Gloucester County Public Schools, and tell him to go forth and investigate, and I'm sure he would consult with legal counsel as well as ensuring that it's in accordance with federal law, state law, and our own policy, just like we did the first time.
BY MR. BLOCK:
Q So if -- so under the Board's policies, if they are presented with an updated birth certificate by a transgender student that has a gender marker different than the gender marker that was on the birth certificate at the time they registered and there are no markings on the birth certificate, to call its authenticity into

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question, the school board would under those circumstances change the student's school records to match their updated birth certificate?
MR. CORRIGAN: Object to form, foundation, calls for a legal conclusion.
Go ahead.
THE WITNESS: As long as all the I's were dotted and T's were crossed in accordance with federal law, state law, and policy JO, the policy allows for the revision of the records so the gender marker could be changed.
BY MR. BLOCK:
Q Two transgender students are in this hypothetical. There are two transgender boys who are both seniors at Gloucester High School in this hypothetical; and their bodies look the same as each other; they both had testosterone; both had chest surgery; but one of them has had an updated birth certificate and the other one hasn't.
Under the Board's policy, the one with the updated birth certificate can use the boys restroom, but the one who has not had an updated

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birth certificate can use the women's restroom; is that right?
A Correct.
MR. CORRIGAN: Object to form, foundation, legal conclusion.
Go ahead.
THE WITNESS: Correct.
BY MR. BLOCK:
Q Even though their bodies are identical?
A Going back to what we spent the majority of the morning talking about, it's tied back to the gender marker on their records. So in the hypothetical you just described, one matches and one doesn't.
Q Do you know if the photocopy of the birth certificate that was delivered to the school by hand was produced in discovery in this case?
A I don't know.
Q What governmental interest is served by the Board's refusal to update Gavin's birth certificate?
MR. CORRIGAN: Object to form.

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Go ahead.
THE WITNESS: It's our -- the policy JO is in place to ensure that any changes to a student's educational records are done in accordance with all applicable federal and state laws.
BY MR. BLOCK:
Q And the Board despite now being aware of the Virginia court order still takes the position that the Gavin's sex was not changed in accordance with Virginia law?
MR. CORRIGAN: Object to form, foundation, and legal conclusion.
Go ahead.
THE WITNESS: I don't recall stating that. We have to bring back in -- the question is have the changes been made to the gender marker, and the answer is no.
And then in addition to the state and federal, there's input from legal counsel.
BY MR. BLOCK:
Q Does not updating the gender marker on his birth certificate advance any interest in

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protecting privacy?
MR. CORRIGAN: I think you misspoke. You said "on his birth certificate."
MR. BLOCK: I'm sorry, Dave?
MR. CORRIGAN: I think you meant transcript. I don't think the question is what you intended it to be, but whatever, go ahead.
THE WITNESS: Can you ask your question again?
BY MR. BLOCK:
Q Yeah. Does the school board's decision to not update the gender marker on Gavin's school records and transcript advance any governmental interest in protecting privacy?
A It's not tied to privacy. It's just -- well, I guess FERPA -- the government interest is tied to making sure that any changes are in alignment with federal and local law and policy JO.
Q So sitting here today, what other information could be presented to you besides a court order that would prompt the Board to update

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Gavin's birth certificate? Sorry. Update Gavin's transcript? I apologize.
A It would go back to that same process we described, so the information provided to date would be provided to Dr. Clemons, Dr. Clemons and his staff would review, counsel would be talked to, and then a decision on how to proceed would be made from that process. There's nothing I can do sitting right here today.
MR. BLOCK: David, can we take a break? We have e-mailed you the copy.
MR. CORRIGAN: Okay.
(A recess was taken.)
MR. BLOCK: Back on the record.
BY MR. BLOCK:
Q All right. So I want to go back to the things that you said to question the validity of the birth certificate that was presented in Gavin's senior year.
And so one of the things you said is it was marked void; is that right?
A The previous version I saw, correct.

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Q All right. And now is -- are you aware whether any other birth certificate copies for other students are marked void?
A I'm not aware.
Q Are you aware that any photocopy of birth certificate produces the word "void" on it because it's not the original document?
A I was not.
Q The second thing that you mentioned was that the letter from the court or from the treating physician -- sorry. Let me pause and I'll get the exact language.
Another thing you mentioned was the certified copy of the court order should accompany the birth certificate; is that right?
A I don't think I ever said that. Again, I would have to pull out the exact administrative code and Virginia Code to see, but there was a series of sections that described what amended forms of birth certificates look like.
MR. BLOCK: Jennifer, can you give them the -- let's give them both, the Code of Virginia

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32.1-269.
Let's mark that as Exhibit C. And the 12 VAC 5-50-320, let's mark that as D.
(Exhibits C and D was marked for identification.)
BY MR. BLOCK:
Q So I want to give you time to review these.
Are these the provisions that you are referring to a moment ago?
A 32.1-269, so Exhibit C is one I was referring to. The second one you provided was in there but doesn't contain -- is not the exact one I was thinking of.
Q Okay. So where do you -- what part of these documents provide the basis for your understanding that the birth certificate that was presented to the Board might not be valid?
A So 32.1-269, Section B, except in the case of an amendment provided for in Subsection D which deals with paternity, a vital record that is amended under this section shall be marked amended and the date of amendment -- so I'll stop there.

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So even the version you've provided me, I still don't see the word "amended" or the date of the amendment.
MR. BLOCK: Let's -- since you're referring to a document of the -- that was handed to you, let's have that marked as Exhibit E for the sake of the record. This is a document that says that it's a birth certificate for Gavin Elliot Grimm, and it says it was filed in Appeal No. 15-2056 as Document 102.
(Exhibit E was marked for identification.)
MR. BLOCK: And even though there's an Exhibit C in the photocopy, this is being marked as Exhibit E in this deposition.
So...
THE WITNESS: I had more, but I wanted to stop there because it's a long sentence. Again, to restate that, shall be marked amended and the date of amendment, so I don't see the word "amended" or the date of the amendment. And to continue, and a summary description of the

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evidence submitted in support of the amendment shall be endorsed on or made a part of the vital record.
I don't see any description of evidence submitted in support of the amendment. I'm not a lawyer, so I don't know what "shall be endorsed on" means, and I can only take a plain English reading of what made a part of the vital record is. To me that means amended, too.
BY MR. BLOCK:
Q So does the school board or the school administration inspect every other birth certificate that's presented to see if the word is -- if the word "amended" is on it or not?
MR. CORRIGAN: Object to form, foundation.
Go ahead.
THE WITNESS: When documents are received in accordance with policy JO, their validity is looked at as part of the process. So making sure that valid documents are included in the request to change an educational record is part of the process.

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This is the same -- we're focused that this particular case is dealing with a birth certificate and a person's gender, but the process is the same and it's afforded to every student regardless of what the request is.
BY MR. BLOCK:
Q So you're not aware of whether or not other photocopies of birth certificates in the school's files also have the word "void" on them --
A Correct, I'm not aware.
Q -- are you?
And so it's possible they do have the word "void" on them; is that right?
MR. CORRIGAN: Object to foundation, speculation.
Go ahead.
THE WITNESS: Possible, sure. I have -- I mean, how does this one -- if every birth certificate -- if you copy it, it gets the word "void" on it, why does this one not have "void" on it?

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BY MR. BLOCK:
Q Well, I think it does on the -- if you look to the left, there's -- it shows up more clearly. It's faint, but it shows it more clearly under state file, name of registrant, you can see in horizontal a faint "void," v-o-i-d.
Do you see what I'm referring to?
A Huh-uh, no, sir.
Q Okay. Now, for the paragraph that you read for me, if you look at the last sentence it says, in a case of hermaphrodism or pseudo-hermaphrodism, the certificate of birth may be corrected at any time without being considered as amended upon presentation to the state registrar of such medical evidence as the Board may require by regulation.
Is that right?
A That's the way the section reads. You read it accurately, yes.
Q And I want to look at the other document marked Exhibit D, the Virginia Administrative Code.

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Have you seen this before?
A I have.
Q You have?
A Yes.
Q Okay. Now, does this say anything about whether or not a birth certificate that has a change of sex on it -- excuse me -- does this regulation say anything about whether a birth certificate that has a change of sex needs to be marked as amended on it?
A It does not.
Q I want to make sure the complete list of the reason you've given for why the birth certificate copy might appear facially irregular. So we talked about the void issue, we talked about it not being marked as amended, and we talked about not having a description of the -- not having the court order included on it.
And is there anything else?
A The strike-through. So I'd be happy to reach into my box over there and pull out the other Code, if that's acceptable. Again, you've provided two, but there's more than two.

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Q Sure. That's fine with me if it's fine with your counsel.
MR. CORRIGAN: Yeah.
THE WITNESS: So it's 12 VAC 5-550-460, methods of correcting or altering certificates.
MR. CORRIGAN: I have a clean copy of that. Want to make copies of it?
MS. SAFSTROM: That would be great.
MR. CORRIGAN: Do you have that one? 460 is the number, Josh.
Can we take a second to make copies of this? Is that all right?
(There was a pause in the proceedings.)
(Exhibit F was marked for identification.)
BY MR. BLOCK:
Q What part of that regulation did you want to refer to?
A Certainly. It's pretty much all of Subsection B or Part B. In all other cases, corrections or alterations shall be made by drawing a single line through the incorrect item,

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if listed, and by inserting the correct or missing data immediately above it or to the side of it, or by completing the blank item, as the case may be, and probably more importantly. In addition, there shall be inserted on the certificate a statement identifying the affidavit and documentary evidence used as proof of the correct facts and the date the correction was made.
Q And you testified that you don't have any knowledge about whether there's a difference between what's on long form birth certificates and short form birth certificates?
A Correct.
Q When -- in the context of decisions about who has legal decision-making authority for a student if the parents are divorced, is the school board ever presented with court orders regarding custody or decision-making?
MR. CORRIGAN: Object to form, foundation.
THE WITNESS: Yeah, I'm not well-versed in all the different types of situations that student services deal with.

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BY MR. BLOCK:
Q What's the typical method for responding to requests to update student records? What's the typical method by which the school communicates its decisions?
A So the superintendent director of student services would work through the issue and either issue a letter indicating the record was changed per the request or not changed per the request. And if not, the reasons why.
Q And for the reasons why, does it -- does the communication identify the specific things that would need to be fixed in order to justify having an amended record?
A If they can be easily identified, yes.
Q That would be typical practice?
A Yes.
Q And what is the typical time period for responding to a request to update school records?
A That I don't know.
Q Has there ever been a previous request to update the gender marker on a student's birth

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certificate -- do that again.
Has there ever been a previous request to update the student's gender marker on their school records?
A Not to my knowledge.
Q Have there been previous requests to update school records based on any type of change to a student's birth certificate?
A Not to my knowledge.
Q And the only communication given to the Grimms about the reasons for denying their request to update the birth certificate was -- I keep making that mistake. I'll say it again.
The only reason given to the Grimms -- say it one more time.
The only communication to the Grimms giving the reasons why the school did not update his school records was the letter sent by the Board's counsel to me; is that correct?
A Correct, to my knowledge.
Q So at school, the school board and school administrators refer -- have honored Gavin's

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request to refer to him by his name Gavin; is that right?
A Correct.
Q And the school administrators also honored his request to refer to him with male pronouns; is that right?
A Correct.
Q Okay. Now, why have they done this?
A My understanding is the -- let's start with pronouns because that's not hard. Pronouns aren't a legal change to some sort of student records. There's no student record associated with pronoun for the name. My recollection is that the name was changed based on the process of the same policy JO.
Q Does the school board think that it's harmful to refer to Gavin with male pronouns?
A Harmful to refer to Gavin with male pronouns, no.
Q I'm going to show you a document that's marked -- that the title of is Gloucester County School Board's Rule 26(a)(2) disclosure.

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MR. BLOCK: Do you have that, Jennifer?
MS. SAFSTROM: Yeah, just one second. The 26(a) disclosures?
MR. BLOCK: Yes.
MR. CORRIGAN: So, Josh, where does this fit under the 30(b)(6) designation? What are we talking about as what the witness was to discuss?
MR. BLOCK: It's the governmental interests from the policy.
Can we have this marked as F for -- G, great.
(Exhibit G was marked for identification.)
BY MR. BLOCK:
Q You haven't seen this before, have you?
A I have not.
Q I want to turn to one, two, three, four, five, six pages in of the double-sided version, so it's probably 12 if you have single-sided.
It's paragraph 41. Do you see that paragraph 41?
A I do.
Q Okay. Just want to direct your attention

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to the second sentence in that paragraph. It says, allowing the biologic female to use a male-designated bathroom facility is one of several gender-affirming care options, but it is creating harm to at least two parties, the harm to the gender incongruent person is that it promotes a pathway to inevitable long-term medical and psychological morbidity.

So my question is, is this one of the governmental interests that is served by the school board's policy to prevent harm to the transgender person from promoting a pathway to inevitable long-term medical and psychological morbidity?

A I'm not sure I even understand what that statement that you just read means.

Q Does the school board contend that allowing a transgender student to use the boys restroom is harmful to the transgender student?

A That was not something considered when this policy was voted on.

Q Are you relying on it as one of the

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governmental interests served by the policy today?

A I would say no.

Q Thanks.

MR. BLOCK: Can we just go on mute for a minute?

MR. CORRIGAN: Sure.

(A recess was taken.)

BY MR. BLOCK:

Q So under -- are you ready, Mr. Andersen?

A Yes, sir.

Q Great. Under the Board's policy, how does it determine the biological gender of a student with intersex characteristics such as genitals that look either male nor female?

A That's not a scenario we ever discussed.

Q And does the policy apply to that scenario?

A Yes.

Q Yes?

A Yes.

Q And so under the policy, how would that person's biological gender be determined?

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A I don't know the innerworkings of how birth certificates work in that scenario, so I don't have a good answer for that.

Q But it would be whatever is on their current birth certificate?

A Correct.

Q And so just to clarify a previous line of questioning, the biological gender policy turns on what the student's current birth certificate is; is that correct?

MR. CORRIGAN: Object to form, foundation, legal conclusion.

Go ahead.

THE WITNESS: As I previously described, it would be based on the gender marking in the student's records as determined by either the birth certificate they submitted when they signed up or, if they want it changed, the one they submitted as part of policy JO.

BY MR. BLOCK:

Q And how does the biological gender policy apply to someone who's lost their genitals in an

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accident?

A That would require additional discussion. There's been no -- not a scenario we thought through all the way when coming up with that policy.

Q And so just to -- I apologize if this is making me repeat something. This is my last question.

So under the Board's policy, a student could have estrogen for purposes of puberty and hormone treatment and fully developed breasts and a vagina through vaginoplasty, and even if that student has all those things, the student would still be designated as having a male biological gender for purposes of the Board's policy if that student's birth certificate still listed them as male?

MR. CORRIGAN: Object to form, foundation, legal conclusion, incomplete hypothetical.

Go ahead.

THE WITNESS: Correct.

BY MR. BLOCK:

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Q So in that scenario, the boys in the boys restroom could be in the same restroom as the transgender girl with a vagina; is that right?

A Say that one more time, please.

Q Boys in the boys restroom could be in the same restroom as a transgender girl with a vagina under the school board's biological gender policy; is that right?

MR. CORRIGAN: Object to form, foundation, incomplete hypothetical, legal conclusion.

Go ahead.

THE WITNESS: Under the scenario you just described, yes.

MR. BLOCK: All right. Thank you, Mr. Andersen. I have no further questions.

MR. CORRIGAN: I don't have any questions. He'll read.

MR. BLOCK: Could we get an expedited version of the transcript as soon as possible. Electronic is fine.

MR. CORRIGAN: I'll take it electronic.

(The deposition adjourned at 12:24 p.m.)

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CERTIFICATE OF SHORT HAND REPORTER - NOTARY PUBLIC

I, Scott D. Gregg, RPR, a Notary Public, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my supervision; that reading and signing was requested; and that I am neither counsel for or related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this day of 2019.

My commission expires July 31, 2020.

Scott D. Gregg | RPR

_____

NOTARY PUBLIC IN AND FOR THE COMMONWEALTH OF VIRGINIA

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Transcript of Dr. Quentin Van Meter

Date: March 18, 2019
Case: Grimm -v- Gloucester County School Board

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
NEWPORT NEWS DIVISION

GAVIN GRIMM, Plaintiff, v. GLOUCESTER COUNTY SCHOOL BOARD, Defendant. :CASE NO. 4:15-cv-54

Deposition of Dr. Quentin Van Meter
Atlanta, Georgia
Monday, March 18, 2019
10:03 a.m.

Job No.: 233197
Pages 1 - 219
Reported by: Robyn Bosworth, RPR, CRR, CRC, CCR

Deposition of Dr. Quentin Van Meter, held at:

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C O N T E N T S

EXAMINATION OF DR. QUENTIN VAN METER PAGE
By Mr. Block

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E X H I B I T S

(Attached to Transcript)

DEPOSITION EXHIBIT		PAGE
Exhibit 1	Gloucester County School Board's Rule 26(a)(2) Disclosure	7
Exhibit 2	Declaration of Quentin L. Van Meter, MD	17
Exhibit 4	American College of Pediatricians "About Us" from website	146
Exhibit 5	Gender Ideology Harms Children	149
Exhibit 6	On the Promotion of Homosexuality in Schools	167
Exhibit 8	Dr. Quentin Van Meter: How Faulty Research by a 1950's Sexual Revolutionist Guided the Modern Transgender Movement	158

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P R O C E E D I N G S

DR. QUENTIN VAN METER,

having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. BLOCK:

Q Good morning, Dr. Van Meter. My name is Joshua Block. I'll be taking your deposition today. I represent the plaintiff, Gavin Grimm, in this lawsuit.

Have you ever had your deposition taken before?

A I have.

Q Great. So you're familiar with the procedure here. I'll be asking questions, and you'll be providing answers. There's three ground rules I'd like to go over with you.

The first, as you already know, is that we have the court reporter writing down everything that we say, so it's important that we don't talk over each other, so I'd appreciate it if you could wait for me to finish a question before you start answering, and I will wait for you to finish answering before I ask the next question. Agreed?

A Agreed.

Q Second, because the court reporter is writing things down, and because the video is a little fuzzy, it's important that you don't respond with visual cues like nodding your head or saying "uh-huh." All your answers need to be verbal so they can appear on the transcript. Okay?

A Okay.

Q And third is it's my job to ask questions that you can understand, so if I say anything that is unclear or you would like me to repeat or rephrase the question, please let me know. And if you do answer my question, I'm going to take that to mean that you understood it. Okay?

A Okay.

Q Great. So let's start with the document that's been marked by the court reporter as Exhibit Number 1.

(Exhibit 1 was marked for identification and is attached to the transcript.)

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BY MR. BLOCK:

Q If you turn to -- a couple pages into the document there's a photocopy with your letterhead on it. Let me know if you found that page.

A I have it here.

Q Great. Do you recognize this letter?

A I do.

Q What is it?

A This is a statement of my opinion regarding information that I gleaned from reviewing records on the Gavin Grimm case.

Q Great. And if you flip to the end of the letter and look at the next page, there's a document that appears to be your CV; is that right?

A That is correct.

Q Okay. So I'll be asking some questions both about the letter and about your CV here.

So let's go back to the beginning of your letter. If you look at paragraph 9.

A Okay.

Q The second sentence says: I have testified at Georgia state legislative committee

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hearings; is that right?
A That is correct.
Q What was the subject of your testimony?
A This was regarding obesity in children, as I recall.
Q And how many times did you testify at the Georgia state legislative committee hearings?
A I testified once, I believe.
Q And in your testimony did you discuss at all any information related to transgender children?
A I did not.
Q Can you think of any way that the subject matter of your testimony at the Georgia state legislative committee hearings would have relevance to the issues in this case?
A No.
Q Okay. So going to the next sentence, you say: In the past six years, I have testified by deposition in Harlen Schneider versus J. Enrique Lujan, MD, in the Circuit Court of the First Judicial Circuit of Okaloosa County, Florida, Civil Division; is that right?

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A That's correct.
Q And what was that case about?
A It was a medical malpractice case.
Q And what was your testimony about?
A It was in -- it was for the defense -- excuse me, for the plaintiff in regard to the quality of medical care. Specific diagnosis, I do not remember.
Q And was this for an endocrine condition?
A This was for an endocrine condition.
Q And to the best of your memory, was the diagnosis at all related to either gender or sexual differentiation?
A It was not.
Q The rest of that sentence after the semicolon says that you also testified in the case of plaintiff, Kimora Gilmer. What was that case about?
A That case was about the death of a young child who had acute onset of thyroid illness which was not recognized by the medical treating facility or the physician, and the patient died as a result.

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Q What was your testimony?
A My testimony was as an expert witness talking about the standard of care in a primary care setting, and the need to have consulted endocrinology appropriately, and that was not done.
Q Now, when you give expert testimony regarding the standard of care, what sources do you look to to determine what the standard of care is?
A Routinely, they will be referencing textbooks. If there are published standards of care outside of a textbook, if it's already outdated or has been updated I will refer, after researching the literature, to the most recent standards of care.
Q Are guidelines from the Endocrine Society one of the sources you look to in other areas of endocrine medical practice to determine what the standard of care is?
A Yes, but I'd like to clarify, there's a difference between guidelines and standards of care, as I understand it. Guidelines are suggestions; standards of care, in terms of my worldview, are what are published and recognized as the -- as the

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most common and generally accepted ways to treat a patient.
Q So in your opinion the standards of care would be found in this textbooks as opposed to guideline recommendations?
A I am not sure.
Q But the guidelines from the Endocrine Society are at least one source that you would usually look to to determine the applicable standard of care; is that fair?
A Not exactly.
Q Could you explain that further?
A Guidelines from the Endocrine Society are based on opinion of the committee that developed the guidelines. They are not necessarily accepted across the board as standards of care.
Q So where would you find the accepted standards of care in that case?
A Most likely they would be in published textbooks.
Q In published textbooks?
A Yes.

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Q So to find the standards of care for treating gender dysphoria, would someone then look to textbooks on treating gender dysphoria?
A They could. There are standards of care published by the American Psychological Association in their handbook published in 2014. The exact name of that textbook, whether it's the Handbook of Human Sexuality or -- it's a title very similar to that, but it's a published textbook of guidelines.
Q Okay. So published textbooks of guidelines from the American Psychological Association would be a source for determining the standards of care for treating gender dysphoria in your opinion?
A Yes.
Q Is there anything else that would be a source for determining the standards of care?
A You could look to articles across the world's literature to see the broad spectrum of opinion and come up with what would be the best-case scenario for the patient.
Q And in general articles that are peer

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reviewed would be the best source of articles to look at; is that right?
A Yes. The whole concept of peer review ideally is to have a team of, if you will, referees that have a broad background that essentially go through and check all the references to make sure that they are valid, that the opinions stated from the references match the information published in the paper. So that would be -- and by peer review, it's somebody in the field of endocrinology, and perhaps in a field of subspecialty so that there is a very critical assessment of the validity of what's being published.
Q So when you say "look at the broad spectrum of opinion," is there a way to quantify what qualifies as a broad spectrum of opinion?
MR. CORRIGAN: Object to the form of the question.
Go ahead.
A A broad spectrum --
BY MR. BLOCK:
Q Sorry. No, no, I'll clarify. Is there a

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way to quantify what constitutes a broad spectrum of opinion for purposes of identifying the standard of care?
MR. CORRIGAN: Same objection.
Go ahead.
A Can you restate the question?
BY MR. BLOCK:
Q Sure. You referenced looking at articles to find a broad spectrum of opinion in order to derive a standard of care. Is there some sort of number of articles that you would look at for that purpose?
A More than the number of articles, the number clearly is important if you were trying to look at the balanced approach to review the subject at hand, there is sort of a general process when you review information and review literature that you look at every side of the subject, every published paper and the quality of that paper and lay them all out in front of you, if you will, and come up with what is a balanced approach to developing your opinion based on different research, different sides

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of an issue, so that you come up with what is best for the patient.
Q So when you have determined your opinion regarding treatment for gender dysphoria, did you look at all sides of the research in forming your opinion, including materials that supported your view and materials that contradicted your view?
A Yes, I did.
Q What sources did you look to for finding opinions that were different from your own?
A I looked at the bibliography for the Endocrine Society guidelines, I looked at the bibliography for the World Professional Association of Transgender Health, I looked in the Handbook of -- that I referred to published in 2014 by the American Psychological Association, I looked at the DSM-V criteria, I looked at articles published in the Journal of Endocrinology and Metabolism, the Journal of Pediatrics, a number of additional journals that I could reference if you need the specifics.
Q And when did you conduct this research?

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A I've been doing this probably five or six years in depth.
Q What research have you done since the time that you filed your declaration in the Carcano versus McCorey case?
A I've done a fair amount of additional research because there have been articles published since that time.
Q Let's look at your declaration in Carcano versus McCorey, which is marked as Exhibit 2 by the court reporter.
(Exhibit 2 was marked for identification and is attached to the transcript.)
A I have it here.
BY MR. BLOCK:
Q Great. And does this appear to be a copy of the declaration that you wrote for that case?
A It does.
Q Who first contacted you about being an expert in the Carcano case?
A I actually do not remember.
Q Do you remember what organization they

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were from?
A It would be a guess.
MR. CORRIGAN: Don't guess.
A Okay. I do not recall exactly, so I don't want to misstate.
BY MR. BLOCK:
Q Well, can you describe, in the best of your recollection, how you came to be an expert in that case?
A We had published the American College of Pediatricians guidelines for care of transgender patients, and that was used, I think, as a reference point for whoever contacted me to ask me to be -- to provide information for this case.
Q To the best of your knowledge, has the American College of Pediatricians ever been used as a source for determining what the standard of care is in a court proceeding?
A Yes, it has been -- the American College has filed amicus briefs on a number of subjects, and I do not know whether transgender specifically was one of those. I don't know what level of court it

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has ascended to, but I know it has been used as a document in transgender cases.
Q But my question is not amicus briefs, but if a physician or pediatrician was going about determining the standards of care for a condition, is the American College of Pediatricians publication a source that they would look to?
A Yes, they would review it.
Q Are you aware of any instance in which an expert witness testifying in a case has relied upon them?
A They have mentioned them specifically. I can't give you a specific case, but I know they have been referenced.
Q So you say you don't recall who contacted you about being an expert in the Carcano case. Is it your recollection that you were contacted by someone as opposed to you being the person that initiated contact?
A Yes, I was contacted.
Q And if you look at your declaration. Go back to your declaration in this case.

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MR. CORRIGAN: So Exhibit 1, not Exhibit 2?
MR. BLOCK: Correct.
BY MR. BLOCK:
Q So paragraph 10 says: I provided an expert declaration in the case of Carcano v. McCorey and U.S. v. North Carolina on August 12, 2016; is that right?
A That's correct.
Q And the declaration we just looked at as Exhibit 2 is a copy of that declaration, correct?
A It is.
Q So next sentence says: I testified in Springfield, Illinois, as a plaintiff's expert witness in the case of Cooley versus Paul.
What was that case about?
A That was a case of a child, it had nothing to do with transgender, it was a child who was treated with excessive amounts of steroid over a number of years who suffered severe medical consequences as a result.
Q What was the subject of your testimony?

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A Subject of the testimony was the standard of care for treatment of children with steroids for whatever reason and the monitoring of the side effects of those drugs.

Q And for all of these -- all of the malpractice cases we've discussed so far, did you ever reference the American College of Pediatricians as a source for determining your standard of care in your testimony?

A I did not because the issues that were raised were not issues where the College had a position statement.

Q Did you reference the Endocrine Society in any of your testimony in those cases?

A Not so much the Endocrine Society, but endocrine -- published endocrine textbooks for children.

Q The next sentence in your declaration says: I testified in court in Hamilton County, Ohio, on February 2018 in regard to Jessica Siefert, a transgender teen that had been removed from the custody of her biological parents.

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Can you tell me about that case?

A I was to provide information to the judge as an expert witness on the subject of transgender medicine presenting the broad spectrum of opinion on the appropriate treatment.

Q And you testified in court to a judge in that case?

A I testified by Skype to a judge.

Q How did you come to be involved in that case?

A The parents' attorney found me because of the position statement of the American College of Pediatricians.

Q And who was the parents' attorney?

A Let me think for one moment if I can remember the name. I can provide it after the fact. I don't want to guess.

Q What was the context in which this teenager had been removed from the custody of her biologic parents?

A The Hamilton County Child Protective Services removed the child from the family at the

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request of the clinic which was treating this young lady because the parents would not give permission for hormonal treatment for their female child. And so the clinic brought charges, and the Hamilton County DFCS assumed custody of the child and kept her in their custody and were requesting that they be able to grant custody to the grandparents, who indicated they would allow hormone treatment to continue.

And so the parents were requesting returned custody to them from Hamilton County DFCS, and the judge made the decision, after all the proceedings, to give the child custody to the grandparents.

Q And was that the end of the case?

A As far as I know.

Q Do you know if the judge made any findings of fact regarding your testimony?

A I do not. I do know that she made a specific request that the child be evaluated by mental health practitioners who were completely independent of the children's hospital who were part

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of the mechanism for getting the child taken away from her parents. The judge couldn't believe that the evaluation was not done by an independent practitioner because of the way their practitioners testified about the care of that child.

Q But the independent practitioner that the judge asked to do another evaluation ended up agreeing with the clinic; is that right?

A I do not know. The child was 17 years and 10 months of age at the time of the proceedings, and so it's a bit moot. Two months into the proceedings she was age of consent, so she could pretty much do whatever she chose.

Q Do you have a copy of the testimony that you provided in that case?

A I do not.

Q What is -- in your declaration the next sentence says: I testified via Skype in Alberta Province, Canada.

What was that case about?

A That case was a suit by parents in the school district in Alberta who had a child, an

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autistic child, who was recruited into an organization at school without the parents' knowledge.

The child was approached by a teaching assistant for the class with kids with special needs and autism, and that -- without the parents' notice, the teaching assistant told the girl that, first, she was a lesbian, and then secondarily that she was transgender. The parents were not aware of any of this information, and so their concern was the school did not share information that was important for the parents to know about their child in the school setting, and they thought that that was an inappropriate thing for the school district to take the responsibility without the knowledge of the parents. So that was -- that was the crux of the case.

Q So what was your testimony about?

A My testimony was just to give them some background information about what transgenderism as a concept is, the historical background of how it has come to be as a concept in medicine, and to give

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the broad spectrum of published literature background for that case.

Q And did you testify in court too?

A No, this was just by Skype. This was -- actually, this -- I was interviewed -- was not in court. I was interviewed by the plaintiffs' attorneys.

Q Do you know what the --

A I'm sorry.

Q Do you know what the outcome of that case was?

A I want to correct. I was interviewed by the defense attorneys primarily, I'm sorry.

I do not know what the outcome is.

Q If we can turn to your CV. Do you have any education or training related to gender dysphoria or gender identity disorder?

A My training at my fellowship at Johns Hopkins was the first introduction to me of what then was called transsexualism, but which is now referred to in current terminology as transgenderism. So that was in 1978 that I was

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introduced to that concept.

Q Have you had any other training?

A No specific training because there is not a -- there is not a curriculum, if you will, to teach transgender medicine that is available.

Q Did you have any clinical training?

A The clinical training was in the fellowship years, and then subsequently meeting with experts in the field, attending a conference of the joint Pediatric Endocrine Society and European Society of Pediatric Endocrinology in New York, but it was not so much a course, it was just a conversation.

Q And would conversations of that sort generally in your field qualify as clinical training?

A No.

Q Okay. So the only training that you had related to transsexualism, gender identity disorder, gender dysphoria, took place during your fellowship at Johns Hopkins; is that right?

A That's correct.

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Q So during your fellowship, did you actually provide any treatment for people with transsexualism, gender identity disorder or gender dysphoria?

A I did not personally do so, but I was -- the attending physicians and -- were providing the care. It was we were used as consultants to evaluate the clinical status of these patients, but we did not specifically write prescriptions for medication, we did not make recommendations for surgery.

Q You did a pediatric -- a fellowship in endocrine pediatrics; is that right?

A That's correct.

Q So what role, if any, did you have in providing recommendations for the treatment of adults with transsexualism, gender identity disorder or gender dysphoria?

A Well, we were sort of observers, if you will, of the clinical circumstances because these were adult patients, and we were pediatric trainees. Johns Hopkins's adult endocrinology division did not

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take care of these patients.
Dr. John Money was the professor on the faculty, and he worked exclusively with the pediatric department, developed his own protocol, and treated adult patients, and we were taught about that, and we were instructed about what was going on with those patients, their clinical status, and their response to therapy.
Q So you were -- in terms of how you were informed about the treatment of those patients and their responses, could you tell me the context in which you were informed of that?
A That we were informed that with clinical conference -- case conferences.
Q About how many of those?
A I recall four specific patients that we learned about in a fair amount of detail at the time. I remember I still have teaching slides from those patients in my teaching slide library. There were, I believe, as many as 12 patients overall in the program during the time that I was there at Johns Hopkins, and those cases were subsequently

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reviewed and reported in the medical literature.
Q And did you provide any input in the treatment of those patients?
A I did not.
Q Did not?
A I did not.
Q You say in your report that during your time at Johns Hopkins you had above-average exposure to children with disorders of sexual differentiation; is that right?
A That's correct.
Q What do you mean by "above-average exposure"?
A Well, the endocrine fellowship training programs are essentially all university based, and because Johns Hopkins was the place where steroid biochemistry and physiology and the physiology of sexual differentiation was primarily outlined, the effect of steroid hormones on the development of the fetus, patients were referred there because the faculty were world renowned. And so comparing that to another center in another city, we tended to get

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more referrals there because of the reputation, if you will, of the clinical faculty.
Q So how many children were you exposed to regarding disorders of sexual differentiation?
A In the two years of my clinical fellowship I would -- and this is an estimate -- would say somewhere between 50 and 75 patients.
Q And did you treat any of those patients?
A Yes, I did.
Q How many of them did you treat?
A I would say almost all those patients that I told you about are patients that I actually treated or was involved in the treatment. There were -- as a fellow you share the treatment experience with other training fellows. Because of the numbers of patients we all got to see most of these very interesting patients.
Q Now, all of these patients were children with DSDs, not transsexualism, gender identity disorder or gender dysphoria; is that right?
A That's correct.
MR. CORRIGAN: What's a DSD?

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THE WITNESS: Disorder of sexual differentiation.
MR. CORRIGAN: Sorry.
BY MR. BLOCK:
Q The fellowship ended in 1980; is that right?
A That is correct.
Q Have you had any training in psychiatry?
A No, I have not, other than its implication and recognition of mental health disorders in the general pediatric population and how mental health issues are related to endocrine diseases, but not specifically in the active treatment with medication.
Q Have you had any training in psychology?
A As part of our pediatric residency program, we were exposed to courses and information on pediatric mental health issues with psychiatry faculty, psychology faculty. In my Navy career of 20 years in the hospitals where I was stationed, there were clinical psychologists on the faculty that regularly integrated their work with the

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endocrine population of patients, most notably the diabetic patients.

Q But you did not personally receive any training; is that right?

A I received training; I just did not have a certification as a mental healthcare provider.

Q Would you feel qualified to appear as an expert witness regarding psychology or psychiatry for a condition other than gender dysphoria?

MR. CORRIGAN: Object to form.

Go ahead.

A No.

BY MR. BLOCK:

Q Have you done any scientific research related to transsexualism, gender dysphoria or gender identity disorder?

A I have not.

Q Have you done any scientific research related to transgender people?

A I have not.

Q Have you done any scientific research related to gender identity issues at all?

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A I have not done any research, I have just reviewed the literature.

Q Have you published any articles or books addressing transsexualism, gender identity disorder or gender dysphoria?

A Our letter in regard to the Endocrine Society guidelines was just published in this month's edition of the Journal of Clinical Endocrinology and Metabolism, so that is published in a peer-reviewed journal. I have submitted for publication an article about the potential pathways of treatment for transgenderism; do not know the status of that acceptance.

Q Tell me the -- what you're referencing as something published in the Journal of Endocrine and Metabolism, that was a letter to the editor; is that right?

A That's correct.

Q Is it your understanding that letters to the editor are peer reviewed?

A They are.

Q And are letters to the editor based on independent research?

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A Letters to the editor are very specifically required to have a number of references, and they're reviewed before publication.

Q But my question is about research like your independent research. The letter to the editor wasn't based on that, right?

A No, this was not based on a research study.

Q What is the nature of the peer review for letters to the editor?

A The letters to the editor, as I understand, are reviewed by peers for accuracy, appropriateness of references, and content, and then they are recommended for publication or not.

Q And the second publication you referenced regarding -- was it pathways of treatment for gender dysphoria?

A Yes.

Q What was the name of it? What was the name of that article again?

A It's a commentary article bringing transparency to treatment of transgender persons.

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Q And where did you submit that article for publication?

A It has just been submitted to a journal that I do not recall the name of, I'm embarrassed to say. It just was finished last week and sent to the person who was to get it to the publication for review. There was evidently a possibility of several journals, and if it is not accepted or reviewed appropriately, it will be sent to another journal.

Q Is the journal that you submitted it to a peer-reviewed journal?

A Yes, it is.

Q Is the journal called The New Atlantis?

A No.

Q Is it a journal that specializes in endocrinology?

A I do not believe it is.

Q Is it the Journal -- what's the subject matter of the publications in general?

A I don't want to misspeak, so I might -- I

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think I have an idea of the name of the journal called Issues in Law and Medicine.

Q Do you know who publishes it?

A I do not.

Q I'm sorry, did you answer? I couldn't hear.

A I do not know.

Q So other than the letter to the editor, do any of your publications listed on your CV address transsexualism, gender dysphoria, gender identity disorder or related issues?

A They do not.

Q Have you given any presentations about gender dysphoria, gender identity disorder or transgender issues?

A I have.

Q How many?

A 11 or 12.

Q And are any of those presentations listed on your CV at all?

A I do not believe they are.

Q Why not?

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A I didn't think about putting them on, and most of them are in the past year, and I specifically did not think about putting them on the CV, not for any reason other than I was focusing on publications more than anything else. There are a list of presentations given on general endocrine subjects in the past. If you need specifics of those, I can provide that, I just didn't put it on the CV.

Q So where -- in what context did you give these presentations about transgender issues?

A I gave a series of lectures in Australia on behalf of the Australian Family Association, I gave a presentation at the International Federation of Therapeutic Choice, I gave a presentation to the Matthew Bulfin Conference -- joint conference at the American College of Pediatricians, I gave -- and I'm giving another one to this -- the same group this year in early April, and I've given a talk on transgender medicine in the Southern Pediatric Endocrine Society meeting on two occasions.

Q Tell me about this -- the Southern Pediatric Endocrine Society meeting. What sort of meeting is that?

A It is -- it's a regional meeting of pediatric endocrinologists which occurs -- has been occurring annually. We had a year off last year. It involves pediatric endocrinologists in Kentucky, Tennessee, Virginia, South Carolina, North Carolina, Georgia, Florida, Alabama, and Mississippi. So they're inviting -- the invitation is to pediatric endocrinologists in those areas to come together and do a -- either a planning session or case presentations.

Q When did you give your presentation?

A The first presentation was in 2016. The most recent presentation was last month in Orlando, Florida.

Q Do you have copies of your presentations?

A I do.

Q Is it easy for you to provide copies without that being burdensome?

A They're PowerPoint presentations. I could present --

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THE WITNESS: I could give them to you.

MR. CORRIGAN: Okay.

MR. BLOCK: We'll follow up with counsel about that.

BY MR. BLOCK:

Q So looking at the other organizations, I want to make sure I have the list, so you have -- you gave presentations to the Australian Family Association. Is that a medical organization?

A It is -- no, it's not.

Q And you gave a presentation at the International Association of Therapeutic Choice; is that correct?

A That's correct.

Q What is the International Association of Therapeutic Choice?

A It's a consortium of mental health providers around the world, so it's primarily based on, again, mental health issues.

Q Is it fair to say that it's an organization that supports the option of patients seeking therapies to change their sexual

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orientation?
MR. CORRIGAN: Object to form.
Go ahead.
A It's an organization that asks for ability to provide counseling that the patients request.
BY MR. BLOCK:
Q To change their sexual orientation?
A That is often an outcome, but it's not the goal.
Q And does the organization also support the ability of patients to seek therapies that change their gender identity?
A Again, it is at the beginning of this subject, so they have no particular guidelines other than those that are recommended by the American Psychological Association, which they use as a reference for standards of care for treatment.
Q What's your understanding of the American Psychological Association's position on therapy to change a person's sexual orientation or gender identity?
A The concept of the idea is that there is

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fluidity in both circumstances, and that's -- that is their statement specifically, that there is fluidity. It doesn't recommend, as I understand, anything that should or should not be done, other than things that are proven to be harmful.
Q Is there anything that this association focuses on besides sexual orientation or gender identity?
A I do not know.
Q So not that you're aware of?
A Not that I'm aware of.
Q The next organization you referenced sounded like you said Matthew Bulfin. Am I hearing that correctly?
A It's Matthew B-U-L-F-I-N.
Q And what's that?
A It's a conference that's given every other year, I believe, and it involves issues of bioethics in medicine.
Q Is that conference religiously affiliated?
A No, it is not.
Q What organization is the conference

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affiliated with?
A It's affiliated with the American College of Pediatricians and the American Association of Pro-Life Obstetrics and Gynecology.
Q So are there any other organizations that you gave conference presentations to other than the ones that we've discussed?
A I gave a presentation on the history of transgender medicine to the Teens for Truth conference in I believe it was Houston, Texas, in February of 2017, I believe. That could be a guess. I don't want to state that on the record.
Q What is Teens for Truth?
A It was a conference for teens to come together and learn about issues of human sexuality.
Q But what specifically were they learning?
A Things -- cases were presented to them by individuals who had experienced certain issues in their lives that they wished to let the teens know that they needed to be open about these issues, discuss them with their parents, discuss them with a therapist, and hopefully resolve their depression

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and anxiety.
Q So is this -- the presenters are people who said that they formerly identified as being gay or transgender, and that they no longer do so?
A There was no case of transgender in that particular conference. There was a focus on the family and adverse childhood events, so to essentially get the kids to open up about things that had happened in their lives and be able to have a vehicle to bring those things up to their parents or healthcare providers.
Q So the "truth" referenced in Teens for Truth is that someone who struggled with same-sex attraction could have treatment that makes them not be gay; is that right?
A No.
MR. CORRIGAN: Object to the form of the question.
Go ahead.
A The answer is no. It was essentially aimed at trying to get kids to open up about the truth of what was going on in their lives that

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brought them to the point of depression or suicide or severe anxiety.

BY MR. BLOCK:

Q But all of these children, their -- their depression or other anxiety was related also to same-sex attraction; is that right?

A Not all.

Q Many?

A Some.

Q So the conference had nothing to do with overcoming same-sex attraction?

A That was a subject that was discussed.

Q What other subjects were discussed?

A As I recall, concept of sexual abuse was a major topic, coming out from under the concept of sexual abuse; stories of patients who had experienced rape and how that affected their life, and being able to come out whole on the other side of those kind of issues; children who had grown up in families where there was enormous amount of psychological and behavioral malfunction of parents in raising the child, a lot of it that had to do

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with sexual activity and sexual abuse and trying to bring this to the forefront as a reason to seek therapy and to be healed. And the healing had to do with resolution of depression and anxiety, specifically.

Q Did it have anything to do with lessening same-sex attraction?

A If that was -- if that was something that happened, it was not -- it was not shunned as an option, but the option was not specifically to focus on that as the only -- only outcome, it was more on trying to get these children to be able to be functional kids in their lives. If part of the resolution was that they changed their sexual attraction to any degree at all, that was what was viewed as an outcome, but the outcome was primarily to avoid depression and suicide.

Q So what's your understanding of what the name of the organization references with respect to truth?

A The organization, I think, chose the title to be able to allow kids to discuss things with their parents, and to discuss things that were very difficult that otherwise would be buried.

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Q You're a pediatric endocrinologist, correct?

A That's correct.

Q You have a private practice?

A I do.

Q What's the age range of your patients?

A From birth to completion of their first undergraduate college degree.

Q Have you ever been sued for medical malpractice?

A I have.

Q Have you ever treated or evaluated patients with gender dysphoria, gender identity disorder or gender discordance?

A I have.

Q How many?

A Within the past two years, I have about 12 patients, active patients. I had one patient in 1993 when I came to the Atlanta area. And a family moved from Southern California -- it was a military

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family, and they moved often, and they brought their child in to ask me if I would provide estrogen therapy for that child, who had been evaluated by a psychiatrist in the Los Angeles area, and the parents were advised that upon the next move that that child should be allowed to assume the identity of a female.

When the child came to see me, the patient was 13 years old, had a female name and pronouns, and dressed as a female. The school board of the county asked me to help them develop a policy for that child to be able to -- to have physical education at a time of day when the child could go home from school and not have to worry about sharing locker facilities that did not match the biologic sex. Fayette County School Board here in the Atlanta area allowed the child access to a unisex bathroom in the school. So I helped them develop a policy for that child.

At that particular time I canvassed all of my mentors across the country to ask them how to handle the estrogen therapy, because there was no

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appropriate FDA indication to treat such a child, and there had been no standards of care set up for that.

They advised me that they had no experience in this field subsequent to the closure of the clinic at Johns Hopkins -- no, there were no recommendations professionally by any professional societies in the United States, and so they suggested that I use our practice attorneys to draw up an informed consent for the parents to sign indicating that they were choosing to have their child treated with estrogen at their request, even though we did not know about the potential adverse outcomes that might happen over the long run.

I treated that child for six months, and the family then moved out of the geographic region, and I have no idea what happened to that child after that.

So that was my very first case of a transgender patient in my clinic, and there was no reference source of standards of care or clinical experience that I could find across the United States at the time.

Q This was in 1993, you said?

A Yes.

Q So that was the first transgender patient since your fellowship; is that correct?

A That's correct.

Q So when's the next time you treated a transgender patient?

A Approximately two years ago I began receiving referrals for transgender patients to my private practice office.

Q And so this was after you filed your declaration in Carcano versus McCorey?

A I might be off on the date. It might be that as of three years ago I started seeing transgender patients. It's in the past two years that the numbers have increased.

Q Did these patients all come to you after the American College of Pediatricians had published statements disagreeing with providing hormone therapy to transgender youth?

A They did.

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Q And so what sort of treatment do these people that come to you ask for?

A They ask for anything from hormone therapy to -- hormone therapy specifically, because that's in the purview of endocrinology.

Q In what context are these patients referred to you?

A It's usually a self-referral.

Q Are they familiar with your position on the American College of Pediatricians?

A None have stated so.

Q So what treatment do you provide these people?

A I evaluate their history, I evaluate their physical condition, their status in puberty, I review the -- in depth the family and social history, and then I request the ability to be able to talk to their counselors who have evaluated them in the first place. If they have not done so, I refer them to a general counselor in their area to evaluate the undercurrent emotional issues.

Q And then after that, what do you do? Do you provide any treatment to them?

A I do not provide any hormone treatment.

Q So why make them go through this evaluation if you don't provide that treatment?

A Because that treatment is harmful. It's proven to be harmful. The vast majority of scientific literature looks at the side effects short-term and long-term, and mostly long-term, and indicates that there is potential damage.

So I explain to the parents that I am very much caring and compassionate for this child, and I will do everything I can to help them through and be sure that they have the appropriate evaluation of their mental health issues that are brewing beneath the surface. And I would say without question every single patient that has come in has significant emotional health history issues.

Q So you're not actually providing any treatment to the patients yourself; is that right?

A I am not providing hormone therapy. I am providing them information on what hormones do; I explain the physiology of hormones; I explain the

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history of treatment and the options that are -- that they read about; I discover from them, by interview, what they have learned and what sources they have used to learn that information.

Q So but you don't treat them?

MR. CORRIGAN: Object to form.

A That in my -- I'm not giving them hormones, but I am treating them in the sense of evaluation and continued contact to be sure that their needs are being met in terms of emotional evaluation.

BY MR. BLOCK:

Q What continued contact do you have with them?

A I see them every three months.

Q What diagnostic code do you use to bill it to insurance?

A There is -- there is a code for transgenderism.

Q So you use the diagnostic code for treating transgenderism for follow-up appointments with patients after you tell them that you don't

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provide hormone therapy?

A Well, I code out the physical exam, the evaluation and the history on the initial exam, and then I code out subsequent counseling appointments where it's essentially a conference appointment. If it requires an evaluation of their physical condition and their stage of progression in puberty, that is coded as a physical exam.

Q How many counseling appointments do you have with a typical patient?

A Again, these particular patients are seen every three months.

Q But how many times?

A Ongoing as far as possible.

Q I guess I'm confused about what the check-in would be, like, for the second time.

A The check-in is to ask what they understand. It is a very complex issue to deal with. Particularly in the younger children, I find that many things that we have -- I have interviewed them and found information about from them as individuals, both in private interview with them,

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and also with their parents, is that they, many times because of their age, do not understand a lot of what we talked about and a lot of the information we gathered previously.

So it is very important, based on the maturity of the patient and their understanding, to be able to go back and make sure they are on the same page with me in terms of what I know they know, and what I have taught them, and what I have suggested for them, and how their counseling is going.

Q And so you need to have -- so you need to have, like, a third or fourth or a fifth check-in for that purpose?

A I do not want these patients to be lost, okay? That's the problem. If they're lost to care, then I have not done my job to my best ability. So it's like any condition where you are constantly in touch with the patient, such as a patient with obesity. You keep in touch with them, you bring them back, you see what's going on with all of the issues, school performance, et cetera, et cetera.

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It's a complex review of history and any physical changes, and I demonstrate to them the depth to which I am trying to keep them in the fold and make sure that their needs are being met appropriately.

Q By your phrase "keeping them in the fold," do you mean making sure that they're not receiving gender-affirming hormone therapy?

A I wouldn't be providing that, so if they share that with me, I would assume they're not -- that's not something that I can continue or recommend for them, so I would probably part ways at that point in time and say, you know, you have a choice to come here, or you have a choice to go someplace else. I've done to my best ability all I can to help you. My door is open, you can call 24/7 and request to be in touch with me through my practice, and I will be available to help you with anything that I can.

Q Do you have any qualifications as a mental health counselor?

A I do not.

