No. 16-273

IN THE
Supreme Court of the United States

GLOUCESTER COUNTY SCHOOL BOARD,

Petitioner,

v.

G.G., by his next friend and mother, DEIRDRE GRIMM,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN COLLEGE OF PHYSICIANS, AND 17 ADDITIONAL MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF RESPONDENT

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TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 3

ARGUMENT 5

I. What It Means To Be Transgender And To Suffer From Gender Dysphoria 5

A. Gender Identity 8

B. Gender Dysphoria 11

1. The Diagnostic Criteria And Seriousness Of Gender Dysphoria 11

2. The Accepted Treatment Protocols For Gender Dysphoria 14

II. Excluding Transgender Individuals From Facilities Consistent With Their Gender Identity Endangers Their Physical And Mental Health, Safety, And Well-Being 24

A. Exclusionary Policies Exacerbate Gender Dysphoria And Are Contrary To Widely Accepted, Evidence-Based Treatment Protocols 25

B. Exclusionary Policies Expose Transgender Individuals To Harassment And Abuse In Gender-Segregated Spaces 27

C. Exclusionary Policies Exacerbate Stigma And Discrimination, Leading To Negative Health Outcomes 29

D. Exclusionary Policies Lead To Avoidance Of Restroom Use, Harming Physical Health 32

E. Exclusionary Policies Harm Adolescent Social And Emotional Development—With Lifelong Effects 35

CONCLUSION 37

APPENDIX: ADDITIONAL *AMICI CURIAE*

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INTEREST OF *AMICI CURIAE*[1]

Amici are 20 leading medical and mental health organizations. Collectively, *amici* represent hundreds of thousands of physicians and mental health professionals, including specialists in pediatrics and adolescent care, family care, internal medicine, and endocrinology; tens of thousands of medical students; over one hundred thousand physician assistants; and millions of nurses.

Amicus curiae, the American Academy of Pediatrics ("AAP"), is the largest professional association of pediatricians in the world, with over 64,000 members. Through education, research, advocacy, and the provision of expert advice, AAP seeks the optimal physical, mental, and social health and well-being for infants, children, adolescents, and young adults.

Amicus curiae, the American Psychiatric Association, with more than 36,000 members, is the nation's leading organization of physicians who specialize in psychiatry. The Association has a particular interest in this Court's understanding of the lessons of scientific study and professional experience in the application of federal law to cases involving individuals who often are patients of the Association's members.

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[1] Pursuant to Rule 37.6, *amici curiae* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* and their counsel made a monetary contribution to its preparation or submission. Both parties have consented to the filing of this brief.

Amicus curiae the American College of Physicians ("ACP") is the largest medical specialty organization in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

This brief is also submitted on behalf of 17 additional medical and mental health organizations, listed in the Appendix to this brief. All *amici* share a commitment to improving 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, which include living in accordance with one's gender identity in all aspects of life; 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 Respondent, 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 to the individual 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 to bring the body into alignment with the individual's gender identity. Although in the past transgender people were subjected to practices to try to change their gender identity to conform it to their birth-assigned sex, that approach has been broadly discredited as both ineffective and potentially harmful.

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, exacerbating the condition; exposes them to stigma and discrimination as well as potential harassment and abuse; harms their physical health by causing them to avoid restroom use; and impairs their social and emotional development, contributing to poorer health outcomes throughout life. Similarly, transgender students who are required to 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] Gender identity can also be described as the "maleness and femaleness a person feels on the inside; how that identity is projected to the world; and how others mirror that identity back to the individual."[3] Transgender people differ from cisgender (*i.e.*, non-transgender) individuals, whose gender identity aligns with the sex assigned at birth.[4]

Recent estimates suggest that approximately 1.4 million transgender adults live in the United States, or

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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] Russell B. Toomey et al., *Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth: School Victimization and Young Adult Psychosocial Adjustment*, 46 Developmental Psychol. 1580, 1581 (2010) (quoting Gianna E. Israel, *Translove: Transgender Persons and Their Families*, 1 J. GLBT Family Studies 53, 55 (2005)).

