IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

AUGUST DEKKER, et al.,
Plaintiffs,

V. **Case No. 4:22-cv-00325-RH-MAF**

SIMONE MARSTILLER, et al.,
Defendants.

EXPERT DECLARATION OF

GEETA NANGIA, MD

I, Geeta Nangia, MD, have been retained by counsel for Defendants in connection with the above captioned litigation.

1. I have been asked by counsel for the Defendants to provide my expert opinion on the treatment and diagnosis of gender dysphoria in minors; the Florida Medicaid Generally Accepted Professional Medical Standards (GAPMS) Determination on the Treatment of Gender Dysphoria published by Florida's Agency for Health Care Administration (AHCA) in June 2022, along with its attachments; and Fla. Admin. Code. R. 59G-1.050 which prohibits Medicaid coverage of puberty blockers, hormone and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics.
2. I am over the age of 18. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

BACKGROUND AND QUALIFICATIONS

3. I am a Board Certified Child and Adolescent Psychiatrist and Adult Psychiatrist. I obtained my B.A. in Biochemistry and Molecular Biology from Boston University and my M.D. from Boston University School of Medicine. My training in Psychiatry and Child and Adolescent Psychiatry was at The Medical University of South Carolina, where I completed my fellowship training in 2007. I have been active in teaching medical students and residents throughout my career.

4. I have worked in the field of Child and Adolescent Psychiatry as a community psychiatrist in a wide range of settings over the last fifteen years, providing comprehensive psychiatric services for children and families. I chose to work as a community psychiatrist because I desired to evaluate and treat a wide range of mental health disorders, and wanted to see young people in the context of their families and their community systems (i.e. schools, extracurriculars, local supports). I have worked in both rural, urban, and suburban areas, in outpatient and inpatient settings, as well as in residential care. I have been very active in school consultations and advocating on a community level for mental health accommodations for youth in school. I have worked toward providing access to mental health care for youth who are underfunded, and who lack services due to barriers of access and cost. I have always provided psychiatric evaluations and psychotherapy and medication management for children and youth, as well as providing family therapy. I have been a part of multiple interdisciplinary teams.

5. Much of my career has been spent focusing on educating, equipping, and supporting families of children who struggle with depression, anxiety, and other mental health issues

by stressing the importance of attachment between parents and children, helping children to find their homes as a safe place to connect, where they feel nurtured, supported, and loved. It is connection and attachment to secure caregivers that form the foundation for healthy childhood development, allowing a child to progress through the developmental trajectory, and onward toward establishing a healthy identity.

6. Most recently, after working in the primary care setting with one of the area's largest pediatric providers to provide behavioral health services for more complex pediatric mental health cases, I am working as the CEO of an organization called Known and Loved, while continuing community mental health care through my private practice. Known and Loved exists to provide educational support for children and families, with a focus on children who have been in foster or adoptive care. Our Board is a group of physicians in multiple fields who desire to make a difference in the broader community for children and families.

7. Over the course of my career seeing a broad range of psychiatric disorders in children and adolescents, I have treated over a thousand patients with gender dysphoria. Given the nature of being a community psychiatrist, I have the benefit of being involved with childrens' care not just in my office, but also with their families, schools, and outside support systems. This provides me with the ability to have a more complete perspective on their development and the interventions that produce the best outcomes for their overall well being. My medical opinion below is based upon my extensive broad based clinical experience as a community based Child and Adolescent Psychiatrist, my training, developmental and neurodevelopmental theory and data, and review of the literature presented on this subject.

8. My previous expert witness testimony has been in family court regarding abuse, custody, and recommended interventions for the mental health of minors.

9. I have reviewed the Florida Medicaid Generally Accepted Professional Medical Standards (GAPMS) Determination on the Treatment of Gender Dysphoria published by Florida's Agency for Health Care Administration (AHCA) in June 2022, along with its attachments; and Fla. Admin. Code. R. 59G-1.050(7) which prohibits Medicaid coverage of puberty blockers, hormone and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics.