Q And would you describe your meetings with

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these patients as involving mental health counseling?

A Not mental health counseling, but evaluation of where they stand and how they are doing both physically and emotionally because as an endocrinologist we deal with depression and anxiety in patients very frequently with chronic, nonfatal illness.

Q Do you ever refer the patients to mental health counselors?

A I do.

Q Which ones?

A Ones that are covered by their insurance.

Q Is there any -- is there any specific counselors that you generally try to refer people to, assuming that they're covered by insurance?

A I try to hook them up with a personality that I believe would be a good fit in terms of the child's level of comfort. Most often, adolescent males I refer to male counselors, adolescent females to female counselors.

Q And Allan Josephson, is he one of the

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counselors you refer people to?

A I don't recognize that name.

Q Do you make sure that the counselor that you're referring people to share your views about the dangers of gender-affirming therapy?

A Not often. I basically try to find somebody who is a general counselor who understands anxiety and depression and who will delve into the adverse childhood events which lie beneath the surface.

Q Do you have a preference for referring people to counselors who are members of the American College of Pediatricians?

A They're -- no, I do not because there are not very many members of the American College. American College members, full members are pediatricians, Board-certified pediatricians. There are some ancillary associate members in fields of surgery and mental health who have aligned themselves with the College as being interested in helping and aligning themselves with our guidelines, but those are people from across -- they're not in

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my geographic region.

Q Do you have a preference for referring people to counselors who are members of the Christian Medical and Dental Association?

A I do not.

Q Is that a no? Sorry, I didn't hear.

A That's a no.

Q Are you familiar with the Christian Medical and Dental Association?

A I am.

Q Are you a member?

A I am not.

Q In your practice, your private practice, do you treat children with DSDs?

A I do.

Q How many?

A I have, perhaps, four active patients who qualify as having disorder -- no, I have six patients who I follow currently.

Q Over the course of your career, on average how many patients a year would you say you have with DSDs?

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A With DSDs? The six patients I mentioned are patients that are in the practice that are geographically in the Atlanta metro area or within the state where we're the closest -- we are a conveniently located practice. So the number is fairly stable.

These are really rare kids. Those that require any sort of team approach, we are developing a DSD multi-specialty clinic at Emory University locally where they can get essentially local care for any urologic or gynecologic types of surgeries, and so it's a newly developing entity we have put together in the Atlanta metro area. It is brand new.

Before that the cases were rare enough that if -- I would refer back to Johns Hopkins a number of the patients over the years I practiced in Atlanta who required any surgical intervention.

MR. CORRIGAN: What do you think about a break?

MR. BLOCK: We can -- that's okay, we can do that. Five minutes?

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MR. CORRIGAN: Sure.
THE WITNESS: Good.
MR. BLOCK: Okay, great.
(Recess 11:17-11:28 a.m.)
BY MR. BLOCK:
Q So before the break we were talking about your treatment of transgender patients or patients with gender dysphoria, and I just want to make sure I have an understanding of the facts.
So from the date of your end of your fellowship, the next time you treated someone with gender dysphoria or gender identity disorder was in 1993; is that correct?
A That is correct.
Q And then since 1993, you haven't treated any other transgender children until a couple of years ago; is that correct?
A That is correct.
Q And by "couple of years," that means two or three years?
A Yes.
Q And what is the total number of patients

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with gender dysphoria that you've treated during that time period?
A 12.
Q 12 total.
Are all 12 of them -- 12 of them currently active patients?
A Let me think for a minute. I think one -- one patient has left the geographic area.
Q So you're currently seeing 11?
A I included the -- well, 11 is fine, yes.
Q Okay. And what is the longest that one of these active patients has been seeing you for?
A Three years.
Q And how many appointments would you say you've had with that patient over the course of three years?
A That one has had six -- six visits.
Q And does that patient -- does that patient expect to have more visits in the future?
A The visits tapered off. The patient is primarily managed by the mental health provider.
Q When is the last time you've seen that

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patient?
A About six months ago.
Q And how old is the patient?
A The patient would now be around 15.
Q And has the patient, to the best of your knowledge, received any gender-affirming therapy?
A No.
Q Have any of your patients, to the best of your knowledge, received gender-affirming therapy?
A I do not know of any who have.
Q Have any of the patients that you've seen for transgender issues socially transitioned?
A Some were socially transitioned as they presented. One is still socially transitioned. The others have essentially stopped the social transition.
Q But they had started the social transition before seeing you, and after they saw you they stopped?
A That's correct.
Q And would you say that you encouraged them to stop social transition?

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A Their mental health therapist made that -- helped them guide them toward that advice. I specifically -- again, my role is to explain what the options are and what I know about complications, and I do not -- I do not force the patient to take any particular route other than to stick with the therapist. I'm very, very insistent on the fact that they maintain their contact with the therapist. And if the therapist ends up not being a good fit not -- for any other reason other than they don't get along, I find a new therapist.
I'm in a role, if you will, of sort of a subset of primary care in that -- in the world of transgender in that I am taking the responsibility of making sure that the therapy is continuing, and the patient is not lost to follow-up.
Q And when the patients come to you in the first instance, how many of these 12 had therapists that had already treated them and recommended that they see an endocrinologist?
A It's an estimate of about half of them were already seen by a therapist.

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Q And half weren't?
A And half were not.
Q So the half that were already seen by the therapist, how many of them did you encourage to find a different therapist?
A All of them.
Q All of them?
A Yes.
Q And why did you encourage them to have a different therapist?
A Because it was my sense that the therapist that they were seeing was not dealing at all with the basic issues that I could glean, was not paying attention to the undercurrent depression and anxiety.
Q And you saw yourself as being able to diagnose that more than their therapist that they had before seeing you?
A The patients gave the history of what they were -- what the sessions were about, the parents gave the history of their input and what was told to them by the therapist, and it did not include any

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treatment for depression or anxiety, it did not include any evaluation in depth of what the parents shared with me.
So in those cases I felt that it seemed that they were being superficial and not actually paying attention to the undercurrent mental health issues, and so instead of trying to treat those mental health issues and evaluate them in depth, I referred them to somebody who could do a better job.
Q And that was your opinion for all of the patients that you saw that had already been seeing a therapist; is that right?
A That is correct.
Q So when you encouraged them to see a different therapist, did you -- what was the explanation you gave them for why you were encouraging them to see a different therapist?
A Because I felt that their emotional health history had not been adequately evaluated by feedback given to me by either the patient or the parents or both.
Q So the therapists that they were referred

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to, did you have any prior knowledge of those therapists' opinions with respect to treatment for gender dysphoria?
A In one case I did.
Q And what was your knowledge of those opinions?
A This particular individual essentially said that they had had a good deal of clinical experience, that they would not necessarily have an agenda set ahead, but they wanted my -- they wanted me to know that they might possibly suggest affirmation therapy.
Q And you referred that patient to that therapist?
A I did.
Q What are the age ranges of these patients when they come to you?
A I have had a patient as young as six, and patients as old as 17.
Q So in what context -- half of the patients had not been seeing a therapist, so how do they come to be in your office in that case?

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A The parents either sought out an endocrinologist and found me because I was on their insurance plan, or they were referred by their pediatrician.
Q Did any -- to the best of your knowledge, any of the patients that came to you know in advance of your opinions with regard to gender-affirming therapy?
A I do not know.
Q Do you know if their parents knew?
A I do not know.
Q Did any of them come to you with -- did all of them come to you seeking gender-affirming therapy, or did any of them come to you to talk someone out of seeking gender-affirming therapy?
MR. CORRIGAN: Object to the form of the question.
Go ahead.
A All of them came to me with concern that there were issues of gender incongruence to some degree.
They asked what kinds of services I

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provide, and I tell them that I provide an in-depth evaluation of their physical condition, and a review in depth of their family and social history with siblings and adults in their lives, and that I am fairly up front as I get to the end of my evaluation to say that I do not provide hormone treatment therapy, but that I do recommend before they go anywhere that they seek out a very thorough, in-depth evaluation of their mental health.

BY MR. BLOCK:

Q So to the best of your knowledge, none of the parents of the patients knew in advance that you would not be providing transition-related care?

A I did not know, and I did not ask.

Q So you had said that there was one situation where you knew in advance the therapist's views on gender-affirming care before you made the referral, but for the other 11 therapists that you referred people to, you didn't know their views in advance?

A The one that I referred to was the very first case that I asked among my mental health

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practitioners in the Atlanta area who had referred to me and I had referred to them in my medical history of treating patients in Atlanta, and the one psychiatrist, one child psychiatrist that I had the most referrals from and who I referred to very often suggested that this person was the counselor who had the most clinical experience, and he knew her personally and thought that she unquestionably would review everything with an open mind, and that I should consider talking with her, which I did, and I found out that she -- the insurance that she accepts is very limited, so it ends up not being possible for the parents to get to her very often as a result of that.

In the meantime, I began talking to the other providers and asking them if they would help me with evaluations of kids that came to me with transgender issues in regard specifically to going in and looking at the review of adverse childhood events and family dynamics that would set up depression and anxiety that needed to be evaluated, and that's the depth of what I know about.

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Many of these people say they had no specific training in transgender issues, but I said, that's not what I'm asking you to do. I'm asking you to evaluate the undercurrent pathology, emotional pathology that exists that I sense is going on based on my clinical experience with these patients, clinical literature which says that that's the issue, and that I would like to have them evaluated, and I've not had any pushback with those practitioners.

Q So you've -- with the one exception of this therapist that doesn't take a lot of insurance, the other therapists you've referred people to don't have any experience treating transgender individuals?

A I don't know. They do have experience in treating mental health in general, and this is a mental health issue.

Q Right. But for transgender individuals, they don't have any experience specifically with respect to that; is that correct?

A I do not know.

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Q And when you provide -- when you have a conversation with the therapist that you're referring them to, do you disclose that you do not provide gender-affirming care in your practice?

A I do.

Q So -- and do they -- how do they respond once you disclose that?

A They respond that they're very interested in evaluating the patient, and they will provide that service.

Q Have any therapists declined?

A I had one therapist who said that they were not comfortable with the idea of treating transgender patients; that they would prefer not to.

Q And did you have any prior knowledge whether any of these therapists provided counseling to people struggling with same-sex attraction?

A I do not.

Q Did any of the therapists that you talked to indicate in advance that they agreed with your views with respect to not providing gender-affirming therapy?

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A They respect the fact that I practice as I do, and they would evaluate the patient, and if they were unsuccessful with their endeavors would be open-minded to recommend, if necessary, other places to go to treat.

Q What do you mean by "unsuccessful with their endeavors"?

A This is a long-term process of evaluation, which is why these cases are all ongoing. This is therapy that takes a long time to work with the families and the patients to understand all the dynamics. This is experience that's been published by -- primarily by Kenneth Zucker in his extensive work with these families.

It is not an easy problem to solve. It takes a lot of attention and time. And so if at the end of -- if they're not successful with getting this child to improve their mental health, they're going to try to find somebody else who can do that for them if they're not -- if it's not working for them.

Q So success would be defined as improving

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mental health without having any gender-affirming therapy?

A I think because of the fact they know I do not provide gender-affirming therapy, that they would let me know if the issue was beyond their area of expertise and success, and they would refer to somebody else.

Q So the only therapy that they personally would be able to provide would be to address mental health issues without providing gender-affirming therapy, and if -- but they would not themselves as part of their treatment be providing any gender-affirming therapy, that wasn't an option for what they would personally be providing?

A I don't know what they provide. I just know that I refer to them to evaluate the undercurrent issues, and that's where my focus is. I think that they would rather -- well, I can't speak for what they do.

Q Did you refer these patients just for evaluation?

A Evaluation and treatment.

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Q So to provide ongoing therapy also?

A Yes.

Q And if the -- and the therapists report back to you on the state of their treatment?

A They do.

Q And for the patients, how many of the patients would you view as having improved psychologically?

A It's a process in the work. I would say two patients of those have resolved their issues successfully and moved on, and the rest are works in progress.

Q So of the 12, two you would say have successfully resolved their issues?

A Yes.

Q And how do you determine that; how do you know that they've successfully resolved their issues?

A Feedback from the therapist, and the patient's own description of how they feel, and the fact that their gender incongruence has resolved.

Q I'm sorry, are you still speaking?

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A Yes. No, no, I finished. I said that --

Q Okay.

A -- the way I know is input from the therapist, and also input from the patients themselves in terms of what they describe of no longer being -- feeling that they are born into the wrong body.

Q How old were these two patients?

A One was 15, and one was 17.

Q You referenced Kenneth Zucker; is that right?

A Yes.

Q Who is Kenneth Zucker?

A He is a Ph.D. psychologist from Toronto who established a clinic for evaluation of children with transgender issues. He coined the term "gender identity disorder." I believe he's a member of the World Professional Association of Transgender Health. He is widely published, widely respected for his opinions on evaluation and treatment with mental health -- providing mental healthcare.

Q You would view him as an expert in the

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field; is that right?
A Yes.
Q And you would view his therapy as being in accordance with proper standards of care for treating transgender youth; is that right?
A That is correct.
Q And you said he's a member of WPATH; is that right?
A I believe he is. I don't know of the status of that membership. I know he has been in the past.
Q Are you aware of Dr. Zucker's views on the appropriateness of hormone therapy for transgender youth whose dysphoria persists through adolescence?
A I believe he indicates that as an adult that those patients could be considered for therapy. If their lifelong evaluation and therapy did not bring about desistance of their gender incongruence, that hormone therapy could be appropriate.
Q I want to just make sure we're talking about terms like "adults," when we use that term. My -- so my question is people whose gender

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dysphoria persists through adolescence, not necessarily legal age of majority in a given country, is it your understanding -- what's your understanding of his views in providing hormone therapy for people whose dysphoria persists through adolescence?
MR. CORRIGAN: Object to form of the question.
Go ahead.
A My understanding is that if with consistent therapy there is persistence of gender incongruence, that those specific patients, and there are a very small percentage of them -- it might be warranted for them to be considered for hormone therapy.
BY MR. BLOCK:
Q And do you think someone providing hormone therapy to those patients is engaging in child abuse?
A If they are treating a child, I would say that that is essentially treating the patient and causing harm. Whether I specifically use the term

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"child abuse," it is known to have inappropriate long-term effects, it is not evaluating -- it's not paying attention to the core issue, it is preventing that child from being able to make it through natural puberty with their natal hormones to allow them to resolve these issues through counseling and personal experience of living in the biologic body unaltered by opposite hormone therapy.
So it is -- I would say it is inappropriate to do that.
Q So my question isn't about people who have not yet come through puberty. My question is about people whose dysphoria persist through puberty. So, for example, someone who is 16 years old and falls within that small category of people we referred to earlier about for whom Dr. Zucker thinks treatment might be appropriate, do you think it is child abuse to provide that group of teenagers with gender-affirming hormone therapy?
A So adolescence goes actually up through age 21, technically. It happens that age of majority sort of falls in the last stages of

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adolescence in this country. I would think that it's inappropriate for a patient to be treated while they are still going through puberty.
Puberty goes up in boys -- the final stages of an average travel through puberty for a boy is 18 and for a girl is 16 and a half, so the hormonal changes that are happening in the process of puberty that is physiologic continues to that point. The development of the brain, however, continues up through age 25.
So there are things that are supposed to happen as a result of going through puberty. If it is altered, if it is stopped in any way, if it is then changed with cross-sex hormones, you are throwing into the human body hormones that are incompatible with the physical biologic body, and you are creating harm.
So I would say my purview of patients as far as I can make recommendations is up through the age of consent. If they come to me after, as one patient has, I still recommend to them that they consider carefully other options and pay attention

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to other options instead of doing hormone-affirming and surgical therapy. That's my advice to them at that point in time.

Q Dr. Zucker's published research on rates of persistence and desistance of gender dysphoria among children; is that right?

A Yes, he has.

Q And what's your understanding of what his research shows about the age at which persistence is more likely than desistance?

A A persistence occurs at the end of puberty as they have finished going through puberty. Desistance occurs anywhere along the way.

Q So it's your understanding of Dr. Zucker's research that rates of desistance remain high until boys reach the age of 21 or girls reach the age of 16 or 16 and a half?

A No, there is a curve of slower amounts of desistance. The vast majority of patients who are allowed to go through natural puberty desist.

Q Yes, but for people who continue to have gender dysphoria once they start going through

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puberty, are you familiar with the rates of desistance for that group of people?

A That group of people if left alone desist. It's a smaller percentage as they get older and farther along in puberty, but blocking puberty is not an appropriate thing to do because it's not physiologic.

So the desistance rates from his published work show that there are -- as you got older and older the desistance rate lessened, but that in the group of all the patients, including those who entered puberty, that desistance was remarkably high.

Puberty is a six-and-a-half-year event for a boy and about a five-year event for a girl. Five or six years. And so that is a time spectrum during which if you say if you enter puberty, he's talking about people that have been in puberty, who have been counseled, who have not had affirmation medical therapy, that the majority of those kids desist. A small percentage do not, and his recommendation personally, based on his experience, is those would

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be patients who would be candidates potentially for hormone therapy.

Q And do you know either way about whether he thinks the age where desistance rates are no longer high comes around age 15 or so?

A That -- his opinion has changed as far as I know. His first published studies in his paper in 2012 indicated older age. I have not had a direct conversation with him but have had opportunity to know his opinions, and he is waffling a little bit on the upper end of that, saying that there are patients in late adolescence versus young adulthood. It's a matter of semantics more than anything else.

Q So but you disagree with his view that hormone therapy should be considered for transgender youth whose dysphoria persists until late adolescence; is that right?

A Yes, I do. I'm not -- he is not an endocrinologist. I am. I'm aware of the endocrine side effects and the long-term morbidity that's caused by cross-hormone therapy, and I could not recommend it for any adult.

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But I do not practice adult medicine. I'm a pediatrician. I go up through my age range up through age 21 or 22, and in no circumstance would I recommend cross-hormone therapy personally as an endocrinologist. That's my field of expertise.

Q But that's a view that Dr. Zucker does not share?

A I don't know about his background in endocrinology and why he makes that recommendation, but -- and I don't know the exact age. I know it was late adolescence because the desistance rates that he published originally and that also come up from studies in Europe show desistance is very, very high.

Q I just want a yes-or-no question that Dr. Zucker disagrees with you with respect to providing hormone therapy for people whose gender dysphoria persists until late adolescence.

MR. CORRIGAN: Object to form.

Go ahead.

A I think the term here is -- that we're wrestling with is "late adolescence," what he means

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by late adolescence, and what I mean by late adolescence, and I don't personally know now what he means by late adolescence. I knew what he published before, and I don't know what his opinion is today.

BY MR. BLOCK:

Q He thinks hormone therapy could be considered appropriate for some people, and you think hormone therapy is never appropriate for anyone; is that correct?

A Would you restate that question?

Q Yeah. So he thinks that gender-affirming hormone therapy may be medically appropriate for some people, and you think it is never medically appropriate for anyone; is that right?

A That is correct.

Q Do you consider yourself to be an expert in gender dysphoria?

A I am -- I consider myself an expert in the endocrine management of patients with gender dysphoria.

Q When do you think you became an expert?

A With experience of treating patients, with

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experience of background at Johns Hopkins. Essentially -- I consider myself as having more experience than most because of my longevity of clinical experience and training from Johns Hopkins. So it could be argued what is an expert, and I guess you can ask me specifically what you mean.

Q Well, at the time that a patient came to you in 1993 seeking treatment, did you at that time consider yourself to be an expert in treating gender dysphoria?

A I considered myself having as much clinical experience as anybody I knew, and I verified that by talking to people in the field of endocrinology across the United States and found that what I knew they knew, and we forged together forward with a treatment plan.

Q So in 1993, would you have put yourself forward to be an expert witness in a case involving the treatment of transgender individuals?

MR. CORRIGAN: Object to the form of the question.

Go ahead.

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A That was not a topic of medical treatment at that time, that was a standard of care. So as much as anybody could be defined as an expert, I would have had as much clinical experience as most people who were defined as experts at the time.

BY MR. BLOCK:

Q Wouldn't someone who had actually provided hormone therapy to someone be more qualified as an expert in 1993?

MR. CORRIGAN: Object to form.

Go ahead.

A There weren't people at that time that were in the mainstream of medicine that we know of, okay? Children were not treated with hormone therapy that anybody in the field of pediatric endocrinology was aware of at the time that I could find in this country.

BY MR. BLOCK:

Q But you had not -- at that time you hadn't treated adult transgender people with hormone therapy either; is that right?

A No, I was aware and taught extensively

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about hormone intervention of those adult patients.

Q But you hadn't treated them?

A I did not treat them specifically. I was taught about the treatment, and the case studies were reviewed as they were ongoing.

Q So your view is that once you finished your fellowship in 1980, you had sufficient qualification to be an expert in the treatment of gender dysphoria?

A No.

Q So at what point did you develop sufficient qualification to be an expert in the treatment of gender dysphoria?

A Over the past six to 10 years, since the publication of the guidelines of the Endocrine Society in 2009, specifically, I began the evaluation of the world's literature that I could find and discussions among my endocrine peers to gain as much knowledge as I possibly could, and I was aware of the number of increases in gender transition clinics that were growing and developing in the United States. I was a little bit alarmed

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about the fact that those clinics were established without anybody who had had any training of any kind in a formal curriculum, and I was worried about the quality of medicine.

I began looking at the effects of -- I already knew what we were doing in the field of endocrinology trying to prevent the side effects of opposite hormone effects on the human body as the patients developed through adolescence and young adulthood. Those are disease states for which we had standards of care to treat.

So as I began seeing that these guidelines were being implemented, I became concerned and learned more and more and more about what was going on and became then as much of an expert by evaluation of literature; discussion amongst my peers. And then I began treating patients -- these patients as they came to my office as of about three years ago.

So that is how I would say that I understand the treatment of transgender patients, the adverse effects of hormone therapy, and -- both

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short term and long term, and so that's where I would say that I would ask patients to come to see me for the specific reason because of my expertise, evaluation, and concern for those patients.

So the word "expert" is hard to nail down. I would say experienced.

Q Did you say patients came to you for a specific reason; did I hear that right?

MR. CORRIGAN: Object to form.

A They come to me because they have an issue of concern about gender incongruence. They know that I'm a endocrinologist, and that's where they're supposed to go to get evaluated to look at their stage of puberty, to find out what resources are available to them.

BY MR. BLOCK:

Q So I have the time frame right, the first Endocrine Society guidelines on treating trans kids was published in 2009; is that right?

A That's correct.

Q So you said it was about five or six years after that that you conducted the literature review

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that has made you an expert in this area; is that right?

A No, it was at that time when they were published that I became quite concerned about the recommendations being essentially 180 degrees out of the mainstream of hormone evaluation and hormone treatment effects in children, and so I began in depth at that point in time starting to review the literature and discuss among my peers.

Q Beginning around 2009?

A Yes.

Q If we can turn to your declaration in this case, Exhibit 1, to paragraph 34. If we can look at the second sentence: There has been a flurry of non-peer-reviewed articles in journals and newsletters circulated to general pediatricians that promote the ideology of transgenderism without specific support.

What non-peer-reviewed articles are you referring to?

A There are articles in what we call throwaway journals. They're called Pediatric

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Annals, Contemporary Pediatrics, Pediatric News, Endocrinology Today, these are -- Endocrinology Today is aimed at endocrinologists. But these are things that come to physicians' offices free of charge, they're also available online now instead of in the print versions. They are articles written talking about transgender health, talking only affirmation.

When they first started being published back in as early as 19 -- excuse me, 2004, there was mention up front in each of these articles about the high desistance rate in children and adolescents, and then, more recently, that has essentially disappeared.

But these are articles that when you look at the references, many times they are discussions on Good Morning America, they are references to conferences that WPATH provides teaching sessions or local conferences in geographic regions, they're not in peer-reviewed journals.

Q Is it your position that all of the articles that are supportive of gender-affirming

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therapy are published in non-peer-reviewed journals?
A No.
Q So, in fact, many of the articles are published in peer-reviewed journals; is that right?
A No, some are.
Q Are any of these articles cited in your report?
A The ones in peer-reviewed journals? Yes.
Q Yes. Which ones?
A Pediatrics, International Journal of Transgenderism, Journal of the American Academy of Child and Adolescent Psychiatry, PLoS One, Child and Adolescent Psychiatry -- excuse me, that's not a journal, that's a textbook. Those are the ones that I've cited.
Q Which is the one that you said was a textbook?
A It was Zucker's chapter, Child and Adolescent Psychiatry.
Q So is Pediatrics a journal that is viewed as a source of guidance in your field?
A Pediatrics is a peer-reviewed journal,

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yes.
Q Is it viewed as a source of guidance by practitioners in your field for --
A Yes, it is.
Q Yes?
A Yes.
Q Would you consult articles in Pediatrics as part of your review of literature for determining the standard of care?
A Yes, I would.
Q Now, when you previously discussed how you determined standards of care and you talked about conducting a broad survey, how do you decide which of the opinions in that broad survey are going to constitute the standard of care?
A I review the article thoroughly, I look at the design of research if there is research involved. If it's a summary view I look for what's recommended in terms of breadth of opinion. There are articles written that are ostensibly to cover the entire field, all aspects of it, all opinions, and come up with a sort of presentation at the end,

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what we call a balanced presentation for the reader then to make an assessment, and perhaps the writer of that particular review article would do the same.
I look at things like the Endocrine Society guidelines and the references they use, I look -- and, again, when you go to the specific references, that's a step beyond just reading the article, it's actually looking at what studies are referenced to look those up.
It's an arduous task, but on key issues, many times I will request of my local medical librarian copies of those articles so that I can see whether or not what was gleaned from that reference is actually proving the point or not.
In some cases I already know the articles, and if I find that they're at odds with what the author cites them to represent, that brings into question the quality of the article.
So the design of the research, and then the number of references and where they come from allows me to make a personal opinion on -- and then I discuss that amongst my endocrine -- pediatric

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endocrine peers to find out what they feel and how they approach things, and we go from there.
Q When you were conducting your research regarding treating gender dysphoria, was anyone -- were you receiving any payment from any source while conducting that research?
A No.
Q No?
A "No" is the answer, yeah.
Q So tell me if I am mischaracterizing this, but my understanding from your earlier testimony is you had said that standards of care means the most generally accepted way of treating. Is that something that you believe?
MR. CORRIGAN: Object to form.
Go ahead.
A Standards of care are somewhat fluid in that sometimes they are published, sometimes they are not, sometimes they are in development and changed with new developments that come along, so they are essentially a consensus across the board of practitioners. Often they are guided by a

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professional organization, hopefully with a balanced approach so that the guidelines that they develop to become or be considered standards of care represents all aspects of the subject thoroughly reviewed and brought to the table for consideration.

BY MR. BLOCK:

Q And is it your understanding that standards of care are always supported by 30-year long-term research studies?

A They are a combination of longstanding review of literature, clinical research studies in the past, and then new studies that have -- that might be on the forefront of the issue.

Q So are there any standards of care representing the general consensus of practitioners that are not supported by long-term studies?

A Yes, the Endocrine Society guidelines are not supported by any long-term studies of quality.

Q So I'm talking about -- by "Endocrine Society guidelines" are you referring to guidelines regarding treatment of transgender people or in general Endocrine Society guidelines for other

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conditions as well?

A The ones that I pay attention to are those that are published that are germane to children, and it just so happens having spent a lot of time looking specifically at the transgender guidelines I found, with critical review, that there was very little scientific basis for the recommendation.

I have not done the same thing in depth with every single one of the Endocrine Society guidelines because many of them deal with patient populations that are adult and disease states that are in adults that do not pertain specifically to children.

So in things like treatment of type 1 diabetes and those types of things, those guidelines, again, are graded, and they generally are based on good scientific evidence.

Q Sitting here today, you don't -- you don't know whether the quality of research supporting the Endocrine Society guidelines for gender dysphoria is of higher or lower quality than the research of the Endocrine Society guidelines for other conditions?

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A In the guidelines that I have read, these guidelines have very low scientific evidence compared to the others that I reviewed.

Q Which others have you reviewed?

A Treatment of hypercortisolism, treatment of thyroid disease in the perinatal period. Those are some that come to the forefront in recent times. Treatment of disorders of sexual differentiation is another one.

Q Treatment disorders of sexual differentiation guidelines are supported by long-term research?

A Yes, they are.

Q And I asked a question asking about standards of care, and you answered talking about the Endocrine Society guidelines, so I want to get an answer to my question about standards of care.

So my question is: Is it your understanding that the standard of care with respect to a particular issue is always supported by long-term research?

MR. CORRIGAN: Object to form.

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Go ahead.

A It should be.

BY MR. BLOCK:

Q But is it?

A No.

Q Why not?

A I would only be conjecturing as to why not.

Q And yet a particular treatment might represent the consensus of practitioners among a field even if it is not supported by long-term research; is that right?

A It's a consensus of some individuals in the field, not all individuals in the field.

Q But I'm talking about consensus for purposes of standard of care.

A I can't answer that. The standards of care is a term that gets applied to things that are published.

I am not -- my experience with standards of care previously was in dealing with medical malpractice and what the standard of care was in

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terms of the disease state and the applied treatment and whether or not it met that standard or if it was outside the standard of care, and if it was, were there extenuating circumstances as to why it was.

The standards of care from WPATH are published as standards of care by that organization, and they call them standards of care, they don't call them guidelines. It's SOC. And so it's basically use of the language to promote that as a pathway for treatment by that organization.

Q What, in your view, is the accepted standard of care for treating gender dysphoria in adolescence?

A Accepted standards of care that has been proven effective are -- well, my standard of care, which is based on what has been proven to be effective in allowing desistance to occur, is that in-depth counseling be the predominant feature of treatment, and that hormone manipulation is not.

Q I'm not asking about your standard of care, I'm asking for what are the consensus standards of care for treating gender dysphoria in

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adolescence?

MR. CORRIGAN: Object to form.

Go ahead.

A All I know is my conversations with my endocrine peers is that they are alarmed by what has been reported as a standard of care by WPATH. I would say that the majority of endocrinologists I talk to do not understand the guidelines or why they are recommended. They are labeled as standard of care by an organization that calls them a standard of care, and that's what they are, they are recommendations.

BY MR. BLOCK:

Q Is there any written material or sources that you think do represent the consensus standards of care among practitioners for treating gender dysphoria in adolescence?

A No, they are being developed.

Q By whom?

A Endocrinologists and mental healthcare providers.

Q What do you mean by "being developed"; they're being written down?

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A They're being developed, they're being put together. Conversations are happening, groups are getting together who are concerned about WPATH recommendations, about the Endocrine Society recommendations, and they're asking for a dialogue so that everyone can basically come to the table and open up a discussion instead of having it be dictated from one side of the equation.

Q What organization are they having these discussions in?

A It's nothing organized specifically. It's a number of individuals who are concerned across the country who are representatives from their field of interest. We talked about it at length at the Southern Pediatric Endocrine Society at that meeting. Many, many concerned folks. Probably 75 percent of the people expressed significant concern about the WPATH guidelines and wondered what should or could be done to essentially come back to the table and redevelop guidelines that took into account the entire complexity of the issue.

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Q Come back to the table and redevelop guidelines in the Endocrine Society or through a different organization?

A Well, this is the Southern Pediatric Endocrine Society, so that's not -- that's its own loose organization that represents pediatric endocrinologists in the southeastern United States, so cannot speak to the other subgroups.

The Pediatric Endocrine Society has a special interest group in transgender health, and it was our hope that at the annual meeting next month in Baltimore that we could come together and have a discussion with individuals in that special interest group about our concerns.

It turns out that the special interest group for transgender medicine is not meeting at the Pediatric Endocrine national meeting in Baltimore. There will be a session on disorders of sexual differentiation, which I intend to attend.

Q So as far as you're aware, there are no written drafts of any guidelines from a medical organization that you think represents a consensus

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standards of care for treating gender dysphoria in adolescence?

A There are no written guidelines that is a consensus of the broad spectrum of endocrinologists across this country. There are guidelines written by a special interest group, but not by the majority of endocrinologists across the country.

Q Do you provide treatment for precocious puberty in your practice?

A I do.

Q To delay puberty -- you do. Sorry.

And are there long-term studies on the long-term effects of providing treatment for precocious puberty?

A The treatment for precocious puberty is usually short lived. It's on an average about a year and a half to two years. It is rarely longer than that.

Because of that, there are studies now of 18 years of experience, in particular with Depot Lupron, that look at the effectiveness of treatment, the restarting of puberty naturally, the fertility

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of those individuals who have been treated, any general health issues that happened, and in that young child group -- age group who were not of the age of puberty but are starting puberty, there appears to be benefit socially in terms of, particularly in females, of avoiding menstruation in the very early primary grades, also preserving adult height to some extent. And those are the two goals for which we use that interruption of therapy.

But it is not approved or recommended for long-term use, and it is not approved or recommended for the age of adolescence when calcium bone accretion occurs, and when brain development is very dependent upon the presence of those hormones as the body physiologically goes through puberty.

Q Are there long-term studies on the safety of the treatment, though, the negative health effects?

A There are long-term studies in adults because the GnRH agonists, as they are called, that's gonadotropin-releasing hormone agonists, were used extensively and for longer periods of time in

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adults with hormone-dependent tumors, prostate cancer in males, and estrogen-dependent tumors in females, and there are evidently mental health issues that have surfaced in the long term that are now being recognized and evaluated by the companies that developed those therapies. We do not have any long-term experience in children because the therapy is not used for long term.

Q Going back to paragraph 35 of your declaration, you say -- sorry, yeah, 35, about seven or eight sentences in, the sentence begins with "The response to these guidelines." It says: The response to these guidelines was the burgeoning of gender identity clinics in the United States from three to over 45 in a period of seven years.

Do you see where I'm reading from?

A I do.

Q So is your opinion that the Endocrine Society guidelines led to more gender identity clinics?

A Yes.

Q So these hospitals with these clinics all

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followed the Endocrine Society guidelines; is that right?

A These clinics decided that they needed to have gender identity clinics to treat patients who would be coming into their practices. I do not know why each of the individual clinics developed, because I am not a part of those clinics, I don't know what administrative decisions were made. It is just an interesting phenomenon that once the guidelines were published that there was literally this very rapid increase in the number of centers treating children.

Q And these centers treat the children in accordance with the Endocrine Society guidelines; is that right?

A I do not know each individual center, I just know a few of the centers where I've had a chance to have a dialogue with the clinic directors. And in the case of the clinic in Cincinnati, I was told that 100 percent of patients were affirmed. I have tried to find out as best I can just by asking people directly the percentage of patients that are

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affirmed and those that are sent through counseling, and I am not given a clear answer, but I have the sense that the patients go in the door, and they're affirmed.

Q By "affirmed" you mean provided hormone therapy, cross-sex hormone therapy?

A Initially they are affirmed with counseling to the family to allow the patient to live in the role they wish to assume, trying to get the family to adjust to that and accept that, and then to work with the school systems to be sure that the child is called by the pronouns they wish to be called and the name that they wish to be called by, and then when they -- they show the first signs of puberty to have puberty blocked, and then at some point in time after that, now as young as age 13 or 14, to receive cross-sex hormones, to have mastectomies if they are a female wishing to trans to a male identity, and then to wait, at least so far in this country, to age 18 before they have any additional surgical procedures done.

Q And these gender identity clinics are all

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over the country; is that right?

A That is correct.

Q How many patients would you estimate they're treating?

A I only have anecdotal evidence that in the state of New York that there is 700 patients per year. I don't know if it's a single clinic or a multiplicity of clinics in a healthcare system.

I know that in the local system here in Atlanta, that in 2016 they had 45 patients in that calendar year that were maintained as patients. In 2017 that number increased to around 80. The data for 2018 has yet to be published.

Those data I happen to know because it's part of the U.S. News and World Report grading system that if you have a transgender clinic that's active, you get higher point scores on your area of excellence in providing children's healthcare. So that I know at least for our local healthcare system is a strong motivation for them to maintain a transgender clinic is because they get recognition nationally as being a center of excellence at a

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higher level the higher the points that they garner.

Q So -- but you know what the numbers are for the upcoming year?

A I do not.

Q You do not.

At the Southern Pediatric Endocrine meeting that you were at, were there these gender identity clinics at any of the states where the meeting participants came from?

A Yes.

Q About how many?

A I knew specifically of two in Florida, one in Virginia, I knew of the Emory clinic as well, was not -- there's a clinic -- a gender identity clinic in South Carolina. There were no members from that organization or that state at the meeting, as it turned out. I don't specifically know about Kentucky. Mississippi I'm not aware of. Alabama has a gender identity clinic in Birmingham, although the person that is in charge of that clinic, who I know personally, was not in attendance at the meeting.

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Q You personally know the person in charge of the clinic in Alabama, is that what you said?

A Yes. I personally know the two in Florida, I do not personally know the person that runs the clinic in Virginia, I do personally know the person that runs the clinic in South Carolina, don't know who runs it in Mississippi, and that's -- those are people I know personally.

Q So the people that you know personally who run these clinics, do you think they are practitioners of child abuse?

A I think they are misguided in terms of recommending hormone therapy. The term "child abuse" is a flashy term in my worldview to catch attention. I would say that my concern for these individuals is that there are going to be adverse outcomes in their patient population because of what they recommend and what they -- how they are treating, and I don't think that they are necessarily paying attention to the broader literature, which says that that treatment is harmful more than it is beneficial. They are very

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much drawn to the Endocrine Society guidelines because they are convenient, and they themselves have no personal experience.

Q Do you consider them just in their -- as practitioners to be unqualified as -- in general as pediatric endocrinologists?

A Not at all.

Q You consider them to be conscientious practitioners?

A I do.

Q And you think that they are acting in what they believe is the best interest of their patients?

A I think that they are practicing in what they do believe is the best interest, but I also believe they are not informed. And when they have a chance -- when I have a chance to talk with many of them, they -- they are kind of taken aback by the fact that there is so much evidence that shows what the Endocrine Society guidelines recommend is contrary to the long-term health of the patient.

They had not considered that. It was not presented to them. They trusted the Endocrine

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Society to be the voice of reason and assumed that all this information had already been reviewed and came out with a predominantly positive outcome, and they are, a lot of them, quite astonished.

Q Is it your opinion that the Endocrine Society guidelines do not discuss adverse health effects?

A They discuss them in three of the recommendations in the first iteration, and four in the second iteration, the 2017. They are the only scientifically valid graded recommendations that carry literature with them, and all of them say that there is concern that there are no long-term studies of the long-term effects, that they are aware of, of the hormone -- cross-hormone therapy and puberty blocking, and that there must be studies designed to assess that before they can -- they would assess as being safe and sound. Despite those statements, they recommend that the treatment be done.

Q If we look at paragraph 45 of your declaration --

MR. CORRIGAN: It ends at 41.

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A Mine ends at 41.

BY MR. BLOCK:

Q That's what I meant, 41. Apologies. The second sentence in paragraph 41 says: Allowing a biologic female to use the male-designated bathroom facility is one of several, quote, gender affirming, unquote, care options, but it is creating harm to at least two parties. The harm to the gender incongruent person is that it promotes a pathway to inevitable long-term medical and psychological morbidity.

And that's what you think, right; that's your view?

A That is my opinion.

Q All right. So what if the student has already completed puberty, has had surgery, and is taking hormones, is that harm still present?

A The harm has been done.

Q So what additional harm is inflicted by allowing that student to at that point use restrooms consistent with their gender identity?

A Well, you are adding to the long-term

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psychological morbidity of that patient, which is proven to happen in the long-term studies of adults who have lived 20 to 30 years in a transgendered identity situation. Their mental health issues are still quite high.

So if you -- your -- anything you do that keeps the patient away from the therapy that they need -- and all of these patients -- and Dr. Zucker recommends exactly the same, despite whether or not they are given hormone therapy, they are never emotionally well, and they need long-term mental health.

So if you add something that is -- we're talking about -- in the case of the school system, we're talking about kids that would not have had surgery yet. So we're talking about kids that might have had cross-hormone therapy and been socially transitioned. At that point in time you are adding affirmation that that is a beneficial -- proven beneficial event to allow them to have a presence in the bathroom of the opposite of their biologic sex.

And there are no studies that say that

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that is true; there are no studies that say that that is not true. There are no studies in existence.

Q So you think -- in terms of adults you think that affirming an adult transgender person's gender identity is harmful to their health?

A I do.

Q Are there any long-term studies on the mental health outcomes of people who identify as being formerly transgender?

A No, they are beginning to develop at this point in time. They have not been available on those who have desisted subsequent to medical and surgical because these patients are just now beginning to come out to the forefront. A, it is the age with which they approach this, they have been transgendered long enough to recognize and to have the strength to return back to their biologic sexual identity and are now beginning to speak out, write, publish, gather like-minded people together so that they can publish their clinical experience.

But this is a brand-new group. This is

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where -- this is the end point of people who did -- had these things only as adults, not as children, back as far as 30 years ago.

Q So but -- so there are published studies saying that even after receiving treatment, the population of transgender people may have, as a whole, poorer health outcomes than the population of non-transgender people, right? Those are the studies you were referring to previously; is that right?

A That's correct.

Q But there are no studies on assessing what their mental health outcomes would have been without the gender-affirming care, right?

A No.

Q So what you're saying -- "no" means there are no long-term studies, correct?

A There are no long-term reputable studies. There are long-term things that are published, but they are laced with -- as essentially a Cochrane review of those -- all those studies shows that the study design is extremely poor, that it is -- it's a

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preselected population, does not represent 100 percent.

The only study that's published that has 100 percent of participants evaluated at the end is the Swedish study, which is condemned outright because it says what it says. There is incredible amount of increase in mental health morbidity as a result of medical and surgical transitioning. It's the only study that had 100 percent of participants.

Q Sorry. That's your understanding of what the Swedish study says, that as a result of receiving care affirming their identity, the mental outcomes are worse as a result of receiving that treatment?

A It compares it to no one, unfortunately. That's the one downside to that is it did not have a control group of those who did not receive medical and surgical care. It was a review of 100 percent of the patients.

So it's called into question without a control group to say that you're comparing itself to itself, but the statistics are there that there's a

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19-fold increase in completed suicides compared to the general Swedish population.

Q So but there are -- so for the type of treatment that you are recommending of just having counseling for underlying health issues, there is no scientifically valid study saying that those health outcomes are better than what the health outcomes would be if the same patient received gender-affirming care?

A That's absolutely correct. We have one study which is all affirmation which is Zucker's, and we have the one study all surgical and medical from Sweden, okay. We know Zucker reported all of his patients, not just some of his patients. Sweden reported all of their patients, not just some. What has not been done is a longitudinal study of side-by-side groups randomized to an arm of counseling only versus affirmation with counseling, medical treatment, and surgery.

No such study exists or has been designed. There needs to be that study, and until that study is completed and the results are evaluated 20 to 30

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years post treatment, post beginning of treatment, we will not be able to say without question that one is better than the other in terms of long-term outcome.

What we do -- what we do know is that there are so many adverse side effects of the medical and surgical side that creates medical morbidity that would not otherwise exist that the logical assumption is we are creating a disease state by intervening that way, we are creating mentally healthy individuals by doing the affirmation pathway, and what we need to do is have an unbiased study that looks side-by-side, and no study exists.

Q If that study were conducted and the evidence in that study showed that the mental health outcomes for people receiving affirming -- gender-affirming care were better, would you then provide gender-affirming hormones in your medical practice?

A I would -- there are two issues here: There's the mental health which is very important,

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and there's the medical health in terms of side effects. So I would have to have -- be shown that the medical side effects and the mental health effects were predominantly beneficial and the downside and adverse effects on both sides were minimal before I would recommend that.

Q So but if the evidence did show that, then you would personally provide gender-affirming hormone therapy?

A I probably wouldn't because I wouldn't be practicing medicine at that time, I probably would not be alive, so it's a theoretical question.

Q Yeah, but so asking a theoretical question, let's say the study came out tomorrow, would you in that situation personally provide gender-affirming hormone therapy, or are there other reasons why you may still not provide it?

MR. CORRIGAN: Object to form of the question.

Go ahead.

A Yeah, if the medical and mental health issues were better in the affirmed pathway, I

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would -- I would likely change my mind.

BY MR. BLOCK:

Q Let's look at the paragraph 41 again. Near to the bottom it says: The second party harmed is the student without gender incongruence who must suffer emotionally while being told they must tolerate the presence of an opposite sex individual in a sexually segregated space and embrace the regulation which gives the gender incongruent person special privileges as if it were based on civil rights founded on immutable biology.

Did I read that right?

A Yes.

MR. CORRIGAN: Let me -- can I interrupt for a second?

MR. BLOCK: Yeah.

MR. CORRIGAN: He's not going to offer that opinion. I can tell you that in this case he's not going to offer that opinion. I know it's in his thing, and you can ask him about it, but he's not going to offer that opinion at trial.

MR. BLOCK: Okay.

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BY MR. BLOCK:

Q I'd still like to ask you a few questions. So the harm that you're talking about there is not harm limited to the possibility of exposure to nudity; is that right?

A It is primarily harm due to exposure to nudity, and that is just a general survey of asking any adolescent males and females in a social discussion, how would you feel if a naked person of the opposite sex entered your locker room naked and while you were naked? Would that bring you a zone of comfort, would you grade it as neither one way or the other or fantastically wonderful, can't wait until it happens, or I wouldn't want that to happen? And it's pretty much universal, I wouldn't want that to happen.

That's just a nonscientific study. There is no -- I am not aware -- I would just assume that the standards that we have set up legally in sexually segregated spaces is there for a reason for privacy. And whoever has done any sociologic studies of that -- we could go back. I am not aware

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of those studies. At this point in time it has been essentially what I would refer to as common sense.

Q So but talking about a restroom in particular, not someone walking in naked into a locker room, talking specifically about a restroom, is it your opinion that there is harm to a non-transgender person in having to tolerate the presence of a transgender person in the restroom even if there is no exposure to nudity?

A I have -- I'm not aware of any study that says that. Outside of a courtroom if you ask my opinion, exposure to -- if you're in a restroom standing in front of a urinal and you have your pants down around your ankles, and you've inserted a device through which you can direct urine from your vagina into the urinal, I think that would probably cause some people to take notice, but there's no study. I'm not aware of any study.

Q How about if someone uses a stall?

A What happens in a stall if it's got floor-to-ceiling --

MR. CORRIGAN: Object to form.

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Go ahead.

A If it's in privacy, I can't tell you.

BY MR. BLOCK:

Q So in that situation there would be no harm to the non-transgender student?

MR. CORRIGAN: Object to form.

A I cannot say that.

BY MR. BLOCK:

Q So you don't know whether it would be harmful?

A I do not know whether it would be harmful.

Q You say special privileges, as if they were based on a civil right founded on immutable biology. Do you think that civil rights should be based only on immutable biology?

MR. CORRIGAN: Object to form, legal conclusion.

Go ahead.

A So I think in terms of things like religious faith, that is something that is not immutable biology, and I think that intolerance of religious faith becomes an issue of the right of

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expression and -- personal right of expression.

I don't feel that something that is furthering a detrimental mental health issue is a civil right, especially when it is advertised as if it is immutable biology and it's based on that that we can treat that person as if that were a biologic race or a biologic sex, which it is not.

BY MR. BLOCK:

Q Do you have a medical basis for an opinion on what traits should be protected by civil rights laws and which ones shouldn't?

MR. CORRIGAN: Object to the form. That's why he's not giving the opinion.

Go ahead.

A Yeah, I mean, my personal opinion here in this deposition is I would think that race and gender -- and biologic sex are immutable and should be considered to allow people to have specific rights or not be denied rights.

BY MR. BLOCK:

Q So if the person using the boys' restroom is a transgender teenage girl who has been having

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affirming hormone therapy since before -- had puberty blockers and affirming therapy and has fully developed breasts, do you think that it is harmful to the non-transgender boy to tolerate the presence of her in the restroom?

MR. CORRIGAN: Object to form.

Go ahead.

A I cannot say that that person would be harmed. It depends on the individual.

BY MR. BLOCK:

Q So what about the -- what about the transgender girl who has been receiving affirming hormone therapy, is changing in the school locker room, do you think that's harmful to the non-transgender boys in the locker room with her?

MR. CORRIGAN: Object to form. We're not here to talk about locker rooms. He'll answer the question.

Go ahead.

A I would personally assume that there would be a level of discomfort of having opposite sex nudity in the same locker room.

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BY MR. BLOCK:
Q But their chromosomal sex is the same, so if the opposite sex nudity is solely as a result of hormone therapy, then is your answer the same?
MR. CORRIGAN: Same objection.
Go ahead.
A Yes, it would be.
BY MR. BLOCK:
Q So what -- so it would be -- it would be better -- just to clarify that question and answer, so it would be uncomfortable for a non-transgender boy to be in a locker room with a transgender girl, meaning someone who is assigned male at birth but has fully developed breasts as a result of hormone therapy?
A That would be --
MR. CORRIGAN: Object to form.
Go ahead.
A That would be uncomfortable in my opinion.
BY MR. BLOCK:
Q And do you have an opinion on whether it would be harmful?

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A I cannot opine on that. I think there would be uncomfortableness. I don't -- it depends on the individual.
I would imagine in the scheme of things for a biologic male who has very large breasts that have been induced by hormone therapy, that that would cause people to notice, comment, to not be comfortable, to try to figure out what's going on, and that they might think that they would -- they definitely would be uncomfortable. I don't know if it causes mental harm. I'm not a mental health practitioner.
Q Do you have a medical opinion on whether that transgender girl with breasts who was assigned male sex at birth should be using the boys' locker room or a separate facility by herself?
MR. CORRIGAN: Object to form.
Go ahead.
A I think that for the sake of all parties that there needs to be a private space for that person to disrobe where they are comfortable in a private space and other people are comfortable in

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their private space. So a gender-neutral changing space, if you will.
BY MR. BLOCK:
Q But the person who has to use that space would be the transgender girl, not the non-transgender boys; is that right?
A It would be available for anybody.
Q And it would be better if she used that separate facility?
MR. CORRIGAN: Object to form.
Go ahead.
A It would be better if she used that facility because of privacy of other individuals. There are also biologic males who feel very self-conscious about their physical appearance who would like to have a gender-neutral space where they are completely private where they don't have to disrobe in front of anybody of either sex because of how they feel about themselves. Adolescent boys who have a small amount of breast development are very, very sensitive about that and often very embarrassed, and if they were -- if the school would

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provide a neutral space for that person to disrobe, shower, and redress, there would be benefit to both parties.
BY MR. BLOCK:
Q How about the presence of a non-transgender boy who is gay in the male locker room --
MR. CORRIGAN: Object to form.
BY MR. BLOCK:
Q -- would that create harm to other boys who have to tolerate his presence?
MR. CORRIGAN: We're far afield from the designation.
Go ahead.
A No, I don't see that would. If that gay boy were uncomfortable, I would like to have that gay boy have a place to go where he is comfortable. So if there were a private space for him to disrobe, shower, and dress, that should be made available.
BY MR. BLOCK:
Q But if he prefers to shower and disrobe in the same locker room that everyone else showers and

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disrobe, you don't have any opinion that he shouldn't be allowed to do that?