[4] Am. Psychol. Ass'n Guidelines, *supra*, at 861.

0.6 percent of the adult population.[5] That said, "population estimates likely underreport the true number of [transgender] people, given difficulties in collecting comprehensive demographic information about this group."[6] Transgender people mirror the U.S. population as a whole. People of all different races and ethnicities identify as transgender.[7] They live in every state, serve in our military, and raise children.[8] Gender identity is distinct from and does not predict sexual orientation, meaning that transgender people, like

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[5] 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. Another estimate puts the total adult transgender population as 0.53 percent of the U.S. population. Halley P. Crissman et al., *Transgender Demographics: A Household Probability Sample of US Adults, 2014*, 107 Am. J. Pub. Health 213 (2017).

[6] Am. Psychol. Ass'n Guidelines, *supra*, at 832.

[7] *See* Crissman et al., *Transgender Demographics*, *supra*, at 214-15; 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.

[8] 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.

cisgender people, can be attracted to males, females, both, or neither, and may identify as heterosexual, gay, lesbian, bisexual, or asexual.[9]

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."[10] 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.[11] The medical community came to recognize that one's gender identity could exist in ways that did not always align with a person's birth-assigned sex.

Much as our profession recognizes 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

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[9] 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.

[10] 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"].

[11] *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

impairment in judgment, stability, reliability, or general social or vocational capabilities."[12]

A. Gender Identity

As previously noted, "gender identity" refers to a person's internal sense of being male, female, or another gender.[13] Every person has a gender identity,[14] which cannot be altered voluntarily.[15] Because gender identity is an internal characteristic, it cannot be ascertained immediately after birth.[16] Many children develop

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[12] 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.

[13] 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.

[14] *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; *see also* Pub. Health Agency of Can., *Questions and Answers*: *Gender Identity in Schools* 1 (2010), http://www.sieccan.org/pdf/phac_genderidentity_qa-eng.pdf.

[15] 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.

[16] Am. Psychol. Ass'n Guidelines, *supra*, at 862.

stability in their gender identity between ages 3 and 4.[17] Everyone—whether they are transgender or cisgender—develops awareness of their gender identity along a "pathway" that "typically includes a progression through multiple stages of awareness, exploration, expression, and identity integration."[18]

"[G]ender expression refers to the way a person communicates gender identity to others through behavior, clothing, hairstyles, voice, or body characteristics."[19] There are many individuals who depart from what others consider to be stereotypical male and female appearances and roles, but that does not make them transgender.[20] 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.[21] In contrast, a

[17] *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.

[18] *Id.* at 835-36.

[19] Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People, supra*, at 1.

[20] Ethan C. Cicero & Linda M. Wesp, *Supporting the Health and Well-Being of Transgender Students*, J. Sch. Nursing 1, 6 (2017) ("Many children will engage in gender creative expressions temporarily or even long term, but not all will have a crosssex gender identity.").

[21]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); 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?

transgender boy or transgender girl is someone who "consistently, persistently, and insistently" identifies as a gender different than the sex they were assigned at birth.[22]

Psychologists, psychiatrists, and neuroscientists are not certain why some people are transgender and others are not, but some research suggests there may be biological influences such as genetic and epigenetic mechanisms.[23] For example, natal females who are exposed to elevated levels of testosterone in the womb may express a male gender identity later in life despite being raised as females.[24] Brain scans and

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pk_association_webpage_menu=1351&pk_association_webpage=4655 [**hereinafter "WPATH Standards of Care"**].

[22] *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; Marco A. Hidalgo et al., *The Gender Affirmative Model: What We Know and What We Aim to Learn*, 56 Human Development 285, 286 (2013); Kristina R. Olson et al., *Mental Health of Transgender Children Who Are Supported in Their Identities*, 137 Pediatrics 1, 2 (2016), http://pediatrics.aappublications.org/content/pediatrics/early/2016/02/24/peds.2015-3223.full.pdf.