10. I am being compensated at an hourly rate of 350.00 for documentation and review, and 550.00 for deposition or trial testimony. My compensation does not depend on the outcome of this litigation, my opinions, nor the testimony that I provide.

OBSERVING THE RISING PREVALENCE OF GENDER DYSPHORIC YOUTH AND EVALUATING PRESENT TREATMENT MODELS

11. Escalating Prevalence of Youth Presenting with Gender Dysphoria or as Transgender: I have been a physician since 2002. Over the last decade, there has been a dramatic increase in the number of children and adolescents who experience gender dysphoria or who identify as transgender in my practice. In my early years of practice from 2007-2010, the overall prevalence of transgender youth was less than one percent of my outpatient patient population in a traditional community setting in Pennsylvania. Between 2019-2022, the number of youth presenting with gender dypshoria or as transgender increased to thirty percent in a similar outpatient community setting in South Carolina. A

study published by UCLA School of Law in June 2022 cites that the prevalence of transgender youth and young adults, ages 13-24 has doubled in the last five years. (1)

IMPORTANCE OF ANALYZING CHANGES IN PATIENT PRESENTING CONCERNS

12. When the prevalence of a particular presentation increases, regardless of what presentation that is, physicians must ask themselves several important questions in order to provide the best quality care to patients. Important questions regarding the increased prevalence of gender dysphoria or transgenderism among youth must be raised.

13. One question that must be asked is regarding confounding factors: Is the prevalence rate impacted by factors that make the data unreliable? (i.e. data can be affected by changes in the regions where measures are taken, or by differences in referral base, culture, faith, time period, social and physical environments, or concurrent medical/psychological presentations)?

A. Comparing my own patient populations during the two time periods above, my area of practice has remained rural or suburban,, my referral base has consistently been pediatric primary care, and my clinic community setting has been outpatient, However, there have been changes over time in the social culture that my patients have encountered, and there has been a dramatic increase in psychiatric disorders amongst the general patient population that I see. Additionally, children have reported a heightened feeling of distance and lack of connection with their parents in recent years when presenting initially for care.

B. One explanation for social culture changing has been the advent and expansion of social media. Ways in which this may be affecting the prevalence of transgender youth are plentiful. Social media enables the spread of information pertaining to many issues, including those related to sexual development, sexual orientation, and gender. There has been a dramatic increase in the global public discourse surrounding LGBTQA issues amongst youth. There has been widespread content circulating on transgenderism, accompanied by passionate advocacy that is highly regarded by all ages. Celebrities have highlighted LGBTQA issues, and have used various forms of media to promote and glamorize transgenderism. On a local level, information sharing has led to the popularity of LGBTQA clubs at schools, community groups dedicated to raising awareness and acceptance, and enthusiastic support networks for those who identify as LGBTQ. Support for transgenderism is now the new social norm. Whereas children and youth used to feel more isolated if they identified as LGBTQ and face adverse social consequences for being open about their identity, they now are often embraced, cared for, and even praised for their courage and confidence in many settings.

C. Families have also shifted their response over time. Parents in my patient population today more readily embrace their children with gender dysphoria today in comparison to a decade ago due to heightened awareness of the issue. While harmful prejudice does still exist and members of the LGBTQA community still face discrimination, the change in response on every level from government, to schools, and to families, has been dramatic. Colleagues of mine, as well as the

present literature, reflect this increasing acceptance and support of transgender and gender dysphoric youth.

D. While such changes can be viewed as positive by many, due to improvements in social justice and equity, the concern when analyzing the data becomes that the remarkable increase in youth reporting gender dysphoria or transgenderism, may not be completely accurate. Rather, the data may reflect youth who are seeking to be part of a community, who are seeking connection and engagement, who want to be affirmed and advocated for, and who are wanting to be part of a passionate and supportive social group.

14. A second question that must be asked pertains to screening and assessments: Are screening tools or evaluations for gender dysphoria different now than they were previously?