MR. CORRIGAN: Object to form.

A There should be no reason why he should not be able to. He should be able to use that male locker facility.

MR. BLOCK: This is an okay place for me to take a break if it's okay with you. I can also keep going if that's what you prefer.

MR. CORRIGAN: I'm always up for a break. Any ideas on how long we'll be doing this?

MR. BLOCK: A couple hours.

MR. CORRIGAN: Okay. We'll take a break.

MR. BLOCK: Sorry, what?

MR. CORRIGAN: We'll take a break.

MR. BLOCK: Okay. So how about see you at 10 minutes?

MR. CORRIGAN: Sure. Are you going to have lunch, or what are you going to do about that?

MR. BLOCK: We'll have a longer break for lunch then, so come back at 1:30.

MR. CORRIGAN: That's fine. That should

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be fine.

(Recess 1:02-1:39 p.m.)

BY MR. BLOCK:

Q Good afternoon, Dr. Van Meter.

You're a fellow with the American College of Pediatricians; is that right?

A Yes.

Q And you've been a fellow since 2007, correct?

A That is correct.

Q Did you have any role at the American College of Pediatricians before 2007?

A No.

Q How did you first come into contact with the American College of Pediatricians?

A The inaugural president was a personal friend of mine. He encouraged me to join the organization because it had very specific benefits for children's health that were somewhat different and more appropriate than the other major pediatric professional organization, the American Academy of Pediatrics.

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Q Did he identify any particular recommendations or positions that were more appropriate than the recommendations of the American Academy of Pediatrics?

A Well, the American Academy of Pediatrics, I was a member during my residency and joined in 1976, was very active in local chapters, I was a chapter chairman for the Uniformed Services West, was the legislative committee director for the Georgia chapter. I am still a member of the Georgia chapter of the AAP because an awful lot of what they do has a lot of benefit for children and also looks after the ability for pediatricians to be able to practice quality medicine.

Q So what made him think that you had a need for looking at an organization with different policy recommendations?

A The American College guidelines on a number of subjects are essentially based on what is purely the published science, and it's devoid of political flavor. It basically says we're going to be taking care of the needs of children, not the

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wants of the adults. The American Academy had been leaning toward paying more attention to the wants of the adults in a number of areas.

I put together in 1994-1995, I believe, what I sort of thought of as a children's Bill of Rights for healthcare for the state of Georgia, and we passed it through the House and the Senate chambers in the Georgia legislature but not in the same year because of the way the legislature ran, and we were unable to get both houses to approve of it and get it to the Governor's desk for signature. We brought that document from Georgia to the national AAP, where it was essentially devoured by politics and thrown away.

And that was the beginning of my sense that the American Academy of Pediatrics and its very small executive group of district chairmen was not speaking for pediatricians, and certainly not speaking in some very important areas about the welfare of kids.

So Joe Zanga knew that. Joe Zanga was actually the president of the American Academy of

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Pediatrics at the time that that resolution came to the floor and was shouted down, and he just was flabbergasted.

And I think that he knew how I felt about that, so he asked me if I wanted to consider joining another professional organization that was going to be free from the political needs of the adults in the room and essentially took care of the biologically and scientifically proven needs of children, and that's basically the motto of the American College of Pediatricians is "Best for Children," and that's -- everything we do is through that filter.

Q So after 2007, were there any specific policies of the American Academy of Pediatrics that you disagreed with?

A There were issues of demeaning the value of heterosexual parents adopting children versus same-sex parents adopting children. They came out with a policy statement which was really, really unfortunately very poorly written and very badly documented in the technical support documents which

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favored -- at least favored, if not suggested, that same-sex parenting was probably more beneficial than heterosexual biologic parenting, and certainly more than heterosexual families adopting children. That was -- that was a statement that was very hard to justify because it wasn't based on science.

So that was one issue, but that actually happened before I even joined the College. I was still -- I had a bad feeling about the American Academy based on their rejection of our children's Bill of Rights, which had broad political spectrum support from both sides of the political aisle, which was trashed.

And I thought knowing how the -- how those things happen, how policies are made and how little of the membership has input -- at no time as a general member was I asked to give any input or review policy statements that were being adopted by the American Academy of Pediatrics.

They specifically condemned circumcision, and then they turned around and then reapproved circumcision, then they approved genital mutilation

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of females, and then they quickly withdrew that, and they were just following the political winds. That's not good for any professional organization to do flip-flops and make policy statements that are embarrassing and clearly not based on science.

So that's why I finally relinquished my membership in the American Academy. I held on as long as I could to the national organization. The Georgia chapter has its own unique ability to help kids in Georgia deal with Medicaid issues and access to care, things that are near and dear to all of our hearts here as practitioners in the state of Georgia. They're very effective, and they are highly respected in our legislature, so I've maintained my membership with them.

Q So you've been on the board of directors since 2008, right?

A Yes.

Q When did you become vice president?

A Two and a half years ago.

Q And when did you become president?

A It was earlier than anticipated because we

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restructured and developed the position of executive director, and the current president was elevated to that position as a paid employee, and so as vice president, I assumed the presidency on the 1st of July of 2018.

Q When was the American College of Pediatricians formed?

A I believe it was 2002.

Q Why did it form?

A Dr. Zanga was very upset about the issue before the recommendation in regard to the condemning or belittling the benefits of heterosexual parenting, which sociologic research had shown was solid and beneficial to children. The Academy refused to recognize that, and so that was the turning point for, I guess, a nucleus of people who decided that they wanted an organization that actually, again, forgot the needs and political wants of adults and looked after what is best for children.

Q By belittling heterosexual parenting, you mean that the American Academy of Pediatrics said

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that parenting by same-sex couples is not harmful to children?

A No, that's not -- they said that, but they also essentially inferred that it was possibly better than for heterosexual parenting. That's just stepping across the line without any scientific evidence at all.

What it did is it forced individuals to critically go back through, and there was one particular individual who went through every single reference on the technical support paper for that and found it completely full of holes, misrepresenting science.

And, again, it was an agenda that seemed to be pushed through by a very small nucleus of individuals, perhaps 35 people at that time were speaking for 60,000 members who were in the American Academy of Pediatrics at the time as members. And I was one at that time, and I never -- I never saw anything published, it wasn't placed in any place for review or discussion, it just happened, and so that's -- that was the turning point.

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Q Did Dr. Zanga believe that same-sex couples should be allowed to legally adopt?

A Yes.

Q He did believe it should be legal?

A Yes.

Q Isn't it true that the American College of Pediatricians filed a legal brief supporting Florida's law prohibiting same-sex couples from adopting?

A The problem is that there is subsequent research that has been out that's -- that shows that there are detrimental effects of that, and that if there is a detrimental effect it should be explained and not accepted as a -- an unharmful beneficial thing when there is actual harm that happens.

So if there is a circumstance where there is no other place for a child to go and circumstances are that -- are as such that a same-sex couple can adopt a child, but do not advertise it as equal to or better than a heterosexual couple.

Q Did the American College of Pediatricians take a position defending a Florida law that prohibited same-sex couples from adopting under any circumstance?

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MR. CORRIGAN: Let me interject here. Why are we talking about this? How does this have anything whatsoever to do with our case?

MR. BLOCK: He's the president of this organization.

MR. CORRIGAN: But what does that have to do with anything? I don't see how -- we're here talking about transgender individuals, and we're talking about restroom use, and that's what our case is about, and this talking about whether or not the organization that he's the president of filed a brief in a case dealing with whether same-sex couples can adopt children has nothing to do with that.

I think -- I think we're wasting time, I don't think there's anything related to the case, it has nothing to do with anything in his report, there's just no basis for it, Josh. And if you have some basis for it, then please tell me.

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MR. BLOCK: He's saying that this organization has standards of care for treating people with gender dysphoria that are better than the American Academy of Pediatrics, they use this as a reputable organization, more reputable than the American Academy of Pediatrics. This is completely fair game.

MR. CORRIGAN: But those things have nothing to do with each other.

MR. BLOCK: David, if you want to -- this is totally fair game. I'm going to be asking these questions. You can object to their relevance.

MR. CORRIGAN: I think this deposition is going off track to talk about things unrelated to this case for a purpose having nothing to do with this case, and I don't want that to happen, I don't think it should happen. I don't think -- this would not be legitimate cross-examination at trial. There's zero chance a judge would say, let's talk about the position of the American College on whether or not same-sex couples can adopt. I just can't imagine that's admissible testimony or ever

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could be in this case.
MR. BLOCK: It goes to bias, and we're allowed to develop a record on that.
MR. CORRIGAN: But what is the bias that it goes to?
MR. BLOCK: Well, why don't you wait until we finish asking questions about their positions, and I think it will be shown.
MR. CORRIGAN: If you want to get to questions that have anything to do with our case and bias, that's fine. I don't think this bias has anything to do with bias in our case.
So -- so let's make sure we're clear because I'm -- at some point I'm going to instruct him not to answer, and we're going to have to take it to the judge, so you may want to be really careful about how long you spend on things having nothing to do with our case because I'm not going to sit here and just have this deposition be about thing that are unrelated to our case. I've been very patient, and now you're crossing over.
BY MR. BLOCK:

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Q So is it true that Joseph Zanga characterized -- is it true that Zanga described the organization as one with the Judeo-Christian traditional values?
A That might be his opinion. There is nothing in its charter that is based on any tenet of religious faith. No particular faith is required for membership. That is not a question that is asked afore of members as they apply. The membership criteria is Board-certification in pediatrics. It does not require that you be a person of faith of any strife or person without any particular religious faith, any political strife, without any sexual orientation, without -- there is no -- that's not part of what makes up the organization.
Q Let's go to Exhibit 4.
(Off-the-record discussion.)
(Exhibit 4 was marked for identification and is attached to the transcript.)
BY MR. BLOCK:
Q Do you have that document in front of you?

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A I do.
Q Do you recognize what this document is?
A It is, I believe, from the website, College website.
Q It's on the part of the website that says About Us; is that right?
A That's correct.
Q Would you turn to -- go down to Core Values of the College. You see that. Yes?
A Yes.
Q Number 2 says: Recognizes that good medical science cannot exist in a moral vacuum.
What does -- what do you mean by that?
A It means that ethics play an incredible role in the practice of medicine and the application of science to medicine.
Q So when it says that science cannot exist in a moral vacuum, is the Academy -- the College's position on care for transgender people based on a moral principle?
A It's based on a scientific principle. It's based on an ethical principle to do no harm,

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yes.
Q So what -- just if you can explain the relationship between science and the moral principles. How -- are there ever situations where the two come into conflict?
A Well, I think that there is an issue here in terms of transgenderism of not paying attention or avoiding the reality of solid science to promote a social agenda, and that is -- there is harm as a result of that, and that's not -- that's objectionable in terms of a moral precept.
Q But what is the moral background that science is located in when you say "can't exist in a moral vacuum"?
A If you do not pay attention to concepts of ethics you will likely do harm to your patients, and that's to be avoided.
Q If you turn the page -- so the bottom of this page says history. If you turn the page it appears under history where it says -- if you look to the third line down, third sentence, it says: The College bases its policies and positions upon

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scientific truths within a framework of ethical absolutes.

What ethical absolutes does this refer to?

A This refers to sort of the Hippocratic oath, if you will, again keeping to the basic principles we all swear to when we accept our medical degree of doing no harm to patients, not ending life, the Hippocratic principles, but overall, above all do no harm.

Q Let's look at -- so this'll be -- this is Exhibit 5.

(Exhibit 5 was marked for identification and is attached to the transcript.)

BY MR. BLOCK:

Q Do you recognize this document?

A I do.

Q Sorry, do you have the document in front of you?

A I do.

Q Okay. Do you recognize this document?

A I do.

Q Okay. The title of the document is Gender

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Ideology Harms Children, correct?

A That is correct.

Q And if you turn the page, there are -- there's three authors it's attributed to, and one of them is you; is that correct?

A That's correct.

Q So at the very beginning of the document it says: The American College of Pediatricians urges healthcare professionals, educators, and legislators to reject all policies that condition children to accept as normal a life of chemical and surgical impersonation of the opposite sex.

Did I read that right?

A Yes, you did.

Q So according to this document, schools shouldn't be sending a message that gender transition is normal, right?

A That is correct.

Q And schools should be discouraging students from transitioning genders, correct?

A To their -- to their detriment to affirm.

Q So the schools should discourage it?

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A It should not -- yeah, they should discourage it.

Q Do you think that a school is acting in the best interest of a child by calling the child by pronouns that are different than the sex assigned to them at first?

A We don't feel that that is appropriate or beneficial to the child.

Q So you think it's harmful to the child?

A Yes.

Q And by agreeing to use the child's -- changing a child's new name as consistent with their gender identity, you think that's harmful to the child also, right?

A Yes.

Q And go to -- are you aware -- are you aware about what Gloucester County School Board's policies are with respect to what pronouns it uses to refer to transgender children?

A I was aware in this particular case that they allowed this patient to assume a new name and new pronouns.

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Q And you believe that allowing them to do so was harmful to him, correct?

A I do.

MR. CORRIGAN: Just to be clear, he's not being offered for those opinions. His only opinions where he's being offered for are strictly with respect to restroom use, which is the issue in the case.

BY MR. BLOCK:

Q So is there any basis to conclude that using the restroom as opposed to being referred to by particular pronouns is uniquely harmful or -- to a transgender student?

A It is part of the process of affirming something which at the time is just a gender confusion, a state of mind, not a biologic reality, and anything that promotes that is not of benefit to the child. And --

Q Turn the page to paragraph 8. It says: Conditioning children into believing a lifetime of chemical and surgical impersonation of the opposite sex is normal and helpful is child abuse.

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Did I read that right?
A You did.
Q So when I referenced the term "child abuse" before you said it was a flashy term. Am I accurately characterizing your testimony?
A Yes.
Q So why do you use that term here in this paragraph?
A Primarily for emphasis.
Q The next sentence says: Endorsing gender discordance as normal via public education and legal policies will confuse children and parents, leading more children to present to, quote, gender clinics, unquote, where they will be given puberty-blocking drugs. This, in turn, virtually ensures they will, quote, choose a lifetime of carcinogenic and otherwise toxic cross-sex hormones, and likely consider unnecessary surgical mutilation of their healthy body parts as young adults.
Did I read that right?
A You did.
Q So is one of the harms in allowing a

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transgender student to change pronouns and names and restroom usage consistent with their identity that it will confuse non-transgender students as well?
A It is confusing to non-transgender students because they do not understand, especially at young ages, what is -- is happening to their classmates, or they are in a state of mind with Erikson's basic premise of being very concrete thinkers, and they think a five-year-old child is essentially, from what I've read, not being an expert in the field of mental health, but what the experts say, a five-year-old believes that if a man leaves a room and comes back in dressed as a woman and wearing women's makeup, to appear to be a woman, that that man has changed into a woman. That's the level of psychological assessment at that age.
By age seven there is an ability for a child to recognize that perhaps that is just a costume and not a real person of the opposite sex.
So if you were, at the elementary school age, promoting aggressively that gender is whatever you want it to be, you are basically bringing in an

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ideology that is programming the child to be confused and upset. And there are certainly clinical cases where that's happened, and the parents have brought legal action against school systems.
Q Let's look at the last -- the very end of the statement. So this is after the clarification at the bottom of the paragraph, the bottom line is the final sentence says: For this reason, the College maintains it is abusive to promote this ideology, first and foremost for the well-being of the gender dysphoric children themselves, and secondly, for all of their non-gender-discordant peers, many of whom will subsequently question their own gender identity, and face violations of their rights to bodily privacy and safety.
Did I read that right?
A You did.
Q What do you mean by it will cause many of their non-gender-discordant peers to question their own gender identity?
A Well, there is a phenomenon with the

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advent of social media where the incidence of gender identity issues has exponentially -- has geometrically increased, and the ratio has flipped from two-to-one male to female to two-to-one female to male. It's a social contagion phenomenon amongst kids who are coming together as groups and deciding that they are transgender and would like to have their surgeries done together and travel to the identity of the opposite sex.
These kids are coming out of the woodwork literally in larger and larger numbers as a social contagion phenomenon. Society itself, it's not that it's just more acceptable. It exceeds that kind of mathematical computation. So it is -- it is a contagion that's happened, and it's certainly promoted by Internet.
Q So if the school affirms the gender identity of the transgender student, that transgender student could spark a social contagion that causes other students to say they're transgender too?
A Absolutely. It has happened, and it's

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documented.
Q So by not allowing the transgender student to use the same restrooms as cisgendered students with their gender identity, the school is stopping the spread of a social contagion; is that right?
MR. CORRIGAN: Object to the form of the question. The witness is not being called in this case to discuss these very issues; he's not speaking on behalf of the school board.
Go ahead.
A I have no proof to say that not allowing use in a bathroom would make that difference. Again, there is no study I'm aware of that says using the gender-identified non-biologic sex bathroom has any benefit or any detriment to the long-term outcome of a patient. Those studies have not been done.
BY MR. BLOCK:
Q So my question is that you believe that if a transgender student is affirmed and allowed to use the bathroom consistent with their identity, then that is more likely to cause other students to think

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they might be transgender too?
MR. CORRIGAN: Object to form of the question.
Go ahead.
A It is theoretically quite possible.
BY MR. BLOCK:
Q So going to Exhibit -- going to jump ahead here to Exhibit -- I think this is 8.
(Exhibit 8 was marked for identification and is attached to the transcript.)
BY MR. BLOCK:
Q Do you have that document in front of you?
A Almost.
Q Do you have it in front of you now?
A I do.
Q The title of this article is, Dr. Quentin Van Meter: How Faulty Research by a 1950's Sexual Revolutionist Guided the Modern Transgender Movement; is that right?
A Yes.
Q And do you recall giving an interview to Breitbart for purposes of this article?

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A I did.
Q Did you read this article when it came out?
A Yeah, I saw it after it came out.
Q Was there anything in the article that you thought was inaccurate or mischaracterized your views?
A I had some questions about sort of interpretive sentences when I read it. I would have to read it back through completely to go back through and pick those out again, but in general the flavor and the purpose of the article was to -- was to essentially discuss John Money and his influence on the sexual health, mental health side of issues in this country.
Q Sorry, if you give me one second. If you turn to page 4 of 6.
A I have it.
Q So the second paragraph there, it says: According to Van Meter, since the transgender movement has developed every patient that come to him claiming to be in the wrong body, quote, have

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come from a totally dysfunctional family, unquote.
And just to continue this next paragraph says, quote, there's nothing normal about the environment where these children are brought up, unquote, he said. Quote, there are emotional traumas left and right. It's so obvious that what we're doing is painting over the trauma, unquote.
Do those quotes accurately reflect what you told the reporter for this article?
A Yes.
Q So do you think that if someone is transgender or thinks they're transgender it's the fault of the family?
MR. CORRIGAN: Object to form.
A If the child is transgender, they have chosen this as an answer to relieve them of dealing with a stress that is in their environment. Sometimes it's the family, sometimes it's the extended family or the social environment of the child.
BY MR. BLOCK:
Q But if someone is transgender, that often

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indicates that they come from a totally dysfunctional family; is that right?

A The word "totally" might be a pejorative type of word that was used in the interview. There is always trauma, always emotional trauma, and always a level of dysfunction in the family. Divorce, separation, sexual abuse, death, all those things affect the child.

Q You think that is true for all transgender people?

A All the transgender patients I have cared for.

Q So all 12 --

A Yes.

Q -- of them?

A Yes.

Q How about the one in 1993?

A There was a lot of trauma. This was a military family that moved every six to nine months. I did not broach the subject of sexual abuse by any member of the family, siblings or adults, but the child was severely traumatized by the rapidity and

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frequency of moves from community to community.

Q Last paragraph of this article, which is page 5, it says, quote, this is the recruitment of a cult, unquote, Van Meter said. Quote, it's so scary, and I'm so overwhelmingly worried about the welfare of the population of people 30 years out, unquote.

Is that quote accurate -- an accurate reflection of what you told the reporter?

A Yes.

Q So can you explain what you mean by "this is the recruitment of a cult"?

A This is an ideology which is promoted by some to essentially use this as a valid medicalized diagnosis to gather children and to treat them, and their purpose is to see what happens when the treatment is over and make a decision then, just like John Money did some 40 years earlier with an idea that was not based on any known science that -- to be beneficial, and then to come out with an experimentation at the other end.

The cult aspect of it is what's happening

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on the Internet and the recruitment of patients by websites and blogs, and all that's happening as if they're pulling in the kids unwittingly, most often against their parents' wishes and without their parents' knowledge, and then they are sucked into the ideology, which is very much like a cult.

Q You think the American Academy of Pediatrics is recruiting children into a cult?

A The American Academy of Pediatrics produced a statement written by one individual promoting this concept, and specifically and most dangerously saying that under no circumstance is there any need for psychological evaluation.

That is one individual, the author of that paper, and 35 -- as many as 35, perhaps a little less, of administrative people rubber stamping this as a promotional position of the American Academy of Pediatrics.

It is abysmal, it is embarrassing, it is dangerous, and the fact that they say they represent and are supported by all now 67,000 members is entirely and completely untrue.

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Q Do you think the author of that paper is recruiting children into a cult?

A I don't know the author. I cannot speak to that. I just know that he wrote a paper and a position that's based on really essentially fraudulent -- fraudulent information. He misquotes papers. He ends up saying the papers say one thing to support his point, and when you pull the reference, you find out that it does not support the paper.

The article was very carefully critiqued by an independent psychologist in the field of psychology and lesbian gay psychology, and he himself is a pro -- a proponent, an advocate for gay people, and he tore this apart as absolutely abysmal trash.

Q So you believe that schools can help kids by discouraging students from being transgender; is that right?

MR. CORRIGAN: Object to form of the question.

Go ahead.

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A I believe schools can help kids by making sure that the family is fully aware and that they are aware that there is counseling going on and there's an intervention that the family is involved in, and I think that's as far as schools can go. That's as much as I can say on that subject.

BY MR. BLOCK:

Q But they shouldn't be sending a message that being transgender is an equally acceptable lifestyle to have?

MR. CORRIGAN: Object to form, not designated for this purpose.

Go ahead.

A Yes, I think that's inappropriate for them to be promoting something which, as Kenneth Zucker said, is not a delusional disorder but is a delusion.

BY MR. BLOCK:

Q So would one way to send that message be to stigmatize transgender students, would that be a way of sending that message?

A No.

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MR. CORRIGAN: Object to form, object to foundation.

Go ahead.

A No.

BY MR. BLOCK:

Q So what are the ways they can send that message that transgender students have a delusion?

A They could deal with the student themselves and make sure the student is in the care of a mental health provider.

Q I want to turn to -- actually, you said before you're familiar with the Christian Medical and Dental Association; is that right?

A Yes.

Q How are you familiar with them?

A I took -- A, I know they exist. I'm not a member. I took a course from them on preparation for speaking to the media. It's a generic course that teaches you how to be interviewed, how to respond most effectively to questions so that the -- your interview can be used more appropriately, to not do run-on sentences, to not mumble, to face the camera, and they basically train you on how to do that appropriately and give you a critique of what you've done in front of a camera or in front of a microphone so that you can improve some of your bad habits.

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Q Have you read their position statement on transgender identification?

A I have not.

Q I'd like to turn to Exhibit 6.

(Exhibit 6 was marked for identification and is attached to the transcript.)

BY MR. BLOCK:

Q Do you have that document in front of you?

A I do.

Q Do you have that document in front of you?

A I do.

Q Do you recognize the document?

A I do.

Q It's called, On the Promotion of Homosexuality in Schools; is that right?

A That's correct.

Q If you look in the right-hand column on the fourth checkmark down it says: The homosexual lifestyle carries grave health risks; is that right?

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A Yes.

MR. CORRIGAN: Let me interject here. This is something having to do with homosexuality in schools. To my knowledge our case has nothing to do with homosexuality in schools, okay? This is about transgender bathroom -- transgender restroom use. I don't see how this is in any way related, relevant, has any significance whatsoever, so I object to any questions regarding this.

MR. BLOCK: It goes to the credibility of his opinion and whether or not it represents medical mainstream.

MR. CORRIGAN: His opinion is that there's no science to support the notion that using a restroom of any description has any effect on a transgender youth. I don't see how that opinion is in any way influenced by whether or not this American College has a paper on a promotion of homosexuality in schools. Just completely unrelated, not admissible, never going to be part of

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our case.
Go ahead.
MR. BLOCK: You're proffering him as an expert on what the mainstream medical view is, and this goes to his views being outside the mainstream and being based on ideology and not based on science.
MR. CORRIGAN: I am not offering him as an expert on what the mainstream view of anything is. I'm just telling you that his opinion is, based on his review of the literature and et cetera, that there is no scientific basis, medical basis, psychological or other basis for anyone saying that using a particular restroom has any effect on that person one way or the other.
That's what our case is about, and that's what he's going to testify to. He's not going to talk about any of this, and this has nothing to do with our case.
MR. BLOCK: But we can explore bias, and we can explore the ability to draw valid conclusions from reviews of evidence.

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MR. CORRIGAN: If they have anything to do with the case that would be true, but when they have nothing to do with the case, they're just -- it's totally irrelevant, totally tangential, totally collateral, and has nothing to do with the case. So I just don't see the benefit of talking about these types of things.
MR. BLOCK: Bias is always relevant and not collateral.
MR. CORRIGAN: What's relevant?
MR. BLOCK: Bias.
MR. CORRIGAN: What's the bias? Our case is about transgender, it's not about homosexual. You're confusing two concepts.
MR. BLOCK: That he has opinions about homosexuality and gender identity that are based not on science but based on ideology or moral bias.
MR. CORRIGAN: But homosexual is not part of our case, and you're asking questions about homosexual. I just don't see how it has anything to do with -- it's like saying the arm and the pancreas are two parts of the body.

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MR. BLOCK: You can't put forth an expert and not allow me to build a record exploring bias.
MR. CORRIGAN: But again, the bias has to be somehow related to the case. You can't just talk about what kind of bias he may have that has nothing to do with the case.
MR. BLOCK: If you want to take it to the judge and explain why I shouldn't be able to ask him about a document from this organization that is On the Promotion of Homosexuality in Schools, you're welcome to put that issue before the judge.
MR. CORRIGAN: Okay, I will.
MR. BLOCK: Excellent. So you're instructing him not to answer any questions on, On the Promotion of Homosexuality in the Schools?
MR. CORRIGAN: I'm instructing you to ask a question that has something to do with our case. If it's related to this document, I'm not going to object to it, but if it has nothing to do with our case I'm going to continue to object to you asking questions about topics unrelated to the issues in our case.

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MR. BLOCK: You can object all you want. I'm -- but my question -- I'm going to continue asking questions.
MR. CORRIGAN: Ask your next question.
BY MR. BLOCK:
Q So let's look at the second sentence of the bolded at the top, which is a sentence that is very similar to a view that you express in this case. It says, quote, these organizations recommend promoting homosexuality as a normal, immutable trait that should be validated during childhood as early as kindergarten.
So you disagree -- just as you disagree with being transgender as being promoted as a normal, immutable trait, you also disagree with schools promoting homosexuality as a normal, immutable trait; is that right?
MR. CORRIGAN: Object to form.
Go ahead.
A That is correct because there is no biologic basis for same-sex attraction. That has been stated by both sides of political aisle. It is

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a fact there is no biology. It is a combination of things, but it is not biologically based. And that's -- that's in published science, that's truth, that's not a bias. It's been evaluated and scoured and looked for by advocates for the gay community, and they specifically state there is no such basis. So, again, that is science, it's not a bias.

The College is about what is science, not what is about hopeful things that you would wish would be true, but you have to look at everything that's actually biologically sound and proven, and that's what that sentence is based on.

BY MR. BLOCK:

Q And so homosexuality is also not normal, right?

MR. CORRIGAN: Object to form.

A The statement is that promoting it as an immutable biologically based norm is not -- is not based on valid science.

BY MR. BLOCK:

Q If we go to the second checkmark on the right-hand column, just as affirming a transgender

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student's identity can be harmful, this checkmark says: Declaring and validating a student's same-sex attraction during the adolescent years is premature and may be harmful.

Is that right?

MR. CORRIGAN: Object to form.

Go ahead.

A This is based on the handbook of the APA, which says that there is an incredible amount of fluidity in and out of same-sex attraction, and that validation is premature.

BY MR. BLOCK:

Q And can be harmful?

A If it's -- if it's premature and ends up causing ill health, it's harmful.

Q And the next checkmark says that -- you testified that many -- that all transgender people have a dysfunctional -- dysfunction in their background. This checkmark says: Many youths with homosexual attractions have experienced a troubled upbringing, including sexual abuse, and are in need of therapy.

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Is that right?

MR. CORRIGAN: Object to form of the question, object to mischaracterization of prior testimony.

Go ahead.

A The answer to that is yes, it's proven based on published science.

BY MR. BLOCK:

Q So you agree -- and you agree with that. You agree with what that checkmark says, right?

MR. CORRIGAN: Object to form.

Go ahead.

A Yes, I do.

BY MR. BLOCK:

Q And so when it says that youths with homosexual attraction, quote, are in need of therapy, what sort of therapy are they in need of?

A They're in need of therapy to evaluate and treat their depression and anxiety.

Q And that their homosexuality is sort of tapering over underlying depression and anxiety resulting from trauma?

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A No, it coexists and cannot be and should not be validated as being purely due to societal rejection or pressure.

That is such an important right of the gay community to be able to be recognized that their own suffering and anxiety and depression should be treated as for exactly what it is and not to be dismissed as unimportant or not even present.

It is a huge disservice to the mental health of the gay community that that -- that is glossed over as if those things don't exist when they do.

The conservative estimates that I read are that 40 percent of people with a gay lifestyle suffer significant depression and anxiety, and they're not getting the therapy they need.

So the advocates for the gay community strongly are coming out to say they need this therapy, they should be encouraged to go for that therapy. It is not to change anything, it is to make them be functional adults so that you lessen the long-term suicide risk, which is the end of

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severe depression in many cases.
Q And how did you acquire this knowledge?
A Reading standardized publications and articles written today and available for anyone to read.
Q And when you treat patients, do you provide any counseling or discouragement from being gay?
A No.
Q Do you ever talk to them about health risks associated with the homosexual lifestyle?
A I generally try to talk to them first about risks of sexual activity in general, then specifically if there are things that put them at specific risk based on their -- about the things that they do in terms of sexual activity, I point out those things, I talk about STDs, and I talk about depression and anxiety.
Q So before we leave this document, is there anything about this document Exhibit 6, that you disagree with?
MR. CORRIGAN: Object to the form.

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A The purpose of this document was in response to the promotion at the letter of the superintendent of the schools that was done through the Obama Administration which the College felt was a harmful avoidance of the serious and significant issues associated with promotion of this as if it were -- it had no downsides to it in any aspect.
So a statement needed to be brought out that brought up conversations that talked about STDs, that talked about depression and anxiety and the adverse outcomes that can happen. It's not that they always do, but it's a risk. It talks about the risks that these kids face, and if you promote something that has risks, you need to be up in the forefront and mention those risks without glossing over them as if they did not exist.
So that's -- that was the point of the paper is to present the risks. The known, scientifically proven risks.
BY MR. BLOCK:
Q Do you have any religious beliefs related to being lesbian, gay, bisexual or transgender?

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A I do not.
Q Does the -- do you have any religious beliefs about acting on same-sex attraction?
MR. CORRIGAN: I'm going to object to anything about his religious beliefs or his personal beliefs. I don't see how it has relevance or potential relevance.
Go ahead.
A I do not impose my religious faith on anyone. It is my personal journey. I use my religious faith to balance with science to keep me with a compass of doing things that are, again, not in a moral vacuum, that have -- again, focus on, above all, doing no harm, behaving well, not hurting the patient in any possible way that is intentional or based on any bias, not based on any harmful -- harmful ideas I may have about behavior. So it's -- that's where my faith comes into my professional life.
BY MR. BLOCK:
Q The American College of Pediatrician files amicus briefs; is that right?

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A They do.
Q And those amicus briefs express the views of the College, right?
A They do.
Q I'm sorry, I didn't hear the answer.
A I do.
Q So do you play any role in approving the content of amicus briefs?
A I know of some of them, particularly on the transgender issue. Some of the other briefs I'm not an author of, but they were filed. I'm not aware of the absolute design and content, I just know that they exist.
Q But is it fair to attribute statements made in amicus briefs filed on behalf of the American College of Pediatricians to the views of the American College of Pediatricians?
MR. CORRIGAN: Object to form of the question.
Go ahead.
A Yes.
BY MR. BLOCK:

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Q So is it the belief of the American College of Pediatricians that, quote, it's not beyond the scope of a court to acknowledge the moral foundation of God's laws when considering the institution of marriage, unquote?

MR. CORRIGAN: Object to form.

A That is a philosophical, beneficial concept that is -- it's looked at from its scientific validity to have a benefit to the patient or the family that marriage has a historical construct that is based on society and most often verified and sanctified by a religious faith germane to the population, and that is to the benefit of the child to have -- to come from an intact family, and that anything that can be done to promote intact biologic families is probably the most ideal of circumstances. And if something is less than ideal, so be it, but if you're trying to promote what is ideal, you label that as ideal.

BY MR. BLOCK:

Q Does the moral foundation of God's law have any relevance to the treatment of transgender

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people?

A No, I'm basing it on -- purely on science. I don't -- I think the way it would be looking at a theologic concept is it is appropriate to harm children, and if that is -- if your faith structure or your theology suggests that there is harm to be done to a patient and you are doing harm, perhaps that's not within the precepts of what your faith might guide you to do, so that's how it comes into play.

Like it does -- it's an ethical structure to be sure that we are paying attention and validating what we do on science and not falling into a trap of validating something on popularity or social pressure.

Q Is it true that the American College of Pediatricians told the Alabama Supreme Court it should ignore the opinion of the Supreme Court in Obergefell?

THE REPORTER: Supreme Court in...

MR. CORRIGAN: Obergefell. Obergefell.

MR. BLOCK: O-B-E-R-G-E-F-E-L-L.

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A Yes, they did.

BY MR. BLOCK:

Q Do you agree with that?

A The point was, again, the concept of what is best for children is an intact biologic family. That does not have any potential for increased adverse outcomes for the child. And so, again, it's the foundation of the family in that regard and that opinion that the College chose to say what is best for children in an ideal circumstance, the ideal was that the Obergefell decision should not be -- should be ignored at the Alabama court level.

Q And you think that if a court says that the school board in this case should let transgender students use restrooms in line with their gender identity that the school board should ignore that court decision?

MR. CORRIGAN: Object to form, object to foundation.

A I would not make that statement.

MR. CORRIGAN: Witness not being called for that purpose.

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Go ahead.

A I would not make -- I would not tell the school to go against a court decision.

BY MR. BLOCK:

Q So if there's a conflict between what the law requires and what your medical views are, you would think that the school board would need to do what the law requires, right?

MR. CORRIGAN: Object to form.

Go ahead.

A The school board should do what the law requires, and if they are at odds with that law, they should file suit and take it through legal proceedings.

BY MR. BLOCK:

Q Going back to Exhibit 5 just one more time, that's the On the Promotion of Homosexuality in Schools. I just need to know is there anything in this statement that you disagree with? I just want to have that on the record.

MR. CORRIGAN: Object to form, object to foundation.

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Go ahead.
A I'm going to carefully go through each point.
BY MR. BLOCK:
Q Yes, sir, take a minute.
A Okay, I concur with all points.
Q Thank you.
I want to take a couple minutes to revisit what we were talking about before about these 12 patients that you've been treating over the past two to three years related to gender dysphoria.
Is there -- was there any precipitating event that you're aware of that caused people to start coming to you two to three years ago for treatment in connection with gender dysphoria?
A Nothing that I perceived as a specific event. I thought it reflected just a general increase in the number of transgender clinics and the online presence of transgender-promoting websites and blogs that would be responsible, but that is my perception without any basis on scientific research.

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Q Do you identify yourself within your medical network as an endocrinologist who provides treatment for gender dysphoria?
A Yes.
Q And when did you start identifying yourself that way?
A When I began accepting patients and getting feedback from practitioners, when I began discussing things amongst my endocrine peers, that's when I began to make sure that people knew that I was very willing and able to have these patients come to my office for evaluation.
Q And did you start describing yourself as someone who provides treatment for gender dysphoria before or after the first of these 12 patients came to see you?
A I was -- I was quiet and didn't say much because I was gathering information, so it was until actually perhaps a year before the first patient came in at a time when I had put together enough of my own review of the literature to feel very strongly that there was a need for this service, and

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it happened to coincide with the time that the Emory University medical campus opened their transgender clinic.
Q So before -- in the time period before you started identifying yourself as a practitioner who provides treatment for gender dysphoria, the only transgender patient who had come to see you was this one in 1993; is that right?
A That is correct.
Q Now, when you describe yourself as a practitioner who provides treatment for gender dysphoria, do you include in that description your -- what your views are with respect to providing gender-affirming hormone therapy?
A The people that I talk to professionally who know me as endocrinology colleagues know how I feel because I've spoken in front of them, so I am assuming everyone knows how I feel.
Q Is there, like, insurance networks or your medical groups that you're associated with, is there like a lookup feature where patients can find a doctor in an area that provides treatment for gender

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dysphoria, and certain people's names pop up if they identify as that sort of certain practitioner?
A I am not aware I am on such a list.
Q Is it on your website?
A No, it is not.
Q So of the 12 patients that come to you, about how many were referred to you by -- referred to you specifically?
A About half of them are referred, and the other half spontaneously found me.
Q The half who spontaneously found you, to the best of your knowledge, were they aware of your views with respect to gender-affirming therapy?
A I was aware at least two of those. One of the parents sought me specifically because they had seen one of my talks on YouTube.
Q For the ones that were referred -- for the patients who were referred specifically to you, who made those referrals?
A Pediatricians.
Q Pediatricians that you knew?
A Yes.

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Q In what capacity did you know them?
A From prior referrals from endocrine patients over the span of the last 28 years. Up to 28 years.
Q Did those pediatricians -- do you know whether those pediatricians shared your views with respect to gender-affirming therapy?
A I do not.
Q Do you know whether they knew those views at the time they referred the patients specifically to you?
A I do not.
Q You said that two of the patients you think have had success in resolving their dysphoria, and 10 are work in progress; is that right?
A That's correct. One of them moved out of the area, and I don't know what has happened in follow-up with that patient.
Q Are there -- are there any patients who saw you for an initial consultation but then decided to seek treatment with someone else instead of continuing to follow up with you?

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A I am unaware of any.
Q And so the 10 that are in -- that are a work in progress -- or are there nine that are a work in progress? I just want to get the number right.
A That's correct, it's nine.
Q Nine. The nine that are a work in progress, have they reported any lessening of their symptoms of gender dysphoria?
A They are working through issues and seem to be in better mental health, but some of them are still struggling with issues. Some of them are young, so some of them are coming back and just we are revisiting the same overall view, and they're works in progress.
Q So did I get it right that some have shown improvement with respect to depression and anxiety, but at the same time not showing improvement in resolving their feelings of gender discordance?
A I'm trying to specifically categorize those which are not living affirming the gender-incongruent lifestyle, and I think the

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majority of them are back to being -- living in their biologic body as that gender at least outwardly for the school and for purposes of other people outside the family. But the family is working within the family to work these kids through that process and to do healing amongst themselves.
Q For the follow-up visits after the initial visit with these patients, do you conduct a medical exam on the follow-up visit?
A I conduct a medical exam if I sense that something is going wrong. For instance, several of these children are obese and are increasing their body weight significantly because every patient that comes in is weighed and measured, and I want to address that issue because it's a co-morbidity in some ways, but it's also innate for them to become obese. So I'm aware of, in kids like that, that I want to pay attention to those issues.
If the parents describe something that they think is puberty that's happening, I'll do a physical exam. So it is very much case by case.
Q But there's some patients that for the

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follow-up visits you don't conduct a medical examination, correct?
A If it's -- particularly since the visits are designed to try to be three months apart and nothing physically is changing, I would sort of mandatorily do a full physical exam at least once a year.
Q So what happens at a visit like that where there's no medical examination, it's a check-up after three months?
A First it's an interview with everybody in the room, and then it is permission to have the child and either parent. If the parents are not -- are not functional together, I will interview the parents individually, I will then sort of reinterview them together to discuss the things that I have permission to talk about between the two of them that might be constructive of things that I might learn about that situation, and then I ask permission to interview the child individually without the parents in the room.
Q And what do you bill that as to insurance?

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A That's as a counseling visit as a parent conference. It usually is about a 30-minute visit. Sometimes it's longer if things are sort of opening up and there are re-questions and re-education, or in the case of a split family if it's the first time I've been able to actually interview or take -- get information from a parent who had previously been absent it takes longer, so it's all based on time. But it's done as a parent conference visit.

Q Do you have a license to provide counseling?

A I have a license to provide evaluation of children's health.

Q After the initial evaluation when you're providing continued visits, is it -- would counseling be a fair description of what occurs in those visits?

A No, it's basically information gathering.

Q And what do you do with the information that you gather?

A I record it in the record. If there is education to be done in terms of questions and

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answers about the medical side, those are explained, reexplained.

Often because of the nature of the visits there's a lot of emotional tension, and there's not necessarily a lot of constructive listening, so I go back over again and be sure that everyone understands the medical aspects of what's going on and what they might have read on the Internet, what they might have new concerns about, and I address those things, but I do not do counseling for depression and anxiety.

Q You said you spoke about transgender-related issues to the International Association of Therapeutic Choice; is that right?

A That's correct.

Q How did you come to become familiar with the International Association of Therapeutic Choice?

A I was approached by their director and asked if I would be willing to come and talk on the history of transgender health in the United States.

MR. BLOCK: If you'll just give me a minute. We can go off the record for a second.

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(Recess 2:59-3:02 p.m.)

BY MR. BLOCK:

Q So when you said before that you at some point made it be known that you were interested in seeing patients that were seeking care for gender dysphoria, how did you communicate that to others?

A By word of mouth at regional meetings mostly.

Q Regional meetings of endocrinologists?

A Yes.

Q Do any patients get referred to you through the American College of Pediatricians?

A I -- I actually don't believe I've had a patient come specifically referred from the College. We do have a referral base for pediatricians who are members so that if a family calls and said, is there a pediatrician in my area who's a member of the College, we can tell them who is in their geographic region and hook the two of them up. So that is -- I'm not aware of actually having a family come to me referred by the College.

Q Are you aware of having a family come to

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you being referred by a pediatrician who's a member of the College?

A Yes, because there are members in Georgia, and I would -- I would guess that, yes, that has happened, but I can't -- I don't have a documentation of an individual's name.

Q So during the first visit when someone comes to you for treatment for gender dysphoria, do you conduct an examination to determine how far along in puberty the patient is?

A Absolutely, yes.

Q And so what's the purpose of doing that if you're going to not provide hormone therapy regardless of what stage of puberty the individual is in?

A Well, staging of puberty is in the DNA of being an endocrinologist so that at any visit that we do, whether they have a diagnosis of type 1 diabetes or hypothyroidism or vitamin D deficiency, rickets, staging them in puberty is exceedingly important because it's part of what affects their growth.

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Human growth, statural, and weight gain are related and timed with puberty and are affected by puberty, and so it is essentially, as I said, in our DNA as endocrinologists to be sure we have staged puberty no matter the age of the patient.

We do not assume that just because the concept of a pubertal-related symptom is not brought up that we should not verify that the patient is indeed not pubertal or is pubertal and is in what stage of puberty and how they are growing and how they have grown before if we can gather the data and watch them grow as they move forward.

Q So you do this initial evaluation, you have a discussion where you warn the patients about harms associated with gender-affirming therapy, you encourage them to see a counselor, and then what's the explanation you give for why they should come back for a check-up in three months?

MR. CORRIGAN: Object to form.

Go ahead.

A My story to them is that I am there to care for them, and that I will dedicate my time and

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effort to absolutely everything that is beneficial to them, and that I know this is a confusing, painful experience for them, and that it is my job to monitor how they are doing and how we are moving in the direction that is to their greatest benefit, and so that's why they come back.

And I say it's easy to get lost in the woodwork, and if I don't -- it's the same thing I do with my diabetic patients who don't come back for follow-up, we contact them and make sure that they do come back because we know there is a necessity for them to be followed to be sure all is going as beneficially as it possibly can be, so that's the same principle.

BY MR. BLOCK:

Q But why followed by you instead of by the psychologist or psychiatrist that you're referring them to?

A The psychiatry part is one part of the equation. The questions about what to do in terms of endocrinologic intervention are always hovering around the edge, and the psychologist is very

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definitely interested in anchoring them back to me to discuss anything that -- any questions the parents may have. Particularly with the advent of Internet access, the parents read over and over again about new ideas, new concepts. They need somebody to anchor to that talks about hormones and the effects of hormones, and that's why they come back.

Q So even after the first visit, a parent might come back to you with repeated questions about hormones possibly being a good course of treatment, and you have to explain to the parent repeatedly why they're not; is that right?

A In part, but it's also because most of these families are split families, and one parent will see doubt in the mind of the parent who is the one who's been bringing them in, and the parent needs to come back and be reassured, or the other parent wants to come and hear what I have to say, and we have not talked before.

So this is such a -- this is not something where you have a sit down, one discussion, send them

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to the counselor and you're done. This is a multifaceted approach for a very complex psychological issue that involves a lot of pain and agony, and the patient -- here is the poor patient in the middle trying to figure out what to do, what the answer is.

And if they know that somebody is dedicated to them from the medical side as well as from the counseling side, it is our hope that that gives them some place to hang on to and a sense that somebody really does care, even if they don't necessarily agree with the patient, that they want them to be -- to understand how dedicated we are to their welfare and how compassionate we really are.

It's very difficult to talk to a very sullen 14- or 15-year-old who sees you for the first time and convince them that you're on their team, and so it takes time.

Q But from the very first meeting, though, you make clear to the parents that under no circumstances will you be recommending gender-affirming hormones, right?

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A That's correct.
Q And are there any other conditions that you treat in which you have the series of follow-up conferences without providing medical treatment as part of it?
A It's not often, but diabetes would be one of them. There is so much overlay of issues with compliance and whatnot that don't have to do with physical wellness at the moment that require visits to come back and predominantly talk about behavioral responses and things that are germane to our clinical experience in the field of diabetes, so those kids, we'll bring them back.
Normally they're every three months, but it is not uncommon in the adolescent years for us to see them back a month after they've been seen before to give them a pep talk, try to give them the responsibility for managing their diabetes, set them up for success with telephone contact and office website secure communications so that we can try to invest this child back in their diabetes care.
There are often points in time where the

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mental health issues are so overwhelming that we literally jettison to primarily back to an aggressive mental health intervention scheme and let the diabetes kind of go for a while because it's impossible for those kids to get their blood sugars in control or even care about managing their diabetes when they're overwhelmed with depression, so that's another circumstance where often the visit will be predominantly information gathering, team building, putting together things like that.
Q And you said before that one of the reasons why you decided you wanted to start making it known that you would provide -- that you would see patients seeking care for gender dysphoria was because you thought there was a need for it; is that right?
A That is correct.
Q To the best of your knowledge, is there any other pediatric endocrinologist that you're aware of that provides the same course of office visits that you do to patients who have come to you seeking care for gender dysphoria?

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A It's very limited because the guidelines have been so pervasive, and what happens is that -- and this was an admission by a number of the pediatricians in our regional meeting last month in Orlando is they say, I don't take care of these patients, I send them to the centers. So that's -- they kind of punt. And they are -- they were relieved.
My presentation of a case study of one particular patient just all of a sudden brought into their minds, and they shared this with me, thank goodness. Thank goodness. How do we do this? How do we do this? What have you got written? Can you come talk to us in Birmingham? Can you give us a presentation for pediatricians where we can -- we can get the people in the community to understand that there are other avenues than the transgender clinics as they now exist?
Q But in terms -- but as far as you're aware, are there any other endocrinologists that you are aware of who provide the same course of treatment for gender dysphoria that you provide?

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A Yes. Yes.
Q Who?
A There's a pediatric endocrinologist, Paul Hruz, in St. Louis, I believe Robert Hoffman in Indianapolis. There's just a few of us because we're just -- we're just starting to put together communications that are effective among our endocrine communities.
We can't -- you know, I can't get invited to national endocrine meetings because they won't have me. I've tried the American Association of Clinical Endocrinologists on two occasions over the past three years to do a balance -- what I call a balanced-dialogue type of a presentation, and I specifically have been told no, that that's not going to happen, and it could not happen, so...
And at those very same meetings they had transgender clinic directors do a presentation, which is basically telling everybody, this is what you do, this is how you do it, this is the only way that's effective, send your patients to us, and that's -- that's what happened.

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So it's hard to get -- it's hard to get colleagues unless you literally spend the time of contacting them individually and saying, let us tell you our experience.

I share my -- the paper that I've submitted for publication with other endocrinologists to let them know. When I presented in Orlando, the positive feedback from the community was about three out of four people coming to me afterwards saying, please tell us more, please tell us more, so that's it.

It's a slow -- this movement is just beginning to get an anchor because of the validity in science that we've been able to prove.

Q What's your understanding about why these organizations refuse to let you provide a presentation on the course of treatment you provide?

A I have -- sheer conjecture. I have not been able to talk to the meeting directors directly. I have communicated one way with them most recently both by e-mail and telephone message, and that individual for the meeting of the American

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Association of Clinical Endocrinologists in Los Angeles, I believe it's next week, that person chose not to communicate back with me.