[23] *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; Am. Psychol. Ass'n Task Force Report, *supra*, at 52-53; Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1895 (2008).

[24] Arianne B. Dessens et al., *Gender Dysphoria and Gender Change in Chromosomal Females with Congenital Adrenal Hyperplasia*, 34 Arch. Sexual Behav. 389, 395 (2005).

neuroanatomical studies of transgender individuals may also support this explanation.[25]

B. Gender Dysphoria

As noted above, being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."[26] 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.[27]

1. The Diagnostic Criteria And Seriousness Of Gender Dysphoria

The Diagnostic and Statistical Manual of Mental Disorders, currently in its fifth edition ("DSM-5"), 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'

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[25] *See, e.g.*, Elesline Hoekzema et al., *Regional Volumes and Spatial Volumetric Distribution of Gray Matter in the Gender Dysphoric Brain*, 55 Psychoneuroendocrinology 59, 60, 70 (2015); Baudewijntje P.C. Kreukels & Antonio Guillamon, *Neuroimaging Studies in People with Gender Incongruence*, 28 Int'l Rev. Psychiatry 120 (2016); 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/.

[26] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals*, *supra*.

[27] Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 451-53 (5th ed. 2013) **[hereinafter "DSM-5"]**.

duration, as manifested by at least two" out of six criteria, and "clinically significant distress or impairment in social, occupational, or other important areas of functioning."[28] 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" because of that incongruence; (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.[29]

Puberty and the associated development of sexual characteristics can trigger or exacerbate gender dysphoria.[30] 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. For instance, a deepening voice for male-assigned

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[28] *Id.* The definition of gender dysphoria in children is similar, but focuses on age-appropriate markers such as preferences for toys, games, and playmates, and preferred roles in make-believe play or fantasy play.

[29] *Id.* at 452.

[30] Am. Psychol. Ass'n Task Force Report, *supra*, at 45; Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 3.

individuals or the growth of breasts and the beginning of a menstrual cycle for female-assigned individuals can cause severe distress. For some, puberty manifests as "a sudden trauma that forces to consciousness the horror that they are living in a body that is totally at odds with the gender they know themselves to be but which has been kept securely underground."[31]

Individuals suffering from gender dysphoria may be preoccupied with altering their genitals or secondary sexual characteristics (*e.g.*, breasts in natal females or a deepening voice or facial hair in natal males) in order to bring them into line with their gender identity.[32] If untreated, gender dysphoria can cause debilitating distress, depression, impairment of function, substance abuse, self-mutilation to alter one's genitals or secondary sex characteristics, other self-injurious behaviors, and suicide.[33] In addition to the negative

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[31] Diane Ehrensaft, *From Gender Identity Disorder to Gender Identity Creativity: True Gender Self Child Therapy*, 59 J. Homosexuality 337, 345 (2012).

[32] DSM-5, *supra*, at 455-56.

[33] *See, e.g.*, DSM-5, *supra*, at 455 ("Impairment (e.g., school refusal, development of depression, anxiety, and substance abuse) may be a consequence of gender dysphoria."), 458 ("Gender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks, especially in individuals from resource-poor family backgrounds."); Stephanie A. Brill & Rachel Pepper, *The Transgender Child: A Handbook for Families and Professionals* 202 (2008) (discussing risk of self-mutilation); Laurence Claes et al., *Non-Suicidal Self-Injury in Trans People: Associations with*

health conditions directly attributable to gender dysphoria, transgender individuals—particularly those whose gender identity is not validated or supported by others—are frequently subjected to prejudice and discrimination in multiple areas of their lives (*e.g.*, housing, employment, school, healthcare) that exacerbates these negative health outcomes.[34]

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 change the patient's gender identity to make it consistent with the patient's sex assigned at birth.[35] There is no evidence that these methods