A. With regard to screening tools, assessments, and evaluations in my own practice, I have always sought to provide comprehensive care that is non-discriminatory. I have always asked my clients how they identify, and have created a welcoming environment for LGBTQA patients. I am up to date on my awareness of the recommendations made by major medical organizations, ask open ended questions, and I understand and reflect appropriate terminology. The breadth of information in the medical community has grown exponentially, and I am aware of and have read the literature in my field and much of it in primary care.

B. Most of my colleagues would also acknowledge that while screening tools have been modified or refined in recent years, they have provided safe and supportive environments for LGBTQA youth.

C. For this reason, I believe evaluations and screening tools to be mostly consistent and comprehensive, and less of a contributor to the increased prevalence of transgenderism or gender dysphoria.

15. A third question that must be asked is regarding under or over reporting: Are patients more likely to report the presentation now versus in the past? If so, then what has led to further reporting?

A. Based on widespread information, advocacy, dialogue, acceptance, and approval today for transgender youth in comparison to a decade ago, it is likely that youth are more likely to report gender dysphoria openly. Stigma reduction has likely also contributed to this, and has been a benefit to those youth who had previously struggled silently with this issue in fear of social consequences.

B. However, there may also be a problemsome large amount of overreporting based on youth participating in what is called the "bandwagon effect". What I have seen in my clinical work is that many adolescents who previously never had gender dysphoria, but who have been struggling with peer acceptance, suddenly describe feelings of belonging to a group when identifying as transgender. They are often embraced by LGBTQA peers rather instantly and find support that they hadn't experienced before, including from online communities. Their former feelings of being unsure about fitting in seem to be absolved by their membership in a larger movement that is gaining a lot of international traction and attention. Such observation of my patients makes me weary of increasing numbers of youth becoming vulnerable to adopting a movement's ideologies, principles, and

behaviors merely in an effort to attain the reward of widespread affirmation and approval that the movement provides.

C. This "bandwagon effect", defined more specifically as the inclination of individuals to join in their preferences or behaviors with what they perceive to be emerging majorities or dominant positions in society, likely affects the prevalence of reporting that we are seeing. Indeed, with numbers doubling in the last five years, the present trajectory would also lead us to believe that gender dysphoria may be on target to reach much higher numbers.

D. As written cited in the GAPMS, the French National Academy of Medicine wrote: "Parents addressing their children's questions about transgender identity or associated distress should remain vigilant regarding the addictive role of excessive engagement with social media, which is both harmful to the psychological development of young people and is responsible for a very significant part of the growing sense of gender incongruence."(17)

EVALUATING PSYCHOSOCIAL DEVELOPMENTAL THEORY AND NEUROLOGIC DEVELOPMENT DATA

16. Do the well founded theories of psychosocial development and current neurologic data help explain the increased prevalence of gender dysphoria in youth? For this, physicians must consider theories of psychosocial development and pediatric neurological development data for children and adolescents.

17. Fundamental Theory of Psychosocial Development:

A. Childhood and "Industry vs Inferiority": According to the widely accepted theories of Erik Erikson, children are developing human beings. Children go

through several stages of psychosocial development. They enter the stage of "industry vs. inferiority" between ages 5-12, wherein their major milestone is attaining the virtue of competence. During this stage, a child's peer group becomes more important. The child views his or her peers as being highly significant. The child's self concept begins to form more closely around peer approval or disapproval. Children's reactions of feeling confident or proud, rejected and incapable, often form around their accomplishments and the responses of their peers. If their efforts are reinforced by praise and reward, they feel industrious ("competent"). They exude a readiness to move past this stage and further along the developmental trajectory. If, however, they feel rejected, or disapproved of, they feel inferior ("Incompetent"), causing a halt in development and an inability to move forward along the developmental trajectory. [2]

B. Adolescence and "Identity vs Role Confusion": According to Erikson, adolescents ages 12-18 who successfully moved forward from the former phase of development, enter the stage of "Identity vs Role Confusion". During this stage, they are searching for a sense of self and identity. They experience intense exploration of personal values, beliefs, and goals. Adolescents begin to analyze and think more deeply about their own morality and ethics, and determine their individual identities based upon their life experiences.