Q In your declaration if you go to paragraph 29 of it, going back to Exhibit 1. Are you at that page now?

A I am.

Q Great. The paragraph 29 says: Up until recent -- up until the recent revision of DSM-IV criteria, the American Psychological Association held that gender identity disorder (GID) was the mental disorder described as a discordance between the natal sex and gender identity of the patient.

Is that right?

A That's true except there is a misstatement. It's the American Psychiatric Association, and I apologize for that inaccuracy. They both have the same initials, APA, but it is the American Psychiatric Association that generates the DSM criteria.

Q And do you have any opinion on whether it was appropriate for the APA to no longer describe

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gender dysphoria as a mental disorder?

A I'm not a mental health practitioner. I really find it difficult to sometimes use the correct words without offending people who are licensed and trained in mental health issues.

I learned actually from Dr. Zucker that the word "disorder" is very specifically chosen and cherished in the mental health community for very specific purposes. Prior to that conversation with him I would -- was thinking that anybody who had transgender or gender incongruence had the disorder, and that, I learned, is not the case. It is sort of living a delusion, but not living with a delusional disorder. So I find that the removal of the "gender identity disorder" is a disservice to the patients.

So did Dr. Zucker, from indirect conversation as I learned in between my statement to the Carcano case and this that when the APA group, again, it doesn't represent all psychiatrists, but it's the group that develops the criteria, and they are -- they're parsed into interest groups, they pushed very strongly to eliminate any pathologic

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reference to gender identity issues.

And Dr. Zucker argued -- and, again, this is not from a conversation with him, but through second parties who talked to him about this personally, he argued that if you remove it, the suffering is going to be legendary as it is, and it's going to be ignored and will not be allowed to be treated by third -- and covered as a service by third parties who cover healthcare costs, insurance mainly, and that medications then wouldn't be covered.

And it was a disservice to the patients to eliminate the disorder, but if they were going to pressure to do that, would they please replace it with "gender dysphoria" so that there was a medical condition that would allow that patient to seek and be treated and have that as covered services by government entities and private insurance.

Q So did I hear you right that one of Dr. Zucker's reasons was to ensure that medicines would be covered?

A That treatment of any kind would be

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covered.
Q But including hormone therapy, correct?
A I assume that, yes, but, again, I didn't write that policy, and I didn't talk to him directly to know.
Q Have you ever talked to Dr. Zucker directly?
A No, I have not.
Q So do you have any views on the APA's decision to remove homosexuality as a mental disorder?
MR. CORRIGAN: Now we're getting far afield again --
A I do not.
MR. CORRIGAN: -- with the conversation about homosexuality. We're not here to talk about homosexuality. Has nothing to do with our case.
Go ahead.
A I do not have any issues with the removal. My issue is that the mental health issues are being overlooked, and that's a disservice to people who are gay and lesbian, and that we should do

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everything we can to help these individuals and advocate for them to recognize things that need treatment instead of pretending that they are not there, and therefore worsening the quality of their life overall.
BY MR. BLOCK:
Q Going back briefly to the formation of American College of Pediatricians, is it accurate to say that the catalyzing event for forming the American College of Pediatricians was the AAP's position on children raised by same-sex parents?
A As I understand it historically, it was.
Q One more minute. I may come back and finish.
(Brief recess.)
BY MR. BLOCK:
Q One more line of questions. In terms of the issues in this case with Mr. Grimm, do you think that by preventing Mr. Grimm from being allowed to use the boys' restroom, that that was actually something that was to his medical and mental benefit to prevent him from using the restroom?

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A In the sense that it was an affirmation, I personally believe that affirmation is harmful, so -- that I would say that was a harmful concept to let him use the bathroom of the sex he wished he were.
Q So when the board decided to stop letting him use the bathroom, you think that -- the bathroom consistent with his gender identity, you think that was to his benefit?
A Yes.
Q Is that right?
A Yes.
Q Okay. And is that because you think by not affirming him, by not letting him use the restroom, the school was making it any less likely that he would continue to be transgender?
MR. CORRIGAN: Object to form of the question.
A Can you restate the question again?
BY MR. BLOCK:
Q Sure. Is it your opinion that by not allowing Mr. Grimm to use the boys' restroom, that

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the school was making it less likely that he would continue to identify as being transgender?
A That would be a -- an opinion of mine personally based on the fact that anything that pushes affirmation ends up pushing the patient farther along on a spectrum which will inevitably involve cross-sex hormones and eventually surgical mutilation.
Q But -- so in Mr. Grimm's case, since he has already had cross-sex hormones and already had surgical chest surgery, and -- is it still your view that preventing him from using the boys' restroom would make it less likely that he would continue to identify as being transgender?
MR. CORRIGAN: Object to form of the question, beyond the scope.
Go ahead.
A So the concept is that, as Dr. Zucker has pointed out in his opinions as well, is that anything that you do that affirms the patient, because there is no -- there's no avenue that is successful up to that point in time in bringing the

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patient to desistance, that you're essentially pushing for ongoing mental health issues that need to be continually addressed.

And I would say that anything that does harm to that child -- the continuation of cross-sex hormones, the acute effects are masculinization of the body, the long-term effects for Mr. Grimm are going to be increased risk for medical conditions that he would not otherwise have as a result of that continued treatment.

So anything that pushes him to continue the hormone therapy, feeling that it is the only avenue or the only beneficial avenue, is to his harm. And therefore I would say if the school chose to not affirm him with a bathroom, that gives him a concept that perhaps there is not benefit in that, there's no proven benefit, no proven harm as an isolated event, but if it's part of the big picture of affirmation, that the Gloucester County School System should have no part of it.

BY MR. BLOCK:

Q But focused specifically on someone who is

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17 or 18 -- which Dr. Zucker does not think that hormones should be precluded for someone who is 17 and 18, correct?

MR. CORRIGAN: Object to form.

Go ahead.

A Dr. Zucker is not an endocrinologist. I'm an endocrinologist. I know about the harmful effects of hormones, and I disagree with that, that opinion of his, if that's what he agrees at this point in time.

Dr. Zucker's opinion on the persistence of the -- of gender dysphoria has to do with children who have started from young childhood and progressed up through adolescence and, despite constant and significant intervention, do not desist. He was not in general talking about kids who in their mid teens make a decision that they are now transgender and are essentially wishing to be the opposite sex. So it's comparing apples to oranges here.

BY MR. BLOCK:

Q So assuming that we're dealing with someone who has consistently from an early age

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identified with the opposite sex and has -- and other therapies have proven not to be successful, they are a junior or senior in high school, does Dr. Zucker's views provide any support for continuing to exclude that individual from using the boys' restroom, that transgender boy?

MR. CORRIGAN: Object to the form of the question.

Go ahead.

A I would say at any point during -- I disagree with Dr. Zucker. If that's -- if that is truly his opinion that the only route left is affirmation, and nothing else should be done to deal with that patient, then you let them go, I would personally disagree based on the long-term effects of affirmation and long-term hormones because without persistence of the incongruity as a concept, that patient is going to have to require the hormone therapy that's eventually going to be causing them a significant medical morbidity.

BY MR. BLOCK:

Q What if a patient has -- is 18 and has had

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genital surgery so that they no longer have -- it's a transgender woman and no longer has their male gonads and needs hormones, in that case would you still oppose gender-affirming hormone therapy for that individual?

A I recommend that that patient go back on the physiologic levels of their natal sex hormones at that age to maintain their body's health without harm.

Q And that would also be your view if the patient were 40 instead of 18, right?

A Yes. Yes.

Q And you think that when it comes to the issues of providing hormones, you are in a better position to make judgments about the benefits and risks than Dr. Zucker is because you are a trained endocrinologist, and he's not; is that right?

A That is correct.

Q And so would the converse be true, that a trained psychologist is in a better position to make decisions about what psychological care a transgender individual needs than an endocrinologist

is?

A Yes.

MR. BLOCK: Okay. That's all the questions I have.

MR. CORRIGAN: He'll read.

(Off the record at 3:31 p.m.)

ACKNOWLEDGEMENT OF DEPONENT

I, DR. QUENTIN VAN METER, do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct and complete transcription of the testimony given by me, and any corrections appear on the attached errata sheet signed by me.

_____ _____

(DATE) (SIGNATURE)

CERTIFICATE

I, Robyn Bosworth, RPR, CRR, CRC, CCR-B-2138, do hereby certify that the witness was first duly sworn by me pursuant to stipulation of counsel and that I was authorized to and did report said proceedings.

I further certify that the foregoing transcript is a true and correct record of the proceedings; that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision; that review was not waived; and that I am neither attorney nor counsel for, nor related to or employed by, any of the parties to the action in which this deposition was taken; and that I have no interest, financial or otherwise, in this case.

IN WITNESS WHEREOF, I have hereunto set my hand this 22nd day of March, 2019.

Robyn Bosworth

_____

ROBYN BOSWORTH, RPR, CRR, CRC, CCR-B-2138

Gloucester High School

6680 Short Lane
Gloucester, VA 23061

Mr. T. Nathan Collins
Principal

TO: Mrs. Deirdre Grimm

FROM: Mr. T. Nathan Collins TNC

DATE: October 14, 2014

RE: Restroom use for Gavin Grimm at GHS

CC: Ms. T. Durr, Gavin Grimm

This is a follow up of our meeting from this morning in reference to Gavin Grimm having accommodations for restroom use at GHS. In attendance were: Mr. T. Nathan Collins, Mrs. Deirdre Grimm, Gavin Grimm, and Ms. Durr.

Effective Monday October 20, 2014

- *Restroom Use:*
  Gavin may go to any male student restroom at Gloucester High School. He will need a restroom stall with a door, one which will be selected by Gavin. Gavin will notify Ms. Durr if and when this need changes.

- *Responding to verbal harassment, threatening behavior, and other conflicts:*
  Gavin will ignore, or respond to questions with an appropriate response. Gavin will attempt to remove himself from the situation immediately. If Gavin believes a verbal harassment and or threatening language/behavior has been directed toward him, or if there is any other conflict, he will notify Ms. Durr immediately.

- *Other needs:*
  No other needs are needed at this time.

Phone (804) 693-2526

Fax (804) 693-7685

From: "Dr. Walter R. Clemons" <wclemons@gc.k12.va.us>

Date: October 22, 2014 7:31:18 PM

To: "Randy Burak" <georgeburak@cox.net>; "Kevin Smith" <kevin.smith@rivhs.com>; "Kimberly Hensley" <kimberlyehensley@gmail.com>; "Anita Parker" <Anita.Parker@gc.k12.va.us>; "Charles Records" <charles.records@gc.k12.va.us>; "Carla Hook" <hookc@cox.net>; "Troy Andersen" <troyandersengp@cox.net>

Subject: **Transgender Issue & GHS Pep Rally**

Attachments:

Just FYI. Two issues that I would like to discuss with you tomorrow in closed session include a transgender issue at GHS as well as student behaviors at the GHS pep rally last week. Contact has been made (to Mr. Collins and some Board members) regarding these issues and I want us all to be on the same page in our responses. Also, the paper has contacted Mr. Collins and a Board member (GloQuips)regarding student consequences as a result of student behavior from the pep rally last week. Mr. Collins informed me that some student actions were inappropriate and that he has shared with students that student behavior will be taken in consideration for future events. However, there has not been any action taken against any students at this time stemming from last week. Mr. Collins said he is still trying to identify some students for inappropriate conduct. Finally, I will forward you some literature on the transgender issue that Elizabeth Ewing (VSBA) sent to me when we had a discussion on this issue previously. Furthermore, I will have Mr. Collins present tomorrow evening so he can fill you in on his actions thus far relating to these issues. Have a great day!

Dr. Walter R. Clemons

From:	Nate Collins
Sent:	Thursday, October 23, 2014 12:05 PM
To:	Dr. Walter R. Clemons
Cc:	Tiffany Durr
Subject:	transgender info
Attachments:	GHS transgender.docx; bathroom plan.docx

Dr. Clemons,
Please find attached background information related to use of GHS restrooms by a transgender student: a memo with background information and a copy of the written plan developed regarding bathroom use. Please let me know if you need additional information.

Thanks,

Nate

October 23, 2014

To: Dr. Walter R. Clemons, Superintendent

From: Mr. Nate Collins, Gloucester High School Principal

Subject: Transgender Student Background Information

This is in reference to a tenth grade student at Gloucester High School who is transgender, and identifies as male and his use of male restrooms at GHS. GHS school counseling staff provided information included here.

The student's middle school and ninth grade counselors reported meeting with the student frequently in eight and ninth grade due to anxiety he experienced related to his identity. In ninth grade, because of the severe anxiety he experienced, the student was placed on homebound mid-year until the end of the 2013-2014 school year.

During the summer of 2014 the student provided the School Counseling Department at Gloucester High School with proof of a legal name change, in which the student's name was changed on school documents. The student stated by changing his name his identity is more accurately reflected. In addition to changing his name, the student requested that other students and staff identify him as "he" in oppose to "she". During the current academic school year, the student continues to report experiencing anxiety. The student has stated fear of not being identified by the correct pronoun(s) and possible lack of understanding by students and staff contributes to his anxiety at school. The student has also reported using the women's bathrooms is a concern as it relates to his identity.

At the beginning of the school year, a plan was put in place to accommodate the student's bathroom use concerns. An administrative decision was made and the student was informed by his school counselor he may use the bathroom in the school clinic. In the case of an emergency the student was given permission to use a staff bathroom on the D wing of the school, in which the majority of his classes are located. At the beginning of the school year, the student and his mother reported the student will begin hormone therapy during the month of October. In early October, prior to the anticipated date of the student beginning hormone therapy, the student met with his school counselor and requested permission to use male student bathrooms either before or once he begins hormone therapy. This request was brought to my attention. I consulted with Dr. Clemons and with school counseling staff members to review available legal references. Redacted

Redacted

Redacted During a meeting with the school principal, school counselor, the student, and the student's mother, the student was informed by the school principal he may begin using student male bathrooms at Gloucester High School on October 20, 2014 and a written plan for doing so was developed.

Subject: Re: Issue at GHS
From: Carla Hook <hookc@cox.net>
Date: 10/27/2014 2:29 PM
To: REDACTE @cox.net

I do not believe any plans exist to send home notification to parents.

Legal counsel is Reed Smith in Richmond. Like you, I questioned what legal basis there is to require this. This was an oral opinion given to the superintendent. We have asked for written opinion citing chapter and verse.

Thanks--Carla

On 10/27/2014 1:52 PM, REDACTED @cox.net wrote:

> More thoughts:
>
> 1. Is the SB planning on formally notifying the parents of these boys that they are sharing their bathroom with a female? They have the right to know!
>
> 2. Exactly what "legal counsel" was questioned? What law or precedent was their decision based upon as I find no such precedent or law within VA?
>
> Every parent except 1 that I have spoken to is OUTRAGED over this. A formal notice should be sent out from GHS informing the families at GHS what is occurring.
>
> REDACT

---- Carla Hook <hookc@cox.net> wrote:

> Hi REDAC n.
>
> As of right now, transgendered students are allowed to use the restroom of their self-identifying gender. This decision was made at the building level and before the issue was brought to the attention of the school board. However, the building administrators did consult with executive staff in the superintendent's office before making any decision (ie the superintendent and assistants). They in turn consulted legal counsel. When this was brought to the attention of the school board, the majority declined to take any action at this time but did agree to seek a formal written opinion from legal counsel.
>
> Hope that helps clarify.
>
> Carla
> On 10/24/2014 2:07 PM, REDACTED @cox.net wrote:
>
> > First of all, let me thank you for replying. I have sent 2 emails and you are the ONLY person decent enough to take the time to reply. To say the least, I am disappointed in the lack of response from GHS, Clemons and the entire school board.
> >
> > Certainly wish this brought me peace but it certainly does not. I appreciate your response and understand the steps that need to be taken.
> >
> > However, on Wednesday I emailed Principal Collins and have yet to receive any response. My email was simple and was only asking for an answer to whether this young lady is using the boys bathroom. And if so, who gave her permission. I would appreciate those questions being answered as they are not confidential regarding a single student but impacts my son as he is in the boys bathroom.
> >
> > Many thanks,
> > REDACT

---- Carla Hook <hookc@cox.net> wrote:
Thanks REDACTED n. The Board has taken no action on this issue as of this time. However, we have requested a legal opinion from counsel as to our legal obligations to transgendered students. There has been some suggestion that we may be legally obligated to allow cross-gendered use of restroom facilities. I find that difficult to believe, but we are checking into it.

I will also say that I oppose cross-gendered use of restroom facilities; however, mine is not the only opinion on the Board in this regard. I would strongly encourage you to attend the next meeting during pubic comment period, as well as any others concerned about this issue.

Thanks--Carla

On 10/24/2014 10:37 AM, REDACTED @cox.net wrote:
Carla,

Just following up with you as you suggested regarding last nights meeting and what ultimately became of the situation at GHS.
Thanks,
REDACTED

---- Carla Hook <hookc@cox.net> wrote:
There is nothing on the agenda tonight whereby this issue will be discussed in open session, and as I stated a policy change must be done in open session. We do have some student matters to discuss in closed session (after the regular work session) and given these emails and calls it is safe to assume such a student issue will be discussed.

As a work session, there is no public comment time, but there will be public comment time during our regular meeting in November.

Again, I would encourage you to contact us after the meeting. We cannot discuss specific students, but will be able to discuss policy implementation.

Carla

On 10/23/2014 10:49 AM, REDACTED @cox.net wrote:
Carla,

Thanks for replying. Will this be discussed tonight? If so, will it be open or closed session? I would love to be a part of that conversation but both of my kids of athletic activities tonight. This is not a road we need to go down.

Thanks,
REDACTED

---- Carla Hook <hookc@cox.net> wrote:
REDACTED

Thank you for your email. I had not heard about this particular issue until a phone call from another parent last night.

While it is true that we only discuss specific students in closed session, any issues of a policy nature are only done in open session. If this rumor it true, I can assure you it is of tremendous concern to me as well. As you know, I also have two sons. Rumors, particularly among teenagers, can take on a life of their own, so I look forward to

getting all the facts.

I would encourage you to contact me or other Board members again after our meeting tonight.

Thanks--Carla

On 10/23/2014 9:57 AM, REDACTED @cox.net wrote:
I have been told by numerous individuals that there is currently a young lady either using the boys bathroom or requesting permission to use the boys bathroom. Apparently this young lady is uncomfortable in the girls bathroom and was allowed to use a private admin bathroom last year as she wants to be a boy.

Words can not express how dumbfounded I will be if this proves true. For respect of this email I will have to assume it is and express my utmost concern on this issue. I am the mother of a GHS son and an elementary aged daughter. This should not be allowed to happen for reasons I would assume would be obvious:

When does 1 students comfort level or rights come before an entire student body?

If she is still biologically a female she should be using the female restroom. There is certainly more privacy in there than they boys.

Have you considered the possible reactions of what could transpire with her in the boys bathroom? She could be humiliated or physically assaulted by boys in the bathroom. That is certainly a possibility in todays world and a can of worms I would pray you would try to avoid. She could also accuse of boy or boys of a verbal of physical assault that never happened and I am smart enough to know that boy would be guilty until proven innocent!

Are you ok with letting a boy in the same circumstance enter the girls bathroom with his God given genitalia?

What's next the locker rooms? Why not let a boy claiming to be a female trapped in a girls body change close and shower with the girls in their respective locker room? Why don't we send the same young lady in question into the boys locker room to change, She doesn't need a private area. She could certainly use their restroom, change in the presence and shower with them, right?

Please consider all aspects of this issue before making any judgment. This school system has SO many important issues and failures to deal with and correct that I would certainly hope this should be an easy decision to deny this young ladies request. When you start treating one child different and allowing special treatment for one over all others that is an ugly path that you won't want to go down.

Respectfully,
REDACTED

Subject: Re: GHS Restrooms
From: Carla Hook <hookc@cox.net>
Date: 10/31/2014 8:34 AM
To: REDACTED @gmail.com>

There was no vote in this matter, as we are not allowed to vote in closed session. The closed session last night was to discuss a particular student. Nonetheless, a majority has still declined to intervene in the current practice at the high school. I was in the minority in that regard with Mr. Records. I believe that females should use the female restroom and males should use the male restroom. If there is a student that has difficulty with this arrangement, I believe there are other appropriate alternatives that take into consideration the needs of all students.

However, we will be seeking a public vote on this practice at our next regularly scheduled meeting, Nov. 11 at TCW.

Thanks for checking--Carla

On 10/31/2014 7:46 AM, REDACTED wrote:

> Good Morning, Carla,
>
> I received an email from Charles Records this morning regarding the transgender restroom situation. For the record, as obviously, I disagree with this outcome, I would like to know precisely how you voted on this matter, as Charles mentioned the decision was not unanimous.
>
> REDAC

Diane Gamache

From: Diane Gamache
Sent: Wednesday, November 05, 2014 10:47 AM
To: 'Carla Hook'; John Hutchinson; JoAnne Wright; Betty Jane Duncan; Anita Parker; Charles Records; Dr. Walter R. Clemons; Kevin Smith; Kevin's Phone; Kimberly Hensley; Randy Burak; Troy Andersen
Cc: Carol Dehoux; Randy@Office
Subject: Proceeding w/Agenda

Importance: High

As I now understand it, REDACTED following the 10-30 closed meeting – I REDACTED REDACTED.

I believe that the Chair plans to determine if a majority of the Board wishes to revisit the matter, and if so, he will notify me of such. For now, I am going to proceed with publishing the agenda without the discussion being added.

Diane

From: Carla Hook [mailto:hookc@cox.net]
Sent: Tuesday, November 04, 2014 8:01 PM
To: Diane Gamache; John Hutchinson; JoAnne Wright; Betty Jane Duncan; Anita Parker; Charles Records; Dr. Walter R. Clemons; Kevin Smith; Kevin's Phone; Kimberly Hensley; Randy Burak; Troy Andersen
Cc: Shirley Chirch
Subject: Re: Draft Agenda for November 11th Monthly SB Meeting

I think we need to add appropriate use of restroom/locker room facilities to the agenda, discuss and vote and be done with this issue for now.

On 11/4/2014 1:16 PM, Diane Gamache wrote:

> Please let me know if you would like any additions or changes made as I plan to publish this tomorrow (Wednesday, November 5, 2014). Thanks!
>
> Diane

Dr. Walter R. Clemons

From:	Carla Hook <hookc@cox.net>
Sent:	Sunday, November 09, 2014 9:32 PM
To:	Anita Parker; Charles Records; Kevin Smith; Kimberly Hensley; Randy Burak; Troy Andersen; Dr. Walter R. Clemons
Subject:	FYI
Attachments:	motion.docx

Whereas the GCPS recognizes that some students question their gender identities, and

Whereas the GCPS encourages such students to seek support and advice from parents, professionals and other trusted adults, and

Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore

It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with sincere gender identity issues shall be provided an alternative private facility.

Gloucester (Va.) County School Board

PRESS RELEASE

FOR IMMEDIATE RELEASE ON DECEMBER 3, 2014

CONTACT: George R. (Randy) Burak, Chairperson
Phone: (804) 695-6399
Email: Georgeburak@cox.net

Gloucester School Board prepares to discuss, likely vote at Dec. 9 meeting on restroom/locker room use for transgender students

Gloucester, Va. -- As the Gloucester County School Board members prepare to discuss and likely vote on how to handle the use of school restrooms and locker rooms by transgender students, they continue to seek guidance and input from many sources around the county, state and nation.

"Issues around transgender students are facing schools districts across the country, and we are seeking to learn from the best resources available," said School Board Chair George (Randy) Burak. "This issue is not about one student; rather, it's about all our students. We as a Board are seeking to do what's best for our district in an open, transparent manner."

Process and Perspectives

The Gloucester School Board has received legal guidance from several sources, both locally and around the state. It has reviewed guidance from the U.S. Department of Education's Office for Civil Rights, along with a variety of literature from interested organizations around the country.

The Board has received a great deal of input from the local public through emails, phone calls, comments at the Nov. 11 School Board meeting, and community meetings. Several Board members and Superintendent Walter Clemons recently attended the Virginia School Boards Association's annual conference in Williamsburg, which had an entire working session, "Transgender Protections in Public Schools: Recent Developments," presented by a law firm.

Burak said: "Our Gloucester School Board has undergone a very detailed, professional, and deliberative process, examining many differing opinions and guidance viewpoints. I believe that our district will become stronger for all our students as a result of the research we've done, the discussions we've had, and the ultimate conclusions we'll reach."

Current Situation and Options

While the Gloucester County Public School district adheres to general non-discrimination principles similar to most U.S. school districts, it currently does not have guidelines specifically addressing gender identity and the use of restrooms and locker rooms.

That means that the School Board could decide to adopt specific guidelines to address these issues; or the Board could further define what fully accommodating transgender students would look like and how it would operate on a daily basis.

Good news for all students

One positive outcome of all the discussion is that the District is planning to increase the privacy options for all students using school restrooms, according to Superintendent Dr. Walter Clemons.

Plans include adding or expanding partitions between urinals in male restrooms, and adding privacy strips to the doors of stalls in all restrooms. The District also plans to designate single-stall, unisex restrooms, similar to what's in many other public spaces, to give all students the option for even greater privacy.

"This situation has created the opportunity for us to make things better for all our students and to make our school buildings more accommodating to a wide variety of needs," said Dr. Clemons. **"We have listened to what our parents, students, and other constituents have told us, and we are working to act on their suggestions for the benefit of everyone."**

Background

This issue of restroom use consistent with gender identity first came to the attention of Gloucester schools in October when a transgender student asked campus leaders to use the bathroom of that student's gender identity. Due to student privacy concerns, the issue was initially handled confidentially, and the School Board was informed immediately afterward. While the Board is not legally required to act on the matter, the Board is taking the opportunity to consider developing new guidelines, or further defining the current general practice of non-discrimination.

Since that time, the Board has been reviewing the various options and determining how to best meet the needs of all students in Gloucester schools.

Next Steps

The Board will discuss and likely make a decision at their upcoming monthly meeting at **7 p.m. Tuesday, Dec. 9, at the T.C. Walker Auditorium**. As always, the public is invited to attend.

Anyone interested in expressing views on this or other matters to School Board members can email SchoolBoard@gc.k12.va.us, or call (804) 693-1424 to leave a message.

About the Gloucester (Va.) School Board

The Gloucester School Board is the official policy-making body for Gloucester County Public Schools. The elected Board is composed of seven members representing the five magisterial districts, along with two who serve at large. The 2014 School Board members are Randy Burak, chair; Kevin Smith, vice-chair; Troy Andersen; Kimberly Hensley; Carla Hook; Anita Parker; and Charles Records.

More information about the Gloucester School Board and the Gloucester County Schools may be found at http://gets.gc.k12.va.us/.

RECORDED MINUTES OF THE GLOUCESTER COUNTY SCHOOL BOARD GLOUCESTER, VIRGINIA

DECEMBER 9, 2014

The regular monthly meeting of the Gloucester County School Board was held on Tuesday, December 9, 2014. The Chairperson called the meeting to order at 5:30 pm at the Thomas Calhoun Walker Education Center.

I. ROLL CALL

Roll call was taken by the Acting Clerk, and the following persons were recorded as present: George R. (Randy) Burak, Chairperson, Troy M. Anderson, Kimberly (Kim) E. Hensley, Carla B. Hook, Anita F. Parker, Charles B. Records, and Kevin M. Smith, Members. Also present for the closed meeting: Walter R. Clemons, Ph.D., Superintendent of Schools, and John E. Hutchinson, Assistant Superintendent for Administrative Services and Acting Clerk.

II. CALL FOR CLOSED MEETING

At 5:42 pm, a motion was made by Mr. Records, seconded by Ms. Parker, and unanimously approved to adjourn for a closed session, pursuant to *Code of Virginia*, 1950, as amended, Section 2.2-3711 (A), Subsection 1, for the discussion of personnel matters (monthly appointments, resignations, etc.). At 6:32 pm, the Chairperson declared a recess, and the meeting was relocated to the Thomas Calhoun Walker Education Center auditorium.

III. RETURN TO OPEN MEETING/CERTIFICATION

Note: Ms. Diane Clements Gamache, Clerk, recorded the remainder of the meeting. The Clerk noted that all members were present for the open meeting.

At 7:00 pm, a motion was made by Mr. Smith to reconvene the meeting into open session and certify that the Gloucester County School Board, while in closed session, discussed only public matters lawfully exempted from open meeting requirements provided in Subsection A of Section 2.2-3711 and that only public business matters that were identified in the motion convening the closed session were heard, discussed or considered. The motion was seconded by Ms. Hensley and approved as follows:

Mr. Andersen	Aye	Mr. Records	Aye
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Ms. Parker	Aye		

IV. MOMENT OF SILENCE/PLEDGE OF ALLEGIANCE – Ms. Campbell Farina, SAC representative, led the Board and citizens in a moment of silence followed by the Pledge of Allegiance to the flag of the United States of America.

V. PERSONNEL ITEMS

A. Approval of Monthly Personnel Actions — A motion was made by Mr. Records, seconded by Mr. Andersen, and unanimously adopted to approve the monthly listing of personnel appointments, staff leave, and contract changes **(approved copies attached to minutes)**.

VI. ADDITIONS/CHANGES/ADOPTION OF AGENDA

Dr. Clemons recommended the following changes to the *revised* agenda **(attached to minutes)** as published: Moving policy, File JHCH from Consent to Item C under Administrative Services' Items; and re-ordering School Board Members Items' immediately following Citizens' Comment Period. A motion was made by Mr. Smith, seconded by Mr. Records, and unanimously adopted to approve the agenda as amended.

VII. APPROVAL OF ITEMS CONTAINED IN THE CONSENT AGENDA

A motion was made by Mr. Smith to approve the Consent Agenda as amended (listed below). Motion was seconded by Mr. Andersen and approved with a roll call vote:

Mr. Andersen	Aye	Mr. Records	Aye
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Ms. Parker	Aye		

ITEMS CONTAINED WITHIN THE CONSENT AGENDA:

A. Approval of Minutes of November 5, 2014 Special (3-Member Panel Hearing) Meeting
B. Approval of Minutes of November 11, 2014, Monthly Meeting
C. Approval of Policy Manual Update
   a. IF-R: Program of Studies (revision)
D. Informational Central Food Service Financial Report as of October 31, 2014
E. Informational Membership Report as of November 21, 2014
F. Informational Suspension Report for November, 2014
G. Informational Visiting Teachers Report for November, 2014
H. Informational Transportation Report for November, 2014

VIII. STAFF PRESENTATIONS/RECOGNITIONS

A. Presentation of Diplomas to GHS Winter Graduates – Dr. Toni Childress, GHS Staff, Mr. Nate Collins, GHS Principal, and Mr. Burak awarded diplomas to the GHS winter graduates. Students present who received their diplomas were: Rebecca Gayle Allen, John Raye Gaddis, Ashley Michelle Kearns, Alexandra Judith Rodriguez, Sebastian Leigh Sain (Advanced Diploma), Justin Raye Schultz, and Travor Jameel Wilson. Three other graduates were not present: Cassidy Reid Preston, James Jack Spence, and Keith Randall Thrift, Jr.

B. Recognition of Mr. Rusty West, Project Lead the Way Teacher – Dr. Wagner congratulated Rusty West for receiving the Project Lead the Way National Teacher of Excellence Award. Mr. West was one of six instructors recognized on the national level for their outstanding commitment to educating students in the STEM disciplines and preparing them with the skills to be successful in college and their careers.

C. Updates on Boards/Commissions by School Board Members – There were none.

IX. CITIZENS' COMMENT PERIOD

Mr. Burak asked if there were any persons present who wished to address the Board. He asked that all persons state their name, the district in which they reside and to limit their remarks to two (2) minutes or less. He stated that Mr. Ted Wilmot, County Attorney, would act as the official time-keeper. The following citizens came forward to speak:

Steve Sikes-Nova (teacher/GEA spokesperson)
Brian McGovern (President of GEA)
Ralph VanNess (Ware)
Donna Pierce Freeman (teacher/Ware)
Pastor Fred Carter (Gloucester)
Gavin Grimm (student)
Deirdre Grimm (Gloucester)
Jacklynn Lehiff (Abingdon)
Scott Williams (Abingdon)
Savannah Williams (Abingdon)
Kathryn Lindsay (Abingdon)
Dianne Carter deMayo (Hayes)
Andrew Palas (Gloucester Point)
Amy VonFossen (Ware)
Adam Carpenter (Gloucester Point)
Campbell Farina (Abingdon)
Karen Pauley (White Marsh)
Barbara King (Abingdon)
Mike Enz (Abingdon)
Catherine Foley (Abingdon)
Marc Farina (Abingdon)
Reese Williams (Ware)
Howard Mowry (Gloucester Point)
Paul Martin (Gloucester Point)
Janet West
Linda Wall (Buckroe Beach)
Don Mitchell (York)
David Wilcox (York)
Terry Brennan (Abingdon)
Michelle Larson (York)
Maritza Cooper (Petsworth)
Ira Johnson (Petsworth)
Gabrielle Johnson (Ware)
Christina Klein (Hayes)
Alex Westfall (Gloucester)
Jacob Hangdahl (Hayes)
Kelly Williams (Gloucester Point)

Note: Change in Order of Items

XII. SCHOOL BOARD MEMBERS ITEMS

A. VSBA Capital Conference – Monday, January 26, 2015 at the Richmond Marriott @ $170 per person. Board members should contact the Clerk for pre-registration purposes if they would like to attend.

XII. SCHOOL BOARD MEMBERS ITEMS – continued

B. Adoption of Resolution re: Funding of Public Education in Virginia – Mr. Burak stated that a resolution proposed in conjunction with the Virginia School Boards Association and the Virginia Association of School Superintendents, was included in the agenda regarding calling upon the Virginia General Assembly to immediately increase the state's share of funding for public education to the level of quality that is prescribed by them in the Standards of Quality and expected by all of the Commonwealth's citizens. A motion was made by Mr. Andersen and seconded by Ms. Parker to adopt the resolution as presented. The Clerk recorded the following vote:

Mr. Smith	Aye	Ms. Parker	Aye
Mr. Records	Aye	Ms. Hensley	Aye
Mr. Andersen	Aye	Mr. Burak	Aye
Mrs. Hook	Aye		

C. Other Matters as brought up by Board Members

1. Discussion of Use of Restrooms/Locker Room Facilities – Mr. Burak stated that a motion had been postponed at the November 11, 2014, until the December 9, 2014, meeting and was in order for consideration at this time. He read the motion to be considered as recorded in the November 11, 2014 minutes:

"Mrs. Hook read the following resolution and made a motion to adopt said resolution:

Whereas the GCPS recognizes that some students question their gender identities, and
Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and
Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore
It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

The motion was seconded by Mr. Records."

A motion was made by Mr. Records, and seconded by Mr. Andersen to bring the original motion back to the table for a vote.

Mr. Andersen stated that he would like to politely request from one Board member to another that anyone recuse themselves from voting if they felt they had a conflict of interest, pursuant to Code of Va, 1950, as amended, Section 2.2-3100 or Board policy, File BBFA.

Following comments by each Board member, the Clerk polled on the postponed motion under consideration (carried 6 to 1):

Ms. Parker	Aye	Mr. Smith	Aye
Ms. Hensley	Naye	Mr. Records	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Mr. Andersen	Aye		

X. STUDENT ADVISORY COMMITTEE (SAC) ITEMS) – Ms. Farina had no items.

RECESS – At 9:18 pm, the Chair called for a 5-10 minute recess. At 9:28 pm, he called the meeting back to order.

XI. SUPERINTENDENT'S ITEMS

A. Comprehensive Plan Update/Reminder of Next Meeting Date – Dr. Clemons reminded Board members and the public that the next Comprehensive Plan development meeting would be held on Wednesday, December 17, 2014, 7:00 pm at the Thomas Calhoun Walker Education Center. He stated that the School Board would have the final decision on the Comprehensive Plan.

B. Discussion of Possible Additional Budget Meeting with Board of Supervisors – Dr. Clemons stated that he would speak with Ms. Brenda Garton, County Administrator, about the possibility of holding another joint budget work session with the Board of Supervisors, as this was discussed at the September joint meeting and the School Board was again receptive.

Mrs. Hook asked if it might be possible to hold a 1-hour meeting with the local and state legislators prior to the opening of the General Assembly, and Dr. Clemons stated that he would check into it and get back to the Board.

XIII. HUMAN RESOURCES ITEMS

A. Monthly Departmental Report – Dr. Juanita Smith, Director of Human Resources, presented information on the activities of the department during the month, and expressed her appreciation to her staff. She also announced that Ms. Ashley Field had recently earned Nationally Board Certified Teacher status and Mr. Andersen asked that she be recognized at the January Board meeting.

XIV. ADMINISTRATIVE ITEMS

A. Monthly Departmental Report – Mr. Hutchinson reviewed departmental activities accomplished during the month.

B. Update on Redistricting Plans – Mr. Hutchinson stated that preliminary numbers would suggest that attendance zones would remain the same for middle schools when Page opens; however, they are continuing to monitor elementary school numbers.

Mr. Records asked if information on previous studies on the Page site, etc. had been sent to the Board of Supervisors. Dr. Clemons and Mr. Hutchinson both noted that they would check.

C. Policy JHCH: School Meals and Snacks (new) – A motion was made by Mr. Smith, seconded by Mr. Records and unanimously approved to adopt File JHCH: School Meals and Snacks as a first and second reading.

Mrs. Hook asked if Food Service could make a 10 minute presentation on the status of the School Lunch Act at a future work session, and Mr. Hutchinson agreed to pursue this.

XV. INSTRUCTIONAL ITEMS

A. Monthly Departmental Report – Dr. Wagner reviewed highlights of the month from Instructional Services.

XV. INSTRUCTIONAL ITEMS – continued

Mrs. Hook asked that a report be given to the Board in January on the Adaptive Tests for 6th graders.

B. Continued Discussion on Field Trip Policy (Policy ICA) – Dr. Wagner stated that a VML supplemental policy might be available on an annual basis to cover international travel but stated that there were several options available. It was agreed that he would present different options for the Board at a work session in January or February.

C. Update on Naviance: College and Career Readiness Solutions – Dr. Wagner informed the Board that staff would pursue using Naviance as a sole source since no others were available as a result of the RFP/bid process.

XVI. BUDGET AND FINANCE ITEMS

A. Monthly Departmental Report – Ms. Joanne Wright, Director of Budget and Finance, highlighted tasks and accomplishments of the Budget and Finance Office, and expressed her appreciation to her staff.

B. Acceptance of Donations -- Ms. Wright highlighted the donations received by the division totaling $564.44. A motion was made by Mr. Records and seconded Mr. Smith to accept with grateful appreciation the donations as outlined. The Clerk polled the Board as follows:

Ms. Parker	Aye	Mr. Smith	Aye
Ms. Hensley	Aye	Mr. Records	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Mr. Andersen	Aye		

C. Financial Reports – Ms. Wright presented the following reports that were accepted by the Board as information:

1. October 30, 2014 Financial Report
2. November 25, 2014 Construction Financial Report
3 November 25, 2014, HVAC/Roof Financial Report

XVII. PUBLIC ANNOUNCEMENTS

Mr. Burak read the following public announcements**:**

A. Next GCPS Comprehensive Plan Meeting – Wednesday, December 17, 2014, 7:00 pm @ the Thomas Calhoun Walker Education Center (Cafeteria)
B. Winter Break-Division Closed – Monday-Friday, December 22, 2014-January 2, 2015 – Note: Monday-Tuesday, December 22 (Full)-23 (Half), 2014, are 12-Month Employee Work Days
C. Teachers/Students Return from Winter Break – Monday, January 5, 2015
D. Next Monthly and Annual Organizational School Board Meeting – Tuesday, January 13, 2015, 7:00 pm @ the Thomas Calhoun Walker Education Center (Auditorium)

Mr. Burak asked Board members to consider leadership roles for the January 13, 2015, organizational meeting and let others know if they were interested the Chair/Vice Chair position.

Mr. Burak requested additional information on the use of a PR consultant for such items as redistricting, the new Page Middle School and the budget process. Dr. Clemons stated that he would bring back a recommendation to the Board.

Mr. Records asked if Dr. Clemons would be prepared to give an assessment/synopsis of his first 90 days at the January meeting and Dr. Clements assured him that he would.

XVIII. CALL FOR ADJOURNMENT

At 10:10 pm, there being no further business, a motion was made by Ms. Parker, seconded by Mrs. Hook, and unanimously approved to adjourn the regular monthly meeting of December 9, 2014, until the next monthly and annual organizational meeting at 7:00 pm on Tuesday, January 13, 2015, at the Thomas Calhoun Walker Education Center (Auditorium).

George R. (Randy) Burak, Chairperson

Diane Clements Gamache, Clerk

John E. Hutchinson, Acting Clerk

Attachments (3): To be bound with the official minutes once approved.

1. Bound Agenda for December 9, 2014, Monthly Meeting
2. Revised Agenda for December 9, 2014, Monthly Meeting
3. Approved Monthly and Supplemental Personnel Listing

END
DCG/JEH/:bjd
MIN-12-09-14

Gloucester High School

6680 Short Lane
Gloucester, VA 23061

Mr. T. Nathan Collins
Principal

December 10, 2014

Mr. and Mrs. David and Deirdre Grimm
3624 Fox Haven Drive
Gloucester, Virginia 23061

Dear Mr. and Mrs. Grimm,

This letter will provide notice to you that the Gloucester County School Board at its regularly scheduled meeting on December 9, 2014, adopted the following resolution: "It shall be the practice of the Gloucester County Public Schools to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative private facility."

As a result, Gavin will no longer be able to use the male restrooms at Gloucester High School effective immediately. I will work with you regarding Gavin and options for his restroom usage at GHS.

Please contact me at 804.693.2026 or at ncollins@gc.k12.va.us if you have any questions. Thank you.

Sincerely,

T. Nathan Collins

Phone (804) 693-2526 *Fax (804) 693-7685*

From: "Amy Bergh" <abergh@gc.k12.va.us>
Date: November 19, 2014 12:22:31 PM
To: "Nate Collins" <ncollins@gc.k12.va.us>
Subject: **Restrooms**

Attachments:

I am writing to express my deep concern for the planned changes to C-Hall restrooms. I am not sure that the decision makers are aware of the high usage of those restrooms. With the exception of between first and second block the woman's restroom typically is fully occupied and has a line of several woman waiting to use the facilities. I understand the faculty men's room is fairly heavily used also. On first glance there may not appear to be that many staff members on C-Hall. It is easy to forget that we house a high number of Special Education students with a high number of support staff. It's not just the teachers; but also the paraprofessionals, therapist, drivers that use the C-Hall restrooms. C-Hall is also frequently used by Page staff during the day. Simply using the student restroom does not alleviate the issue as there is almost always a line in there between classes. Most of C-Hall teachers have at least one day that we have no opportunities to use the restroom other than the five minutes during class changes from before 8:00 a.m. with school starting until our lunch at 12:30 p.m. That is a very long time for anyone to wait it but pretty impossible for faculty on diuretics. Of course we could always call security to cover our classes but that seems to be a very poor use of our resources; a loss of instructional time; and they are not always available.

I am very aware of what a difficult issue this is but I truly feel that in the rush to fix one problem we are creating another. Perhaps other options could be more fully examined prior to a final decision being made.

*I know there is a plan for A -Hall and that does make a little more sense because they have six faculty restrooms and two student restrooms.
*The B-Hall restrooms are not even used during the day. Perhaps the doors could be adjusted to accommodate this problem.
*I don't know if anyone is currently using the old Childcare "restroom" C162; perhaps that could be converted as a long term solution.
*The main office has three staff restrooms not counting the principal's; perhaps a door to the hall could be added to the back restroom.
*I believe the custodians even have two private restrooms in their locker rooms; is that still a need?

I know there is no easy solution to this problem but please consider that it is much easier to give a student a hall pass to travel across the school then for a staff member to use the restroom.

Thank you for your considerations,
Amy

GRIMM, GAVIN ELLIOT

Graduation date: 06/10/2017
Diploma type: Standard

Student	Student Address	School
State ID: [redacted] Birth Date: [redacted] Gender: Female Grade Level: Graduated	[redacted]	Gloucester High School Gloucester County Public Schools 6680 Short Lane Gloucester, VA 23061 804-693-2526 (Tel) 804-693-7685 (Fax) Virginia School ID: 036-0260

Year: 2011-2012 Grade Level: 7
Peasley Middle School
2885 Hickory Fork Road Gloucester VA, 23061 804-693-1499 tlawson@gc.k12.va.us

ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
12005	KEYBOARDING		[redacted]	0.50	
Totals:				0.50	

Year: 2013-2014 Grade Level: 9
Gloucester High School
6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us

ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01001	VLC ENGLISH 9	DL	[redacted]	1.00	
02052	VLC ALGEBRA I	DL		0.00	
03001	VLC EARTH SCI	DL		1.00	1.00
04052	VLC WORLD I	DL		1.00	1.00
08001	VLA PE 9	DL		0.50	
08051	VLA HEALTH 9	DL		0.50	
Totals:				4.00	2.00

Year: 2014-2015 Grade Level: 10
Gloucester High School
6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us

ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01002	ENGLISH 10		[redacted]	1.00	
02052	ALGEBRA I			1.00	1.00
03051	BIOLOGY I			1.00	1.00
04052	WORLD HIST II			1.00	1.00
05052	THEATER I			1.00	
05154	ART FOUNDATION			1.00	
08016	VLC PE 10	DL		0.50	
08201	HEALTH PE DR ED 10			1.00	
Totals:				7.50	3.00

Year: 2015-2016 Grade Level: 11
Gloucester High School
6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us

ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01003	VLC ENG 11	DL	[redacted]	1.00	2.00
01104	CREAT WRITING			1.00	
02072	VLC GEOMETRY	DL		1.00	
03005	VLC OCEANOGRAPHY	DL		1.00	
04102	VLC US HISTORY	DL		1.00	
04254	VLC PSYCH	DL		1.00	
Totals:				6.00	2.00

Year: 2016-2017 Grade Level: 12
Gloucester High School
6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us

ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01004	ENGLISH 12		[redacted]	1.00	
02902	ALG FUN DATA			1.00	
04151	US GOVERNMENT			1.00	
19262	ECON PERS FIN			1.00	
Totals:				4.00	

Summary

GPA (Cumulative Weighted):	[redacted]
Rank (Cumulative Weighted):	
Credits Attempted:	23.00
Credits Earned:	22.00
Verified Credits Earned:	7.00
2011 Absences:	6
2013 Absences:	7
2014 Absences:	32
2015 Absences:	96
2016 Absences:	24

Standardized Tests

Test	Subtest	Date	Score

Credentials

Code	Name	Date
9303	Workplace Readiness Skills	02/27/2017

Official Signature and Title (Required): _____ Date: _____

(A) Advanced (AC) Accelerated (AP) Advanced Placement (DE) Dual Enrollment (IB) International Baccalaureate (CC) Commonwealth College Course Collaborative (H) Honors (S) Summer (SC) Credits earned by substitution (DL) Distance Learning

07/19/2018 12:43:06 EDT

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11/19/2014

TRANSGENDER PROTECTIONS IN PUBLIC SCHOOLS: RECENT DEVELOPMENTS

Bradford A. King
(804) 783-7263
Bking@sandsanderson.com
Nicole S. Cheuk
(804) 783-7267
Ncheuk@sandsanderson.com

SANDS ANDERSON

What does "transgender" mean?

- A transgender person has a gender identity (one's internal sense of gender) that is different from the gender identification listed on the individual's birth certificate.
- A "transgender male" is a person born female, transitioning to or living as a male.
- Transgender individuals may or may not seek medical intervention, including hormone treatment or sex-reassignment surgery.

Protections for Students: Federal Law

- Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 et seq. (Title IX):
  - "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance."
  - U.S. Department of Education's Office for Civil Rights ("OCR") interprets this to include gender-based harassment.
  - Gender-based harassment includes verbal, non-verbal or physical aggression, intimidation, or hostility based on sex or sex stereotyping, including failing to conform to stereotypical notions of masculinity or femininity.

Protections for Students: Title IX

- School divisions are not liable for one student harassing another, but may be liable for failing to respond adequately, ***whether or not the harassed student makes a complaint or asks the school to take action.***
- School division may violate Title IX if:
  - Harassing conduct is sufficiently serious to deny or limit the student's ability to participate in or benefit from the educational program;
  - The division knew or reasonably should have known about the harassment; and
  - The division failed to take appropriate responsive action.

Protections for Students: Title IX

- When a school division knows or reasonably should know of possible harassment, it must take immediate and appropriate steps to investigate or otherwise determine what occurred.
- If an investigation reveals that the harassment created a hostile environment, the school district must then take prompt and effective steps reasonably calculated to:
  - End the harassment;
  - Eliminate the hostile environment;
  - Prevent its reoccurence; and
  - As appropriate, remedy its effects.

Office for Civil Rights Complaints

- Arcadia Unified School District (CA) – July 2013 landmark OCR decision.
- Complaint alleged discrimination on the basis of sex against a student, born female but identified as male.
  - Specifically, school division prohibited him from accessing (1) sex-specific facilities designated for male students, and (2) sex-specific student cabins for male students during a school-sponsored overnight camp.
- Without admitting unlawful conduct, school division entered into a resolution agreement agreeing to create "a safe, nondiscriminatory learning environment for students who are transgender or do not conform to gender stereotypes."

Office for Civil Rights Complaints

- Downey Unified School District (CA) – OCR Resolution Agreement issued October 14, 2014:
  - The complaint alleged descrimination based on sex.
    - 1) transgender student born male subjected to different treatment and harassment by District employees because of her gender identity and gender nonconformance; and
    - 2) subjected to sexual and gender-based peer harassment and the District failed to provide a prompt and equitable response to the notice of harassment.
  - OCR investigated the complaint under its Title IX authority.
  - Prior to the conclusion of the investigation, the District expressed interest in voluntarily resolving the case and entered into a Resolution Agreement.

Downey Investigation

- Transgender girl first informed District of her gender identity in kindergarten.
- During the years K-5, the student continued to assert a female gender identity but had not made a gender transition to attend school as a girl – continued to use male name, pronouns, etc.
- She began coming to school dressed as a girl in the fifth grade.
- Complainant asserted that make-up was confiscated, had to write an apology letter for making male students uncomfortable by wearing make-up.
- She was also discouraged from discussing her gender identity with her friends.