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Psychological Symptoms, Victimization, Interpersonal Functioning, and Perceived Social Support, 12 J. Sexual Med. 168 (2015); lore m. dickey et al., *Non-Suicidal Self-Injury in a Large Online Sample of Transgender Adults*, 46 Prof'l Psychol.: Research & Practice 3 (2015); Johanna Olson et al., *Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria*, 57 J. Adolescent Health 374, 379 (2015); Amaya Perez-Brumer et al., *Individual- and Structural-Level Risk Factors for Suicide Attempts Among Transgender Adults*, 41 Behav. Med. 164 (2015).

[34] 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.

[35] Am. Psychol. Ass'n Guidelines, *supra*, at 835; Jack Drescher, *Queer Diagnoses: Parallels and Contrasts in the History of*

alleviate gender dysphoria or that they can prevent someone from being transgender.[36] To the contrary, "purposeful attempts to 'convert,' 'repair,' change or shift an individual's sexual orientation, gender identity, or gender expression" can "often result in substantial psychological pain by reinforcing damaging internalized attitudes,"[37] and can damage family relationships and individual functioning by increasing feelings of shame.[38]

Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual, 39 Arch. Sexual Behav. 427, 436-40 (2010).

[36] Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 26 (noting that no peer-reviewed research exists that "demonstrates the efficacy of conversion therapy efforts with gender minority youth, nor any benefits of such interventions to children and their families"); Jack Drescher, *Controversies in Gender Diagnoses*, 1 LGBT Health 9, 12 (2013) (no empirical evidence that "discouraging childhood cross-gender interests reduces the frequency of persistence into adolescence and adulthood").

[37] 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.

[38] Hill et al., *An Affirmative Intervention for Families with Gender Variant Children*, *supra*, at 10; 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); Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 26 (explaining that "the potential harms of conversion therapy are suggested by clinicians' observations that the behavioral issues and psychological distress" experienced by gender-dysphoric children "improves markedly when their gender identities and expressions are affirmed").

In the last few decades, transgender people and those suffering from gender dysphoria have gained widespread access to the gender-affirming psychological and medical support that they need.[39] For over 30 years, the generally-accepted treatment protocols for gender dysphoria[40] have been aimed at alleviating the distress associated with the incongruence between gender identity and birth-assigned sex, rather than attempting to force individuals to live in conformance with their natal sex.[41] 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").[42] Many of the major medical and mental health groups in the United States, including the American Medical Association, the American Academy of Pediatrics, and the American Psychological Association, recognize the WPATH Standards of Care as representing the consensus of the medical and mental health community regarding the appropriate treatment for gender dysphoria.[43]

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[39] Am. Psychol. Ass'n Guidelines, *supra*, at 835; WPATH Standards of Care, *supra*, at 8-9.

[40] 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.

[41] Am. Med. Ass'n, Comm. on Human Sexuality, *Human Sexuality* 38 (1972).

[42] WPATH Standards of Care, *supra*.

[43] 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.

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.[44] However, there is no one-size-fits-all approach to treating gender dysphoria, and

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[44] 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); Hidalgo et al., *The Gender Affirmative Model*, *supra*; AAP Technical Report, *supra*, at 307-09; Stanley R. Vance et al., *Psychological and Medical Care of Gender Nonconforming Youth*, 134 Pediatrics 1184, 1190 (2014). 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 such as the American Medical Association and the American Academy of Pediatrics 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=%2FAMADoc%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*.

each patient requires an individualized treatment plan that accounts for the patient's specific needs.[45]

For many transgender individuals with gender dysphoria, social transition is a critically important part of treatment. It involves interacting with others and living one's life fully in accordance with one's gender identity. 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.[46] 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.[47]

For some adults and adolescents, hormone treatment to feminize or masculinize the body may be medically necessary to treat their gender dysphoria.[48]

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[45] Am. Psychol. Ass'n Task Force Report, *supra*, at 32.