C. Body image is critical in this stage of development, and Erikson suggests that two identities are forming- "sexual" and "occupational". Erikson says that adolescents may feel uncomfortable about their bodies for some period of time until they can adapt and grow into the changes. Additionally, he says success in this stage leads

to the virtue of "fidelity", which he defines as the ability to commit oneself to others on the basis of accepting others even where there are differences. Adolescents have a desire to belong to society and to be productive. During this period, those adolescents who fail to form a sense of identity experience role confusion, feeling unsure where they fit into society in the long term.

D. Based on Erikson's model of the psychosocial stages, the idea that increased reporting of gender dysphoria may be due to adolescents finding identity, approval, and acceptance among the LGBTQ community becomes more plausible, particularly during a season of vulnerability, psychosexual identity formation, and a need for fidelity.

18. Neurologic Development of Children and Adolescents:

A. Adolescent Brain More Vulnerable to Decision Making in Emotionally Laden Situations and with Peer Involvement: The following are excerpts taken from "Brain Development During Adolescence" [3] *"One of the more influential neurobiological models to explain typical adolescent behavior was developed by the group of BJ Casey in New York.* [4] *The main premise of this model, based on neuroanatomical findings and data from functional imaging studies* [5, 6, 7, 8]*, is that adolescence is a period of neural imbalance caused by the relatively early maturation of subcortical brain areas and the relatively delayed maturation of prefrontal control areas, with the result that, in emotional situations, the more mature limbic and reward systems gain the upper hand, so to speak, over the still relatively immature prefrontal control system. This should not be taken to imply that adolescents are by nature unable to make rational decisions. Rather, in*

situations that are particularly emotionally laden (e.g., in the presence of other adolescents or when there is the prospect of a reward), the probability rises that rewards and emotions will affect behavior more strongly than rational decision-making processes[5,6,9]*. This model has been tested in a series of experimental studies. Recent findings show, however, that the continuing psychological and biological changes of adolescence exert a powerful influence on cerebral structure and function. The brain of the adolescent goes through a new phase of plasticity in which environmental factors can have major, lasting effects on cortical circuitry. This opens up new opportunities for education. For example, for the very reason that adolescents are so readily influenced by emotions, they stand to profit from learning experiences taking place in a positive emotional context that are intentionally designed to train emotional regulation. Given that risky behavior in adolescence has a neurobiological basis, attempts to suppress such behavior completely seem bound to fail. It would be more reasonable to enable adolescents to have emotional experiences in a safe environment, and to increase the social rewards associated with non-risky behaviors through regulatory legislation (e.g., prohibition of certain kinds of advertising) and the provision of emotionally positive models. For instance, the teenage lead character in a television soap opera might decide to opt out of a hard-drinking contest organized by friends. Moreover, the protracted period of neural plasticity in adolescence also makes adolescents more vulnerable to harmful environmental influences* [10]*."*

B. Also in 2013, Casey presented a lecture on *"The Teen Brain: Legal Responsibility"* [11]. Taking from her presentation, Casey's data shows that the prefrontal cortex (involved in decision making and planning) develops at a rate slower than the portions of the brain involved in actions and movement. Emotional systems that reside deep within the brain are still evolving well into adolescence and there is an imbalance between the deeper areas of the brain (ventral striatum and amygdala) and the prefrontal cortex which is more delayed in development. This incongruence is linked to difficulties with self regulation and impulse control in the adolescent brain. Further evidence of this is found when response time is studied by pairing stimuli with rewards and incentives. Without conscious awareness, people have quicker responses when they associate certain stimuli with positive outcomes or incentives. Individuals have slower responses to stimuli when there are fewer expected positive outcomes or rewards. Representation of rewards and incentives is found in the ventral striatum. Across development, studies show that adolescents activate this deeper region of the brain more than young children and adults. When greater activity is seen in the ventral striatum, it is correlated with a higher degree of risk taking behaviors or impulsivity. Another factor that influences response time and accuracy for the adolescent is the presence of peers. According to studies, when peers are present, adolescents make more errors in social cue interpretation and response time. They react more quickly to incentives, and are more drawn to danger and risk taking or impulsive behaviors. Their brain is activated in the areas of the ventral

