UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY,

Plaintiff,

v.

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

Defendants.

Civil No. ____-_____

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

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

I. CREDENTIALS & SUMMARY

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

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

3. I have served as a book and manuscript reviewer for numerous professional publications. I have been the Senior Editor of the first (2003), second (2010), and third (2016) editions of the *Handbook of Clinical Sexuality for Mental Health Professionals*. In addition to five previously solo-authored books for

[1] Society for Sex Therapy & Research Awards, https://sstarnet.org/awards/.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

j. Putting a child or adolescent on a pathway towards life as a transgender person puts that individual at risk of a wide range of long-term or even life-long harms, including: sterilization (first chemical, then surgical) and associated regret and sense of loss; inability to experience orgasm (for

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trans women); physical health risks associated with exposure to elevated levels of cross-sex hormones; surgical complications and life-long after-care; alienation of family relationships; inability to form lasting romantic relationships and attract a desirable mate; and elevated mental health risks of depression, anxiety, and substance abuse. (Section V.)

II. BACKGROUND ON THE FIELD

A. The biological baseline of sex

11. Gender identity advocates commonly refer to the sex of an individual as "assigned at birth." This phrase is misleading. The sex of a human individual at its core structures the individual's biological reproductive capabilities—to produce ova and bear children as a mother, or to produce semen and beget children as a father. As physicians know, sex determination occurs at the instant of conception, depending on whether a sperm's X or Y chromosome fertilizes the egg. Medical technology can now determine a fetus's sex before birth almost as easily as after birth. It is thus not correct to assert that doctors "assign" the sex of a child at birth. Instead, they simply recognize the existing fact of that child's sex. Barring rare disorders of sexual development, anyone can identify the sex of an infant by genital inspection. What the general public may not understand, however, is that every nucleated cell of an individual's body is chromosomally identifiably male or female—XY or XX.

12. The self-perceived gender of a child, in contrast, arises in part from how others label the infant: "I love you, son (daughter)." This designation occurs thousands of times in the first two years of life when a child begins to show

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

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

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

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

B. Definition and diagnosis of gender dysphoria

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

[2] S. Levine (2018), *Informed Consent for Transgendered Patients*, J. OF SEX & MARITAL THERAPY at 6 ("*Informed Consent*"); S. Levine (2016), *Reflections on the Legal Battles Over Prisoners with Gender Dysphoria*, J. AM. ACAD. PSYCHIATRY LAW 44, 236 at 238 ("*Reflections*").

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

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

17. Gender dysphoria has very different characteristics depending on age and sex at onset. Young children who are living a transgender identity commonly suffer materially fewer symptoms of concurrent mental distress than do older patients.[3] The developmental and mental health patterns for each of these groups are sufficiently different that data developed in connection with one of these populations cannot be assumed to be applicable to another.

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

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

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

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

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

[4] S. Levine (2017), *Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria*, J. OF SEX & MARITAL THERAPY at 7 ("*Ethical Concerns*") (available at http://dx.doi.org/10.1080/0092623X.2017.1309482.)

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

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

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[5] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) at 31,384.

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

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

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

C. Impact of gender dysphoria on minority and vulnerable groups .

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

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

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

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

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

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

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

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

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

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

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

28. It should be noted, however, that gender dysphoria is a psychiatric, not a medical, diagnosis even though that is how it is often introduced into court settings. Since its inception in DSM-III in 1983, it has always been specified in the psychiatric DSM manuals and is not specified in medical diagnostic manuals. Notably, gender dysphoria is the only psychiatric condition to be treated by surgery, even though no endocrine or surgical intervention package corrects any identified biological abnormality. (Levine, *Reflections,* at 240.) This medicalization of gender dysphoria is at some level at odds with psychologists' longstanding concerns about or even opposition to "practice guidelines that recommend the use of medications over psychological interventions in the absence of data supporting such recommendations.[13]

[13] AM. PSYCH. ASS'N (2005) *Report of the 2005 Presidential Task Force on Evidence-Based Practice* at 2 (available at https://www.apa.org/practice/resources/evidence/evidence-based-report.pdf.)

29. Gender dysphoria is alternatively **conceptualized in developmental terms**, as an adaptation to a psychological problem that was first manifested as a failure to establish a comfortable conventional sense of self in early childhood or confusion about the self that intensifies with puberty. This paradigm starts from the premise that all human lives are influenced by past processes and events. Trans lives are not exceptions to this axiom. (Levine, *Reflections* at 238.) MHPs who think of gender dysphoria through this paradigm may work both to identify and address the apparent causes of the basic problem of the deeply uncomfortable self, and also to ameliorate suffering when the underlying problem cannot be solved. They work with the patient and (ideally) the patient's family to inquire what forces may have led to the trans person repudiating the gender associated with his sex. The developmental paradigm is mindful of temperamental, parental bonding, psychological, sexual, and physical trauma influences, and the fact that young children work out their psychological issues through fantasy and play. The developmental paradigm does not preclude a biological temperamental contribution to some patients' lives; it merely objects to assuming these problems are biological in origin. All sexual behaviors and experiences involve the brain and the body.

30. In addition, the developmental paradigm recognizes that, with the important exception of genetic sex, essentially all aspects of an individual's identity evolve—often markedly—across the individual's lifetime. This includes gender.

31. Some advocates assert that a transgender identity is biologically caused, fixed from early life, and invariably persists through life in an unchanging manner. This assertion, however, is not supported by science.[14] Although numerous studies have been undertaken to attempt to demonstrate a distinctive physical brain structure associated with transgender identity, as of yet there is no evidence that these patients have any defining abnormality in brain structure that precedes the onset of gender dysphoria. The belief that gender dysphoria is the consequence of brain structure is challenged by the sudden increase in incidence of child and adolescent gender dysphoria over the last twenty years in North America and Europe. Meanwhile, multiple studies have documented rapid shifts in gender ratios of patients presenting for care with gender-related issues, pointing to cultural influences,[15] while a recent study documented "clustering" of new presentations in specific schools and among specific friend groups, pointing to social influences.[16] Both of these findings strongly suggest cultural factors. From the beginning of epidemiological research into this arena, there have always been some countries (Poland and Australia, for example) where the sex ratios were reversed as compared to North America and Europe, again demonstrating a powerful effect of cultural influences.

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

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

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

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

33. In recent years, for adolescent patients, intense involvement with online transgender communities or "friends" is the rule rather than the exception, and the MHP will also be alert to this as a potentially significant influence on the identity development of the patient. Finally, the large accumulating reports of late adolescent and young adult individuals who return to their natally assigned gender identity highlight the error of assuming a trans identity is a permanent feature[17].

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

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

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

E. Four competing models of therapy

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

(1) The "watchful waiting" therapy model

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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