[46] AAP Technical Report, *supra*, at 308; Am. Psychol. Ass'n Guidelines, *supra*, at 840.

[47] Lily Durwood et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. Child & Adolescent Psychiatry 116 (2017); Olson et al., *Mental Health of Transgender Children Who Are Supported in Their Identities*, *supra*.

[48] 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*

Both the Endocrine Society and the Lawson Wilkins Pediatric Endocrine Society consider these treatments to be the standard of care for gender dysphoria.[49] 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; just as they would in any other boy, these hormones will affect most of his major body systems.[50] 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.[51] For children experiencing the onset of puberty, treatment may include medication to prevent further progression of puberty, referred to as puberty blockers.[52] This fully reversible treatment allows these children to delay the

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Nonbinary People 23 (2d ed. 2016); WPATH Standards of Care, *supra*, at 33, 54.

[49] *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).

[50] Hembree et al., *Endocrine Treatment of Transsexual Persons*, *supra*, at 3132-33; *see also* Brill & Pepper, *The Transgender Child*, *supra*, at 217.

[51] Hembree et al., *Endocrine Treatment of Transsexual Persons*, *supra*, at 3140-45.

[52] *Id.* at 3138.

development of secondary sex characteristics that do not match their gender identity, and gives them additional time to decide whether hormone treatment to feminize or masculinize the body is appropriate.[53] These drugs have been used to treat precocious (early) puberty since 1981 without adverse effects.[54]

Surgical interventions may also be an appropriate and medically necessary treatment for some patients. These procedures could include, among other things, chest reconstruction surgery for transgender men, breast augmentation (*i.e.* implants) for transgender women, or genital surgery.[55] Studies show these procedures are effective in reducing gender dysphoria and improving mental health.[56] Because these surgical

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[53] *Id.* at 3133, 3140-41; Am. Psychol. Ass'n Guidelines, *supra*, at 842; WPATH Standards of Care, *supra*, at 18-20.

[54] Annelou L.C. de Vries et al., *What the Primary Care Pediatrician Needs to Know About Gender Incongruence and Gender Dysphoria in Children and Adolescents*, 63 Pediatrics Clinics N. Am. 1121 (2016). Long-term health effects from the use of puberty blockers for gender dysphoria are currently unknown. *Id.*

[55] Hembree et al., *Endocrine Treatment of Transsexual Persons*, *supra*, at 3148-49; *see also* WPATH Standards of Care, *supra*, at 57-58.

[56] 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); Griet De Cuypere et al., *Sexual and Physical Health after Sex Reassignment Surgery*, 34 Arch. Sexual Behav. 679 (2005); Annelou L.C. de Vries, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014); Mohammad Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 Clinical Endocrinology 214 (2010).

procedures are largely irreversible, some are recommended only for transgender individuals who have reached the age of legal majority.[57]

As noted above, guidelines for each of these treatment options emphasize that treatment should be based on each patient's "specific clinical situation,"[58] including their individual medical needs or contraindications.[59] Ultimately—regardless of the particular treatments required for the individual and when such treatment begins—the goal is for individuals with gender dysphoria to experience "identity integration," where "being transgender is no longer the most important signifier of one's identity" and the individual can refocus on their relationships, school, jobs, and other life activities.[60] Thus, the aim in treating gender dysphoria is to reduce the debilitating distress associated with living as the "wrong" gender and enable the patient to live a full and productive life.

Some who oppose the medical protocols for gender dysphoria—including *amici curiae* Dr. Paul R. McHugh et al. in support of Petitioner—claim that supporting gender transition by young people is harmful because they say studies show most gender dysphoric children "desist" and ultimately have a gender identity that

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[57] WPATH Standards of Care, *supra*, at 21.

[58] *Id.* at 21 (adolescent clinical needs), 54-56 (adult clinical needs).