striatum and their amygdalas show heightened activity relative to younger children and adults.

C. Casey concludes that adolescents show impairment in overriding impulses in emotionally charged situations. The imbalance appears to reflect an imbalance between earlier developing emotional centers in the brain and those involved in self control. Lastly, she states that diminished self control is transient and continues to develop in adulthood as these brain systems mature with experience.

D. Of note, Casey is seen as a leader in the field of neurodevelopment. While she has no opinion that I can find on matters of transgenderism in youth, and hence I make no statements linking her with this paper, I regard her work on the adolescent brain with a great deal of respect. Evaluating the data that she presents is critical to the discussion of the increased reporting of gender dysphoria.

E. Gender dysphoria is an emotionally charged subject that often presents at the precipice of adolescent development which is by its very nature an emotionally laden period. Hence, one can conclude that adolescents may show impairment in overriding impulses that result from the brain imbalances that Casey speaks of. In this case, the impulse may be to find acceptance and social affirmation of self.

F. Additionally, Casey's data calls into question the decision making capacity of adolescents, during an emotionally laden time, to make treatment decisions regarding gender transition that are well thought out and rational rather than impulse driven.

EVALUATING TREATMENT MODELS FOR GENDER DYSPHORIA

19. Evaluating Treatment Models: If the measures of increasing prevalence of transgenderism and gender dysphoria are indeed increasing, how should the medical community respond? Are present treatment models for youth who experience gender dysphoria helpful, and which areas require attention and modification for best clinical outcomes?

A. Safe Settings: Comprehensive treatment models for youth presenting as transgender have received a great deal of focus in recent years, due to the rise in awareness and advocacy. One such example includes the Fenway Community Health Model.[12] Models recommended by major medical organizations today often focus on providing an LGBTQA safe setting for youth to talk and have dialogue regarding their feelings, their beliefs, and the issues that they are dealing with. There is an abundance of literature and supportive evidence that creating safe settings for youth with gender dysphoria is critical to their health and well being.

B. Affirmative Care Model and Gender Transition Therapies for Youth: Some models, including those endorsed by the AAP, advise that physicians ask youth about their gender specific pronouns, make efforts to not assume genders, and "affirm" the gender that the youth prefers. "Affirming Care", as it is defined today by major medical organizations, means that youth are affirmed by therapists and medical providers to *be the gender they feel comfortable with.* There are four

major flaws in the affirmative care model when it is applied to practical outpatient care for gender dysphoric youth:

1) First, the affirmative model neglects the adolescent's core internal conflict during the "Identity vs Role Confusion" stage of psychosocial development, during which the adolescent seeks to find belonging and affirmation. By not taking into consideration that adolescents will be vulnerable to making decisions based on simply wanting to fit in, the affirmative care model assumes that adolescent decisions are to be deemed as sustaining, consistent, and evidentiary of the child's chosen gender for life.
2) Second, this model neglects the neurologic data that shows adolescents are likely to make more impulsive decisions to attain incentives or rewards during emotionally charged situations or when influenced by peers. In the case of gender dysphoria, reward could be social approval that the adolescent is already seeking. Therein, the affirmative model calls on physicians to hastily affirm adolescent gender when the adolescent's decisions may be impulse and reward driven rather than rooted in well thought out planning and rational processes.
3) Third, the affirmative model also does not take into consideration the fact that when confounding factors are dealt with in therapy, many adolescents change their minds regarding their gender preference. Often, in my own clinical experience, when issues such as family dynamics, trauma, gender role experiences, attachment, and peer struggles are explored in therapy,