Downey Investigation

- Complainant asserted that after her non-surgical gender transition, school pictures reflected the Student's male name even though wearing a dress and used female name on the picture forms.
- Frequently verbally harassed by her peers – "fag, whore, bitch," etc.
- After complaint, elementary administrators suggested she transfer to another school where no one knew she was a transgender girl.

Downey Investigation

- Prior to start of middle school, Complainant requested to be called by female name and given option of using female restroom or staff restroom.
- Middle school administrator receptive to her requests and she used female restroom and locker room without incident.
- However, she continued to experience peer harassment, being called her former male name, and questioned often about her anatomy.
- The District denied her request for school-wide assembly on gender-based harassment/bullying.

Downey Unified School District Resolution Agreement – October 2014

- Memorializes the Student's use of female-designated facilities.
- District agrees to otherwise treat the Student as a girl in all respects.
- District agrees to amend policies and procedures, train staff, provide age-appropriate instruction to students, survey parents and students about harassment, and ensure appropriate supports for the Student and other transgender students who request it.

State Law Protections for Transgender Students (not exhaustive)

- Maine – Maine Human Rights Act
- Arizona – High School League recently approved its first transgender athlete.
- California (August 2013) – Requires pupils be permitted to participate in sex-segregated school programs and activities, including athletic teams and competitions, and use facilities consistent with their gender identity, irrespective of the gender listed on their pupil records.
- Colorado, Hawaii, Illinois, Iowa, Maryland, Minnesota, New Jersey, New York, North Carolina, Oregon, Vermont, Washington and D.C. all have laws specifically protecting transgender students in public schools from harassment and/or discrimination.

Transgender Student Athletes

- February 2014 – Virginia High School League adopted transgender student-athlete policy.
  - When a school identifies a transgender student who seeks to participate it must submit a letter requesting an appeal to the district chairman and VHSL Director.
  - A transgender student-athlete may compete in the gender of their birth certificate unless they have undergone sex reassignment.
  - A student-athlete who has undergone sex reassignment may participate in the re-assigned gender when the student has undergone the surgery (1) before puberty; or (2) after puberty under certain conditions:
    - Surgical anatomical changes have been completed;
    - Hormonal therapy is being administered in a verifiable manner and for a sufficient length of time; and
    - If student stops hormonal treatment, they will be required to participate in sport consistent with birth gender.

Transgender Student Athletes

- VHSL rule mirrors the International Olympic Committee requirements.
- Currently, 18 other states have transgender student-athlete policies, although not all require gender reassignment surgery.
- Florida requires:
  - A written statement from the student affirming the consistent identity and expression to which the student self-relates;
  - Documentation from individuals such as, but not limited to, parents /legal guardians appointed by a court of competent jurisdiction, friends and/or teachers, which affirm that the actions, attitudes, dress and manner demonstrate the student's consistent gender identification and expression;
  - A complete list of all the student's prescribed, non-prescribed or over the counter, treatments or medications;
  - Written verification from an appropriate health-care professional (doctor, psychiatrist, and psychologist) of the student's consistent gender identification and expression.

Case law

- Doe v. Regional School Unit 26 (Also – Doe v. Clenchy)– Maine Supreme Judicial Court (January 30, 2014)
  - Suit filed pursuant to Maine Human Rights Act (MHRA) – prohibits discrimination based on sexual orientation in public accommodations, educational opportunities, employment, housing, and other areas.
  - Transgender female had been allowed to use girl's restroom pursuant to a 504 plan that addressed her gender identity issues and upcoming transition to fifth grade – "gender dysphoria."
    - Gender dysphoria – medical term for psychological distress resulting from having a gender identity different from the sex that one was assigned at birth.
  - In fifth grade a male student followed her into the restroom on two occasions claiming he was entitled to use it also.

Case law

- Doe, continued.
  - The Court had to consider the relationship between MHRA and a provision of the state Sanitary Facilities law, which requires schools to provide clean toilets that are separated according to sex.
  - Court found that Sanitary Facilities law does not establish guidelines for the use of school bathrooms, rather it establishes cleanliness and maintenance requirements.
  - The school division's decision to ban student from the girl's bathroom, based not upon a change in student's status but on others' complaints, constituted discrimination prohibited by MHRA.

Case law

- Doe, continued.
  - Over the student's parents' objections, the school required her to use the single-stall, unisex staff bathroom.
  - The 504 team met again to discuss transition to middle school and determined student would not use girl's bathroom in middle school.
  - Court acknowledged that many of the school officials exhibited tremendous sensitivity and insight over several years, but the school came under intense public scrutiny which caused it to reconsider the steps it had taken and reverse course.
  - First time a state court declared it unlawful to deny a transgender student access to the bathroom that matches the gender with which she identifies.

Case law

- Coy Mathis v. Fountain-Fort Carson School District 8 – June 17, 2013 decision of Colorado Division of Civil Rights
  - Found sufficient evidence to find that the school district "discriminatorily denied the Charging Party equal terms and conditions of goods, services, benefits, or privileges; equal treatment based on harassment; and the full and equal enjoyment of the goods, services, facilities, privileges, advantages or accommodations in a place of public accommodation due to the Charging Party's sex and sexual orientation."

Case law

- Mathis, continued.
  - Charging Party – six year-old transgender girl who had, since 18-months old, non-verbally expressed her female gender identity through her likes and dislikes.
  - Between ages of 4 and 6 began articulating her belief that she was a girl.
  - Enrolled in kindergarten as a boy, but wore girl's clothes, chose female playmates.
  - Between August 2012 and December 2012 (in first grade) – Charging Party used the girl's restroom, accompanied by a female classmate without issue.

Case law

- Mathis, continued.
  - Superintendent found out and instructed the Principal to inform the family that the Charging Party could no longer use the girl's restroom, but could use the boy's restroom or adult staff single-user restrooms. (changed to gender-neutral after the Mathis family left school).
    - School district had received only one complaint from a former district parent regarding her use of the girl's restroom.
  - The division of civil rights relied on the fact that Charging Party identifies as female and possesses documents identifying her sex as female in finding that school district discriminated against student.
  - The evidence demonstrated that socially, legally and medically the Charging Party is considered female (without gender reassignment surgery), and therefore she was discriminated against.

Hypothetical

- How would you handle the following: a school club is going on an overnight excursion underwritten by the parents, where they plan to bunk four students per hotel room. What accommodations if any would your school districts make for a transgender student in terms of sleeping arrangements?

Transgender Student Records

- Arises often with transgender alumni seeking employment or applying to other educational institutions after graduation.
- The Family Educational Rights and Privacy Act (FERPA) allows parents or eligible students to review education records and request that the school change records that are inaccurate, misleading or in violation of the student's privacy.
  - 1991 Family Policy Compliance Office opinion letter concluded that FERPA does not apply to a transgender former student requesting a name and gender change in his or her education records.
  - Rationale is that the change is substantive decision of the school division.
  - This rationale may be changing based on privacy standard.
- Changing the records avoids the possibility of a discrimination claim and maintains the student's privacy. By not changing the records, school is essentially disclosing that student's transgender status to anyone who sees their records.

Transgender Student Records

- Declining to update records is simple, consistent approach, less administrative burden.
- However, not changing the records may cause the person viewing them to question the applicant's honesty, forcing the individual to disclose their status.
- If a district would amend or change a record for a change in name based on marital status, then it should process a name change based on gender status in the same manner.
- It is not unlawful to require a court order or amendment of state/federally issued identification prior to changing records.

Trending

- Non-binary students – neither male nor female, sometimes known as "genderqueer".
  - Genderqueer was one of 56 gender identity options added to Facebook in February 2014.
- Pennsylvania school division reports that a student requested to be called by a different name from the female name previously used and have all pro-nouns be non-gender specific.
- Argument: the legal construct of how gender is tracked and recorded is Binary (male/female), therefore there is no legal authority for the accommodation requested.

Best Practices

- Respond immediately to claims of harassment/bullying.
- Permit use of facilities based on gender identification.
- Provide training/professional development.
- Provide school-wide assemblies on gender-based harassment/bullying.

Protections for Employees – Federal Law

- Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.) prohibits discrimination in employment on the basis of sex.
- The Courts have been inconsistent about whether this includes discrimination based on gender-identity.
- The Equal Employment Opportunity Commission (EEOC), has recently interpreted Title VII to include discrimination on the basis of gender identity.
- No federal law expressly prohibits LGBT bias, despite Congress having proposed the Employment Nondiscrimination Act, prohibiting sexual orientation and gender identity bias in the workplace almost every year for past 20 years.

Macy v. Holder, Appeal No. 0120120821 (U.S. EEOC, Apr. 20, 2012).

- In December 2010, Macy, a transgender woman then presenting as a man, applied for a Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) position at a crime laboratory.
- Macy asserted that after a discussion of her credentials and experience, the director of the lab told her that position was hers, assuming no problems arose during her background check.
- In March 2011, Macy informed the background check investigator that she was in the process of transitioning from male to female.
- Five days later, she was told that the position was no longer available.
- Three months later, Macy filed an EEOC charge against the ATF, alleging discrimination on the basis of her sex, gender identity, and sex stereotyping.

Macy v. Holder, cont'd

- The EEOC held that gender-identity based discrimination is banned under Title VII.
- The case then went back to the Department of Justice, which has jurisdiction over discrimination complaints against ATF.
- On July 8, 2013, the DOJ issued its finding that "ATF discriminated against complainant based on her transgender status, and thus her sex."

Lambda Legal and Freedom to Work

- In July 2013, Lambda Legal and Freedom to Work announced that it had reached a settlement with a private employer, also a government contractor, on behalf of a Maryland transgender woman.
- The woman filed a charge with the EEOC alleging that she was subjected to physical and verbal harassment in the workplace over a two year period, including comments such as "tranny," "drag queen," and "faggot."

Lambda Legal and Freedom to Work

- The EEOC issued a letter with a determination of reasonable cause to believe the company violated Title VII of the Civil Rights Act, stating:
  - The investigation revealed that Charging Party was subjected to derogatory gender-based comments that were frequently made by both co-workers and supervisors. Both Charging Party and witness interviews revealed that Respondent's management failed to take corrective action despite being fully aware of the harassment Charging Party was being subjected to. This lack of corrective action enabled the harassment and offensive atmosphere to continue.

LGBT Bias Charges, Resolutions Up

- EEOC Commissioner Feldblum shared at an October Employment Law Institute that in calendar year 2013 the EEOC received 834 charges raising allegations of sexual orientation discrimination ("GO") and 199 charges alleging gender identity or transgender bias ("GT").
  - 417 resolved, 9 cause findings.
- In first six months of 2014 – EEOC received 459 GO charges and 81 GT Charges, 11 cause findings.
- Feldblum acknowledged that the increase has more to do with the change in the agency's attitude toward the handling of such claims than with legal developments internally or in the courts.

Protections for Employees – State law

- On January 4, 2014, Governor McAuliffe signed Executive Order Number 1, prohibiting discrimination based on sexual orientation and gender identity.
- The Executive Order applied to all state agencies, not school boards.
- Same-sex marriage is permitted in Virginia as of October 6, 2014.

Best Practices - Employees

- Updating nondiscrimination policies to expressly include LGBT bias.
- Training for supervisors and employees on gender-based discrimination and harassment.
- Equal employee benefits to same-sex couples (possible special open enrollment for couples married prior to Virginia's legalization of gay marriage).
- Make sure updated nondiscrimination policies include a process for workers who are transitioning from male to female or vice versa, and information regarding name changes, and restroom use.

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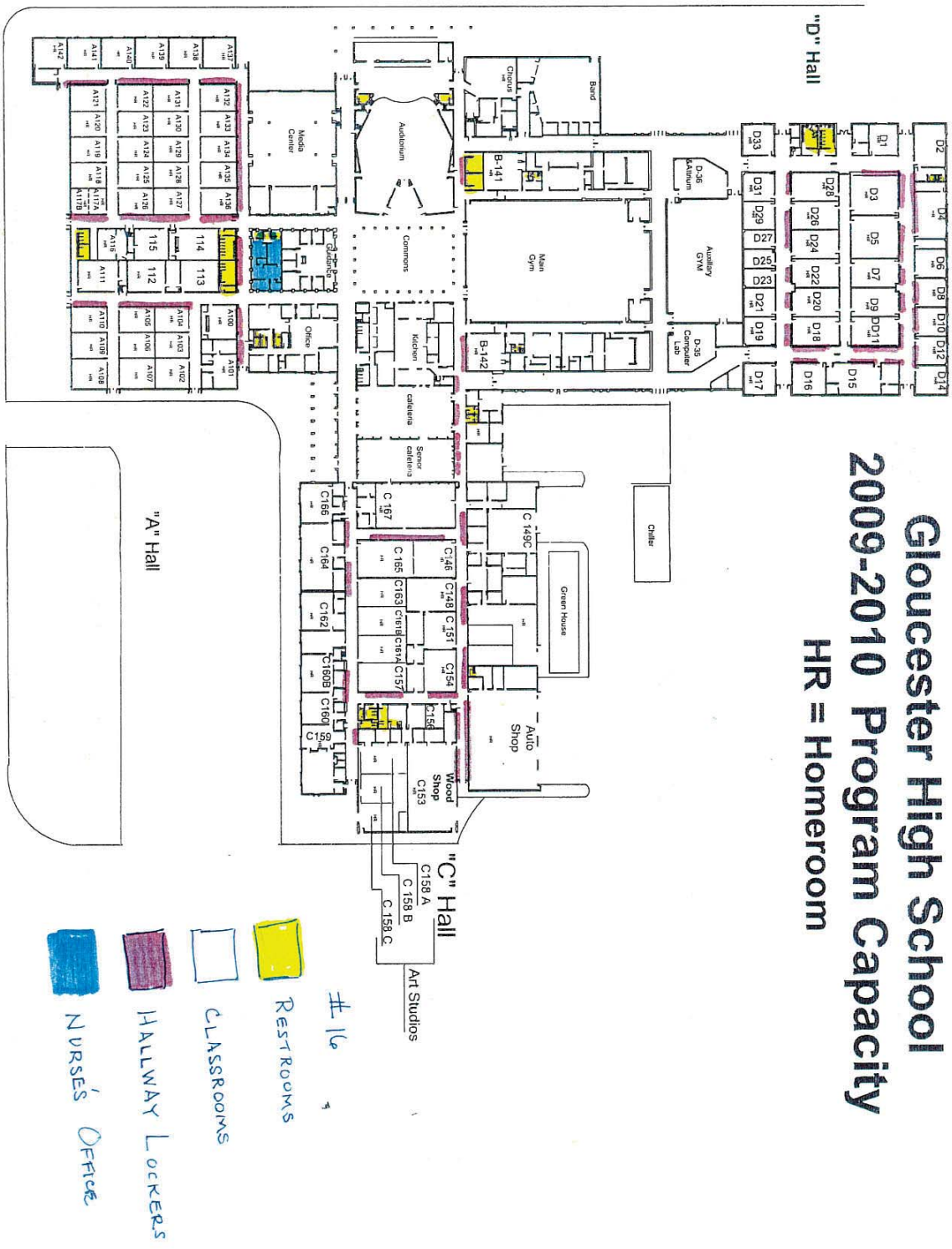
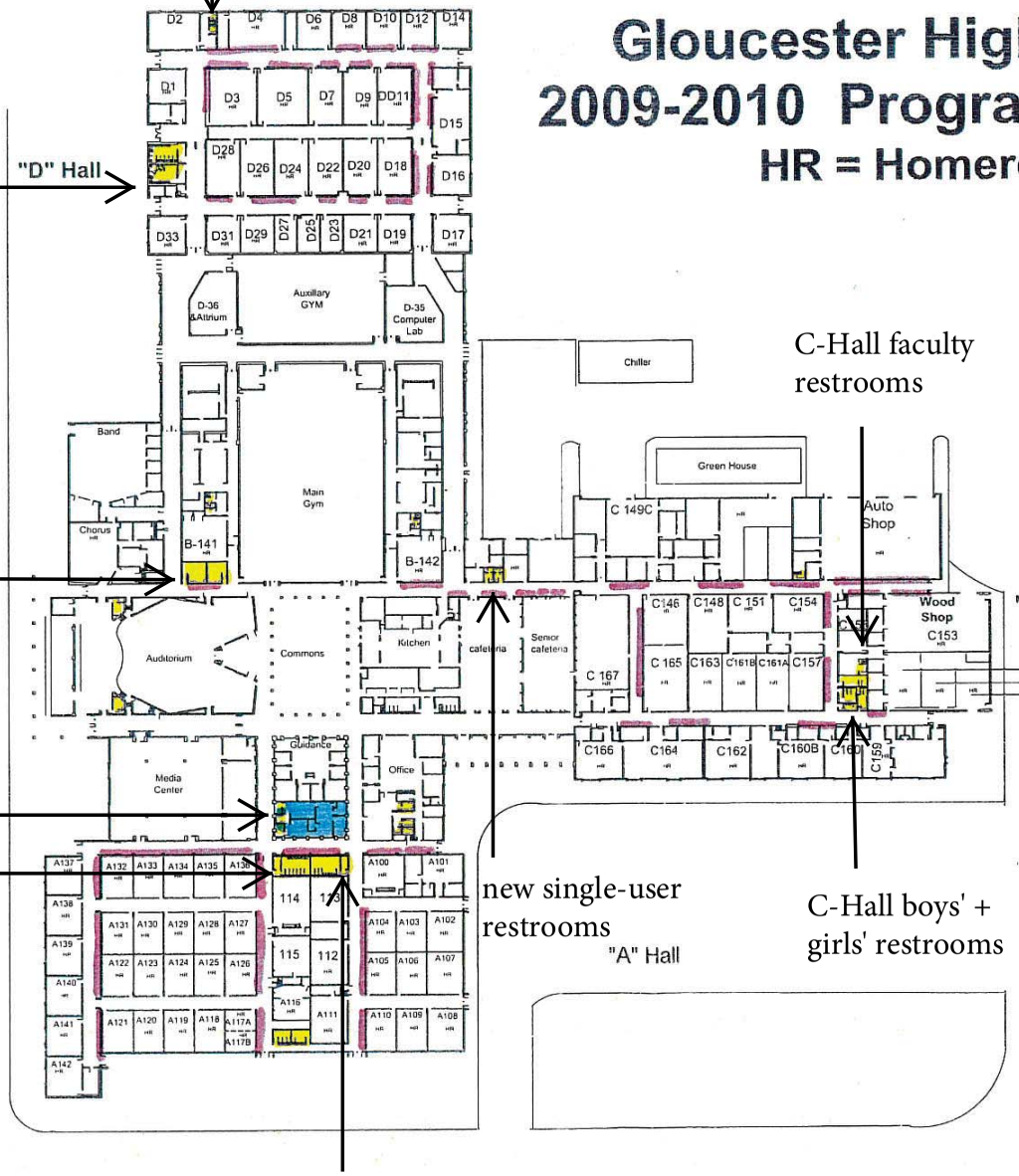


Gloucester High School
2009-2010 Program Capacity
HR = Homeroom

16

faculty restroom

Gloucester High School
2009-2010 Program Capacity
HR = Homeroom



D-Hall boys' + girls' restrooms

B-Hall multi-user restrooms

Nurse's restroom

A-Hall boys' + girls' restrooms

new single-user restrooms

C-Hall faculty restrooms

C-Hall boys' + girls' restrooms

new single-user restroom

#16

RESTROOMS

CLASSROOMS

HALLWAY LOCKERS

NURSE'S OFFICE

6th Grade Wing – Teachers' Room – 1 non-ADA restroom with single commode and sink
Main Office – Principal's Office – 1 non-ADA restroom with single commode and sink
Main Office (staff) – unisex – 1 non-ADA restroom with single commode and sink
Clinic – 1 ADA restroom with single commode and sink
By Gym (staff) – men – 1 non-ADA restroom with single commode and sink
By Gym (staff) – women – 1 non-ADA restroom with single commode and sink
By Gym – boys – 1 ADA stall; 1 regular; 3 urinals without partitions
By Gym – girls – 1 ADA stall; 1 regular
Boys' Locker Room – 2 non-ADA stalls; 4 urinals without partitions; 8 individual showers
Boys' Locker Room – Coach's Office – 1 non-ADA restroom with commode and sink and shower
Girls' Locker Room – 4 non-ADA stalls; 8 individual showers
Girls' Locker Room – Coach's Office – 1 non-ADA restroom with commode and sink and shower
Custodial Office – 1 non-ADA restroom with single commode and sink
Kitchen – 1 non-ADA restroom with single commode and sink
Industrial Arts – boys – 2 non-ADA stalls; 3 urinals without partitions
Industrial Arts – girls – 3 non-ADA stalls

Gloucester High

A Hall – boys – 3 non-ADA stalls; 7 urinals with partitions
A Hall – unisex – 1 non-ADA stall; 1 urinal with partition
A Hall – girls – 6 non-ADA stalls
A Hall (staff) – women – 2 non-ADA stalls
A Hall (staff) – women – 3 non-ADA stalls
A Hall (staff) – men – 1 non-ADA stall; 3 urinals without partitions
B Hall – boys – 1 ADA stall; 1 regular; 4 urinals with partitions
B Hall – girls – 1 ADA stall; 1 regular
C Hall – boys – 2 non-ADA stalls; 2 urinals with partitions
C Hall – girls – 3 non-ADA stalls
C Hall (staff) – women – 2 non-ADA stalls
C Hall (staff) – men – 1 non-ADA stall; 1 urinal with partition
C Hall – new unisex – 1 non-ADA stall and sink
C Hall – new unisex – 1 non-ADA stall and sink
D Hall – boys – 1 ADA stall; 2 regular; 3 urinals with partitions
D Hall – girls – 1 ADA stall; 5 regular
Teachers' Lounge – men – 1 non-ADA restroom with single commode and sink (has 1 grab bar)
Teachers' Lounge – women – 1 non-ADA restroom with single commode and sink (has 1 grab bar)
Main Office – unisex – 1 ADA restroom with single commode and sink
Main Office (staff) – men – 1 ADA restroom with single commode and sink
Main Office (staff) – women – 1 ADA restroom with single commode and sink
Locker Room - Main – boys – 1 gang shower; 1 non-ADA restroom without stall; 3 urinals without partitions
Locker Room – JV – boys – no shower; 1 ADA stall; 2 regular; 2 urinals with partitions
Locker Room – Main – girls – 26 stall shower (not used); 2 non-ADA stalls
Locker Room – JV – girls – no shower; 1 ADA stall; 3 regular
Auditorium – boys – 1 non-ADA restroom with single commode and sink
Auditorium – girls – 1 non-ADA restroom with single commode and sink
Clinic – boys – 1 ADA restroom with single commode and sink
Clinic – girls – 1 ADA restroom with single commode and sink
Kitchen – unisex – 1 non-ADA restroom with single commode and sink
Main Hall (across from Office) – boys – 1 ADA stall; 2 regular; 4 urinals with partitions
Main Hall (across from Office) – girls – 1 ADA stall; 2 regular

LEGAL DEPARTMENT
LESBIAN GAY
BISEXUAL
TRANSGENDER &
AIDS PROJECT

AMERICAN CIVIL LIBERTIES UNION FOUNDATION

December 23, 2016

David P. Corrigan
Harman Claytor Corrigan & Wellman
Post Office Box 70280
Richmond, VA 23255

Via email to dcorrigan@hccw.com

RE: School records for Gavin Grimm

Dear David,

Pursuant to our conversation, I am writing to request that Gavin Grimm's school records be updated so that any school records submitted in connection with Gavin's college applications identify him as male, in accordance with his amended birth certificate. Some college applications are due as early as January 3, 2017.

I make this request in the hopes that we can amicably resolve this discrete issue in time for Gavin's applications to college. As discussed, in making this specific request, I am not waiving or limiting Gavin's legal rights under Title IX or any other source of law to be treated consistently with his male gender identity and the male designation on his birth certificate in other respects.

Sincerely,

/s/ Joshua A. Block

Joshua A. Block
Senior Staff Attorney
LGBT and HIV Project
American Civil Liberties Union
125 Broad St., New York, NY 10004
■ 212.549.2593 ■ jblock@aclu.org

AMERICAN CIVIL LIBERTIES UNION FOUNDATION
LESBIAN GAY BISEXUAL TRANSGENDER & AIDS PROJECT

PLEASE RESPOND TO:
NATIONAL OFFICE
125 BROAD STREET, 18TH FL.
NEW YORK, NY 10004-2400
T/212.549.2627
F/212.549.2650
WWW.ACLU.ORG/LGBT

SAN FRANCISCO OFFICE:
39 DRUMM STREET
SAN FRANCISCO, CA 94111

CHICAGO OFFICE:
180 NORTH MICHIGAN AVENUE
SUITE 2300
CHICAGO, IL 60601-7401

WASHINGTON, D.C. OFFICE:
915 15TH STREET, NW
WASHINGTON, D.C. 20005

harman claytor corrigan wellman
THE CIVIL LITIGATION FIRM
Celebrating 25 years

DAVID P. CORRIGAN
804.762.8017
dcorrigan@hccw.com

January 18, 2017

VIA EMAIL
Joshua A. Block, Esq.
American Civil Liberties Union
125 Broad Street
18th Floor
New York, NY 10004

RE School Records for G.G.

Dear Josh:

I am writing in response to your December 23, 2016 letter with respect to school records for G.G. I apologize for taking so long to get back to you, but I was waiting for a School Board meeting, and one finally occurred on January 17, 2017. The previous meeting was snowed out.

In considering your request that "G.G.'s school records be updated so that any school records submitted in connection with G.G.'s college applications identify him as a male, in accordance with his amended birth certificate," the School Board considered the following:

(1) The copy of the birth certificate that you provided, (attached);
(2) The relevant school policy JO, (attached);
(3) Virginia Code §32.1-269, (attached); and
(4) Virginia Administrative Codes §12VAC5-550-320, §12VAC5-550-450 and §12VAC5-550-460, (attached).

Based on the School Board's review of these materials, the School Board declines to change the official school records.

Please feel free to submit additional materials, and, of course, your client has the right under school policy JO, see page 8 Correction of Education Records, to a hearing

POST OFFICE BOX 70280 | RICHMOND, VA 23255
4951 LAKE BROOK DR. | SUITE 100 | GLEN ALLEN, VA 23060
OFFICE 804.747.5200 | FAX 804.747.6085 | WEB HCCW.COM
member of the harmonie group

to challenge the information believed to be "inaccurate, misleading or in violation of the student's rights."

I look forward to hearing further from you.

Very truly yours,

David P. Corrigan

DPC/kns
Enclosures

LEGAL DEPARTMENT
LESBIAN GAY
BISEXUAL
TRANSGENDER &
HIV PROJECT

ACLU
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION

January 18, 2017

Denise McNerney
Office of the Clerk
Supreme Court of the United States
1 First Street, N.E.
Washington, DC 20543

Via UPS and email

***RE: Gloucester County School Board v G.G.*, No. 16-273**

Dear Ms. McNerney,

AMERICAN CIVIL LIBERTIES
UNION FOUNDATION
LBGT AND HIV PROJECT
125 BROAD STREET, 18TH FL.
NEW YORK, NY 10004-2400
T/212.549.2627
F/212.549.2650
WWW.ACLU.ORG/LGBT

Pursuant to Supreme Court Rule 32.3, Respondent respectfully requests permission to lodge redacted copies of (a) a September 9, 2016, order from the Gloucester County Circuit Court directing the State Registrar to issue an amended birth certificate listing Mr. Grimm's sex as "male," and (b) the amended birth certificate issued to Mr. Grimm on October 27, 2016.

The court order and birth certificate are relevant to Respondent's claims for prospective relief and for damages from the date the birth certificate was provided to the Gloucester County School Board. As public records, these documents may be considered on review of a motion to dismiss. *See Papasan v. Allain*, 478 U.S. 265, 268 n.1 (1986); Wright & Miller, *et al.*, 5B Fed. Prac. & Proc. Civ. § 1357 (3d ed.).

Although the court order and birth certificate were issued after the Fourth Circuit and district court issued their rulings, this Court may take judicial notice of the documents as public records. See S. Shapiro, K. Geller, T. Bishop, E. Hartnett, & D. Himmelfarb, Supreme Court Practice § 13.11(k), p. 744 (10th ed. 2013) ("The taking of judicial notice of facts outside the record is part of the inherent power and function of every court, whether a trial or appellate tribunal." (footnote omitted)).

Please let me know if there is any additional information I should provide in connection with this request.

Respectfully submitted,

Joshua A. Block

Counsel of Record for Respondent

Cc: Kyle Duncan

Schaerr | Duncan LLP
1717 K Street, NW, Suite 900
Washington, DC 20006
kduncan@schaerr-duncan.com

AMERICAN CIVIL LIBERTIES
UNION FOUNDATION

SCHAERR
DUNCAN
LLP

January 19, 2017

Denise McNerney
Office of the Clerk
Supreme Court of the United States
1 First Street, N.E.
Washington, DC 20543

RE: *Gloucester County School Board* v. *G.G. ex rel. Grimm*, No. 16-273

Dear Ms. McNerney,

I write on behalf of Petitioner Gloucester County School Board ("Board") in response to Respondent's letter of January 18, 2017, seeking leave under Supreme Court Rule 32.3 to lodge non-record materials respecting Respondent's amended birth certificate. The Board opposes Respondent's request.

It is well established that this Court does not base its decisions on matters outside the record. See, *e.g.*, *FW/PBS, Inc.* v. *City of Dallas*, 493 U.S. 215, 235 (1990) ("[W]e may not rely on the city's affidavit, because it is evidence first introduced to this Court and 'is not in the record of the proceedings below.'") (quoting *Adickes* v. *S.H. Kress & Co.*, 398 U.S. 144, 157–58, n. 16 (1970)); *Wygant* v. *Jackson Bd. of Educ.*, 476 U.S. 267, 278 n.5 (1986) (plurality) (taking issue with dissent's "unprecedented reliance on nonrecord documents that respondent has 'lodged' with this Court"); *Witters* v. *Wash. Dep't of Servs. for the Blind*, 474 U.S. 481, 486, n. 3 (1986) ("[T]his Court must affirm or reverse upon the case as it appears in the record"). This rule bars consideration of any amended birth certificate and related materials, which, as Respondent's letter admits, "were issued after the Fourth Circuit and district court issued their rulings." Ltr. at 1.

Respondent's letter offers no reason for disregarding that settled rule. *First*, Respondent asserts without explanation that the materials are "relevant," but "relevance" is no reason to consider extra-record materials. *Second*, even assuming relevance matters, Respondent offers no explanation why the materials are, in fact, relevant. There is good reason for that: *none* of the various legal positions taken below—whether by the Board, the district court, the Fourth Circuit, the Department of Education, or Respondent—turn on Respondent's birth certificate. *Third*, Respondent has unaccountably delayed bringing this matter to the Court's attention. Respondent's letter claims that a county court directed issuance of the

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amended certificate on September 9, 2016, four days *before* Respondent's brief in opposition was filed. If Respondent considered that a significant development, Respondent had the opportunity to inform the Court before it granted certiorari. *Cf.* S. Ct. R. 15.2 ("admonish[ing]" counsel of their "obligation to the Court to point out in the brief in opposition, and not later, any perceived misstatement made in the petition").

Please do not hesitate to contact me if you need anything further.

Sincerely,

S. Kyle Duncan
Counsel of record for Petitioner

cc: Josh Block
Counsel of record for Respondent

GLOUCESTER COUNTY SCHOOL BOARD
The Thomas Calhoun Walker Education Center
6099 T.C. Walker Road
Gloucester, Virginia 23061

For Immediate Release

Date: February 13, 2019
To: All Local Media Outlets
From: Gloucester County School Board
Subject: Notice of Public Hearing

Notice is hereby given that the GLOUCESTER COUNTY SCHOOL BOARD will hold a public hearing on **Tuesday, February 19, 2019, at 6:30 p.m.,** or as soon thereafter as the matter may be heard, in the Auditorium of the Thomas Calhoun Walker Education Center, 6099 T.C. Walker Road, Gloucester VA 23061, for the purpose of obtaining the public's views on and considering the following:

Discussion of a School Board policy on the use of restroom facilities related to the resolution that was adopted on December 9, 2014.

The policy to be discussed would allow transgender students to use the restroom consistent with the student's asserted gender identity when the following criteria have been met:

(1) the student has appropriate medical documentation from a licensed, treating healthcare provider who specializes in the treatment of transgender individuals; and
(2) the student has consistently asserted the student's gender identity for a period of at least six months; and
(3) the student has undergone treatment recommended by the student's healthcare provider, which may include social transition or hormonal therapy for at least six months.

The December 9, 2014 resolution states:

Whereas the GCPS recognizes that some students question their gender identities, and
Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and
Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore
It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

All interested persons are invited to attend the hearing. **Public comment is expected to be received beginning at 7:00 p.m., or as soon thereafter as may be heard.**

Meetings are broadcast via Cable Channel 47

GLOUCESTER COUNTY SCHOOL BOARD
The Thomas Calhoun Walker Education Center
6099 T.C. Walker Road
Gloucester, Virginia 23061

For Immediate Release

Date: February 21, 2019
To: All Local Media Outlets
From: Gloucester County School Board
Subject: Restroom Resolution

The Gloucester County School Board will not be taking any action at its February 21 work session on the possible alternative restroom resolution that was presented at its work session on February 19. In addition, the School Board has not set a time frame for when any action will be taken or when any further discussion will be held regarding the resolution. Finally, the School Board will not be providing any additional comments on this matter at this time.

RECORDED MINUTES OF THE
GLOUCESTER COUNTY SCHOOL BOARD
GLOUCESTER, VIRGINIA

NOVEMBER 11, 2014

The regular monthly meeting of the Gloucester County School Board was held on Tuesday, November 11, 2014. The Chairperson called the meeting to order at 5:35 pm at the Thomas Calhoun Walker Education Center.

I. ROLL CALL

Roll call was taken by the Acting Clerk, and the following persons were recorded as present: George R. (Randy) Burak, Chairperson, Troy M. Anderson, Kimberly (Kim) E. Hensley, Carla B. Hook, Anita F. Parker, Charles B. Records, and Kevin M. Smith, Members. Also present for the closed meeting: Walter R. Clemons, Ph.D., Superintendent of Schools, and John E. Hutchinson, Assistant Superintendent for Administrative Services and Acting Clerk.

II. CALL FOR CLOSED MEETING

At 5:36 pm, a motion was made by Ms. Hensley, seconded by Mrs. Hook, and unanimously approved to adjourn for a closed session, pursuant to *Code of Virginia*, 1950, as amended, Section 2.2-3711 (A), Subsection 1, for the discussion of personnel matters (monthly appointments, resignations, etc.) and Subsection 7, for consultation with legal counsel. At 6:50 pm, the Chairperson declared a recess, and the meeting was relocated to the Thomas Calhoun Walker Education Center auditorium.

III. RETURN TO OPEN MEETING/CERTIFICATION

Note: Ms. Betty Jane Duncan, Deputy Clerk, recorded the open meeting.
The Deputy Clerk noted that all members were present for the open meeting.

At 7:00 pm, a motion was made by Mr. Smith and seconded by Ms. Hensley to reconvene the meeting into open session. The motion was approved as follows:

Mr. Andersen	Aye	Mr. Records	Aye
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Ms. Parker	Aye		

There was no certification for the closed session at this time. The Chairperson stated that the Board had recessed from the closed session and would resume that closed session at the conclusion of the opening meeting.

IV. MOMENT OF SILENCE/PLEDGE OF ALLEGIANCE – Mr. Burak noted that today was Veterans' Day and extended thanks to all veterans who had served our country. Ms. Campbell Farina, SAC representative, led the Board and citizens in a moment of silence followed by the Pledge of Allegiance to the flag of the United States of America.

V. PERSONNEL ITEMS – (moved to consideration after closed session)

VI. ADDITIONS/CHANGES/ADOPTION OF AGENDA

There were no changes to the agenda as previously revised and published. A motion was made by Ms. Hensley, seconded by Mr. Records, and unanimously adopted to approve the agenda as revised and published.

VII. APPROVAL OF ITEMS CONTAINED IN THE CONSENT AGENDA

A motion was made by Ms. Hensley to approve the Consent Agenda (listed below). Motion was seconded by Mr. Andersen and approved with a roll call vote.

Mr. Andersen	Aye	Mr. Records	Aye
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Ms. Parker	Aye		

ITEMS CONTAINED WITHIN THE CONSENT AGENDA:

A. Approval of Minutes of October 14, 2014, Monthly Meeting
B. Approval of Minutes of October 23, 2014, Special (Work Session) Meeting
C. Approval of Minutes of October 30, 2014 Special (Closed) Meeting
D. Approval of Disposal of Equipment Valued in Excess of $500
E. Approval of Policy Manual Update ($1^{st}/2^{nd}$ Readings)
   1. FF: Public Dedication of New Facilities (new)
   2. FFA: Naming of School Facilities (new)
   3. BBFA: School Board Members Conflict of Interest (revision)
   4. BDDF: Voting Method (revision)
   5. EFB: Free and Reduced Price Food Services (revision)
   6. FE: Playground Equipment (revision)
   7. FG: Retirement of Facilities (revision)
   8. JO: Student Records (revision)
   9. KFB: Administration of Surveys and Questionnaires (revision)
   10. KH: Public Gifts to Schools (revision)
   11. KKA: Service Animals in Public Schools (revision)
   12. LCA: Charter Schools (revision)
   13. LCA-E: Charter School Application Addendum (form revision)
F. Informational Central Food Service Financial Report as of September 30, 2014
G. Informational Membership Report as of October 30, 2014
H. Informational Suspension Report for October, 2014
I. Informational Visiting Teachers Report for October, 2014
J. Informational Transportation Report for October, 2014

VIII. STAFF PRESENTATIONS/RECOGNITIONS

A. Presentation of VSBA Academy Awards – Dr. Clemons presented the following VSBA Academy Awards:

Mr. Burak	Achievement	Mrs. Hook	Excellence
Mr. Andersen	Achievement	Ms. Parker	Honor
Ms. Hensley	Recognition	Mr. Smith	Recognition

B. Updates on Boards/Commissions by School Board Members

Ms. Hensley gave a report on WHRO. Ms. Parker provided information on the Education Foundation. Mrs. Hook made remarks regarding the Chesapeake Bay Governor's School.

IX. CITIZENS' COMMENT PERIOD

Mr. Burak asked if there were any persons present who wished to address the Board. He asked that all persons state their name, the district in which they reside and to limit their remarks to three (3) minutes or less. A number of citizens addressed the issue of accommodations for transgender students including:

Ralph Van Ness (Ware)
Rev. Eddy Aliff (Virginia Assembly of Independent Baptists)
Savannah Williams (Abingdon)
Terry Brennan (Abingdon)
Deidre Grimm
Gavin Grimm
Joy Sampson (Petsworth)
Kelly Williams (Abingdon)
Mark Faulkner (Ware)
Lorraine Walsh (Abingdon)
Drew Palas (Gloucester Point)
Kathryn Lindsay (Gloucester Point)
Jacklynn Laniff (Abingdon)
Brian Byrd (Gloucester Point)
Ira Johnson (Petsworth)
Patricia Ray (Petsworth)
Kim Ward (Ware)
Melisa Wamsley (Petsworth)
Ray Wamsley (Petsworth)
Season Palas (Gloucester Point)
Paul Martin (Gloucester Point)
Christi Jackson Feliciano (White Marsh)
Elisa Nelson (Abingdon)
Amy VanFossen (Ware)
David Grimm
Robert Teagle
Howard Mowry (Gloucester Point)

Mr. Burak thanked all citizens who came forward to speak regarding this matter.

X. STUDENT ADVISORY COMMITTEE (SAC) ITEMS) – Ms. Farina offered remarks regarding the transgender accommodation issue.

XI. SUPERINTENDENT'S ITEMS

A. Comprehensive Plan Update/Reminder of Next Meeting Date – Dr. Clemons reminded Board members and the public that the next Comprehensive Plan development meeting would be held on Monday, November 17, 2014, at 7:00 pm at the Thomas Calhoun Walker Education Center (Cafeteria). He expressed thanks to all who have attended previous meetings and provided valuable input in the process.

XII. SCHOOL BOARD MEMBERS' ITEMS

A. VSBA Annual Convention – November 19-21, 2014 at Doubletree by Hilton Williamsburg. The Clerk has registered all School Board members who are able to attend. Opening session begins at 2:00 pm on Wednesday, November 19, 2014, followed by a break from 4:00-4:30 pm, followed by the President's Reception at 5:30 pm, followed by dinner at 7:00 pm.

B. Other Matters as Brought Up by Board Members

1. Discussion of Use of Restrooms/Locker Room Facilities – Mrs. Hook read the following resolution and made a motion to adopt said resolution:

Whereas the GCPS recognizes that some students question their gender identities, and

Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and

Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore

It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

The motion was seconded by Mr. Records.

A motion was made by Ms. Parker and seconded by Ms. Hensley to postpone action on the resolution and motion offered by Mrs. Hook until the December 9 meeting of the Board. A roll call vote was called for, and the Deputy Clerk recorded the following vote:

Mr. Andersen	Nay	Mr. Records	Nay
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Nay	Mr. Burak	Aye
Ms. Parker	Aye		

Motion was carried by a vote of 4-3. Motion offered by Mrs. Hook will be considered at the December 9 meeting of the Board.

XIII. ADMINISTRATIVE ITEMS

A. Recommendation to Restrict Outside Food Sharing at Elementary Schools – Ms. Shirley Chirch, Environmental Health and Safety Manager, and Ms. Lauren Giddings, School Health and Safety Board representative, reviewed the recommendation from the Board regarding the restriction of outside food sharing at the elementary schools. Due to an increasing number of students with life threatening food allergies and the potential for fatal reactions from unintended exposure to them, the following guidelines were recommended by the School Health Advisory Board:

XIII. ADMINISTRATIVE ITEMS (continued)

• During the normal instructional day, no homemade or commercially prepared treats or food items, which are intended to be shared with students, will be allowed at the elementary level. This will not include food items that are part of the instructional process or school sponsored activities which are planned in advance.

A motion was made by Mr. Andersen, seconded by Ms. Hensley, and unanimously approved to adopt the guidelines as recommended by the School Health Advisory Board.

B. Discussion of Redistricting Plans – Mr. Hutchinson stated that the Redistricting Committee would be reactivated in preparation for the opening of the new Page Middle School. The first meeting of the committee will be held in January 2015 with a presentation and recommendation to the Board in March. School Board members are needed to serve on the committee. Mr. Andersen and Mr. Records agreed to serve on this committee. Mr. Records stated that this would be an opportunity for the Board to consider restructuring grade levels among the schools throughout the school system.

At 8:55 pm, the Chairperson called for a brief recess. The meeting was reconvened at 9:07 pm.

C. Monthly Departmental Report – Mr. Hutchinson reviewed departmental activities accomplished during the month.

XIV. INSTRUCTIONAL ITEMS

A. Recommended GCPS Local Assessment Plan – Dr. Bess Worley, Instructional Supervisor, provided information on the Virginia Department of Education Local Assessment Guidelines. It was the consensus of the Board to move forward with plans for developing local assessments in accordance with state guidelines.

B. Monthly Departmental Report – Dr. Wagner reviewed highlights of the month from Instructional Services. Ms. Hensley asked for further information on requirements for lesson plans on the elementary level. Dr. Wagner will provide this information to Board members through e-mail.

XV. BUDGET AND FINANCE ITEMS --- CONSIDERED OUT OF ORDER FROM PUBLISHED AGENDA

A. Monthly Departmental Report – Ms. Joanne Wright, Director of Budget and Finance, highlighted tasks and accomplishments of the Budget and Finance Office.

B. Acceptance of Donations -- Ms. Wright highlighted the donations received by the division totaling $11,055.00. A motion was made by Mr. Records and seconded by Ms. Parker to accept with grateful appreciation the donations as outlined. The Deputy Clerk polled the Board as follows:

Ms. Parker	Aye	Mr. Smith	Aye
Ms. Hensley	Aye	Mr. Records	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Mr. Andersen	Aye		

XV. BUDGET AND FINANCE ITEMS (continued)

C. Informational Financial Reports – Ms. Wright presented the following reports which were accepted by the Board as information:

1. September 30, 2014, Financial Report
2. October 30, 2014, Construction Financial Report
3. October 30, 2014, HVAC/Roof Financial Report

Ms. Hensley inquired what process the Board would follow if they wished to consider hiring a public relations person. Ms. Wright explained the process of bidding for services. Dr. Clemons will bring back a recommendation on this matter at the next meeting.

XIV. INSTRUCTIONAL ITEMS (continued)

The Board considered the remainder of the Instructional Items at this time.

C. Update on Naviance: College and Career Readiness Solutions – Dr. Wagner stated that Mr. Bill Lindsey with the County Purchasing Department had been consulted and would be soliciting bids for college and career readiness services/programs. Further information will be provided to the Board in December.

D. Approval of Proposal to Assess Dual Enrollment Fees to Students for 2015-16 – The Board discussed the proposal to assess dual enrollment fees beginning in 2015-16. A motion was made by Mr. Andersen and seconded by Ms. Hensley to approve the proposal to assess dual enrollment fees in the amount of $15.00 ($5.00/credit hour) to students beginning in 2015-16. The Deputy Clerk recorded the following roll call vote:

Ms. Parker	Aye	Mr. Smith	Aye
Ms. Hensley	Aye	Mr. Records	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Mr. Andersen	Aye		

E. Update on Year-Round Program Proposal at Abingdon Elementary – Dr. Wagner apprised the Board on the status of the year-round program grant. Funds allocated by the state are insufficient to provide the program as written in the grant. After considerable discussion, a motion was made by Mrs. Hook and seconded by Mr. Smith to stop the planning process for a year-round program at this time and allow the grant funds to revert to the VDOE. Upon a voice vote, the motion was approved by the majority of the Board with Mr. Records voting nay.

F. Continued Discussion on Field Trip Policy (File IICA) – Dr. Wagner informed the Board that the division's insurance carrier had indicated that supplemental insurance plans were available for purchase to provide certain coverages for international trips. After discussion, it was the consensus of the Board to have Dr. Wagner obtain further information from the carrier to bring back to the Board in December. Revisions to the policy to cover international travel also will be considered at a future meeting.

G. VDOE Academic Review for Schools Accredited with Warning (GHS/Page) – Dr. Wagner outlined the process by which the VDOE will conduct academic reviews for schools accredited with warning. Teams/contractors will visit the schools on December 11 to observe classrooms, review lesson plans and curriculum, and meet with school staff. At the conclusion of the site visit, the team will present a report with recommendations to the VDOE.

XVI. PUBLIC ANNOUNCEMENTS

Mr. Burak read the following public announcements**:**

A. Next GCPS Comprehensive Plan Meeting – Monday, November 17, 2014, 7:00 pm @ the Thomas Calhoun Walker Education Center (Cafeteria)
B. G.H.S. Fall Athletic Awards Ceremony – Tuesday, November 18, 2014, 7:00 pm, G.H.S. (Auditorium)
C. Professional Days (Students Off) – Monday-Tuesday, November 24-25, 2014
D. Professional Work @ Home Day (Students Off)/SBO Open ½ Day – Wednesday, November 26, 2014
E. Thanksgiving Holidays-All GCPS Schools and Offices Closed, Thursday-Friday, November 27-28, 2014
F. Next Monthly School Board Meeting – Tuesday, December 9, 2014, 7:00 pm @ the Thomas Calhoun Walker Education Center (Auditorium)

CLOSED MEETING

At 10:52 pm, the Board resumed the closed session.

At 10:59 pm, a motion was made by Ms. Hensley, seconded by Mr. Records, and unanimously approved to extend the meeting to 11:15 pm.

At 11:14 pm, a motion was made by Ms. Parker, seconded by Mrs. Hook, and unanimously approved to extend the meeting to 11:30 pm.

At 11:30 pm, a motion was made by Mr. Records, seconded by Mrs. Hook, and unanimously approved to extend the meeting to 11:45 pm.

At 11:36 pm, a motion was made by Mrs. Hook to reconvene the meeting into open session and to certify that the Gloucester County School Board, while in closed session, discussed only public matters lawfully exempted from open meeting requirements provided in Subsection A of Section 2.2-3711 and that only public business matters that were identified in the motion convening the closed session were heard, discussed or considered. The motion was seconded by Ms. Hensley and approved as follows:

Mr. Andersen	Aye	Mr. Records	Aye
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Ms. Parker	Aye		

V. PERSONNEL ITEMS – (agenda item moved to be considered after closed session)

A. Approval of Monthly Personnel Actions — A motion was made by Mr. Smith, seconded by Ms. Hensley and unanimously adopted to approve the monthly listing of personnel appointments, staff leave, and contract changes. **(Approved copies attached to minutes)**

XVII. CALL FOR ADJOURNMENT

At 11:37 pm, there being no further business, a motion was made by Ms. Hensley, seconded by Mr. Records, and unanimously approved to adjourn the regular monthly meeting of November 11, 2014, until the next monthly meeting on Tuesday, December 9, 2014, 7:00 pm at the Thomas Calhoun Walker Education Center (auditorium).

George R. (Randy) Burak, Chairperson

Betty Jane Duncan, Deputy Clerk

John E. Hutchinson, Acting Clerk

Attachments (3):

1. Bound Agenda for November 11, 2014, Monthly Meeting
2. Revised Agenda for November 11, 2014, Monthly Meeting
3. Approved Monthly and Supplemental Personnel Listing

Note: The attachments will be bound with the official minutes once approved.

END
BJD/JEH/:bjd
MIN-11-11-14

No. 15-2056

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

G.G., by his next friend and mother, **DEIRDRE GRIMM**,

Plaintiff-Appellant,

v.

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant-Appellee.