adolescents no longer report gender dysphoria. If I were to prematurely "affirm" a child's preferred gender, I would risk causing irreparable harm by not exploring all of the other complex issues the adolescent faces that may be affecting gender preference. As my colleagues' experiences and much literature also emphasizes the role of therapeutic exploration [13] it is clear that adolescents with gender dysphoria require tremendous diligence in mental health care and considerable time is required by providers for thorough therapeutic exploration prior to any decision to affirm a gender choice.

4) The fourth and last flaw in the affirmative model is that it prompts the clinician to move past therapeutic exploration, to treatments such as hormones, chest binders, and surgeries that can potentially cause harm to a child or adolescent's mind, body, and self concept. Despite the voices in the medical community who state that such treatments are harmless and reversible, or even beneficial for mental health, the studies on long term outcomes and safety are lacking, and anecdotal data is growing that would point to such treatments as being potentially irreversible, highly impactful on reproductive ability, and life altering to the point of even causing suicidal thoughts due to shame and regret. The potential for harm is significant- both from a psychiatric standpoint and from a medical standpoint to the adolescent. [14]

20. The longest follow up study of sexual reassignment surgeries extended for 30 years in Sweden, where transgenderism is highly accepted and supported. Fifteen years into

the study, the suicide rate in those who had reassignment surgery was twenty times the rate in controls.[14] It cites, "The study identified increased mortality and psychiatric hospitalization compared to the matched controls. The mortality was primarily due to completed suicides (19.1-fold greater than in control Swedes), but death due to neoplasm and cardiovascular disease was increased 2 to 2.5 times as well. We note, mortality from this patient population did not become apparent until after 10 years. The risk for psychiatric hospitalization was 2.8 times greater than in controls even after adjustment for prior psychiatric disease (18 percent). The risk for attempted suicide was greater in male-to-female patients regardless of the gender of the control. Further, we cannot exclude therapeutic interventions as a cause of the observed excess morbidity and mortality." This study further demonstrates problems for the gender affirmative model. Additionally, it is necessary to consider this long term study in the discussion that arises regarding suggested higher suicide risk in those with gender dysphoria, and the assumption that is made stating that suicide rates will decline if gender affirming treatments are provided. Indeed, the results in this study after the ten year mark would contradict that assumption.

21. In 2014, Hayes, Inc. reviewed the scientific literature and found that evidence on long-term results of sex reassignment was too sparse to support meaningful conclusions and gave these studies its lowest rating for quality. It stated, "Statistically significant improvements have not been consistently demonstrated by multiple studies for most outcomes. … Evidence regarding quality of life and function in male-to-female adults was very sparse. Evidence for less comprehensive measures of well-being in adult recipients of cross-sex hormone therapy was directly applicable to [gender dysphoric]

patients but was sparse and/or conflicting. The study designs do not permit conclusions of causality and studies generally had weaknesses associated with study execution as well. There are potentially long-term safety risks associated with hormone therapy but none have been proven or conclusively ruled out."

22. In 2016, the Centers for Medicare and Medicaid Services addressed whether sex reassignment surgery would be covered under their plans. It stated that it lacked evidence that it benefits patients. (15) It cited, "Based on a thorough review of the clinical evidence available at this time, there is not enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria. There were conflicting (inconsistent) study results—of the best designed studies, some reported benefits while others reported harms. The quality and strength of evidence were low due to the mostly observational study designs with no comparison groups, potential confounding, and small sample sizes. Many studies that reported positive outcomes were exploratory type studies (case-series and case-control) with no confirmatory follow-up."

A follow up memo (16) stated, "Overall, the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding (a situation where the association between the intervention and outcome is influenced by another factor such as a co-intervention), small sample sizes, lack of validated assessment tools, and considerable lost to follow-up."

23. My own clinical experience with youth who undergo hormone treatment for blocking pubertal development, or who utilize chest binders, is that many experience immense regret after bodily changes occur. This regret sadly often translates into shame when adolescents decide to transition back to their biological sex, and this creates an entirely new layer of issues that then require therapeutic intervention.

CONCLUSION

24. As a physician, my concern is that we must, as a medical community, acknowledge that the rise in the prevalence of gender dysphoria is correlated with the rise of social LGBTQA advocacy and awareness movements. Developmental theory supports that adolescence is a critical period of identity formation and wanting to belong, and a period of vulnerability. Neurodevelopmental models show us that youth are susceptible to impulse driven decisions, particularly in the presence of peers. While advocacy and awareness are critical to building a stronger society, it must be understood that the vulnerability of the developing brain leads it to be drawn toward impulsive choices, and ideologies that gain quick traction and lead to social approval, connection, and affirmation are alluring during this period. To provide children with the ability to make very serious medical choices that affect their overall health and self concept for the rest of their lives, including their reproductive capability, during a season of such tremendous neurodevelopmental growth and susceptibility is risky, at best.

I conclude that I am in agreement with the Florida Medicaid Generally Accepted Professional Medical Standards (GAPMS) Determination on the Treatment of Gender Dysphoria published by Florida's Agency for Health Care Administration (AHCA) in June 2022 [18], along with its

attachments; and Fla. Admin. Code. R. 59G-1.050 which prohibits Medicaid coverage of puberty blockers, hormone and hormone antagonists, and sex reassignment surgeries. In my opinion, children under the age of eighteen should not receive these aforementioned treatments or any other medical interventions that hinder or change their natural development.

We must not let our desire to help youth with gender dypshoria cloud our clinical judgment and cause us to make hasty decisions about treatments that carry profound risk and for which our only reliable long term study is a 30 year follow up showing an increase in suicide and suicidal thoughts ten years post treatment [14].

We must simultaneously take steps to protect youth and treat them with respect by providing them with non-discriminatory care that focuses on kindness, respect, and safe settings for communication and therapeutic exploration, all while taking into consideration the complexity of the factors that influence them, and the risks of treatments for which we don't have the long term scientific data to support.

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

Geeta Nangia, MD

Geeta Nangia MD

References:

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[15] June 2016 *Proposed Decision Memo for Gender Dysphoria and Gender Reassignment Surgery* Centers for Medicaid and Medicare Services

[16] June 2016 *Memo for Gender Dysphoria and Gender Reassignment* Centers for Medicaid and Medicare Services

[17] Feb 2022 *Medicine and Gender Transidentity in Children and Adolescents* French National Academy of Medicine

[18] June 2022 *Florida Medicaid Generally Accepted Professional Medical Standards (GAPMS) Determination on the Treatment of Gender Dysphoria* Florida's Agency for Health Care Administration (AHCA)

Geeta Nangia, M.D.

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EDUCATION

Boston University School of Medicine — **Boston, MA**
Doctor of Medicine — May 2002

Boston University — **Boston, MA**
Bachelor of Arts Biochemistry, Molecular Biology — May 1998

INTERNSHIP AND RESIDENCY

Medical University of South Carolina — **Charleston, SC**
Child and Adolescent Psychiatry Fellow — June 2007

Medical University of South Carolina — **Charleston, SC**
General Psychiatry Resident — June 2006

EXPERIENCE

KNOWN AND LOVED — **Greenville, SC**
CEO — **2021-present**
Educating, equipping, and supporting the growth of healthy families in our region. Providing mental health education and support to parents, with a special focus on foster and adoptive families. Helping parents to establish secure and healthy attachments with children, thereby improving their mental health outcomes.

Journey of the Heart, LLC — **Piedmont, SC**
Child and Adolescent Psychiatrist — **2022-present**
Providing behavioral health care for children and families, specializing in complex cases and trauma.