On Appeal from the United States District Court
for the Eastern District of Virginia
Newport News Division

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN COLLEGE OF PHYSICIANS, AND 15 ADDITIONAL MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFF-APPELLANT

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DISCLOSURE OF CORPORATE AFFILIATIONS AND OTHER INTERESTS

FRAP RULE 26.1 and LOCAL RULE 26.1

Pursuant to FRAP 26.1 and Local Rule 26.1, American Academy of Pediatrics, the American Psychiatric Association, the American College of Physicians, the American Medical Association, the American Academy of Child and Adolescent Psychiatry, the American Academy of Family Physicians, the American Academy of Nursing, the American Academy of Physician Assistants, the American Medical Women's Association, the American Nurses Association, the American Psychoanalytic Association, the Association of Medical School Pediatric Department Chairs, the Endocrine Society, GLMA: Health Professionals Advancing LGBT Equality, Mental Health America, the National Association of Social Workers, the Society for Adolescent Health and Medicine, and the Society for Physician Assistants in Pediatrics, who are *amici curiae*, make the following disclosure:

1. No *amicus* is a publicly held corporation or other public entity.
2. No *amicus* has any parent corporations.
3. No publicly held corporation or other publicly held entity owns 10% or more of the stock of any of the *amici*.
4. No publicly held corporation or other publicly held entity has a direct financial interest in the outcome of the litigation.

5. This case does not arise out of a bankruptcy proceeding.

Dated: July 31, 2017

JENNER & BLOCK LLP

/s/ Scott B. Wilkens

Scott B. Wilkens

Counsel for Amici American Academy of Pediatrics, et al.

KELLOGG, HANSEN, TODD, FIGEL & FREDERICK, PLLC

/s/ Aaron M. Panner

Aaron M. Panner

Counsel for Amicus Curiae American Psychiatric Association

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INTEREST OF *AMICI CURIAE*[1]

Amici are 18 leading medical and mental health organizations: the American Academy of Pediatrics, the American Psychiatric Association, the American College of Physicians, the American Medical Association, the American Academy of Child and Adolescent Psychiatry, the American Academy of Family Physicians, the American Academy of Nursing, the American Academy of Physician Assistants, the American Medical Women's Association, the American Nurses Association, the American Psychoanalytic Association, the Association of Medical School Pediatric Department Chairs, the Endocrine Society, GLMA: Health Professionals Advancing LGBT Equality, Mental Health America, the National Association of Social Workers, the Society for Adolescent Health and Medicine, and the Society for Physician Assistants in Pediatrics.

Collectively, *amici* represent hundreds of thousands of physicians and mental health professionals, including specialists in pediatrics and adolescent care, family medicine, internal medicine, and endocrinology; over one hundred thousand physician assistants; and millions of nurses. *Amici* share a commitment to improving

[1] *Amici* hereby certify that no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money intended to fund preparation or submission of this brief, and no person other than *amici* and their counsel contributed money intended to fund preparation or submission of the brief. The parties have consented to the filing of this brief.

the physical and mental health of all Americans—regardless of gender identity—and to informing and educating lawmakers, the judiciary, and the public regarding the public health impacts of laws and policies.

Amici submit this brief to inform the Court of the medical consensus regarding what it means to be transgender; the protocols for the treatment of gender dysphoria; and the predictable harms to the health and well-being of transgender adolescents when they are excluded from restrooms that match their gender identity.

SUMMARY OF ARGUMENT

Transgender individuals have a gender identity that is incongruent with the sex they were assigned at birth. The medical community's understanding of what it means to be transgender has advanced greatly over the past century. It is now understood that being transgender implies no impairment in a person's judgment, stability, or general social or vocational capabilities. According to recent estimates, approximately 1.4 million transgender adults live in the United States—0.6 percent of the adult population.

Many transgender individuals, like Plaintiff-Appellant, have a condition called gender dysphoria, which is characterized by clinically significant distress and impairment of function resulting from the incongruence between one's gender identity and the sex assigned at birth. The international medical consensus regarding treatment for gender dysphoria is to assist the patient to live in accordance with his or her gender identity, thus alleviating the distress. Treatment may include any or all of the following: counseling, social transition (through, *e.g.*, use of a new name and pronouns; new clothes and grooming; and use of single-sex facilities, including restrooms, most consistent with the individual's gender identity), and hormone therapy and surgical interventions.

Access to single-sex facilities that correspond to one's gender identity is a critical aspect of social transition and, thus, successful treatment of gender

dysphoria. By contrast, excluding transgender individuals from facilities consistent with their gender identity undermines their treatment; exposes them to stigma and discrimination; harms their physical health by causing them to avoid restroom use; and impairs their social and emotional development. Similarly, transgender students who must use separate facilities that other students are not required to use are at risk of being bullied and discriminated against and suffer psychological harm. The stigma and minority stress that result from discrimination can, in turn, lead to poorer health outcomes for transgender individuals.

ARGUMENT

I. What It Means To Be Transgender And To Suffer From Gender Dysphoria

Transgender individuals have a "gender identity"—a "deeply felt, inherent sense" of their gender—that is not aligned with the sex assigned to them at birth.[2] Transgender people differ from cisgender (*i.e.*, non-transgender) individuals, whose gender identity aligns with the sex assigned at birth.[3]

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[2] Am. Psychol. Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 Am. Psychologist 832, 834 (2015) **[hereinafter "Am. Psychol. Ass'n Guidelines"]**; *see also* David A. Levine & Comm. on Adolescence, Am. Acad. of Pediatrics Technical Report, *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, 132 Pediatrics e297, 298 (2013) **[hereinafter "AAP Technical Report"]**. Although most people have a gender identity that is male or female, some individuals have a gender identity that is "a blend of male or female[,] or an alternative gender." Am. Psychol. Ass'n Guidelines at 834.

[3] Am. Psychol. Ass'n Guidelines, *supra,* at 861.

Recent estimates suggest that approximately 1.4 million transgender adults live in the United States, or 0.6 percent of the adult population.[4] That said, "population estimates likely underreport the true number of [transgender] people."[5] People of all different races and ethnicities identify as transgender.[6] They live in every state, serve in our military, and raise children.[7] Gender identity is distinct from and does not predict sexual orientation; transgender people, like cisgender people, may identify as heterosexual, gay, lesbian, bisexual, or asexual.[8]

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[4] Andrew R. Flores et al., The Williams Inst., *How Many Adults Identify as Transgender in the United States?* 2 (2016), http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

[5] Am. Psychol. Ass'n Guidelines, *supra*, at 832.

[6] *See* Halley P. Crissman et al., *Transgender Demographics*: *A Household Probability Sample of US Adults, 2014*, 107 Am. J. Pub. Health 213, 214-15 (2017); Andrew R. Flores et al., The Williams Inst., *Race and Ethnicity of Adults Who Identify as Transgender in the United States* 2 (2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Race-and-Ethnicity-of-Transgender-Identified-Adults-in-the-US.pdf.

[7] Gary J. Gates & Jody L. Herman, The Williams Inst., *Transgender Military Service in the United States* (2014), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Transgender-Military-Service-May-2014.pdf; Sandy E. James et al., Nat'l Center for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 2 (2016), http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf; Rebecca L. Stotzer et al., The Williams Inst., *Transgender Parenting: A Review of Existing Research* (2014), http://williamsinstitute.law.ucla.edu/research/parenting/transgender-parenting-oct-2014.

[8] Am. Psychol. Ass'n Guidelines, *supra*, at 835-36; James et al., Nat'l Center for Transgender Equality, *Report of the 2015 U.S. Transgender Survey*, *supra*, at 246.

The medical profession's understanding of gender has advanced considerably over the past fifty years. Throughout much of the twentieth century, individuals who were not gender conforming were often viewed as "perverse or deviant."[9] Practices during that period tried to "correct" this perceived deviance by attempting to force transgender people to live in accordance with the sex assigned to them at birth. These efforts failed and caused significant harm to the individuals subjected to them.[10]

Much as our professions recognize that homosexuality is a normal form of human sexuality—and that stigmatizing gay people causes significant harm—we now recognize that being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."[11]

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[9] Am. Psychol. Ass'n, *Report of the APA Task Force on Gender Identity and Gender Variance* 26-27 (2008), https://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf **[hereinafter "Am. Psychol. Ass'n Task Force Report"]**.

[10] *Id.*; Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* 13, 25 (2015), http://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf.

[11] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (2012), https://psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2012-Transgender-Gender-Variant-Discrimination.pdf.

A. Gender Identity

"[G]ender identity" refers to a person's internal sense of being male, female, or another gender.[12] Every person has a gender identity,[13] which cannot be altered voluntarily[14] or ascertained immediately after birth.[15] Many children develop stability in their gender identity between ages 3 and 4.[16]

"[G]ender expression refers to the way a person communicates gender identity to others through behavior, clothing, hairstyles, voice, or body characteristics."[17] There are many individuals who depart from stereotypical male and female

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[12] Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People, Gender Identity, and Gender Expression* 1 (2014), http://www.apa.org/topics/lgbt/transgender.pdf.

[13] *See* Caitlin Ryan, Family Acceptance Project, *Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual, & Transgender Children*, 17 (2009), http://familyproject.sfsu.edu/sites/default/files/FAP_English%20Booklet_pst.pdf.

[14] Colt Meier & Julie Harris, Am. Psychol. Ass'n, *Fact Sheet: Gender Diversity and Transgender Identity in Children* 1, http://www.apadivisions.org/division-44/resources/advocacy/transgender-children.pdf; *see also* Am. Acad. of Pediatrics, *Gender Identity Development in Children* (2015), https://healthychildren.org/English/ages-stages/gradeschool/Pages/Gender-Identity-and-Gender-Confusion-In-Children.aspx.

[15] Am. Psychol. Ass'n Guidelines, *supra*, at 862.

[16] *Id.* at 841. "Although gender identity is usually established in childhood, individuals may become aware that their gender identity is not in full alignment with sex assigned at birth in childhood, adolescence, or adulthood." *Id.* at 836.

[17] Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People, supra*, at 1.

appearances and roles, but who are not transgender.[18] Indeed, most people who express their gender in a non-stereotypical or non-conforming manner are or become comfortable with the sex they were assigned at birth.[19] In contrast, a transgender boy or transgender girl "consistently, persistently, and insistently" identifies as a gender different than the sex they were assigned at birth.[20]

Psychologists, psychiatrists, and neuroscientists are not certain why some people are transgender. Some research suggests there may be biological influences,[21] including, for example, exposure of natal females to elevated levels of

[18] Ethan C. Cicero & Linda M. Wesp, *Supporting the Health and Well-Being of Transgender Students*, J. Sch. Nursing 1, 6 (2017).

[19] World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* 5 (7th Version, 2011), http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655 **[hereinafter "WPATH Standards of Care"]**.

[20] *See* Meier & Harris, *Fact Sheet: Gender Diversity and Transgender Identity in Children*, *supra*, at 1; *see also* Cicero & Wesp, *Supporting the Health and Well-Being of Transgender Students*, *supra*, at 6.

[21] *See* Am. Acad. of Pediatrics, *Gender Non-Conforming & Transgender Children* (2015), https://healthychildren.org/English/ages-stages/gradeschool/Pages/Gender-Non-Conforming-Transgender-Children.aspx; Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1895 (2008).

testosterone in the womb.[22] Brain scans and neuroanatomical studies of transgender individuals may also support these biological explanations.[23]

B. Gender Dysphoria

Being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."[24] However, many transgender individuals are diagnosed with gender dysphoria, a condition that is characterized by debilitating distress and anxiety resulting from the incongruence between an individual's gender identity and birth-assigned sex.[25]

1. The Diagnostic Criteria And Seriousness Of Gender Dysphoria

The Diagnostic and Statistical Manual of Mental Disorders codifies the diagnostic criteria for gender dysphoria in adolescents and adults as follows: "A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two" out of six criteria, and "clinically significant distress or impairment in social, occupational, or

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[22] Arianne B. Dessens et al., *Gender Dysphoria and Gender Change in Chromosomal Females with Congenital Adrenal Hyperplasia*, 34 Arch. Sexual Behav. 389, 395 (2005).

[23] *See, e.g.*, Francine Russo, *Is There Something Unique About the Transgender Brain?* Sci. Am. (Jan. 1, 2016), https://www.scientificamerican.com/article/is-there-something-unique-about-the-transgender-brain/.

[24] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals*, *supra*.

[25] Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 451-53 (5th ed. 2013) **[hereinafter "DSM-5"]**.

other important areas of functioning."[26] The six criteria include (1) "[a] marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics"; (2) "[a] strong desire to be rid of one's primary and/or secondary sex characteristics"; (3) "[a] strong desire for the primary and/or secondary sex characteristics of the other gender"; (4) "[a] strong desire to be of the other gender (or some alternative gender)"; (5) "[a] strong desire to be treated" as a gender different from one's assigned gender; and (6) "[a] strong conviction that one has the typical feelings and reactions" of a different gender.[27]

Transgender children often experience intensified gender dysphoria and worsening mental health as the hormonal and anatomical changes associated with puberty cause the body to develop in ways that diverge from the child's gender identity.[28] For instance, a deepening voice for male-assigned individuals or the growth of breasts and the beginning of a menstrual cycle for female-assigned individuals can cause severe distress.

If untreated, gender dysphoria can cause debilitating distress, depression, impairment of function, substance use, self-mutilation to alter one's genitals or

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[26] *Id.*

[27] *Id.* at 452.

[28] Am. Psychol. Ass'n Task Force Report, *supra*, at 45; Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 3.

secondary sex characteristics, other self-injurious behaviors, and suicide.[29] Transgender individuals also are frequently subjected to prejudice and discrimination in multiple areas of their lives, which exacerbates these negative health outcomes.[30]

2. The Accepted Treatment Protocols For Gender Dysphoria

Until the middle of the twentieth century, most mental health practitioners treated transgender people by attempting to make the patient's gender identity consistent with the sex assigned at birth.[31] There is no evidence that these methods alleviate gender dysphoria or that they can prevent someone from being transgender.[32] To the contrary, they can "often result in substantial psychological

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[29] *See, e.g.*, DSM-5, *supra*, at 455, 458; Stephanie A. Brill & Rachel Pepper, *The Transgender Child: A Handbook for Families and Professionals* 202 (2008) (discussing risk of self-mutilation).

[30] Michael L. Hendricks & Rylan J. Testa, *A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model*, 43 Prof'l Psychol.: Research & Practice 460 (2012); Jessica Xavier et al, Va. Dep't of Health, *The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians* (2007), http://www.vdh.virginia.gov/content/uploads/sites/10/2016/01/THISFINALREPORTVol1.pdf.

[31] Am. Psychol. Ass'n Guidelines, *supra*, at 835; Jack Drescher, *Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual*, 39 Arch. Sexual Behav. 427, 436-40 (2010).

[32] Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 26; Jack Drescher, *Controversies in Gender Diagnoses*, 1 LGBT Health 9, 12 (2013).

pain by reinforcing damaging internalized attitudes,"[33] and can damage family relationships and individual functioning by increasing feelings of shame.[34]

In the last few decades, transgender people and those suffering from gender dysphoria have gained widespread access to gender-affirming psychological and medical support.[35] For over 30 years, the generally-accepted treatment protocols for gender dysphoria[36] have aimed at alleviating the distress associated with the incongruence between gender identity and birth-assigned sex.[37] These protocols are laid out in the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (Version 7)* developed by the World Professional Association for Transgender Health ("WPATH").[38] Many of the major medical and mental health groups in the United States recognize the WPATH Standards of Care

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[33] Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression* (2012), http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender.

[34] Darryl B. Hill et al., *An Affirmative Intervention for Families with Gender Variant Children: Parental Ratings of Child Mental Health and Gender*, 36 J. Sex & Marital Therapy 6, 10 (2010); Robert Wallace & Hershel Russell, *Attachment and Shame in Gender-Nonconforming Children and Their Families: Toward a Theoretical Framework for Evaluating Clinical Interventions*, 14 Int'l J. Transgenderism 113, 119-20 (2013).

[35] Am. Psychol. Ass'n Guidelines, *supra*, at 835; WPATH Standards of Care, *supra*, at 8-9.

[36] Earlier versions of the DSM used different terminology, *e.g.*, gender identity disorder, to refer to this condition. Am. Psychol. Ass'n Guidelines, *supra*, at 861.

[37] Am. Med. Ass'n, Comm. on Human Sexuality, *Human Sexuality* 38 (1972).

[38] WPATH Standards of Care, *supra*.

as representing the consensus of the medical and mental health community regarding the appropriate treatment for gender dysphoria.[39]

The recommended treatment for transgender people with gender dysphoria includes assessment, counseling, and, as appropriate, social transition, puberty-blocking drug treatment, hormone therapy, and surgical interventions to bring the body into alignment with one's gender identity.[40] However, each patient

[39] Am. Med. Ass'n House of Delegates, Resolution 122 (A-08), *Removing Financial Barriers to Care for Transgender Patients* 1 (2008); Am. Psychol. Ass'n Task Force Report, *supra*, at 32; AAP Technical Report, *supra*, at 307-08.

[40] Am. Psychol. Ass'n Task Force Report, *supra*, at 32-39; Am. Psychol. Ass'n & Nat'l Ass'n of Sch. Psychologists, *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools* (2015), http://www.apa.org/about/policy/orientation-diversity.aspx **[hereinafter "APA/NASP Resolution"]**; Am. Psychiatric Ass'n Workgroup on Treatment of Gender Dysphoria, *Assessment and Treatment of Gender Dysphoria and Gender Variant Patients: A Primer for Psychiatrists* 16-18 (2016); AAP Technical Report, *supra*, at 307-09. Some clinicians still offer versions of "reparative" or "conversion" therapy based on the idea that being transgender is a mental disorder. However, all of the leading medical professional organizations have explicitly rejected such treatments. *See* Am. Med. Ass'n, Policy Number H-160.991, *Health Care Needs of Lesbian, Gay, Bisexual, and Transgender Populations* (rev. 2016), https://searchpf.ama-assn.org/SearchML/searchDetails.action?uri=%2FAMA Doc%2FHOD.xml-0-805.xml; Am. Sch. Counselor Ass'n, *The School Counselor and LGBTQ Youth* (2016), https://www.schoolcounselor.org/asca/media/asca/PositionStatements/PS_LGBTQ.pdf; Hillary Daniel et al., *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians*, 163 Annals Internal Med. 135, 136 (2015); AAP Technical Report, *supra*, at 301; Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression*, *supra*.

requires an individualized treatment plan that accounts for the patient's specific needs.[41]

Social transition—*i.e.*, living one's life fully in accordance with one's gender identity—is often a critically important part of treatment. This typically includes publicly identifying oneself as that gender; adopting a new name; using different pronouns; grooming and dressing in a manner typically associated with one's gender identity; and using restrooms and other single-sex facilities consistent with that identity.[42] Transgender children who live in accordance with their gender identity in all aspects of life have lower rates of depression compared to transgender children who have not socially transitioned.[43]

For some adults and adolescents, hormone treatment to feminize or masculinize the body may be medically necessary to treat their gender dysphoria.[44]

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[41] Am. Psychol. Ass'n Task Force Report, *supra*, at 32.

[42] AAP Technical Report, *supra*, at 308; Am. Psychol. Ass'n Guidelines, *supra*, at 840.

[43] Lily Durwood et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. Child & Adolescent Psychiatry 116 (2017); Kristina R. Olson et al., *Mental Health of Transgender Children Who Are Supported in Their Identities*, 137 Pediatrics 1 (2016).

[44] Am. Med. Ass'n House of Delegates, Resolution 122 (A-08), *Removing Financial Barriers to Care for Transgender Patients*, *supra*, at 1; Am. Psychol. Ass'n Guidelines, *supra*, at 861, 862; Madeline B. Deutsch, Center of Excellence for Transgender Health, University of California, San Francisco, *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* 23 (2d ed. 2016); WPATH Standards of Care, *supra*, at 33, 54.

Both the Endocrine Society and the Lawson Wilkins Pediatric Endocrine Society consider these treatments to be the standard of care for gender dysphoria.[45] A transgender boy undergoing hormone treatment, for example, will be exposed to the same levels of testosterone as other boys who go through male puberty; and just as they would in any other boy, these hormones will affect most of his major body systems.[46] Hormone treatment alters the appearance of the patient's genitals and produces secondary sex characteristics such as increased muscle mass, increased facial hair, and a deepening of the voice in transgender boys and men, and breast growth and decreased muscle mass in transgender girls and women.[47] For children experiencing the onset of puberty, treatment may include medication to prevent further progression of puberty ("puberty blockers").[48] This fully reversible treatment allows children with gender dysphoria to delay the development of secondary sex characteristics that do not match their gender identity, giving them additional time

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[45] *See* Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. Clinical Endocrinology & Metabolism 3132, 3132 (2009); *see also* Alessandra D. Fisher et al., *Cross-Sex Hormone Treatment and Psychobiological Changes in Transsexual Persons: Two-Year Follow-Up Data*, 101 J. Clinical Endocrinology & Metabolism 4260 (2016).

[46] Hembree et al., *Endocrine Treatment of Transsexual Persons*, *supra*, at 3132-33; *see also* Brill & Pepper, *The Transgender Child*, *supra*, at 217.

[47] Hembree et al., *Endocrine Treatment of Transsexual Persons*, *supra*, at 3140-45.

[48] *Id.* at 3138.

to decide whether hormone treatment to feminize or masculinize the body is appropriate.[49]

Surgical interventions may also be an appropriate and medically necessary treatment for some patients. These procedures could include chest reconstruction surgery for transgender men, breast augmentation (*i.e.* implants) for transgender women, or genital surgery.[50] Studies show these procedures are effective in reducing gender dysphoria and improving mental health.[51] Because these surgical procedures are largely irreversible, some are recommended only for transgender individuals who have reached the age of legal majority.[52]

Ultimately—regardless of the particular treatments required for a specific individual and when such treatment begins—the goal is for individuals with gender dysphoria to experience "identity integration," where "being transgender is no

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[49] *Id.* at 3133, 3140-41; Am. Psychol. Ass'n Guidelines, *supra*, at 842; WPATH Standards of Care, *supra*, at 18-20.

[50] Hembree et al., *Endocrine Treatment of Transsexual Persons*, *supra*, at 3148-49; *see also* WPATH Standards of Care, *supra*, at 57-58.

[51] William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 Arch. Sexual Behav. 759, 778-79 (2012); Annelou L.C. de Vries, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014).

[52] WPATH Standards of Care, *supra*, at 21.

longer the most important signifier of one's identity" and the individual can refocus on their relationships, school, jobs, and other life activities.[53]

Some who oppose the medical protocols for gender dysphoria—including Dr. Paul R. McHugh et al.—claim that most gender dysphoric children "desist" and ultimately have a gender identity that matches their sex assigned at birth.[54] In fact, studies indicate that children who actually are transgender—those who persistently, consistently, and insistently identify as a gender other than the sex assigned at birth (as distinguished from gender non-conforming children generally)—are unlikely to desist.[55] Moreover, McHugh et al. conflate the vastly different experiences of pre-

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[53] Walter Bockting & Eli Coleman, *Developmental Stages of the Transgender Coming-Out Process: Toward an Integrated Identity*, *in Principles of Transgender Medicine and Surgery* 137, 153 (Randi Ettner, Stan Monstrey & Eli Coleman eds., 2d ed. 2016).

[54] Brief of *Amici Curiae* Dr. Paul R. McHugh, M.D., et al. in Support of Petitioner at 12, *Gloucester County School Board v. G.G. ex rel. Grimm*, 137 S. Ct. 1239 (2017) (No. 16-273), 2017 WL 219355.

[55] *See, e.g.*, Am. Acad. of Pediatrics, *Gender Non-Conforming & Transgender Children*, *supra* ("Research suggest that children who are persistent, consistent, and insistent about their gender identity are the ones who are most likely to become transgender adults."); Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-up Study*, 8 J. Sexual Med. 2276, 2281 (2011); Thomas D. Steensma et al., *Desisting and Persisting Gender Dysphoria after Childhood: A Qualitative Follow-up Study*, 16 Clinical Child Psychol. & Psychiatry 499, 504, 505 (2011); Madeleine S.C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual Outcome of Gender-Dysphoric Children*, 47 J. Am. Acad. Child & Adolescent Psychiatry 1413, 1420-21 (2008). The research relied on by opponents of the standard protocols tracked broad groups of prepubertal children who were referred to clinics for gender expansive non-conforming behavior, and counted any child who did not return for follow-up treatment as someone who desisted, thereby running "a strong risk of inflating estimates of the

pubertal children and adolescents.[56] There is no evidence that adolescents, like Plaintiff-Appellant, whose gender identities do not match their birth-assigned sex, are likely to desist.[57] For these reasons, among others, nearly 600 academics and clinicians with expertise in gender development have challenged Dr. McHugh's work.[58]

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number of youth" who desist. Am. Psychol. Ass'n Guidelines, *supra*, at 842; *see also* Thomas D. Steensma & Peggy Cohen-Kettenis, *More Than Two Development Pathways in Children with Gender Dysphoria?*, 54 J. Am. Acad. Child & Adolescent Psychiatry 147, 147 (2015).

[56] The McHugh et al. brief filed in the Supreme Court relies substantially on a publication of the American College of Pediatricians that Dr. McHugh co-authored, and an article written by the College's president, Michelle Cretella. The American College of Pediatricians "does not acknowledge the scientific and medical evidence regarding sexual orientation, sexual identity, sexual health, or effective health education." Am. Acad. of Pediatrics, *Just the Facts About Sexual Orientation and Youth* (Apr. 13, 2010), https://web.archive.org/web/20101119095249/http://aap.org/featured/sexualorientation.htm (alerting school administrators to a campaign by the College, "which is in no way affiliated with the American Academy of Pediatrics," and encouraging school officials, parents, and youth to "utilize the AAP developed and endorsed resources on this issue for reliable, sound, scientific, medical advice").

[57] De Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, *supra*; Am. Psychol. Ass'n Task Force Report, *supra*, at 48; Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, *supra*, at 763 ("GID that persists into adolescence is more likely to persist into adulthood."); Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 3.

[58] Letter dated Mar. 22, 2017, https://medschool.vanderbilt.edu/lgbti/files/lgbti/publication_files/ExpertLGBTIConcensusLetter.pdf; *see also* Chris Beyrer, Robert W. Blum, & Tonia C. Poteat, Opinion, *Hopkins Faculty Disavow 'Troubling' Report on Gender and Sexuality*, Balt. Sun, Sept. 28, 2016, http://www.baltimoresun.com/news/opinion/oped/bs-ed-lgbtq-hopkins-20160928-story.html.

Thus, while there are those like McHugh et al. who oppose the medical consensus regarding gender dysphoria—as there are outliers in every area of medicine—the protocols discussed above are well-established in the fields of medicine and psychology.

II. Excluding Transgender Individuals From Facilities Consistent With Their Gender Identity Endangers Their Health, Safety, And Well-Being.

Transgender students should have access to the sex-segregated facilities, activities, and programs that are *consistent* with their gender identity—including but not limited to bathrooms, locker rooms, sports teams, and classroom activities.[59] Evidence confirms that policies excluding transgender individuals from facilities consistent with their gender identity (hereinafter, "exclusionary policies") have detrimental effects on the physical and mental health, safety, and well-being of transgender individuals. And while schools like Gloucester High School often provide private restrooms for any student who seeks greater privacy for any reason, forcing transgender students to use those separate facilities sends a stigmatizing message that can have a lasting and damaging impact on the health and well-being of the young person.

In contrast, there is no evidence of any harm to the physical or mental health of other children and adolescents when transgender students use facilities that match

[59] APA/NASP Resolution, *supra*, at 9.

their gender identity. *Amici* are not hearing from their members about students experiencing any such harm—even though numerous states and school districts have policies allowing transgender individuals to use restrooms that match their gender identity.

A. Exclusionary Policies Exacerbate Gender Dysphoria And Are Contrary To Widely Accepted, Evidence-Based Treatment Protocols.

For transgender individuals, being treated differently from other men and women can cause tremendous pain and harm.[60] Indeed, exclusionary polices that force transgender people to disregard or deny their gender identity every time they must use a restroom disrupt medically appropriate treatment protocols. While those protocols provide that transgender individuals should live all aspects of their life in the gender with which they identify, *see supra* at 11-19, exclusionary policies require transgender individuals to live one facet of their lives in contradiction with their gender identity. As a result, exclusionary policies threaten to exacerbate the risk of "anxiety and depression, low self-esteem, engaging in self-injurious behaviors, suicide, substance use, homelessness, and eating disorders among other adverse outcomes" that many transgender individuals face.[61] Those risks are already all too serious: in a comprehensive survey of over 27,000 transgender individuals, 40

[60] *See, e.g.*, Sam Winter et al., *Transgender People: Health at the Margins of Society*, 388 Lancet 390, 394 (2016).

[61] APA/NASP Resolution, *supra*, at 4.

percent reported a suicide attempt—a rate *nine times* that reported by the general U.S. population.[62]

B. Exclusionary Policies Expose Transgender Individuals To Harassment And Abuse.

Exclusionary policies expose transgender individuals to harassment and abuse by forcing them to occupy gender-segregated spaces where their presence may be met with hostility, harassment, and abuse. For example, transgender men are visually recognized as men by other individuals; the presence of a transgender man in a women's restroom would be just as alarming as the presence of a cisgender man in the same women's restroom.

Exclusionary policies thus force transgender individuals to disclose their transgender status, because it is only transgender individuals who must use facilities that are incongruent with their gender identity and how they live and are recognized in the world. Because some children will have transitioned before they arrive in a particular school, exclusionary policies may be the only way that they are forcibly "outed" to their peers as transgender.

Such compelled disclosure of one's transgender status is harmful for at least two reasons. First, control over the circumstances in which a person may choose to disclose being transgender is fundamental to the development of individuality and

[62] James et al., Nat'l Center for Transgender Equality, *Report of the 2015 U.S. Transgender Survey*, *supra*, at 114.

autonomy.[63] Exclusionary policies rob transgender individuals of the personal choice regarding whether and when to reveal their transgender status. Disclosure of one's status as transgender is often anxiety-inducing and fraught; it is critical to a person's sense of safety, privacy, and dignity to have control over when and how that information is shared.

Second, such compelled disclosure exposes transgender individuals to the risk of harassment or abuse. In a 2013 survey, 68 percent of transgender respondents reported experiencing at least one instance of verbal harassment, and 9 percent reported suffering at least one instance of physical assault in gender-segregated bathrooms.[64]

These harms affect youth and adults alike. "[M]any gender and sexual orientation diverse children and adolescents experience harassment, bullying, and physical violence in school environments."[65] Because unwanted disclosure may cause such significant harm, the American Academy of Pediatrics' guidance states

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[63] Am. Acad. of Pediatrics, *American Academy of Pediatrics Opposes Legislation that Discriminates Against Transgender Children* (Apr. 18, 2016), https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAPOpposesLegislationAgainstTransgenderChildren.aspx.

[64] Jody L. Herman, *Gendered Restrooms and Minority Stress: The Public Regulation of Gender and its Impact on Transgender People's Lives*, 19 J. Pub. Mgmt. & Soc. Pol'y 65, 73 (2013).

[65] APA/NASP Resolution, *supra*, at 5; *see* Joseph G. Kosciw et al., GLSEN, *The 2015 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth In Our Nation's Schools* 12 (2016).

that care should be confidential, and it is not the role of the pediatrician to inform parents/guardians about a patient's sexual identity or behavior as doing so could expose the patient to harm.[66] Indeed, the American Academy of Pediatrics announced its opposition to exclusionary policies by noting that they undermine children's ability "to feel safe where they live and where they learn."[67]

C. Exclusionary Policies Exacerbate Stigma And Discrimination, Leading To Negative Health Outcomes.

It is well documented that transgender individuals experience widespread prejudice and discrimination, and that this discrimination frequently takes the form of violence, harassment, or other abuse.[68] For example, in a Virginia survey of transgender individuals, 50 percent of participants reported that they had experienced discrimination in healthcare, employment, or housing, and many individuals had experienced discrimination in more than one area.[69]

Exclusionary policies perpetuate such stigma and discrimination, both by forcing transgender individuals to disclose their status, and by marking transgender

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[66] AAP Technical Report, *supra*, at 305.

[67] Am. Acad. of Pediatrics, *American Academy of Pediatrics Opposes Legislation that Discriminates Against Transgender Children*, *supra*.

[68] Jamie M. Grant et al., Nat'l Center for Transgender Equality, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* 2-8 (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

[69] Judith Bradford et al., *Experiences of Transgender-Related Discrimination and Implications for Health: Results from the Virginia Transgender Health Initiative Study*, 103 Am. J. Pub. Health 1820, 1825 (2013).

individuals as "others" who are unfit to use the restrooms used by everyone else. Such policies inherently convey the state's judgment that transgender individuals are different and deserve inferior treatment.

Research increasingly shows that stigma and discrimination can have deleterious health consequences,[70] including striking effects on the daily functioning and emotional and physical health of transgender persons.[71] A 2012 study of transgender adults found a rate of hypertension twice that in the general population, which it attributed to the known effects of emotions on cardiovascular health.[72] Another study concluded that "living in states with discriminatory policies . . . was associated with a statistically significant increase in the number of psychiatric disorder diagnoses."[73] And a third study demonstrated that past school victimization may result in greater risk for post-traumatic stress disorder, depression, anxiety, and

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[70] *See generally* Am. Psychol. Ass'n, *Stress in America: The Impact of Discrimination* (2016), https://www.apa.org/news/press/releases/stress/2015/impact-of-discrimination.pdf.

[71] *See, e.g.*, Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression*, *supra* ("bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health").

[72] Randi Ettner et al., *Secrecy and the Pathophysiology of Hypertension*, Int'l J. Family Med. (2012).

[73] Bradford et al., *Experiences of Transgender-Related Discrimination and Implications for Health*, *supra*, at 1827.

suicidality.[74] As the American Psychological Association has concluded, "the notable burden of stigma and discrimination affects minority persons' health and well-being and generates health disparities."[75] There is thus every reason to anticipate that exclusionary policies will negatively affect the health of transgender individuals.

D. Exclusionary Policies Lead To Avoidance Of Restroom Use, Harming Physical Health.

Exclusionary policies have more immediate health effects as well. Though most of us take it for granted, all individuals require regular access to a restroom. Exclusionary policies that preclude transgender individuals from using restrooms consistent with their gender identity put transgender individuals to a difficult choice: (1) violate the policy and face potential disciplinary consequences; (2) use the restroom inconsistent with their gender identity or "special" single-user restrooms, which undermines their health care needs and risks discrimination or harassment; or (3) attempt not to use the restroom at all.

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[74] Russell B. Toomey et al., *Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth: School Victimization and Young Adult Psychosocial Adjustment*, 46 Developmental Psychology 1580, 1581 (2010).

[75] APA/NASP Resolution, *supra*, at 3-4; *see also* Institute of Medicine Committee on LGBT Issues and Research Gaps and Opportunities, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* 13 (2011) (noting that "prejudice, discrimination, and violence" underlie the "health disparities" between transgender and cisgender populations).

This difficult choice produces heightened anxiety and distress around restroom use, which may make it difficult for transgender individuals to concentrate or focus at school or work and potentially cause them to eschew social activities or everyday tasks.[76] At least one study of transgender college students associated being denied access to restrooms consistent with one's gender identity to an increase in suicidality.[77]

Studies also show that it is common for transgender students to avoid using restrooms.[78] But that avoidance can have medical consequences, including recurrent urinary tract infections and constipation, as well as the possibility of more serious health complications, including hematuria (blood in the urine), chronic kidney disease or insufficiency, urolithiasis (stones in the kidney, bladder, or urethra), infertility, and cancer.[79]

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[76] Herman, *Gendered Restrooms and Minority Stress*, *supra*, at 75.

[77] Kristie L. Seelman, *Transgender Adults' Access to College Bathrooms and Housing and the Relationship to Suicidality*, 63 J. Homosexuality 1378, 1388-89 (2016).

[78] Am. Psychol. Ass'n Guidelines, *supra*, at 840.

[79] *See, e.g.*, Herman, *Gendered Restrooms and Minority Stress*, *supra* at 75 (surveying of transgender and gender non-conforming people in Washington D.C., and finding that 54% of respondents reported a "physical problem from trying to avoid using public bathrooms" including dehydration, urinary tract infections, kidney infection, and other kidney-related problems); James et al., Nat'l Center for Transgender Equality, *Report of the 2015 U.S. Transgender Survey*, *supra*, at 246; Anas I. Ghousheh et al., *Advanced Transitional Cell Carcinoma of the Bladder in a 16-Year-Old Girl with Hinman Syndrome*, 80 Urology 1141 (2012).

Some transgender students experiencing fear and anxiety about restroom usage may attempt to dehydrate themselves so that they will need to urinate less frequently.[80] Chronic dehydration has been linked to a variety of conditions, including urinary tract infections, kidney stones, blood clots, kidney disease, heart disease, and colon and bladder cancer.[81]

These negative outcomes are not alleviated by forcing students into separate single-user restrooms. Being required to use separate facilities may force disclosure of one's transgender status and cause anxiety and fear related to being singled out and separated from peers. Additionally, single-user facilities are generally less available and more inconvenient, causing people to further avoid restroom use or disrupt their schedules to go to the restroom. Separate restrooms thus do not alleviate the anxiety, fear, or negative health consequences that result from exclusionary bathroom policies.

E. Exclusionary Policies Harm Adolescent Social And Emotional Development—With Lifelong Effects.

Finally, exclusionary policies have a particularly deleterious effect on the social and emotional development of children and adolescents. Discrimination and harassment of children and adolescents in their formative years may have effects that

---

[80] Herman, *Gendered Restrooms and Minority Stress*, *supra*, at 75.

[81] Lawrence E. Armstrong, *Challenges of Linking Chronic Dehydration and Fluid Consumption to Health Outcomes*, 70 Nutrition Rev. S121, 122 (2012).

linger long *after* they leave the school environment. Unsurprisingly, unwelcoming school environments produce particularly poor educational outcomes for transgender individuals.[82] Poorer educational outcomes, standing alone, may lead to lower lifetime earnings and an increased likelihood of poorer health outcomes later in life.[83]

Moreover, and as already discussed, exclusionary policies may produce and compound the stigma and discrimination that transgender children and adolescents face in the school environment. That stigma and discrimination, in turn, is associated with an increased risk of post-traumatic stress disorder, depression, anxiety, and suicidality in subsequent years.[84]

Conversely, evidence demonstrates that a safe and welcoming school environment may promote positive social and emotional development and health

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[82] *See* APA/NASP Resolution, *supra*, at 6; Emily A. Greytak et al., GLSEN, *Harsh Realities: The Experiences of Transgender Youth in Our Nation's Schools* (2009).

[83] *See, e.g.*, Emily B. Zimmerman et al., U.S. Dep't of Health and Human Servs. Agency for Healthcare Research & Quality, *Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives* (2015), https://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html.

[84] Toomey et al., *Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth*, *supra*, at 1581; *see also* APA/NASP Resolution, *supra*, at 6.

outcomes. Numerous studies show that safer school environments lead to *reduced* rates of depression, suicidality, or other negative health outcomes.[85]

* * *

With appropriate support—including safe and supportive schools—transgender youth can become happy and productive adults who contribute much to our society. By making schools into places of stress and conflict rather than welcoming spaces, exclusionary policies worsen stigma and discrimination against transgender students, causing myriad harms to their health, safety, and overall well-being.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge this Court to reverse the judgment below.

[85] AAP Technical Report, *supra*, at 301, 302, 304-05; *see, e.g.*, Marla E. Eisenberg et al., *Suicidality Among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors*, 39 J. Adolescent Health 662 (2006); Stephen T. Russell et al., *Youth Empowerment and High School Gay-Straight Alliances*, 38 J. Youth Adolescence 891 (2009).

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CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMIT

This brief complies with the type-volume limits because, excluding the parts of the brief exempted by Fed. R. App. P. 32(f) (cover page, disclosure statement, table of contents, table of citations, statement regarding oral argument, signature block, certificates of counsel, addendum, attachments), this brief contains 6,429 words, based on the "Word Count" feature of Microsoft Word 2016.

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No. 15-2056

In the

United States Court of Appeals

for the

Fourth Circuit

G.G., BY HIS NEXT FRIEND AND MOTHER, DEIRDRE GRIMM,
Plaintiff-Appellant,

v.

GLOUCESTER COUNTY SCHOOL BOARD
Defendant-Appellee.

**ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
NEWPORT NEWS DIVISION**

AMICI CURIAE BRIEF OF SCHOOL ADMINISTRATORS FROM THIRTY-THREE STATES AND THE DISTRICT OF COLUMBIA IN SUPPORT OF PLAINTIFF-APPELLANT

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UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT
DISCLOSURE OF CORPORATE AFFILIATIONS AND OTHER INTERESTS

Disclosures must be filed on behalf of all parties to a civil, agency, bankruptcy or mandamus case, except that a disclosure statement is **not** required from the United States, from an indigent party, or from a state or local government in a pro se case. In mandamus cases arising from a civil or bankruptcy action, all parties to the action in the district court are considered parties to the mandamus case.

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No. 15-2056 Caption: G.G. v. Gloucester County School Board

Pursuant to FRAP 26.1 and Local Rule 26.1,

(See attached list of amici curiae)
(name of party/amicus)

who is amici curiae, makes the following disclosure:
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1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

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If yes, identify all parent corporations, including all generations of parent corporations:

3. Is 10% or more of the stock of a party/amicus owned by a publicly held corporation or other publicly held entity? ☐ YES ☑ NO
If yes, identify all such owners:

4. Is there any other publicly held corporation or other publicly held entity that has a direct financial interest in the outcome of the litigation (Local Rule 26.1(a)(2)(B))? ☐ YES ☑ NO
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Signature: s/Cynthia Cook Robertson Date: May 15, 2017

Counsel for: Amici Curiae School Administrators

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I certify that on May 16, 2017 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

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INTEREST OF *AMICI CURIAE*[1]

Amici are school districts, superintendents, principals, school board members, general counsel, social workers, and other officials from schools and school districts that have adopted, or are in the process of adopting, inclusive policies and practices for their transgender students.[2] Together, *amici* represent a broad cross-section of schools and districts from thirty-three States plus the District of Columbia, collectively responsible for educating approximately 2.1 million students annually. *Amici* offer valuable perspectives on a number of the issues in this case, based on their broad collective experience with adopting, implementing, and enforcing such policies in their schools. Counsel for *amici* conducted interviews with certain individual *amici* in Fall 2015, Spring 2016, and Fall 2016 to obtain their input for this or earlier versions of this brief; synopses of *amici* interviews are on file with *amici*'s counsel Pillsbury Winthrop Shaw Pittman LLP.

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[1] No counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae*, their members, or their counsel made a monetary contribution to its preparation or submission. The parties have consented to the filing of this brief.

[2] With the exception of *amici* San Diego Cooperative Charter Schools, San Diego Unified School District, San Francisco Unified School District, Achievement First Public Charter Schools, Washoe County School District, School District of South Orange and Maplewood, Las Cruces Public Schools, Arlington County School Board, Montpelier Public Schools, and Washington Central Supervisory Union, *amici* join this brief in their individual capacities based on their experiences as school administrators and not as representatives of their respective schools or districts.

Amici who were not interviewed or are not quoted in this brief have experiences consistent with those expressed herein.

Below is a list of *amici* and their background and relevant experience; the Addendum includes additional information for each *amicus*.

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[3] The acronym "LGBTQ" stands for lesbian, gay, bisexual, transgender, and questioning.

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SUMMARY OF ARGUMENT

Thousands of transgender students attend American schools every day, many of whom – such as Plaintiff-Appellant Gavin Grimm – have come forward to request from their schools the same support and respect for their gender identity that all other students receive as a matter of course. In *amici*'s view, it is both the

legal and professional obligation of all educators to provide that support and respect to *all* students.

Amici's collective experiences refute the hypothetical concerns raised here by Defendant-Appellee Gloucester County School Board: that allowing all students to access sex-specific facilities and amenities that match their gender identity will lead to general disruption; will violate the privacy or "comfort" of other students; or will lead to the abolition of gender-segregated facilities and activities for all students. *Amici* have addressed and in some cases personally grappled with many of the same fears and concerns in their own schools and districts. However, in *amici*'s professional experience, none of those fears and concerns has materialized in the form of actual problems in their schools. Instead, inclusive policies not only fully support the reality of transgender students' circumstances, but also foster a safer and more welcoming learning environment for all students.

ARGUMENT

I. Policies Respectful of Every Student's Gender Identity Minimize Disruptions and Help Create a Safe, Welcoming, and Productive Learning Environment for All.

> *At first, we had our concerns – would letting students participate in activities and facilities that were consistent with their gender identity create problems? What would happen?*
>
> *Ultimately, we decided that we as the adults needed to manage our fears and give students the respect and dignity that they deserved. And I'm pleased to say that none of our fears has materialized.*

Dr. Judy Chiasson Testimony to the California Senate Education Committee on A.B. 1266 (June 12, 2013) ("Chiasson Testimony"), *available at* https://www.youtube.com/watch?v=Xmq9dIQdsNE (last visited Feb. 28, 2017).

As educators who have devoted much of their lives to young people, *amici* recognize that all students deserve equal respect of and equal treatment by their educators. *Amici*'s schools and districts allow transgender students access to the same facilities and opportunities as other students of the same sex. *Amici'*s collective experience is that inclusive policies are necessary for a learning environment that is accessible, safe, and welcoming, which in turn enhances the educational experience for all students. Respecting students' gender identity eliminates the disruption that results from singling out, stigmatizing, and discriminating against transgender students, and avoids disrupting the normal social interactions involved in use of communal facilities. By contrast, refusing to respect a student's gender identity is "toxic for the student – it says 'you are not welcome,' every day." Robert Motley Interview, Oct. 11, 2016.

Defendant-Appellee is reacting to fears over the imagined consequences of fully integrating transgender students into the school community. *Amici*'s experiences reveal that these fears are unfounded. *Amici*'s experiences with the inclusive policies in place in their schools – some for more than a decade – have instead been overwhelmingly positive. Far from being disruptive or potentially

unsafe, inclusive policies have *minimized* disruption and safety concerns. The only disruption is caused by a lack of clarity about how to support transgender students. As Ms. Bruce of the District of Columbia observes, "A policy that requires equal treatment is not difficult to implement. Beyond sorting it out at the beginning, it's not an ongoing, lingering issue[.]" Diana Bruce Interview, Oct. 5, 2015 ("Bruce Interview"). As educators, "[o]ur goal is to make sure that every young person is as present and as able to engage in academic work as possible. Promoting a safe and welcoming environment is a way to promote education." *Id*. The results have been overwhelmingly successful, not only for transgender students, but for all students, faculty, administrators, and communities as a whole.

A. In Contrast to Adults' Unfounded Fears, Students' Experiences in Schools with Inclusive Policies Have Been Positive.

In *amici*'s professional experience, fears and concerns about inclusive policies are almost exclusively held by adults, not students. Students often set a leading example recognizing transgender students' rightful place in school facilities that match their gender identity. *E.g.*, Howard Colter Interview, June 6, 2016 ("As to the students, I am most impressed. They are very understanding and accepting of their classmates. It feels like the adult community is struggling with it more."); Bruce Interview ("Young people are pretty savvy and comfortable, and can understand and empathize with someone who just wants to use the bathroom."); Roger Bourgeois Interview, Oct. 8, 2015 ("Bourgeois Interview")

("Most of the problem is with the adults; the students are pretty accepting of these issues."); Dr. Eldridge Greer Interview, Oct. 14, 2016 ("Greer Interview") ("Students are much more resilient and forward-thinking than we as adults are."); Dr. Rachel Santa Interview, May 27, 2016 ("Santa Interview") ("Adults have more issues than the students do."); Dr. David Vannasdall Interview, Sept. 9, 2016 ("Vannasdall Interview II") ("With the kids, there hasn't been a problem at all."); Kathy Canavan, *Transgender bathrooms already happening in Delaware*, DELAWARE BUSINESS TIMES, May 13, 2016 ("Meece Interview") (quoting Gregory Meece) ("We had a few parents ask some questions, and we've had some express thoughts on it, but the students are 100% accepting.")[4]; Sherie Hohs Interview, Oct. 15, 2015 ("This isn't a kid issue. It's an adult issue."). Based on her more than ten years' experience working with the inclusive policies in place at Los Angeles Unified School District ("LAUSD"), the second-largest school district in the country, Dr. Judy Chiasson recounts:

> Our experience has been that the fears of the adults rarely play out. The students are very affirming and respectful of their classmates. Most of the reaction that I've ever encountered has been in response to people's fears, not the students' experiences. The students' experiences have been overwhelmingly positive. I have yet to be called into a situation to respond to an actual incident; I've only had to respond to fears, and the fears are unfounded.

[4] *Available at* http://www.delawarebusinesstimes.com/transgender-bathrooms-already-happening-delaware/ (last visited Feb. 28, 2017).

Dr. Judy Chiasson Interview, Sept. 23, 2015 ("Chiasson Interview").

Several *amici* have themselves wrestled with many of the same concerns Defendant-Appellee has raised, when first faced with the need to adopt an inclusive policy. Indeed, Dr. Vannasdall's district's initial experience with a transgender student resulted in a complaint and investigation by the U.S. Department of Justice ("DOJ") and the U.S. Department of Education, Office for Civil Rights ("OCR"). He well understands what it is like to grapple with the actual and anticipated negative reactions from some parents and community members. Administrators and others within the school district were concerned that respecting the transgender student's gender identity by treating him like any other boy would be disruptive and burdensome. Dr. David Vannasdall Interview, Sept. 23, 2015 ("Vannasdall Interview I").

A simple, open conversation between administrators and the student and his family revealed their concerns to be erroneous assumptions. *Id*. In that conversation, it became "obvious that this student had no intentions of creating a disruption – he just wanted a home and a place to learn, and not worry about which restroom to use." *Id*. Once the administrators understood that the student was simply asking to be treated like any other boy, their obligation as educators became clear: to help this student, and all of their students, "come to school ready to learn." *Id*.

> If they're worrying about the restroom, they're not fully there to learn, but instead just trying to navigate their day. Give students the opportunity to just be a kid, to use the bathroom, and know that it's not a disruption, it just makes sense.

Id.

Dr. Vannasdall's district reached a voluntary resolution agreement in 2013 with the DOJ and OCR. The resolution agreement included adopting a comprehensive policy respecting students' gender identity covering, among other things, equal access to sex-segregated restrooms and locker rooms consistent with gender identity.[5] The outcome over the past three years has been "very positive for the school, the district, and the students." *Id.*

Dr. Vannasdall now regularly consults with educators across the country, giving informal advice and guidance on inclusive policies for transgender students. *Id.* He understands what it is like to grapple with the actual and anticipated concerns from parents and the community, but when those are the primary concern, "you have people making decisions from the basis of fear and extremes,

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[5] *See* Resolution Agreement Between the Arcadia Unified School District, the U.S. Department of Education, Office for Civil Rights, and the U.S. Department of Justice, Office of Civil Rights, OCR Case No. 09-12-1020/DOJ Case No. 09-12-1020 (July 24, 2013), *available at* http://www.justice.gov/sites/default/files/crt/legacy/2013/07/26/arcadiaagree.pdf (last visited Feb. 28, 2017). *See also* Letter from DOJ and OCR to Arcadia School District (July 24, 2013), *available at* http://www.justice.gov/sites/default/files/crt/legacy/2013/07/26/arcadialetter.pdf (last visited Feb. 28, 2017).

and that's never good for kids." Julie Bosman & Motoko Rich, *As Transgender Students Make Gains, Schools Hesitate Over Bathroom Policies*, N.Y. TIMES, Nov. 4, 2015, at A14 (quoting Dr. Vannasdall).[6] The "game-changer" for Dr. Vannasdall's district and for other districts with which he has consulted is when educators "remember what we are here to do," *i.e.*, to help kids learn. Vannasdall Interview I. Dr. Vannasdall believes that generally school administrators new to dealing with transgender students are "overthinking this issue. This doesn't need to be as tough as some people make it. It can be a good experience for that student and other students as well." *Id*.

Similarly, Dr. Thomas Aberli of Louisville, Kentucky was unfamiliar with this issue when it first arose, and had concerns about possible disruptions or privacy issues. But Dr. Aberli tried to understand the student's request on both a personal level and in terms of the legal obligations of the schools. Dr. Thomas Aberli Interview, Oct. 7, 2015 ("Aberli Interview"). He then developed a policy through an extensive collaborative effort with a panel of school administrators, teachers and parents, in which "[w]e considered the issue very carefully and thoughtfully, and posted all of the evidence we reviewed online." Aberli

[6] A version of this article is available online at: http://www.nytimes.com/2015/11/04/us/as-transgender-students-make-gains-schools-hesitate-at-bathrooms.html (last visited Feb. 28, 2017).

Interview.[7] Some in the community expressed the view that inclusive policies might be fine for schools in Los Angeles, but not in their own community (Kentucky). As Dr. Aberli pointed out in his testimony to the Kentucky Senate Education Committee, however, empathy and equality do not stop at state borders:

> The value of human life is the same in Kentucky as it is anywhere else in this nation. And when we're talking about an issue of civil rights, we're talking about the value we put on human individuals.

Aberli Testimony. Understanding that the policy is about protecting students' basic civil rights helped clarify the issue.

> It helped people to understand that this wasn't about providing a special accommodation or "special rights" – this is about eliminating discrimination. When you tell a person you will do something that makes them stand out from everyone else, *that's* when you start discriminating against them.

Aberli Interview. When the issue was unfamiliar to many in the community, adults and a handful of students questioned the new policy.

> I respect that some people may disagree or even feel uncomfortable with the policy, because honestly, for many people – including myself until a few months ago – they simply weren't knowledgeable, or it wasn't a close enough personal issue in terms of interacting with openly LGBT people to have a comfort level. I acknowledge and

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[7] *See also* Dr. Thomas Aberli Testimony before the Kentucky Senate Education Committee on S.B. 76 (Feb. 19, 2015) ("Aberli Testimony"), video excerpt available at https://www.youtube.com/watch?v=QodplMWsEvQ (last visited Feb. 28, 2017). The materials Dr. Aberli references as having been posted online are available at http://schools.jefferson.kyschools.us/High/Atherton/SBDM.html (last visited Feb. 28, 2017).

> respect that. But I am not going to use someone's discomfort as a means for discriminating against a protected population.

Id. Despite the initial opposition, in practice Dr. Aberli "received zero complaints regarding a specific incident of concern for a violation of privacy. The concerns raised by individuals have all been philosophical." *Id*.

Indeed, in *amici*'s experience, "an affirming policy has a positive effect on other students as well. If everyone is taken care of, students see that and they value that." Denise Palazzo Interview, Oct. 3, 2015 ("Palazzo Interview"). "When kids see that you are respecting all students, then they know that they will be respected. We are showing them how to treat people respectfully and know they will be treated the same." Santa Interview. As Principal Peyton Chapman of Oregon relates:

> Students have high integrity radars – if some youth are made fun of, then they know it could happen to them. These fears keep all students in small boxes. They don't try things out, engage their creativity and figure out who they are and can be. If schools define "who" students need to be and how they should behave, then they are less free to explore themselves, cultures and communities.

Peyton Chapman Interview, May 27, 2016. A policy respectful of every student's gender identity, by contrast, fosters mutual respect and "creates open and innovative environments." *Id*.; *see also* Meece Interview ("I'm really proud of the students who see a student as a human being before they see gender or disability or race.")

B. Frequently-Raised, Hypothetical Concerns Have Not Materialized.

> *There have not been any issues regarding this policy in locker rooms or bathrooms. But it has brought greater awareness of how we can increase privacy for all students.*
>
> Aberli Interview.

No student should be denied access to any gender-specific facilities that are available to other students of the same gender identity solely because he or she is transgender. *Amici* have experience with the hypothetical fears and concerns commonly raised when schools integrate transgender students into gender-specific facilities, including the fear that some individuals might use an inclusive policy to gain access to the facilities of another gender for an improper purpose. *Amici* have found such fears and concerns to be wholly unfounded in practice.

1. Concerns about restrooms have not materialized.

"Questions about bathrooms come up in every staff training, and it's an important thing that school staff want to understand. I think there's an assumption that there will be disruption around restrooms." Bruce Interview. But all schools routinely "deal[] with many more adolescent behavior issues than just who's using the bathroom based on gender identity," and are adept at addressing those issues. *Id*. As with any behavior issue, "oftentimes disruption in our experience has been around inconsistency by staff – and that's why clear guidance for schools is

important[.] . . . Our transgender students just want to use the restroom and be safe when they do it, and that's all they're trying to do." *Id.*

Dr. Aberli of Kentucky similarly reports that Atherton has

> multiple transgender individuals in our school, and restroom access has not been an issue. . . . [T]here has not been any issue at all with respect to the implementation. It's not a big deal when you look at it from a standpoint of, we're dealing with real people, we're dealing with children. Even at the high school level we're dealing with people who have had a hard enough time as it is, and they're just looking for reasonable support from the school in a very challenging social context, or during a very difficult process, as it is for many of them.

Aberli Interview; *see also Gender Inclusive Leadership in Action*, Video Interview by Gender Spectrum with Dr. Pamela Retzlaff, Nov. 17, 2016 ("Retzlaff Interview")[8] ("He's interested in using the toilet, that's it. Not looking at anybody's genitals. Not doing anything else in the bathroom. It's just using the toilet.").

2. Concerns about locker rooms have not materialized.

Although the present appeal focuses on restroom policies, *amici*'s experiences with inclusive locker room policies have also been positive. Diana Bruce explains that "our transgender students are not interested in walking around the locker rooms and checking out anatomy. They're just trying to get through

[8] *Available at* https://www.genderspectrum.org/blog/gender-inclusive-leadership-in-action-episode-1/ (last visited Feb. 28, 2017).

P.E. safely." Bruce Interview. Similarly, transgender students often have their own sense of modesty, particularly about differences in their bodies that do not match their gender identity. As Dr. Vannasdall explains, "Transgender [s]tudents dealing with this are very discreet. . . . The student's goal is just not to stand out." Vannasdall Interview I. Mary Doran of Minnesota concurs: "[W]hen the *coaches* tell me 'this [transgender policy] isn't an issue, isn't a big deal,' that really says something." Mary Doran Interview, Oct. 16, 2015.

Indeed, in the rare instances that *amici* have needed to address locker room issues, it has been to ensure the safety of the transgender students. "The sad truth is that our transgender children are significantly more likely to be the targets of student misconduct, rather than the perpetrators of it." Chiasson Interview; *see also* Ken Kunin Interview, June 10, 2016 ("Kunin Interview") ("The real risk is to people who identify as transgender, or gay, or just 'other.'"). And even there, "[l]ocker rooms aren't a [special] concern because we are already accustomed to dealing with students who have unique or special needs in the locker room context. This is just one more type of student that may need additional support in that space." Palazzo Interview.

3. Concerns about students "posing" as transgender to gain improper access to facilities have not materialized.

Amici have also frequently addressed the concern that transgender students might just be "confused" or likely to change their minds often about their gender

identity, or that non-transgender students might falsely claim to be transgender for some nefarious purpose. Those concerns have not materialized either. Moreover, *amici*'s policies allow schools to make reasonable assessments of individual requests for accommodation. As Dr. Chiasson explained in a letter to Dr. Aberli:

> It is reasonable to expect that a student will exercise consistency with respect to their identity and access to facilities. Students cannot switch their identity arbitrarily or opportunistically. [. . .]
>
> If the school strongly suspects that the request is not legitimate, they should provide accommodation for the student while continuing the conversation to better understand the student's motivation for the request. Being transgender is a deeply rooted identity. . . . It is not subject to arbitrary whims.

Letter from Dr. Judy Chiasson to Dr. Thomas Aberli, May 29, 2014 ("Chiasson Letter").[9] Similarly, Mr. Bourgeois explains that at his school in Massachusetts,

> A student can't just show up and say, "I'm a male, but I want to start using the girls' locker room today." People worry some football player will show up and want to get into the girls' locker room, but we would not allow that. There's a process we go through to work with them and their families, and verify their identity.

Bourgeois Interview. All *amici*'s schools follow a similar policy, and as a general matter, it is easy to identify genuine requests.

> Some people fear someone will masquerade . . . as transgender to be predatory. . . . I've never had that happen, where someone has pretended to be transgender for nefarious reasons. It's just plain silly to think that [a male student] is going to come to school for months on

[9] A copy of Dr. Chiasson's letter to Dr. Aberli is included among the materials posted by Atherton. *See* footnote 7, *supra*.

> end, wear female attire, present as female to all of his friends and teachers, just so he can go into the female locker room.

Chiasson Interview; *see also* Santa Interview ("The hysteria is from misunderstanding. The concern is that the policy will allow a typical high school boy to say he is transgender so he can go peek at girls in the bathroom. I haven't seen it[.]"). Indeed, schools are very adept at dealing with instances of misbehavior in restrooms and locker rooms precisely because it is not particularly difficult for a student to gain access to another gender's facilities.

> Adolescents can be impulsive, and we have had boys and girls dart into the other bathroom. We find them and deal with them. They certainly don't need to masquerade as transgender to engage in that misconduct.

Id.; *see also* Greer Interview ("There are easier ways to get into the girls' bathroom [than posing as transgender] – and we have policies and consequences to address that.").

In other words, schools routinely deal with all sorts of behavioral problems – and *amici* "would have a problem" with any student actively violating another student's privacy, and would deal with that misconduct as it arises. Brian Schaffer Interview, June 1, 2016. Parents, teachers, and administrators alike are always looking out for the safety of all students. A policy respecting transgender students is far more likely to thwart misbehavior in these spaces than to cause it.

II. Schools Can and Should Fully Respect Both the Gender Identity and the Privacy Concerns of All Students.

Many concerns raised with regard to inclusive policies for transgender students involve perceived threats to the "privacy" or "comfort" of other students. As educators, *amici* are respectful of the needs and concerns of all of their students. But *amici* strongly disagree that a school should discriminate against transgender students in order to accommodate complaints that *other* students are "uncomfortable" with sharing a restroom with a transgender person. That is simply not how educators deal with students' discomfort with others or with themselves. To the extent that a student has concerns about sharing facilities with transgender students, schools must help the student deal with that discomfort in a way that does not impinge upon other students' rights to equal treatment.

One simple solution is to offer private facilities to the student who does not want to use the same facilities as a transgender student. Most of *amici*'s schools offer private facilities that may be used by persons of either gender, in addition to gender-segregated facilities. Ms. Bruce recounts that, in her schools,

> [a]ccording to our policy guidance, if a student has a problem, we can make another bathroom available to that student. I haven't heard from our schools, however, of students that have asked to use a different restroom in that circumstance. When I train our school staff, some want to ask hypotheticals, but in our experience, this has not been an issue.

Bruce Interview. Indeed, some students may prefer to use these private facilities for any number of reasons, and are permitted to do so without the need to provide an explanation – including in the rare circumstance that a student might not want to use the same facility as a transgender student.

> [A]ny student who, for whatever reason, feels uncomfortable in a communal setting – whether because of weight, personal comfort, body image, social anxiety, or other reasons – we will accommodate that without the need for explanation, and they can use a private setting such as a nurse's room.

Chiasson Interview. Likewise, Dr. Aberli's school allows any student who wants to use a private restroom to do so.

> What I have clearly communicated in public is that any student may use the front office restroom. We don't ask why. There's a thousand reasons that a student needs privacy, so it's our responsibility to accommodate any student for any reason. It could be shyness, or trauma.

Aberli Interview.

When separate facilities are not available or practical to meet student requests for additional privacy, there are other means of providing extra privacy to students when needed, such as using a curtain to create a separate area, or allowing a student to use the locker room before or after other students. Matthew Haney Interview, June 6, 2016. Accommodating individual students' needs is "something educators do every day," and educators have proven themselves "very flexible and adaptable in adopting new policies for their students" in order to meet their needs.

Vannasdall Interview II. Providing transgender students what they need to thrive in school is no different. Lauren Slager, *Schools Take Steps to Address Needs of LGBTQ Students*, mLIVE Michigan, Apr. 21, 2016 (quoting Craig McCalla) ("We make accommodations for all kids in all different ways. We always have, and there's no reason not to for a specific group of people.").[10]

Even in the rare case where a student might express discomfort with sharing facilities with a transgender student, the solution is not to deny access to the transgender student. Any student expressing such discomfort should be offered alternative facilities or arrangements to address their concerns. As Mr. Bourgeois explains:

> [W]e're not going to tell the transgender student they can't go where they're comfortable. I can still remember the remnants of white people being uncomfortable with black people being in same locker rooms and restrooms, so it's not about whether everyone is "comfortable." Just because some people were uncomfortable didn't mean you treated people as second-class citizens.

Bourgeois Interview; *see also* Arthur DiBenedetto Interview, Nov. 29, 2016 ("The outcry will be similar to the arguments put forth by those who were faced with black students in white schools when desegregation became the law."). Mr. Kunin of Maine agrees that "being uncomfortable doesn't overrule someone's rights," but he also emphasizes that "there are also ways to support the person who is

[10] Available at http://www.mlive.com/news/ann-arbor/index.ssf/2016/04/schools_take_steps_to_address.html (last visited Feb. 28, 2017).

uncomfortable – we would want that person to feel safe and participate, too." Kunin Interview. Although schools should accommodate requests for extra privacy from any student, no transgender student should ever be *forced* to use separate facilities in order to accommodate the actual or anticipated discomfort of other students.

Particularly in the educational context, policies like that of Gloucester County School Board single out and create a serious dilemma for transgender students like Gavin – requiring him either to use a separate restroom simply because he is transgender, or to use facilities that are patently inconsistent with his gender. Having to navigate this problem daily seriously interferes with transgender students' education, impairs their ability to learn and socialize, and results in real physical and emotional harm. Ms. Bruce explains that when transgender students "have reported worrying about whether they can use the restroom that matches their gender identity, they have said they just don't go to the bathroom at school. That can't possibly help them learn." Bruce Interview.

> We don't want them preoccupied with trying not to use the bathroom when they're supposed to pay attention to trigonometry. . . . We want them to know where they can use the restroom, so they can feel more like anyone else in their school and not like an outsider.

Id.; *see also* Kunin Interview ("A school day is too long a time to wait to use the restroom because one is uncomfortable with the options."). Although, as noted above, *amici* routinely offer separate facilities to any student requesting additional

privacy for any reason (including but certainly not limited to transgender students), no student should ever be forced to use a separate facility simply because they are transgender. Dr. Aberli agrees that "making transgender students use the nurse's room" is no answer at all:

> Tell me what we would say to that child – that there's something so freakish about you, and so many people are uncomfortable with you, that you have to use a completely separate restroom than the one you feel like you should be using?

Aberli Interview. Instead, in *amici*'s experience, all students' needs are best served when educators can treat all students equally.

III. Gender-Segregated Spaces and Activities Are Fully Consistent with School Policies Respecting Every Student's Gender Identity.

Amici have also addressed the lurking hypothetical concern that permitting individuals to use facilities consistent with their gender identity will lead to the abolition of gender-specific facilities. Contrary to that "slippery slope" argument, however, all *amici* continue to maintain gender-segregated facilities in their schools. In fact, respecting the gender identity of transgender students *reinforces* the concept of separate facilities for girls and boys; requiring a girl who is transgender to use the boys' restroom or a boy who is transgender to use the girls' restroom *undermines* the notion of gender-specific spaces.

Dr. Chiasson offers an example from her own district, in which a new male student who was transgender had been using the female facilities, incorrectly assuming that, because he was assigned a female sex at birth,

> that he would be required to do so. *It was equally uncomfortable for him to use the girls' facilities as it was for the girls themselves*. When the administration learned of the situation, they told the young man that he could use the boys' facilities. Everyone was relieved.

Chiasson Letter (emphasis added); *see also* Retzlaff Interview ("[H]is classmates were also somewhat relieved because they knew, too, something's not right [about a boy who is transgender being forced to use the girls' restroom]."). Mr. O'Reilly similarly commented that, until he considered the effect of forcing a transgender student to use a restroom inconsistent with gender identity, he "hadn't really understood the literal meaning of the word 'misfit.' When forced to use the restroom for the gender they do not associate with, a student literally becomes a *mis*fit: someone being forced into a place they don't belong." John O'Reilly Interview, Sept. 20, 2015.

Transgender students (like Gavin here) have not sought to eliminate gender-specific facilities – they merely want to use the facilities that correspond with their gender identity. "Far from being disruptive, our experience has been that those students just want to blend in." Bourgeois Interview. "Transgender-affirming policies solve problems, not create them. Even if the law allowed it, forcing a

transgender boy to use the female facilities would be extremely uncomfortable for all parties involved." Chiasson Interview.

CONCLUSION

Defendant-Appellee assumes that policies respectful of an individual's gender identity are disruptive and impinge upon the rights and well-being of non-transgender individuals. *Amici*'s experience as school administrators has proven otherwise: showing respect for each student's gender identity supports the dignity and worth of all students by affording them equal opportunities to participate and learn. Moreover, such policies have not been disruptive – either to the academic climate or to the maintenance of gender-specific facilities – and instead protect the safety and privacy of all youth. *Amici* respectfully request that the dismissal of Plaintiff-Appellant's Title IX claim be reversed, and that the Court hold that Plaintiff-Appellant is entitled to a preliminary injunction.

Respectfully submitted,

Dated: May 15, 2017

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitations of Fed. R. App. P. 29(d) and Fed. R. App. P. 32(a)(7)(B) because this brief contains 6,706 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).
2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in Times New Roman style, with 14-point font.

DATED: May 15, 2017

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CERTIFICATE OF SERVICE

I hereby certify that, on May 15, 2017, I filed the foregoing *Amici Curiae* Brief of School Administrators from Thirty-Three States and the District of Columbia in Support of Plaintiff-Appellant with the Clerk of the Court using the CM/ECF system, which will automatically serve electronic copies upon all counsel of record.

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No. 15-2056

IN THE

United States Court of Appeals for the Fourth Circuit

G.G., BY HIS NEXT FRIEND AND MOTHER, **DEIRDRE GRIMM**,

Plaintiff – Appellant,

v.

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant – Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA, NEWPORT NEWS DIVISION

AMICI CURIAE BRIEF OF THE NATIONAL PTA, GLSEN, AMERICAN SCHOOL COUNSELOR ASSOCIATION, NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS, AND MARYLAND PTA IN SUPPORT OF PLAINTIFF - APPELLANT

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INTERESTS AND IDENTITIES OF AMICI CURIAE

National PTA is a nationwide network of four million families, students, teachers, administrators, and business and community leaders devoted to making a difference for the education, health, safety and well-being of every child and making every child's potential a reality. National PTA is comprised of 54 state congresses, comprising all 50 states, the District of Columbia, U.S. Virgin Islands, Puerto Rico and the Department of Defense Schools in Europe. Additionally, there are more than 24,000 local PTA units nationwide. PTA serves 16.5 million students across the country.

The overall purpose of PTA is to bring together families, educators and business and community leaders to solve the toughest challenges facing schools and communities and engage and empower families and communities to speak up and take action for every child. For more than 100 years, PTA has been a powerful voice for all children, a relevant resource for families and communities, and a strong advocate for public education.

GLSEN is a non-profit education organization that works with students, parents, and educators across the country and around the world to make all schools safe and affirming for all students, regardless of sexual orientation, gender identity, or gender expression. Since 1990, GLSEN has partnered with educators, schools, and districts across the United States to develop, evaluate, and

promulgate LGBT-supportive policies, programs, and practices for K-12 schools. GLSEN's work has contributed to measurable improvements in the school experience of lesbian, gay, bisexual, and transgender students in all fifty states, and is now recognized globally as a key contribution to educational access and opportunity for at-risk youth.

GLSEN's expertise and experience informs the work of UN agencies on the Sustainable Development Goals in Education, legislators and policymakers at all levels in the U.S., and individual schools and districts via our chapter network of 40 local chapters in 27 states. GLSEN also conducts quantitative and qualitative research on the experience of LGBTQ students in K-12 schools, and engagement and advocacy in support of a research-based public policy agenda. In addition, GLSEN's student leadership development and student organizing programs have reached hundreds of thousands of students in all fifty states, mobilized via events like GLSEN's Day of Silence and Ally Week or through GLSEN youth summits or student club support programs. Thousands of alumni of GLSEN's student programs have gone on to lives of service, including work as public and elected officials, business leaders and entrepreneurs, and principals, counselors, and teachers.

The **American School Counselor Association (ASCA)** supports school counselors' efforts to help students focus on academic, career and

social/emotional development so they can achieve success in school and are prepared to lead fulfilling lives as responsible members of society. ASCA provides professional development, publications and other resources, research and advocacy to more than 32,000 school counselors around the globe.

School counselors promote affirmation, respect, and equal opportunity for all individuals regardless of gender identity or gender expression. School counselors encourage a safe and affirming school environment and promote awareness of and education on issues related to transgender and gender-nonconforming students.

The **National Association of School Psychologists (NASP)** is the world's largest organization of school psychologists, representing more than 25,000 school psychologists throughout the United States and 25 other countries, with members in every state, the District of Columbia, and Puerto Rico. NASP's vision is that all children and youth thrive in school, at home, and throughout life. To that end, NASP empowers school psychologists by advancing effective practices to improve students' learning, behavior, and mental health. NASP supports that all youth have equal opportunities to participate in and benefit from educational and mental health services within schools regardless of sexual orientation, gender identity, or gender expression. Critical to this effort is fostering positive, safe, and affirming school environments.

The **Maryland PTA** is a statewide network of over 100,000 families, students, teachers, administrators, and business and community leaders devoted to making a difference for the education, health, safety and well-being of every child and making every child's potential a reality. Maryland PTA is comprised of almost 900 school or community-based PTAs.

INTRODUCTION

Amici[1] are a diverse group of national education organizations whose membership and constituents are on the front lines every day, doing the hard work of educating students through academic instruction and support; furnishing counseling and guidance; and providing opportunities for engagement with peers and others. Critical to this educational mission, Amici seek to build and maintain non-discriminatory learning environments for all students, regardless of their backgrounds, characteristics, or experience.

As educators and education supporters, Amici know that restroom discrimination against transgender students hurts kids. Amici have gained extensive, hands-on experience in what policies and practices best serve all students while providing transgender students with full access to a non-discriminatory learning environment. Amici have seen transgender students' capacity for educational success and healthy development when properly supported, and the tragic harms imposed on transgender students when that essential support is denied. This brief shares this experience with the Court.

As Amici know from their experience, the required use of a separate restroom by transgender students is inhumane and is entirely based on unfounded

[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than amicus made a monetary contribution to its preparation or submission. All parties consent to the filing of this brief.

fears.[2] Such practices are, therefore, inconsistent with established principles requiring equality.

First, as Amici know first-hand, all too common harms occur when transgender students are relegated to the shadows or stigmatized by discrimination. This includes being forced to use a restroom that is not aligned with their gender identity or being shunted to a "special" restroom for transgender students. For example, in those situations, nearly 40% of transgender students fast, dehydrate, or otherwise force themselves not to use the restroom during the school day. *See* Joseph Kosciw, et al., *The 2015 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, & Queer Youth in Our Nation's Schools*, GLSEN (2016) (hereinafter "2015 NSCS") (39.4% avoid restrooms); *see also* Jody L. Herman, *Gendered Restrooms and Minority Stress: The Public Regulation of Gender and its Impact on Transgender People's Lives*, 19 Journal of Public Management and Social Policy 74-75 (2013) (54% of adult transgender students and employees surveyed "reported having some sort of physical problem from trying to avoid using public restrooms"). Transgender students subjected to discrimination also experience elevated levels of severe depression and even suicide. On the other hand, when transgender students are accorded the dignity

[2] As G.G.'s Supplemental Brief has thoroughly addressed Title IX, Amici do not separately address that independent basis. Nor do Amici address any potential damages remedy.

they deserve (*e.g.*, when they are addressed with appropriate names and pronouns and use restrooms that conform to their gender identity), transgender students reflect the same, healthy psychological profile as their peers. Lily Durwood et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth,* 56 Journal of the American Academy of Child & Adolescent Psychiatry 116, 116 (2017).

Second, schools and school districts across the nation have already developed and successfully deployed practical, effective strategies to ensure transgender students receive appropriate support and, ultimately, the educational experiences they need to succeed and live healthy, fulfilling lives. This includes allowing each student to use the restroom that matches their gender identity. The experiences of these schools put the lie to the supposed legitimate justifications for restroom discrimination: preventing students pretending to be transgender from obtaining access to opposite-gender restrooms and protecting privacy. Consistently, inclusionary restroom policies have been implemented with little controversy, great success, and respect for the human dignity and educational needs of the schools' entire student populations.

Anti-discrimination cases have employed "dispositive realities" to reject "self-fulfilling prophecies" that are "routinely used to deny rights or opportunities." *United States v. Virginia*, 518 U.S. 515, 543 (1996). Here, the

dispositive realities are the successful experiences and practices of Amici and other educators throughout the nation in implementing inclusionary restroom policies. Appellee's unsubstantiated prophecies about predators and nudity cannot prevail at the expense of transgender students' rights to take advantage of a "state supplied educational opportunity for which they are fit," *id.* at 550-551; receive full access to non-discriminatory educational facilities; and live free of stigmatizing and discriminatory practices that cause them deep and enduring harms.

SUMMARY OF ARGUMENT

Harm to transgender students is the core of this case. As educators throughout the country understand, equality requires that public schools cannot prejudicially disfavor groups of boys or girls based on unfounded fears. Rather, schools must help all students understand and achieve their full potential so that they become citizens and workers who are productive, engaged, and fulfilled.

Without a school environment that is authentically welcoming and that honors and protects the dignity and best interests of all students—every one of whom is different in some way—many students are harmed. A school that lacks a culture that embraces safety, respect, and inclusion for all, regardless of background and circumstance, injures the disfavored students. *Id.; see also*, Emily Greytak, Joseph Kosciw, Christian Villenas, and Noreen Giga, *From Teasing to Torment: School Climate Revisited, A Survey of U.S. Secondary School Students*

and Teachers, GLSEN (2016), https://www.glsen.org/sites/default/files/TeasingtoTorment%202015%20FINAL%20PDF%5B1%5D_0.pdf.

As set forth in Section I, the discriminatory denial of equal access to restrooms routinely suffered by transgender students like G.G. causes them dire educational and life consequences. Extensive research shows the myriad harms transgender students experience in discriminatory school settings, including when subjected to restroom discrimination. Understanding the severity of these harms is crucial to the Court's consideration of this case. Indeed, as reflected in Supreme Court cases and U.S. Department of Education policies, the contours of federal non-discrimination law have been shaped to prevent real-world harms experienced by students.[3]

As set forth in Section II, the purported bases for inflicting severe harms on G.G. and other transgender students through restroom discrimination are entirely unfounded fears. Educators in many places can and do provide

[3] *See, e.g.*, *Brown v. Board of Educ.*, 347 U.S. 483, 495 n.11 (1954) (premising forbidding "separate but equal" on extensive social science research and information); *Davis v. Monroe County Bd. of Educ.*, 526 U.S. 629, 651 (1999) (examining the severity of student-on-student harassment sufficient to constitute a Title IX claim on the basis of interference with equal access to educational opportunities); U.S. Dep't of Education Sexual Harassment Guidance (2001) (explaining in detail, with examples, the harm to students that is an element of federal harassment standards); U.S. Dep't of Education Racial Harassment Guidance (1994) (same).

transgender students the inclusive and supportive environment they need—including equal access to restrooms—without any harm to other students. Indeed, contrary to Appellee's assertion that the implementation of non-discriminatory restroom policies would "upend the ingrained practices of nearly every school in the Nation . . . ," Br. of Petitioner at 20, *Gloucester County School Bd. v. G.G. ex rel. Grimm*, 137 S.Ct. 1239 (2017) (No. 16-273), schools and districts across the country successfully have implemented restroom policies that neither discriminate against transgender students nor harm others. That record of success exposes the privacy and predator rationales for restroom discrimination as completely unfounded fears.

ARGUMENT

I. RESTROOM AND OTHER IN-SCHOOL DISCRIMINATION SERIOUSLY HARMS TRANSGENDER STUDENTS.

The serious harms and deprivations transgender students suffer as a result of discrimination are undeniably pertinent to equal protection. *See Obergefell v. Hodges*, 135 S.Ct. 2584, 2604, 2606 (2015) (relying on "a grave and continuing harm," "disrespect," and "[d]ignitary wounds"); *Romer v. Evans,* 517 U.S. 620, 635 (1996) (relying on "immediate, continuing, and real injuries."). Likewise, under the Equal Protection Clause, "new insights and societal understandings can reveal unjustified inequality within our most fundamental institutions that once passed unnoticed and unchallenged." *Obergefell*, 135 S.Ct. at

2603. *See also United States v. Windsor*, 133 S.Ct. 2675, 2693, 2696 (2013) (rejecting "tradition" as a rational basis for anti-gay and lesbian discrimination.).

G.G. is one of the approximately 150,000 transgender students who attend grades K-12 schools throughout America.[4] Like other transgender individuals, G.G. has a gender identity that differs from the gender assigned to him at birth. National Association of School Psychologists, Position Statement, *Safe Schools for Transgender and Gender Diverse Students* (2014). Transgender students like G.G. live in all fifty states and U.S. territories; come from different racial, ethnic, and religious backgrounds; are represented in every socioeconomic level; and attend all variety of K-12 schools.

Listen to transgender student Corey Maison:

> *We are just like any other kids. We only want people to accept and love us for who we are.*

Nicole Pelletiere, *'We're Not a Threat': Transgender Teen Shares Powerful Message on Bullying*, ABC News (Feb. 8, 2017), http://abcnews.go.com/Lifestyle/threat-transgender-teen-shares-powerful-message-bullying/story?id=39752422.

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[4] Transgender persons comprise an estimated 0.6% of the adult United States population (approximately 1.4 million adults 18 or older) and 0.7% of youth ages 13 to 17 (approximately 150,000 youth). Jody L. Herman, Andrew R. Flores, Taylor N.T. Brown, Bianca D.M. Wilson, and Kerith J. Conron, *Age of Individuals who Identify as Transgender in the United States*, The Williams Institute (2017).

Instead,

> *Corey was bullied for being transgender when she was younger. The first incident was when a child pushed her down a hill covered in frozen ice, causing injuries to Corey's face. Eventually, Corey was moved to another school as a result of the bullying…*
>
> *"I might look happy now, but I haven't always been…I've known I was different all my life. When I was little I loved to play with dolls and play dress up. I loved painting my nails too. Wearing my mom's high heels was my favorite! But only in the house. Never outside...because I was born a boy. I never had many friends. I didn't fit in with girls, and the boys made fun of me. In 5th grade I was bullied so bad. Almost every day I came home from school crying.... One of the kids told me I should kill myself because no one liked me anyway. He told me no one would miss me if I was dead.*

Id.

Corey Maison's experience is all too common. At school, transgender students often suffer a variety of serious harms—emotional and physical—not because they *are* transgender but as a result of *how they are treated because they are transgender*. These students are particularly vulnerable in elementary and secondary school settings, where harms inflicted by peers and adults significantly impede their education and their prospects for leading fulfilling and productive lives. When a school commits or endorses these acts and omissions, it compounds the harms suffered by transgender students, leading often to tragic consequences.

A. Transgender students suffer a variety of harms at school due to mistreatment by others.

As described by Katharine Prescott, who lost her transgender son Kyler to suicide at age 14:

> *Kyler struggled to be respected and understood at school because of his gender identity. Administrators and teachers clearly were not supportive of his gender identity, and he was misgendered in front of other students on a number of occasions. Because of this, I pulled him out of the traditional classroom and put him in independent study so that he would not be humiliated in this way. Kyler had always loved school, so it was tragic that this basic right to education was infringed upon. Kyler felt stabbed in the heart every time someone would say 'she.' It's really traumatic to keep getting called something you truly feel you're not.*

Statement from Katharine Prescott to GLSEN (Feb. 26, 2017) (document on file with undersigned counsel); *see also* GLSEN, *Mother of Trans Student Lost to Suicide and Advocate for Title IX Guidance Release Statement*, GLSEN, http://www.glsen.org/article/glsen-mother-trans-student-lost-suicide-and-advocate-title-ix-guidance-release-statement (last visited Feb. 22, 2017); Avianne Tan, *California Mother Appeals for Support for Transgender Teens After Losing Son to Suicide*, ABC News (May 27, 2015), http://abcnews.go.com/US/california-mother-appeals-support-transgender-teens-losing-son/story?id=31338159. Kyler's story is by no means unique. "[D]isturbing patterns of mistreatment and discrimination" relating to transgender individuals are well documented. *See, e.g.*, Sandy James et al., The Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality (Dec. 2016), http://www.ustranssurvey.org/report (hereinafter, "USTS").

Transgender students too often encounter school experiences that breed life-long mental, emotional, and socio-economic consequences. In

elementary and secondary education, transgender students are subjected to bullying and harassment at alarmingly high rates. *See, e.g.*, Joseph Kosciw, Emily Greytak, Neal Palmer, and Madelyn Bosen, *The 2013 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools*, GLSEN (2014); Joseph Kosciw, Neal Palmer, Ryan Kull, and Emily Greytak, *The Effect of Negative School Climate for LGBT Youth and The Role of In-School Supports*, 12 Journal of School Violence 45-63 (2012). School climates that are unwelcoming or threatening have a direct bearing on students' well-being and safety. Journal of School Violence, 12(1), 45–63. Of the 40% of USTS respondents who were out as transgender during their K-12 education or believed classmates, teachers, or school staff thought they were transgender: 54% were verbally harassed; 24% were physically attacked; 13% were sexually assaulted; 36% were disciplined for fighting back against bullies; 17% left a school because the mistreatment was so bad; and 6% were expelled from school. USTS at 132.

Compared to transgender students who did not suffer these negative experiences, transgender students who did were more likely to have attempted suicide (52% compared to 37%), more likely to be in serious psychological distress (47% compared to 37%), and more likely to have been homeless (40% compared to 22%). One common and harmful form of discrimination is the refusal to use preferred names or pronouns. An example is calling a transgender boy Stephanie

or she rather than Stephen or he. 50.9% of transgender students report that their schools do not allow them to use their preferred name or pronouns, and many transgender students find that staff or other students intentionally use the wrong name or pronoun. 2015 NCSC at 38. This practice, known as "deadnaming," causes transgender students psychological harm. *See* Singh et al., *Growing Up LGBTQI+: The Importance of Developmental Conceptualizations,* in Affirmative Counselling with LGBTQI+ People (Misty M. Ginicola et al. eds., 2017). One consequence of adopting Appellee's interpretation that Title IX and equal protection permit classifying transgender students based on their gender at birth is that this would *allow* "deadnaming" by teachers and other school officials.

B. The harms suffered by transgender students impair their educational experiences and outcomes.

The negative experiences transgender students suffer impair their ability to learn and fully participate in school. For example, surveys have found that 32% of transgender students report missing at least one school day in the previous month because they felt unsafe at school. *See* 2015 NSCS at 13. Without safe and supportive school environments, transgender students also frequently avoid attending school functions (71.5% report doing so) and participating in extracurricular activities (65.7%). *Id*.

The disruption to education is even worse for those transgender students who are frequently harassed during the school day: 68% of such students

reported having missed school because of concerns for their safety. Emily Greytak, Joseph Kosciw, & Elizabeth Diaz, *Harsh Realities: The Experiences of Transgender Youth in Our Nation's Schools*, GLSEN (2009), https://www.glsen.org/sites/default/files/Harsh%20Realities.pdf. These more frequently targeted students also have lower grades, are less likely to plan to attend college, and have lower educational outcomes than transgender students who attend safer schools. *Id.* at 25.

C. Restroom discrimination severely harms transgender students.

Transgender students suffer particular harms when they attend schools that force them to use *separate* restrooms or to use restrooms that *do not align* with their gender identity. These harms include stigmatization, loss of educational experiences, and increased risk of harassment and assault.

Transgender students who are denied access to restrooms that align with how they live their lives are frequently singled out for unwanted and harmful attention. In some instances, for example, members of the school community find out that fellow students are transgender only when they are forced to use separate or un-aligned facilities. The stigmatization that results from this separate treatment can have powerfully negative impacts on transgender students' well-being. Evidence suggests that denying transgender individuals equal access to restrooms causes severe psychological distress often leading to attempted suicide. Max

Kutner, *Denying Transgender People Bathroom Access Is Linked To Suicide*, Newsweek (Dec. 16, 2016), http://www.newsweek.com/transgender-bathroom-law-study-suicide-454185; Kirsten Clements-Nolle, Rani Marx, & Mitchell Katz, *Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization*, 51 Journal of Homosexuality, 53–69 (2008); *see also*, Hayley Sutton, *Transgender college students are also more at risk for suicide when denied access to bathrooms aligned with their gender*, 13(2) Campus Security Report 9 (2016).

Requiring transgender students to use separate restrooms commonly imposes significant practical burdens not experienced by their classmates. As in this case, these separate restrooms often are further away from classrooms than the regular student restrooms, which causes transgender students to be late for class, resulting in penalties for tardiness and reduced instructional time. 2015 NSCS. Routinely arriving late to class as a result of using the restroom draws unwanted attention, further stigmatizing the transgender student.

Because separate or un-aligned facilities lead to these kinds of harms, nearly 40% of transgender students at times avoid the situation altogether by fasting, dehydrating, or otherwise forcing themselves not to use the restroom throughout the school day even when necessary. 2015 NSCS at 12-13 (39.4% avoid restrooms). Such behavior can lead to medical problems and makes it harder

to focus on academic learning in school. Jody L. Herman, *Gendered Restrooms and Minority Stress: The Public Regulation of Gender and its Impact on Transgender People's Lives*, 19 Journal of Public Management and Social Policy 74-75 (2013) (survey respondents reported that "accessing and using restrooms was disruptive to their daily life at school," and 54% of survey respondents "reported having some sort of physical problem from trying to avoid using public restrooms").

Forcing students to use separate restrooms impairs their ability to develop a healthy sense of self, peer relationships, and the cognitive skills necessary to succeed in adult life. *See* Katherine Szczerbinski, *Education Connection: The importance of allowing students to use bathrooms and locker rooms reflecting their gender identity*, 36 Child. Legal Rts. J. 153 (2016) ("having separate facilities deprives and further stigmatizes students who want to be in the same facilities as their classmates, ultimately leading to their isolation from peers"). Transgender student Drew Adams describes the effects of his experience:

> *Forcing me to use a gender-neutral bathroom was an insult to my identity. It was absolutely humiliating to walk halfway across the school, passing several men's rooms, to find one of the gender-neutral bathrooms to use. I practically hid from administrators who would have thought I was skipping class if I had said I was going to the bathroom while walking past one. My school had decided to alienate me, along with every other transgender student at my school.*

Drew Adams, *My School Failed to Protect Trans Students Like Me, So I Did Something About It*, GLSEN (Feb. 22, 2017), http://www.glsen.org/blog/my-school-failed-protect-trans-students-me-so-i-did-something-about-it.

Requiring a transgender student to use a separate restroom thus deprives that student of equality. That student is branded not just as different but as posing such a danger to other students that he is unfit to share their restrooms. The Supreme Court has rejected time and time again supposedly "separate-but-equal" treatment, including in school facilities. *See Brown v. Board of Educ*, 347 U.S. 483, 495 (1954); *Loving v. Virginia*, 388 U.S. 1, 12 (1967); *Oncale v. Sundowner Offshore Servs., Inc*., 523 U.S. 75, 75 (1998). It does not matter that other students have the option to use the separate restroom. An unconstitutional system of restrooms for "Whites" and "Coloreds" would not be rendered constitutional by changing the latter to restrooms for "Coloreds and Others Wishing To Join Them."

II. THE EXPERIENCES OF MANY SCHOOLS ACROSS THE NATION BELIE THE PURPORTED RATIONAL BASES FOR DISCRIMINATION AGAINST TRANSGENDER STUDENTS.

The Supreme Court has held that a rational basis is lacking when the a policy is merely based on "vague, undifferentiated fears," as that would allow "some portion of the community to validate what would otherwise be an equal protection violation." *City of Cleburne v. Cleburne Living Ctr.,* 473 U.S. 432, 449

(1985). Laws based on "negative attitudes, or fear, unsubstantiated by [properly cognizable] factors" do not pass muster. *Id*. at 448. As Amici know from experience, and as we next demonstrate, Appellee's purported goals of protecting the privacy of non-transgender students and preventing predators are based solely on unsubstantiated fears and negative attitudes towards transgender individuals. *See Whitaker v. Kenosha Unified Sch. Dist. No. 1 Board of Educ.*, 16-CV-943-PP, 2016 WL 5239829, at *4 (E.D. Wisc. Sept. 22, 2016) (holding equal protection denied as school board had "articulated little in the way of a rational basis for the alleged discrimination" and noting that "the court is not clear how allowing the plaintiff to use the boys' restroom violates other students' right to privacy"). *See also Board of Educ. of the Highland Local School Dist. v. United States Dep't of Educ.,* 208 F. Supp. 3d. 850, 874 (S.D. Ohio 2016) (holding equal protection denied as school board had "failed to put forth an 'exceedingly persuasive justification' *or even a rational one*, for preventing Jane from using the girls' restroom." (Emphasis added)).

A. Inclusion and non-discrimination work and harm no one.

The Supreme Court has consistently affirmed that the obligation of educators in the American public school system is to serve *all* students, including all males and females. *See United States v. Virginia*, 518 U.S. 515 (1996). Consistent with that legal history, many schools and districts throughout America

have taken practical steps to develop and implement policies to ensure that transgender students—like all other students—are given full and equal access to a welcoming and supportive educational environment in which they have an opportunity to thrive.

The experience of Janice Adams, superintendent of the Benicia Unified school district in California, provides an example of how administrators with no prior experiences with transgender students successfully implement inclusive policies:

> *One day about eight years ago, a mother came to me and asked what I could do to support her child who would be starting kindergarten in the fall. . . . . Toni was assigned male at birth, but her parents were considering letting her start school as a girl, which is how she had been identifying for some time.*
> *[. . .]*
> *By far the easiest part of the process was the acceptance by Toni's classmates, who embraced her and affirmed her identity. As we worked to balance the need to educate and inform parents while protecting Toni's right to privacy, I met with a small number of concerned parents individually and attended a parent night facilitated by Gender Spectrum. We provided education regarding transgender children to the school's staff, our administrative team and the governing board. For the most part there was a compassionate response to do the right thing. There were people who struggled with changes we put in place, but we continually focused on supporting Toni and doing what was right.*

Janice Adams, Superintendent, Benicia Unified School District in Orr and Baum, *Schools in Transition: A Guide for Supporting Transgender Students in K-12 Schools* (2015), http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/Schools-In-Transition.pdf.

The inclusive policies that have been implemented successfully in many schools across the nation have been designed by state governments, local municipalities, school districts, and/or schools. *See, e.g.*, Boulder Valley School District policy https://www.bvsd.org/policies/Policies/AC-E3.pdf ("[T]he goal is to ensure the safety, comfort, and healthy development of the students who are transgender or gender nonconforming while maximizing the students' social integration and minimizing stigmatization of the students."). Typically, inclusive school policies address the following topics: (i) bullying, harassment, and discrimination; (ii) privacy/confidentiality; (iii) media and community communication; (iv) names, pronouns, and school records; (v) access to gender-segregated activities and facilities, including restrooms; (vi) dress code; (vii) student transitions; (viii) training and professional development; and (ix) publication of the policy. GLSEN Model District Policy on Transgender and Gender Nonconforming Students (2016). Optimally, comprehensive policies and practices also include establishing supportive student clubs (e.g., Gay/Straight Alliance Clubs); training supportive educators; implementing inclusive curricula; and adopting, communicating clearly, and enforcing inclusive policies as well. 2015 NSCS at 53-77.

These approaches are informed by decades of research, collaboration with education and mental health professionals, and prior successes in schools

across the nation. Notably, similar inclusive approaches to policy and practice have been endorsed by the Amici organizations and other national educational and medical organizations.[5]

A critical non-discrimination policy is to allow transgender students equal access to restrooms that recognizes their gender identity. *See, e.g.*, Charlotte-Mecklenberg Schools (NC) http://dig.abclocal.go.com/wtvd/docs/CMS-supporting-transgender-students-training-final_5599792.pdf; El Rancho Unified School District (CA) http://www.erusd.org/pdf/board_policies/5145_3.pdf. Some

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[5] *See*:

- The American Academy of Pediatrics at https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAPOpposesLegislationAgainstTransgenderChildren.aspx;
- The American Psychological Association at http://www.apa.org/pi/lgbt/programs/transgender/;
- American School Counselor Association at https://www.schoolcounselor.org/magazine/blogs/may-june-2016/transgender-student-support;
- The Association for Supervision and Curriculum Development at http://www.ascd.org/publications/newsletters/education-update/jan16/vol58/num01/Charting-a-Course-to-Transgender-Inclusion.aspx;
- The National Education Association at https://www.nea.org/assets/docs/20184_Transgender%20Guide_v4.pdf;The American Federation of Teachers at http://www.aft.org/node/11195; and
- The National Association of School Psychologists at https://www.nasponline.org/assets/Documents/Research%20and%20Policy/Position%20Statements/Transgender_PositionStatement.pdf.
- National PTA at http://www.pta.org/newsevents/newsdetail.cfm?ItemNumber=4838

also provide transgender students with an *option* to use a private facility (*e.g.*, a school nurse's restroom), but such policies make clear that transgender students are not *required* to use those alternatives. *See, e.g.*, Washoe County School District (NV) http://washoecountyschools.net/csi/pdf_files/5161%20Reg%20-%20Gender%20Identity%20v1.pdf ("The use of such accommodations shall be a matter of choice for a student").

Many policies include provisions stating that any student who is uncomfortable using a shared restroom or other facility—because of concern over unwanted exposure to nudity, religious objections, or other reasons—can choose to use alternative options, such as using a privacy partition or curtain or accessing a single-use restroom. *See, e.g.*, Shorewood School District (WI) http://www.shorewood.k12.wi.us/uploaded/Board_Documents/Policies/411_Guidelines_and_Exhibit.pdf?1393865642372 ("Any student who has a need or desire for increased privacy, regardless of the underlying reason, may be provided with access to a single-access restroom where such a facility is reasonable available"); *see also*, Atherton High School, Jefferson County (KY) http://schools.jefferson.kyschools.us/High/Atherton/PDFs/SBDM.pdf ("If a student desires increased privacy, regardless of the underlying reason, the administrator shall make every effort to provide the student with reasonable access to an alternative restroom such as a single-stall restroom."). *See, e.g.*, District of

Columbia Public Schools (DC) https://dcps.dc.gov/sites/default/files/dc/sites/dcps/publication/attachments/DCPS%20Transgender%20Gender%20Non%20Conforming%20Policy%20Guidance.pdf ("Any student, transgender or otherwise, who has a need or desire for increased privacy, regardless of underlying reasons, also has the right to access a single-use bathroom, such as a staff restroom or the bathroom in the nurse's office.").

Thus, schools already implementing inclusive restroom policies have obviated privacy, religious, and other concerns by offering alternative accommodations to any student who objects to or is uncomfortable with sharing restrooms with transgender students. *See, e.g.*, Atherton High School, Jefferson County (KY) http://schools.jefferson.kyschools.us/High/Atherton/PDFs/SBDM.pdf (privacy within the shared facility); District of Columbia Public Schools (DC) https://dcps.dc.gov/sites/default/files/dc/sites/dcps/publication/attachments/DCPS%20Transgender%20Gender%20Non%20Conforming%20Policy%20Guidance.pdf (option of using a private facility). What schools must not do, though, is bootstrap one student's discomfort or objection into a reason to segregate and stigmatize a transgender student or transgender students generally, especially given the well-documented harms that flow from such differential treatment.

Districts and schools that adopt and implement inclusive policies and practices—including restroom policies—establish physically and psychologically safe schools, resulting in better health and educational outcomes for transgender students. All LGBT students benefit from these approaches, but transgender students benefit even more significantly. Emily A. Greytak, Joseph G. Kosciw, and Madelyn J. Boesen, *Putting the "T" in "Resource": The Benefits of LGBT-Related School Resources for Transgender Youth*, 10 Journal Of LGBT Youth 1-2 (2013). In the end, the data is "helping to validate what we know as clinicians, which is that people who are validated and supported in their selfhood are happier, have [fewer] mental health challenges and are more successful. We need to stop making people be who we think they should be and start letting them be who they are." Interview with Johanna Olson-Kennedy, Medical Director of the Center for Transyouth Health and Development, Children's Hospital in Los Angeles on NPR, South Carolina Public Radio (March 23, 2016). This link between LGBT-inclusive policies and improved mental health outcomes is supported by analogous research showing that granting the marriage right to same-sex couples has been associated with reduced suicide rates among adolescent sexual minorities. *See* Julia Raifman et al., *Difference-in-Differences Analysis of the Association Between State Same-Sec Marriage Policies and Adolescent Suicide Attempts*, JAMA

Pediatrics (Feb. 20, 2017), http://jamanetwork.com/journals/jamapediatrics/fullarticle/2604258.