Parkside Pediatrics Behavioral Health — **Greenville, SC**
Child & Adolescent Psychiatrist — **2018-2022**
Providing behavioral health care for children and families. Consulting with pediatricians in primary care.

Edward Via College of Osteopathic Medicine — **Spartanburg, SC**
Community Clinical Faculty and Lecturer — **2015-2020**
Taught medical students about the principles of childhood development and clinical psychiatry.

Carolina Center for Behavioral Health **Greer, SC**
Staff Psychiatrist **2015-2016**
Staffed inpatient unit for children and adults of all ages who were in need of acute crisis stabilization and mental health services.

The Well Planted Child, LLC **Bellefonte, PA**
Private Practice Consulting Psychiatrist **2014- 2015**
Provided school based consultation services for children with behavioral and/or academic difficulties. Assisted teachers in developing effective classroom management strategies and in creating accommodations for children with special needs.

Centre County Christian Academy **Bellefonte, PA**
Kindergarten Teacher **2014-2015**
Volunteered to be a primary teacher for morning academics at a private Christian school for an academic year. Tested classroom modifications and strategies typically recommended by clinical mental health professionals to assess their efficacy. Provided consulting services for children with special needs or behavioral issues.

Diversified Treatment Alternatives **Lewisburg, PA**
Child and Adolescent Psychiatrist **2012- 2015**
Provided evaluation and treatment for children in two residential care facilities. Provided care for a high risk youth population with a special focus on sexual abuse, sexual perpetration, and addiction. Supervised treatment teams who were providing trauma focused treatment for children. Provided care for a partial hospitalization program. Led educational parenting groups on development and attachment.

Sunpointe Health **State College, PA**
Child and Adolescent Psychiatrist **2011-2012**
Adult Psychiatry Inpatient Attending Psychiatrist
Provided inpatient adult psychiatric evaluation and treatment in an acute care setting at Mount Nittany Medical Center. Provided psychiatric consultation for children and for the BLAST Intermediate Unit which serves multiple school districts in the region. Taught medical students during their psychiatry rotation.

Palmetto Christian Psychiatry **Charleston, SC**
Private Practice Psychiatrist **2010-2011**
Provided psychiatric evaluation and treatment for individuals of all ages. Provided individual and family psychotherapy.

Susquehanna Health Medical Group **Williamsport, PA**
Child and Adolescent Psychiatrist **2007-2010**
Adult Psychiatry Inpatient Attending Psychiatrist
Spearheaded The Department of Child Psychiatry at a local community hospital with a mission to serve children who otherwise did not have access to mental health care. Performed evaluations and treatment for children and adults with a

broad spectrum of mental health and developmental disorders. Actively conducted family therapy, psychodynamic therapy, cognitive behavioral therapy, play therapy, as well as group therapy. Provided medication management. Worked with outlying community agencies in all arenas, consulting with and for schools, social services, court systems, pediatricians and primary care physicians, wrap around services, and partial hospitalization programs to coordinate care for children. Taught in the family medicine residency program weekly. Supervised staff therapist and psychiatric nurse. Provided courtroom testimony in custody and abuse cases. Performed on call duties on the adult inpatient unit.

Carolina Center for Behavioral Health **Greer, SC**
Staff Psychiatrist **2006-2007**
Served in a weekend moonlighting position servicing an adult inpatient population while in fellowship training. Managed crisis calls, multiple levels of acuity, and geriatric patients on weekends during my fellowship.

HONORS

Susquehanna Physician Appreciation Award, 2008
Family Medicine Residency Teaching Certificate 2008
Circle of Excellence in Teaching 2003
Ruth Hunter Johnson Prize in Psychiatry 2002

LICENSURES

Pennsylvania Medical License MD 431126 inactive
South Carolina Medical License MD 26215 active

CERTIFICATIONS

American Board of Psychiatry and Neurology, General Psychiatry
American Board of Psychiatry and Neurology, Child and Adolescent Psychiatry