Corey Maison's school experience was transformed as a result of the implementation of inclusive policies.

> *"[S]chool now is wonderful," Maison[']s mother] said. "The staff and students are very accepting. She's treated just like any of the other girls. She's allowed to use the girls' bathroom and locker room, and play on the girls' sports team and cheer team if she wants to."*

Corey Maison (pictured).

Nicole Pelletiere, *'We're Not a Threat': Transgender Teen Shares Powerful Message on Bullying*, ABC News (Feb. 8, 2017), http://abcnews.go.com/Lifestyle/threat-transgender-teen-shares-powerful-message-bullying/story?id=39752422.

B. Discrimination against transgender students is based on unfounded fears.

Some have expressed fears that protecting against restroom discrimination would lead to dire consequences. However, neither educators nor courts should defer to a majority's votes and unfounded fears. *See Cleburne*, 473

U.S. at 448 ("It is plain that the electorate as a whole, whether by referendum or otherwise, could not order [government] action violative of the Equal Protection Clause, and the [government] may not avoid the strictures of that Clause by deferring to the wishes or objections of some fraction of the body politic."). *See also* G.G.'s Supplemental Br. at 48-50 (May 8, 2017), ECF No. 117.

In particular, the widespread, successful, and non-disruptive implementation of inclusive restroom policies in schools every day belies the purported bases for restroom discrimination and exposes them as irrational pretexts. *First*, as shown above, schools around the country have secured equal restroom access for transgender students while protecting the privacy of all students for years. As one district court recently held, when a transgender student uses the restroom for his or her gender, "everyone using the toilets in the 'girls room' is doing so in an enclosed stall with a locking door, and everyone using the toilets in the 'boys room' is doing the same or using a urinal with privacy screens." *Evancho v. Pine-Richlands Sch. Dist.*, No. CV 2:16-01537, 2017 WL 770619, at *14 (W.D. Pa. Feb. 27, 2017).

Second, the experience of these schools and districts contradicts the insupportable claim that transgender-inclusive restroom policies disrupt the school environment. To the point, a 2015 survey of the seventeen largest school districts

in the twelve states (plus Washington, DC)[6] that, at that time, had enacted statewide rules prohibiting discrimination on the basis of gender identity found that "[y]ears after implementing their own anti-discrimination policies, none of the schools have experienced any problems." Rachel Percelay, Media Matters, *17 School Districts Debunk Right-Wing Lies About Protections For Transgender Students* (June 3, 2015), https://mediamatters.org/research/2015/06/03/17-school-districts-debunk-right-wing-lies-abou/203867. Specifically, schools implementing inclusive restroom policies have not experienced any problems as a result. *See* Curtis Tate, et al., *These schools let transgender students use the bathroom, and here's what happened*, Kansas City Star (June 20, 2016), http://www.kansascity.com/news/politics-government/article84811367.html, ("Schools in Missouri and across the nation have quietly made change with little trouble.").

Third, some make the fanciful claim that inclusive restroom policies will be exploited by some students who would pretend to be transgender in their schools in order to convince their principal, counselor, and teachers that they should be allowed to use the opposite gender's restroom. They would then violate school conduct policies and even commit crimes such as voyeurism, sexual assault,

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[6] The survey included the District of Columbia and the following states: California, Colorado, Connecticut, Illinois, Iowa, Maine, Massachusetts, Minnesota, New Jersey, Oregon, Washington, and Vermont.

or rape. *See, e.g.*, Merits Br. of *Amicus* William J. Bennett at 19-22, *Gloucester County School Bd. v. G.G. ex rel. Grimm*, 137 S.Ct. 1239 (2017) (No. 16-273). This claim—otherwise known as the "restroom predator myth"—is a baseless scare tactic. As a coalition of over 200 organizations that work with sexual assault and domestic violence victims noted in a joint statement: "Over 200 municipalities and 18 states have nondiscrimination laws protecting transgender people's access to facilities consistent with the gender they live every day. In some cases, these protections have been in place for decades. These laws have protected people from discrimination without creating harm. *None of those jurisdictions have seen a rise in sexual violence or other public safety issues due to nondiscrimination laws.* Assaulting another person in a restroom or changing room remains against the law in every single state." National Consensus Statement of Anti-Sexual Assault and Domestic Violence Organizations in Support of Full and Equal Access for the Transgender, NSVRC (Feb. 8, 2017), http://www.nsvrc.org/news/news-field/national-consensus-statement-anti-sexual-assault-and-domestic-violence-organizations (emphasis added).

The "restroom predator myth" is especially unfounded in the context of schools, where students attend every school day and are known to school staff. Most inclusive policies include clear procedures for working with transgender students who seek to transition and begin using different restrooms. One common

element of such policies is that students "consistently assert" their gender. States, districts, and schools that have adopted these policies have already resolved the question posed by Appellee in this case: "how is a school to determine a student's gender identity for purposes of managing access to sex-separated restrooms" and other facilities? Br. of Petitioner at 37, *Gloucester County School Bd. v. G.G. ex rel. Grimm*, No. 16-273 (Jan. 3, 2017). The answer is clear: Recognize those students who have consistently asserted a gender identity that does not conform to the gender assigned to them at birth. In other words, the mythical predator-student would have to pretend to be transgender consistently over time and meet with his or her school counselors and other staff to work through the variety of applicable policies and supports. Amici's experience shows that the school "restroom predator" myth—like the nudity and disruption arguments—is utter nonsense.

CONCLUSION

This Court should reverse and require the district court to enter a preliminary injunction against Appellee.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on this 15th day of May 2017, I served the foregoing Amici Curiae Brief of the National PTA, GLSEN, American School Counselor Association, National Association of School Psychologists, and Maryland PTA in Support of Plaintiff - Appellant via the Court's ECF system upon all counsel.

Dated: May 15, 2017

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), the undersigned counsel certifies that this motion:

(i) complies with the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared using Microsoft Office Word and is set in Times New Roman font in a size equivalent to 14 points or larger and,

(ii) complies with the length requirement of Rule 29(a)(5) because it is 6,316 words.

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Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools

Adopted by the Council of Representatives, August 2014. Amended by the Council of Representatives, February 2015. (Suggested citation is included with references.)

WHEREAS people express and experience great diversity in sexual orientation and gender identity and expression;

WHEREAS communities today are undergoing rapid cultural and political change around the treatment of sexual minorities and gender diversity;

WHEREAS all persons, including those who are sexual or gender minority children and adolescents, or those who are questioning their gender identities or sexual orientations, have the right to equal opportunity and a safe environment within all public educational institutions;

Sexual Orientation and Gender Identity

WHEREAS some children and adolescents are aware of their attraction to members of the same gender or of their status as lesbian, gay, or bisexual persons by early adolescence (Remafedi, 1987; Savin-Williams, 1990; Slater, 1988; Troiden, 1988), although this awareness may vary by culture and acculturation (Morales, 1990; Rosario, Schrimshaw & Hunter, 2004);

WHEREAS sexual orientation and gender identity are separate, but related, aspects of the human experience (Bockting & Gray, 2004; Chivers & Bailey, 2000; Coleman, Bockting, & Gooren, 1993; Docter & Fleming, 2001; Docter & Prince, 1997);

WHEREAS some children and adolescents may experience a long period of questioning their sexual orientations or gender identities, experiencing stress, confusion, fluidity or complexity in their feelings and social identities (Hollander, 2000; Remafedi, Resnick, Blum, & Harris, 1992);

WHEREAS there are few resources and supportive adults available and little peer support individually or within student groups for gender and sexual orientation diverse children and adolescents, particularly those residing in rural areas or small towns, (Kosciw, Greytak, Diaz, & Bartkiewicz, 2010; Robinson & Espelage, 2011);

Gender Diversity

WHEREAS a person's gender identity develops in early childhood and some young children may not identify with the gender assigned to them at birth (Brill & Pepper, 2008; Zucker, 2004);

WHEREAS it may be medically and therapeutically indicated for some transgender and other gender diverse children and adolescents to transition from one gender to another using any of the following: change of name, pronoun, hairstyle, clothing, pubertal suppression, cross-sex hormone treatment, and surgical treatment (Coleman et al., 2011; Forcier & Johnson, 2012; Olson, Forbes, & Belzer, 2011);

Consequences of Stigma and Minority Stress

WHEREAS minority stress is recognized as a primary mechanism through which the notable burden of stigma and discrimination affects minority persons' health and well-being and generates health disparities (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer, 2003; Meyer, Schwartz, & Frost, 2008; Mirowsky & Ross, 1989);

WHEREAS many gender and sexual orientation diverse children and adolescents have reported higher rates of anxiety and depression, low self-esteem, engaging in self-injurious behaviors, suicide, substance use, homelessness, and eating disorders among other adverse outcomes (Austin et al., 2009; Corliss, Goodenow, Nichols,& Austin, 2011; Gibson, 1989; Gipson, 2002; Gonsiorek, 1988; Grossman & D'Augelli, 2007; Harry, 1989; Hetrick & Martin, 1988; Mustanski, Garofalo, & Emerson, 2010; Poteat, Aragon, Espelage, & Koenig, 2009; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Russell, Huebner, Dias, & Sanchez, 2010; Savin-Williams, 1990; Schutzmann, Brinkmann, Schacht, & Richter-Appelt, 2009).

WHEREAS many transgender and gender diverse children and adolescents experience elevated rates of depression, anxiety, self-harm, and other health risk behaviors (American Psychological Association, 2009; Coleman et al., 2011; McGuire, Anderson, Toomey, & Russell, 2010);

WHEREAS some gender and sexual orientation diverse adolescents are at an increased risk for pregnancy (Goodenow, Szalacha, Robin, & Westheimer, 2008; Russell et al., 2011; Ryan et al., 2010; Saewyc, Poon, Homma, & Skay, 2008; Savin-Williams, 1990;

WHEREAS, some gender and sexual orientation diverse adolescent sub-populations, including young men who have sex with men, homeless adolescents, racial/ethnic minority adolescents, transgender women of color, and adolescents enrolled in alternative schools, are at heightened risk for sexually transmitted infections, including HIV (Center for Disease Control and Prevention, 2012; Markham et al., 2003), due to complex and interacting factors related to stigma, socioeconomic class and minority stress (Hatzenbuehler, Phelan & Link, 2013; Link & Phelan, 1995; Meyer, 2003; Phelan, Link, & Tehranifar, 2010);

WHEREAS some children and adolescents with intersex/DSD[1] conditions report rates of self-harm and suicidality comparable to individuals who have experienced physical or sexual abuse (Schutzmann, et al., 2009);

WHEREAS individuals with intersex/DSD conditions often report a history of silence, stigma, and shame regarding their bodies and medical procedures imposed on them (MacKenzie, Huntington, & Gilmour, 2009; Wiesemann, Udo-Koeller, Sinnecker, & Thyen, 2010);

WHEREAS invasive medical procedures that are not medically necessary in nature (e.g., genital surgery for purposes of 'normalization') continue to be recommended to parents of intersex/DSD children, often proceed without the affected individual's assent, and lack research evidence on long-term quality of life, reproductive functioning, and body satisfaction (Wiesemann et al., 2010);

WHEREAS adults with intersex/DSD conditions report negative emotional, psychological and physical consequences that result from repeated and often questionable medical exams and procedures that lack research evidence to support their purported long-term reduction of distress (MacKenzie et al., 2009; Wiesemann et al., 2010);

WHEREAS gender and sexual orientation diverse young people with intersecting identities face additional challenges to their psychological well-being as a result of the negative consequences of discrimination based on sexual orientation and ethnic/racial minority status, religious identity, and country of origin, among other characteristics (Garnets & Kimmel, 1991; Herek, Gillis, & Cogan, 2009; Moradi et al., 2010; Poteat et al., 2009; Russell et al., 2011; Ryan et al., 2009; Szymanski & Gupta, 2009);

WHEREAS gender and sexual orientation diverse children and adolescents who come from impoverished or low-income families may face additional risks (Gipson, 2002; Gordon, Schroeder, & Abramo, 1990; Russell et al., 2011);

WHEREAS gender and sexual orientation diverse children and adolescents in rural areas and small towns experience additional challenges, such as living in typically more conservative and less diverse communities (compared to those in urban settings) and having limited access to affirming community-based supports, which can lead to greater feelings of social isolation (Cohn & Leake, 2012; O'Connell, Atlas, Saunders, & Philbrick, 2010);

WHEREAS gender and sexual orientation diverse children and adolescents with physical or mental disabilities are at increased risk of negative health outcomes due to the consequences of societal prejudice toward persons with mental and physical disabilities (Duke, 2011; Hingsburger & Griffiths, 1986; Pendler & Hingsburger, 1991);

[1] **Intersex** refers to a range of conditions associated with atypical development of physical sex characteristics (American Psychological Association, 2006). Intersex individuals may be born with chromosomes, genitals, and/or gonads that do not fit typical female or male presentations (Organization Intersex International in the United States of America, 2013). Since 2006, the medical and research community has used the term **Disorders of Sex Development**. This term refers to congenital conditions characterized by atypical development of chromosomal, gonadal, or anatomical sex (Houk, Hughes, Ahmed, Lee, & Writing Committee for the International Intersex Consensus Conference Participants, 2006). An alternate term — **Differences of Sex Development** — has been recommended to prevent a view of these conditions as diseased or pathological (Wisemann, Udo-Koeller, Sinnecker, & Thyen, 2010). In order to be inclusive of various terminology preferences, this document will use **intersex/DSD** when referring to individuals who are part of this community.

Concerns and Issues in the Context of Schools

WHEREAS many gender and sexual orientation diverse children and adolescents experience harassment, bullying, and physical violence in school environments (Brooks, 2000; Fineran, 2002; Greytak, Kosciw, & Diaz, 2009; Kosciw et al., 2010; McGuireet al., 2010; Poteat & Rivers, 2010; Russell, Franz, & Driscoll, 2001; Sausa, 2005);

WHEREAS low numbers of school personnel intervene to stop harassment or bullying against transgender and other gender diverse students in school settings and may even participate in harassment of transgender and gender diverse students (Greytak et al., 2009; McGuire et al., 2010; Sausa, 2005);

WHEREAS gender and sexual orientation diverse children and adolescents who are victimized in school are at increased risk for mental health problems, suicidal ideation and attempts, substance use, high-risk sexual activity, and poor academic outcomes, such as high level of absenteeism, low grade point averages, and low interest in pursuing post-secondary education (Birkett, Espelage, & Koenig, 2009; Bontempo & D'Augelli, 2002; D'Augelli, Pilkington, & Hershberger, 2002; Kosciw et al., 2010; O'Shaughnessy, Russell, Heck, Calhoun, & Laub, 2004; Russell et al., 2011);

WHEREAS some studies suggest that transgender and other gender diverse students experience even poorer educational outcomes compared to lesbian, gay and bisexual students, including low achievement levels, higher likelihood of being "pushed out" of high school prior to graduation, low educational aspirations, and high incidences of truancy and weapons possession (Greytak et al., 2009; Toomey, Ryan, Diaz, Card, & Russell, 2010);

WHEREAS recent research has identified a number of school policies, programs, and practices that may help reduce risk and/or increase well-being for gender and sexual orientation diverse children and adolescents (Blake et al 2001; Eisenberg & Resnick, 2006; Goodenow, Szalacha, & Westheimer, 2006; Graybill, Varjas, Meyers, & Watson, 2009; Heck, Flentje, & Cochran 2011; Murdock & Bolch, 2005; Szalacha, 2003; Toomey et al., 2010; Walls, Kane, & Wisneski, 2010; Watson, Varjas, Meyers, & Graybill, 2010);

WHEREAS gender and sexual orientation diverse students report increased school connectedness and school safety when school personnel intervene in the following ways: (1) addressing and stopping bullying and harassment, (2) developing administrative policies that prohibit discrimination based on sexual orientation, gender identity and gender expression, (3) supporting the use of affirming classroom activities and the establishment of gender and sexual orientation diverse-affirming student groups, and (4) valuing education and training for students and staff on the needs of gender and sexual orientation diverse students (Case & Meier, 2014; Greytak et al., 2009; Kosciw et al., 2010; McGuire et al., 2010; National Association of School Psychologists, 2011; Sausa, 2005);

The Role of Mental Healthcare Professionals in Schools

WHEREAS school psychologists, school counselors, and school social workers advocate for inclusive policies, programs and practices within educational environments (NASP, 2010a; NASP 2010b; NASP, 2011), and

WHEREAS the field of psychology promotes the individual's healthy development of personal identity, which includes the sexual orientation, gender expression, and gender identity of all individuals (APA, 2002; APA, 2012; Coleman et al., 2011; NASP, 2010a; NASP, 2011);

THEREFORE BE IT RESOLVED that the American Psychological Association and the National Association of School Psychologists affirm that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists affirm that diverse gender expressions, regardless of gender identity, and diverse gender identities, beyond a binary classification, are normal and positive variations of the human experience;

Policies

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will advocate for local, state and federal policies and legislation that promote safe and positive school environments free of bullying and harassment for all children and adolescents, including gender and sexual orientation diverse children and adolescents and those who are perceived to be lesbian, gay, bisexual, transgender or gender diverse;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend schools develop policies that respect the right to privacy for students, parents, and colleagues with regard to sexual orientation, gender identity, or transgender status, and that clearly state that school personnel will not share information with anyone about the sexual orientation, gender identity, intersex/DSD condition, or transgender status of a student, parent, or school employee without that individual's permission;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that school administrations and mental health providers, in the context of schools, develop partnerships and networks to promote cross-agency collaboration to create policies that directly affect the health and wellbeing of gender and sexual orientation diverse adolescents and children;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage state educational agencies to collect data on sexual orientation, taking care to ensure student anonymity, as part of efforts to monitor and study adolescents' risk behaviors in the CDC Youth Risk Behavior Survey, and to develop and validate measures of gender identity for inclusion in the Youth Risk Behavior Survey, as well;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that inclusive data collection be incorporated into the Department of Education's Mandatory Civil Rights Data Collection, another important measurement of youth experiences in schools that could help inform effective interventions to better support gender and sexual orientation diverse children and adolescents in schools;

Programs and Interventions

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists support efforts to ensure the funding of basic and applied research, and scientific evaluations of interventions and programs, designed to address the issues of gender and sexual orientation diverse children and adolescents in the schools;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend the continued development and evaluation of school-level interventions that promote academic success and resiliency, that reduce bullying and harassment, that reduce risk for sexually transmitted infections, that reduce risk for pregnancy among adolescents, that reduce risk for self-injurious behaviors, and that foster safe and supportive school environments for gender and sexual orientation diverse students;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that special sensitivity be given to the diversity within the population of gender and sexual orientation diverse students, with new interventions that incorporate the concerns of sexual minorities often overlooked or underserved, and the concerns of racial/ethnic minorities and recently immigrant children and adolescents who are also gender and sexual orientation diverse students;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists support affirmative interventions with transgender and gender diverse children and adolescents that encourage self-exploration and self-acceptance rather than trying to shift gender identity and gender expression in any specific direction;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage school-based mental health professionals to advocate for efforts to educate and train school professionals about the full range of sex development, gender expression, gender identity, and sexual orientation;

Training and Education

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will encourage education, training, and ongoing professional development about the needs and the supports for gender and sexual orientation diverse students for educators and trainers of school personnel, education and mental health trainees, school-based mental health professionals, administrators, and school staff, and such training and education should be available to students, parents, and community members;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will encourage school-based mental health professionals to learn how strictly binary notions of sex, sex development and gender limit all children from realizing their full potential, create conditions that exacerbate bullying, and prevent many students from fully focusing on and investing in their own learning;

Practices

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage school-based mental health professionals to serve as allies and advocates for gender and sexual orientation diverse children and adolescents in schools, including

advocacy for the inclusion of gender identity, gender expression and sexual orientation in all relevant school district policies, especially anti-bullying and anti-discrimination policies;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage school staff to support the decisions of children, adolescents, and families regarding a student's gender identity or expression, including whether to seek treatments and interventions, and discourage school personnel from requiring proof of medical treatments as a prerequisite for such support;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that administrators create safer environments for gender diverse, transgender, and intersex/DSD students, allowing all students, staff, and teachers to have access to the sex-segregated facilities, activities, and programs that are consistent with their gender identity, including, but not limited to, bathrooms, locker rooms, sports teams, and classroom activities, and avoiding the use of gender segregation in school uniforms, school dances, and extracurricular activities, and providing gender neutral bathroom options for individuals who would prefer to use them; and

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will work with other organizations in efforts to accomplish these ends.

Suggested Citation

American Psychological Association & National Association of School Psychologists. (2015). *Resolution on gender and sexual orientation diversity in children and adolescents in schools*. Retrieved from http://www.apa.org/about/policy/orientation-diversity.aspx

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About This Policy

The working group that wrote this resolution developed additional resources to support and facilitate its dissemination and implementation:

- Introduction to the resolution.
- Context for the resolution.
- Definitions and limitations of language.

Transgender Students and School Bathrooms: Frequently Asked Questions

AMERICAN SCHOOL COUNSELOR ASSOCIATION

gender spectrum

naesp National Association of Elementary School Principals

NASP NATIONAL ASSOCIATION OF School Psychologists

NASSP National Association of Secondary School Principals

About Gender Spectrum

gender spectrum

Gender Spectrum works nationwide to educate individuals, families, communities, and institutions seeking to strengthen or create gender inclusive environments for all youth. We provide an array of services designed to help families, schools, professionals and organizations understand and address the concepts of gender identity and expression.

Endorsed and Supported By:

AMERICAN SCHOOL COUNSELOR ASSOCIATION

The American School Counselor Association (ASCA) supports school counselors' efforts to help students focus on academic, career and social/emotional development so they achieve success in school and are prepared to lead fulfilling lives as responsible members of society.

naesp
National Association of Elementary School Principals

Established in 1921, the National Association of Elementary School Principals (NAESP) leads in the advocacy and support for elementary and middle school principals in the United States and internationally. NAESP supports principals as the primary catalysts for creating lasting foundations for learning through policy development, advocacy, professional development programs, and resources for effective instructional leadership.

NASP
NATIONAL ASSOCIATION OF School Psychologists

The National Association of School Psychologists (NASP) is a professional association that represents more than 25,000 school psychologists, graduate students, and related professionals throughout the United States and 25 other countries. The world's largest organization of school psychologists, NASP works to advance effective practices to improve students' learning, behavior, and mental health.

NASSP™
National Association of Secondary School Principals

National Association of Secondary School Principals (NASSP) is the leading organization of and voice for middle level and high school principals, assistant principals, and school leaders from across the United States. Marking its longstanding commitment to student leadership development, NASSP is home to the National Honor Society and the National Association of Student Councils.

Introduction

Concerns about transgender and other gender-expansive students using bathrooms consistent with their gender identity (rather than the sex assigned when they are born) raise many questions for educators, parents, and students alike. Safety, propriety, privacy, and legality are some of the most common topics being brought up by many people in the school community around this subject.

Schools will be best positioned to address these various issues when they are proactive. Anticipating and listening to these concerns and providing concrete responses to them will allow school officials to successfully navigate the vast majority of situations related to this topic. This is a highly emotional subject for many; assuring those in the community that you and the school have seriously considered the issues they're raising is essential. As institutions charged with educating the communities they serve, schools are well positioned to build the awareness of their various stakeholders about a frequently misunderstood subject that is new for many people.

Below you will find many of the frequently asked questions about transgender students using bathrooms consistent with their gender identity. Before exploring these, we want to help you frame the discussion so you can enter the conversation with confidence and certainty.

CSB: Climate, Supervision and Behavior

At the core of all of the scenarios below, one or more of three issues can be identified: climate, supervision, and behavior. Being mindful of these three aspects of a school's functioning is critical to responding to bathroom questions and concerns.

- **Climate** refers to the "feel" a school has when you walk around the building. A positive school climate is established when a school sets concrete expectations for student conduct. It conveys to the community (staff, students, and parents) what behaviors are and are not acceptable at the school. Strong climate is a product of clear policies, the quality of interactions among adults and students in the school, and intentional strategies that build a culture of respect and inclusion.

- **Supervision** refers to the degree to which adults are paying attention to the school's climate, anticipating and preempting those situations where the climate might be compromised. While adults cannot be everywhere at all times, effective and consistent supervision reassures students that the institution is monitoring what goes on, is aware of areas where kids might feel vulnerable, and responds effectively. Consistent supervision reassures all members of the school community that they can expect to be safe at school. Rather than punitive, supervision is ultimately preventative, a key strategy for reinforcing a school's positive climate.

- **Behavior** refers to the specific actions of individuals—what they say and do. Establishing a positive school climate and supervising it accordingly presumes students know how they are supposed to behave. Schools cannot assume every child knows what appropriate behavior looks like. By clearly conveying what behaviors are and are not acceptable, the issues related to bathrooms move from assumptions and misperceptions about an individual's intent and instead focus on their observable actions.

"I've memorized both the locations of and fastest routes to the few gender-neutral bathrooms on campus because it's the only way I can actually use the restroom."

Options for Everyone

Every child needs to be safe in the bathroom. Too many students avoid using bathrooms out of fear that another student will mistreat or hurt them, physically, or emotionally. The consequences can be severe, impacting a child's health, well-being and their ability to concentrate on learning. By creating a positive climate, supervising it appropriately, and making behavioral expectations clear, schools can reduce all students' fears about safety in these spaces.

For a variety of reasons however, there will remain a small percentage of students who would prefer a more private space than many school bathrooms allow. Whether for cultural or religious reasons, a particular health issue, concerns related to gender or simple modesty, schools should work actively to identify private options that are available to any student who requests access to them. Regardless of the student's underlying reason for using it, such options must be free of stigma; a student who uses a private space should not be ridiculed or singled out by staff or students. Providing private bathrooms should be one of many ways in which schools meet a diversity of student needs. At the same time, a private bathroom space must be **optional**; no child should be required to use such a space.

Gender Support Plans

A Gender Support Plan (GSP) is another essential ingredient in proactively preparing for bathroom-related questions. A GSP is created collaboratively between school leaders, transgender or other gender-expansive students, and their family (when appropriate) to address a variety of issues they may face at school, including bathroom use. GSPs allow the school to establish the necessary conditions for that student to have the most positive experience possible. GSPs also demonstrate the school's commitment to thoughtfully managing the process of addressing these student's needs. However, the development of a GSP should never be used as a way to delay a student's ability to live authentically at school. Rather, it should represent to the student the school's ongoing process for managing student needs and a commitment to their safety.

Frequently Asked Questions

In the scenarios below, you will notice that every situation applies to all students and their behaviors in bathrooms. Despite the concerns being raised, the gender identity and/or body of students are not the variables that need to be accounted for. Instead, focus must be on climate, supervision, and behavior. These, along with non-stigmatized bathroom options and established processes for working with transgender or non-binary students will allow schools to address the various questions and concerns that are raised by parents, staff members and students.

Why can't transgender students just use a private bathroom?

Transgender students already face a great many barriers to acceptance at school, and requiring them to use a bathroom that is designated especially for them is tremendously stigmatizing. A school's insistence that they be segregated from their peers also sends a message that the student's gender identity is not real or valid and represents an official refutation of the child's sense of self. This can be devastating to the child's sense of safety coming from the very adults charged with protecting them. If forced to use a private space, many transgender students will simply not use any bathroom at school, compromising their health and interfering with their ability to focus on learning as they monitor their water intake, avoid foods that will make them thirsty, and/or try to wait to until they get home to go to the bathroom. Make no mistake about it: not allowing a transgender student to use the restroom consistent with their gender identity causes harm—emotionally, physically, academically, and socially. It is not a matter of discomfort. Explicitly denying a transgender student's access to the bathroom corresponding to their gender identity endangers their health and well-being.

What if my child does not feel safe or comfortable being in the bathroom with a transgender student?

Lack of safety and lack of comfort are two different concerns and require different responses from schools.

Schools are legally required to provide a safe learning environment free from physical or verbal harassment. In order to meet this obligation, all schools likely have policies and practices in place to prevent behaviors such as verbal harassment, physical intimidation, inappropriate touching, or invasion of privacy of another student. Accordingly, schools must supervise these spaces appropriately and take action when students violate those policies. However, a student's mere presence does not violate such policies; their simply being in the bathroom does not make another student unsafe. Simply put, a school's responsibility to keep all students safe is not compromised by policies allowing transgender students to use bathrooms consistent with their gender identity or by the presence of transgender students in those bathrooms.

Comfort, on the other hand, is a separate issue. For any number of reasons, a student may not feel comfortable being in the bathroom with other students and require increased privacy. Remedies for these situations include providing more private options such as a staff bathroom, other single stall bathrooms or a bathroom in the nurse's office. Regardless of gender, any student should have access to these alternatives, but no students should be forced to use alternative facilities because some of their peers are uncomfortable with their mere existence. In our experience, when schools make these alternative options available, very few students choose to use them. Their availability is, however, an effective strategy to improve the school climate for those who choose to make use of them.

What if my child is worried about seeing the genitalia of another student or another student seeing their genitalia?

Most students are quite self-conscious about their peers seeing their bodies. With this in mind, it is imperative that schools be specific about which behaviors are and are not acceptable in the bathroom. These include respecting the privacy and honoring the personal space of other students using the facility. Expectations also include not leering at another student or making disparaging comments about another student's body. Students should not be seeing one another partially undressed in the restroom. If for some reason a student needs to disrobe, they should do so privately in a stall or in one of the private spaces described above. These expectations apply to all students.

Regardless of gender identity, it is inappropriate for any student to actively attempt to view another student's genitals. Such behaviors clearly create an unsafe school climate, and may well constitute sexual harassment. Schools have an obligation to respond to such occurrences and have procedures for doing so.

With regard to transgender students, several important ideas must be considered. Even more than their cisgender peers, the vast majority of transgender youth have no desire for anyone to see their bodies. They will typically go to significant lengths to ensure this does not occur. It is extremely unlikely that another student will see their body unless deliberately trying to do so. In fact, this is a very common fear for many transgender youth and their families, and something that schools should be prepared to address in the development of a student's GSP. It should also be noted that much of the fear about transgender students in bathrooms rests on the false notion that a transgender student wants access for an improper purpose, namely to leer at other students. Research has shown this is not an issue in schools with policies that ensure that transgender students can use the bathroom aligned with their gender.

Once again, any student who feels uncomfortable in the student bathroom for any reason should be given the option to use a more private facility as described above.

Q: When a business/school/institution decidedly and clearly shows that it does not recognize and support all gender identities, what effect does this have on you?

"My guard is up, I find myself mentally apologizing for being present (as it is clear I am not welcome there), and I try to avoid that business/school/institution as much as possible for fear of physical harm and verbal abuse.

What is there to prevent a student from pretending to be transgender in order to go into another bathroom (i.e. a boy pretends to be a girl so he can enter the girls' bathroom)?

Kids simply do not announce that they are transgender on a lark. In the experience of the many states and school districts across the country that have had policies in place for years providing transgender students access to the facilities consistent with their gender identity, students have not asserted false gender identities to gain access to facilities. In a recent study of seventeen school districts with such inclusive policies, which together serve over 600,000 students, not a single one reported such scenarios.

Should a student enter bathroom facilities without permission (e.g., on a dare from a classmate), they are violating the school's rules that likely existed long before schools gave transgender students access to the facilities that matched their gender identity. Whether students do so or not will be a matter of the climate and level of supervision at the school. It is entirely unrelated to whether the school has a policy of giving transgender students access to bathrooms based on gender identity. Furthermore, the systematic establishment of Gender Support Plans for transgender students will serve as an effective checkpoint for distinguishing between an authentic versus disingenuous request by a student to use a different restroom.

What should a staff member do if a student requests to use the bathroom consistent with their gender identity and the teacher is unaware that the student identifies as transgender or non-binary?

A staff member caught off guard by a student's use - or request to use - a restroom they've previously not used, might be unsure of how to respond. In such instances, it is critical that the adult proceed respectfully in addressing the situation. This could include speaking privately with the student and inquiring about the request: "I just want to check in and see if this is something new for you. Is using that restroom related to your gender identity? Are there other ways we might support you around your gender at school?" This would be an ideal time to raise the need for developing a Gender Support Plan with the student in order to identify bathroom as well as other gender-related needs. If for any reason the staff member does not feel comfortable in such an instance, they should be instructed to tell the student that they want to insure the child will be supported and request that they be able to share the student's request with a school administrator or counselor.

Are there specific legal requirements associated with allowing or not allowing transgender students to use bathrooms consistent with their gender identity?

On May 13, 2016, the Federal Departments of Education and Justice released a "Dear Colleague Letter" to the nearly 100,000 public schools in the United States. According to the letter, as well as the accompanying guide highlighting policies and emerging practices across the country:

> *A school may provide separate facilities on the basis of sex, but must allow transgender students access to such facilities consistent with their gender identity. A school may not require transgender students to use facilities inconsistent with their gender identity or to use individual-user facilities when other students are not required to do so. A school may, however, make individual-user options available to all students who voluntarily seek additional privacy.*

The letter further recognizes that the recommendations are consistent with Title IX regulations, the federal law prohibiting discrimination based on sex in any educational program or activity receiving federal funding:

> *A school's Title IX obligation to ensure nondiscrimination on the basis of sex requires schools to provide transgender students equal access to educational programs and activities even in circumstances in which other students, parents, or community members raise objections or concerns. As is consistently recognized in civil rights cases, the desire to accommodate others' discomfort cannot justify a policy that singles out and disadvantages a particular class of students.*

Furthermore, 14 states and the District of Columbia have explicit protections against discrimination on the basis of a student's gender identity. Even in states without such protections, discrimination on the basis of sex is prohibited and could encompass a student's transgender status. Many school districts have further articulated a transgender student's right to access bathrooms consistent with their gender identity, including in locations without statewide protections. Finally, it is also important to point out that as of this writing, with few exceptions, no laws prevent schools from allowing transgender students bathroom access consistent with their gender identity.

"As a transguy, simple things like using the bathroom become stressful. When schools recognize and support all gender identities, I can finally be stress-free knowing that, though I'm in public, I'm in a safe and supportive environment."

Do I have to worry about parents of other students filing a suit against my school or me because transgender students are allowed to use bathrooms consistent with their gender identity?

There is nothing that prevents a parent of any student from filing a lawsuit against a school district or individual school employee. However, it should be noted that the scenario that is most likely to unfold is a suit being filed on the basis of a school or district failing to protect a transgender students' safety and access, not the other way around. In terms of protecting students, the data is clear. The only students at risk in relation to bathroom access are transgender students. This was affirmed by the US Department of Education, which found a school district in Illinois in violation of Title IX for denying a transgender high school student access to the sex-segregated facilities. This is yet another reason why it is incumbent upon schools to create a safe school climate, supervise it appropriately, and clearly articulate clear expectations about acceptable behaviors.

What if the bathroom that corresponds to the transgender student's gender identity would not be safe for the transgender student?

If school administrators believe they cannot provide a student with safe use of school facilities, including student bathrooms, then administrators should discuss this with the student during the creation of the GSP. The objective is not to convince the transgender student to rescind the request, but to acknowledge that the school climate and associated supervision are not well enough established to support the student's safety. Potential options for bathroom access should be discussed, such as including greater freedom to use the bathroom during class time, increased teacher presence around bathrooms during passing periods, or a "buddy system." But again, a transgender student should never be forced or pressured into using alternate facilities so that school or district personnel feel more comfortable. Furthermore, the issues related to the transgender student's safety are likely making other students feel unsafe as well. Thus, in addition to addressing this concern with the transgender student, administrators should also identify ways to improve the school climate so that all students can feel safe in the bathroom.

What about students with a non-binary gender identity? Are they allowed to simply switch back and forth whenever they choose?

Students who are non-binary do not identify as either a boy or a girl. School personnel may be confused by the ever-growing variety of labels with which students identify their gender, but addressing bathroom use does not have to be complicated. Schools can accommodate non-binary students by putting a Gender Support Plan in place identifying which bathroom the student will use. What is essential in situations involving non-binary students is working on a case-by-case basis around the student's needs. Our experience has been that doing so within a school climate that is positive and well supervised, with clear expectations for how students are supposed to behave and options for students who request them, non-binary students using restrooms simply does not result in difficulties for anyone on campus.

What can I say to parents or students who are genuinely uncertain about the idea of transgender students using bathrooms?

It can be easy to assume that a parent or student who voices uncertainty about transgender students using bathrooms consistent with their gender identity is insensitive, uncaring or even bigoted. In our experience, that is rarely the case. Most people have never known, or at least been aware of knowing, a transgender person. This lack of familiarity, as well as the public discourse which tends to characterize transgender people as scary or threatening, can create uncertainty, discomfort and sometimes fear. Unfounded as it may be, it is nonetheless often a sincerely held belief.

Thus, in encountering the concerns of others, begin by assuming that they are being raised with positive intent. Recognize and affirm that they may not be familiar with any transgender or gender-expansive children or youth. Reassure them that this is new for many people, perhaps including yourself. Being uncomfortable with something new is natural. Reinforce that your number one priority is making sure every child is safe at school. Every student deserves to use bathrooms and other school facilities and offerings without worrying about being harmed or mistreated. Emphasize the seriousness with which you take any person's behaviors that make another student unsafe.

Ask them to detail the specific concerns that they have. More than likely, they will be one or more of the ideas described above. Try to help them consider for a moment what they would want the school to do if their own child was negatively perceived to be different from the other students, be it for their religion, ability, size or another frequently misunderstood aspect of identity. Ask them how it might feel for such a student to be the subject of others' rejection. If, after all of that, the parent is still concerned about their child using a bathroom that transgender students are also using, gently remind them that you are more than happy to provide their child with a private option. If any student is not comfortable, for any reason, then they can have access to a space where they have the degree of privacy they need, where they will not be worried about the presence of another student.

Should all of our bathrooms be gender neutral?

Given the importance of having options for all students, some schools consider moving towards a campus in which all bathrooms are "gender neutral", or "all gender". If these are single user bathrooms, there seems little reason to keep these designated by gender. Like those in our homes, such bathrooms are available to anyone. Gender neutral can also refer to multi-stall bathrooms that can be used by anyone regardless of gender. These are bathrooms where it is likely that one would encounter people of any gender at the sink or coming in and out of stalls. Having some or all multi-stall bathrooms declared "gender neutral" dispenses with labeling them as "male" or "female," instead opting for signs that indicate anyone is able to use that facility.

If your school decides to create single user or all-gender bathroom facilities, we recommend doing so with an accompanying education plan for informing your community about the purposes for taking this step, and to do so respectfully and with sensitivity to the many viewpoints about this topic. Schools that consider moving towards all gender bathrooms should also be mindful of the need for options for any student who might require or prefer a more private space.

Why are we doing this for just one or two students?

The simple answer is that you are not doing this just for a small group of students. Creating spaces that affirm individuals' gender benefits all students. By emphasizing positive climate, effective supervision and clear behavioral expectations, along with providing non-stigmatized options for any student who needs them, conditions are established that meet the needs of every child.

Conclusion

Discussions about a community's questions regarding bathrooms can quickly break down, in large measure because gender is something most of us take for granted – we simply haven't needed to give it a lot of thought.

It is incumbent upon educators charged with addressing these concerns to engage their community in a healthy and well-informed conversation. A major purpose of our schools is providing education and modeling for how to resolve issues in a diverse society.

Many of the concerns raised about transgender students and bathrooms are based on a lack of familiarity and knowledge about gender in general, and transgender identities specifically. They are based in the fear of the unknown or unfamiliar. As they have throughout the history of our democratic society, many of the inaccurate assumptions being made about gender can be addressed through reasoned conversation and education, the very mission of our schools.

Q: When a business/school/institution decidedly and clearly shows that it recognizes and supports all gender identities, what effect does this have on you?

"This makes me feel welcomed and understood. As a teenager, I want to feel the same as all of my peers. When a place validates my identity it gives me a sense that being transgender doesn't have to be a big thing. It makes me feel reassured, safer, and more normal."

POSITION STATEMENT: TRANSGENDER STUDENTS

SUMMARY

To acknowledge concerns related to marginalization and institutional bias associated with transgender students; state the association's opposition to legislation and policies that discriminate against transgender students; and to provide recommendations for federal, state, and local policymakers and school leaders on how to better support transgender students in the K-12 education system.

ISSUE

According to the American Psychological Association, "transgender" is an umbrella term that incorporates differences in gender identity wherein one's assigned biological sex doesn't match their felt identity (American Psychological Association, 2015). While transgender students are a small percentage of the overall student population in middle and high schools, there seems to be an increasing number of children transitioning in this age group and a greater awareness of transgender issues among principals.

Unfortunately, a climate conducive to the educational success of transgender students remains elusive in many schools. In an annual survey of more than 7,000 students ages 13–21, the Gay, Lesbian & Straight Education Network (GLSEN) found that transgender students were more likely than any other students to have negative experiences at school and were more likely to have felt unsafe and to experience victimization based on

their gender identity or expression. The survey also indicated that 42.2% of transgender students had been prevented from using their preferred name, 59.2% had been required to use a bathroom or locker room of their legal sex, and 31.6% had been prevented from wearing clothes considered inappropriate based on their legal sex.

Fourteen states and the District of Columbia have enacted laws to explicitly prohibit such discrimination in schools based on real or perceived gender identity or expression. While no such federal law exists, courts and the U.S. Department of Education's Office for Civil Rights (OCR), as well as the U.S. Department of Justice's Civil Rights Division, issued significant guidance in May 2016 asserting that Title IX prohibition against sex discrimination encompasses discrimination based on a student's gender identity, including discrimination based on a student's transgender status. The guidance addresses a school's responsibility to provide a safe and nondiscriminatory environment for all students and outlines a school's obligations regarding identification documents and pronouns, sex-segregated activities and facilities, and privacy and education records. In conjunction with the guidance, the Office of Elementary and Secondary Education released a document providing examples of policies and emerging practices for supporting transgender students. Many states have also adopted eligibility rules that explicitly permit transgender students to participate in school sports consistent with their gender identity.

The U.S. Department of Education's Office for Civil Rights (OCR), as well as the U.S. Department of Justice's Civil Rights Division, issued significant guidance in May 2016 asserting that Title IX prohibition against sex discrimination encompasses discrimination based on a student's gender identity, including discrimination based on a student's transgender status.

Nonetheless, state legislatures are increasingly considering legislation that discriminates against transgender individuals with a particular focus on students in K-12 public schools. The Human Rights Campaign reported in February 2016 that 44 anti-transgender bills had been filed in 16 states; more than double the amount in 2015. Twenty-three of the bills are targeted specifically at children in schools, including legislation regarding school sports and public school facilities. In March 2016, North Carolina became the first state to pass a bill that requires transgender students to access restrooms, locker rooms, and shower rooms in accordance with the sex on their birth certificate. Similar bills reached the governor's desk in South Dakota and Georgia, but were eventually vetoed.

GUIDING PRINCIPLE

The Professional Standards for Educational Leaders adopted in October 2015 state that effective educational leaders strive for equity of educational opportunity and culturally responsive practices to promote each student's academic success and well-being.

Students should be able to enter school free of judgment from school officials and their peers. Therefore, the principal must provide an affirming school environment where each student is treated fairly, respectfully, and with an understanding of each student's culture and context.

POSITION STATEMENT: TRANSGENDER STUDENTS

Principals influence the school culture in profound ways, specifically in the values they emphasize and the behaviors they reinforce.

The principal's primary responsibility is to create and sustain a school environment in which each student is known, accepted and valued, trusted and respected, cared for and encouraged to be an active and responsible member of the school community.

The principal also must support a school environment where diversity is valued and accepted and where students from diverse backgrounds and identities are affirmed, supported, and assured equitable educational opportunities and access to school and community-based support services.

RECOMMENDATIONS FOR FEDERAL POLICYMAKERS

- Enact legislation to provide a comprehensive federal prohibition of discrimination in public schools based on actual or perceived sexual orientation and gender identity.
- Periodically review and update guidance that strongly affirms the protections transgender students are afforded under Title IX and provide schools with recommendations on best practices to ensure they are not discriminating against transgender youth and/or their parents or guardians.
- Fully fund Title IV, Part A of the Elementary and Secondary Education Act to improve school conditions for student learning through school based mental health services, bullying and harassment prevention programs, and schoolwide positive behavioral interventions and supports.
- Extend the Qualified School Construction Bond and Qualified Zone Academy Bond programs to continue their important financial support to build, renovate and modernize schools across America.
- Promote policies for student information records that respect transgender students' need for privacy throughout the P-20 education continuum.

RECOMMENDATIONS FOR STATE POLICYMAKERS

- Oppose any attempt to introduce or pass legislation aimed at discriminating against transgender students, including bills aimed at restricting the use of restrooms or locker rooms and participation in sports and other school activities that correspond with a student's gender identity.
- Provide for a sufficient number of school counselors, school psychologists, and school social workers to support safe and welcoming school environments, provide school-based interventions, and coordinate mental health and wellness services for students and their families.
- Provide funding for new school construction and maintenance that will help schools update their facilities to include gender-neutral restrooms, locker rooms and shower rooms.

Align and adjust records policies to eliminate provisions that prevent school leaders from respecting a student's gender identity on their formal record.

POSITION STATEMENT: TRANSGENDER STUDENTS

RECOMMENDATIONS FOR DISTRICT POLICYMAKERS

- Ensure that district policies on bullying and harassment specifically protect students based on real or perceived gender or gender identity.
- Review the GLSEN Model District Policy on Transgender and Gender Nonconforming Students and revise district policies if needed.
- Develop policies and protocols for maintaining correct data for transgender students in the district student information system regardless of the student's legal name or gender marker.
- Provide support for the unique privacy needs of transgender students so they can comfortably participate in field trips, overnight trips, and other school activities.
- Provide ongoing professional development for principals, teachers, and other school staff to increase awareness of transgender issues in schools; create a school climate that avoids gender stereotyping and affirms the gender identity of all children; and to prevent, identify and respond to bullying, harassment and discrimination.
- Ensure that school counselors, school psychologists and school social workers receive specialized training on understanding and responding to the needs of transgender students.
- Assist schools to update their facilities to include gender-neutral restrooms, locker rooms and shower rooms.
- In the annual notices sent to all parents at the beginning of the school year, include a disclosure stating that the district allows students to participate in sex-segregated school programs and activities consistent with their gender identity or expression.
- Widely disseminate the district's nondiscrimination policy and also make it readily accessible to students and parents on the district and schools' websites and in policy manuals available in school offices.

RECOMMENDATIONS FOR SCHOOL LEADERS

- Familiarize yourself with the newly released Title IX guidance and state and district policies regarding transgender students and consult your school or district attorney should you have any questions or concerns.
- Advocate for school district policies that include protections for transgender students if those policies are not currently in place.
- Model and set expectations for students, staff, and parents about how to build a positive school culture where all students feel included and respected, regardless of their gender identity or gender expression.
- Provide training to student leaders so that they are able to communicate and model respect for the gender identity of all students.

POSITION STATEMENT: TRANSGENDER STUDENTS

- Support student clubs that promote gender inclusiveness and display supportive signs and posters in the school.
- Regularly administer a school climate survey of students, parents, and school personnel, and use the data to improve school conditions for all stakeholders.
- Remind your staff, students, parents and community members of the need to support the rights of all students-including transgender students-and that diminishing those rights runs contrary to the values of the school. A student's gender identity or expression is one such right, which should be respected-regardless of whether the student has begun the medical process of gender transition-especially in:
  - Privacy: Unless the student chooses to disclose certain information, his or her transgender status, legal name or sex assigned at birth is confidential medical information and considered "personally identifiable information" under the Family Educational Rights Privacy Act (FERPA). Disclosure of that information to other school staff or parents could violate the school's obligations under FERPA or constitutional privacy protections.
  - Name and pronouns: All school staff should use the student's preferred name and pronoun, which is a sign of respect to the student and affirms his or her gender identity. Documents with the student's birth name should not be circulated, and principals should follow the lead of other school districts that have found solutions to comply with recordkeeping and reporting requirements while also meeting their obligations to safeguard the student's privacy.
  - Dress: Transgender students have the right to dress in a manner consistent with their gender identity or gender expression as long as it complies with the school or district dress code.
  - Restrooms and locker rooms: Unless the student has a preference for another option, transgender students have the right to use the restroom and locker room consistent with their gender identity or gender expression. School leaders should do their best to address the needs of their school community and should provide a private facility, such as a single-occupancy restroom or changing station, or privacy curtains for any student who feels uncomfortable in the restroom or locker room.
  - Physical education and interscholastic athletic activities: Unless your state athletics association has established other rules, transgender students should be allowed to participate in school sports, and health and physical education classes consistent with their gender identity. Enrolling them in the wrong class could disclose their transgender status and be a violation of their privacy.
  - Overnight field trips: Transgender students should have the opportunity to room with peers that match their gender identity, and schools should try to pair the transgender student with peers with whom there is a mutual level of comfort. The school should also honor requests for alternative sleeping arrangements if that is the transgender student's preference.
- School traditions: Transgender students should be allowed to participate in all school traditions, such as homecoming court, in the gender category that matches their gender identity or gender expression.

Ensure that all incidents of discrimination, harassment or violence are thoroughly investigated and that appropriate actions are taken.

- If a student or his or her parent notifies the administration of the decision to transition during the school year, convene a meeting with the student and parents (if they are involved in the process) to discuss their preferences and any concerns to help find solutions that are in the best interest of the entire school community; develop a timeline for the transition in order to create conditions for a safe and supporting environment at the school; provide appropriate information and training for any educators that interact directly with the student on the transition plan, timelines for transition, and any relevant legal requirements; and develop a communications plan that outlines who needs to know what information, when, and how it will be communicated.
- Unless the student, parent, or guardian has specified otherwise, use the student's legal name and the pronoun corresponding to the student's gender assigned at birth when contacting the parent or guardian of a transgender student. While it would be ideal for the parents or guardian to be supported and included in the transition process, school leaders must be mindful of protecting the student's privacy and not creating an unsafe home climate for the student. Ensure that the student and his or her parents, if appropriate, have access to counseling and other mental health services as needed.