[59] Am. Psychol. Ass'n Task Force Report, *supra*, at 38; WPATH Standards of Care, *supra*, at 39-40, 97-103.

[60] 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).

matches their sex assigned at birth.[61] In fact, studies indicate that children who actually are transgender—those who persistently, consistently, and insistently identify as a gender other than their sex assigned at birth (as opposed to children who are gender non-conforming)—are unlikely to desist.[62] Moreover, *amici*

[61] Brief of *Amici Curiae* Dr. Paul R. McHugh, M.D., et al. in Support of Petitioner at 12.

[62] *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) (describing findings consistent with "earlier studies showing that young adolescents who had been carefully diagnosed show persisting gender dysphoria into late adolescence or young adulthood"); 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) (observing that "persisters explicitly indicated they felt they *were* the other sex" and that their dysphoria intensified during early adolescence); 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) (showing that more intense gender dysphoria led to increased rates of persistence). The research relied on by opponents of the standard protocols showing high levels of desistence 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 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) (explaining that prospective

McHugh et al. conflate the vastly different experiences of pre-pubertal children and adolescents.[63] There is no evidence that adolescents, like Respondent, whose gender identities do not match their birth-assigned sex, are likely to desist.[64]

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

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studies of children with gender dysphoria "did not use the fairly strict criteria of the DSM-5, and children could receive the diagnosis based only on gender-variant behavior" meaning that had these studies relied on the narrower "DSM-5 criteria, the persistence rate probably would have been higher").

[63] The McHugh et al. brief 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").

[64] 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.

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 Physical And Mental 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.[65] As described below, 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. Such exclusionary policies undermine well-established treatment protocols for gender dysphoria and exacerbate the condition; expose these individuals to stigma and discrimination as well as potential harassment and abuse by singling them out from their peers; harm their physical health by causing them to avoid restroom use; and impair their social and emotional development, leading to poorer health outcomes throughout life.

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 their gender identity. *Amici* are not hearing from their physician and therapist members about

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[65] APA/NASP Resolution, *supra*, at 9.

students experiencing any such harm—even though numerous states and school districts, covering hundreds of thousands of individuals, have policies allowing transgender individuals to use restrooms that match their gender identity. While some students may feel uncomfortable with the idea of sharing common restrooms with transgender students, just like they might feel uncomfortable with common restrooms for any number of reasons, there is no legitimate basis to fear physical or psychological harm.

Schools like Gloucester High School often provide private restrooms for any student who seeks greater privacy for any reason. But there is a difference in the psychological impact of freely using private restrooms available for any student who chooses to use them and transgender students being forced into private restrooms because others are uncomfortable with who they are. The latter sends a clear and stigmatizing message to the student that he or she is not a welcome member of the community. It is this message that can have a lasting and damaging impact on the health and well-being of the young person.

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.[66] Rather than supporting

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[66] *See, e.g.*, Sam Winter et al., *Transgender People: Health at the Margins of Society*, 388 Lancet 390, 394 (2016).

transgender persons to express their gender identity—as medical protocols suggest—exclusionary policies disregard transgender individuals' gender identity and force them to attempt to do so as well, thus exacerbating gender dysphoria and contributing to the distress it causes. Like the misguided treatments of the past that attempted to "correct" an individual's gender identity, exclusionary policies reflect an outdated view that is inconsistent with current medical knowledge and practice regarding gender dysphoria and its treatment.

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 16-21, 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.[67] Those risks are already all too serious: in a comprehensive 2015 survey of over 27,000 transgender individuals, 40 percent reported a suicide attempt—a

[67] APA/NASP Resolution, *supra*, at 4.

rate *nine times* that reported by the general U.S. population.[68]

B. Exclusionary Policies Expose Transgender Individuals To Harassment And Abuse In Gender-Segregated Spaces.

Exclusionary policies expose transgender individuals to harassment and abuse by forcing them to occupy gender-segregated spaces where their presence may be jarring or unwelcome at best—or, at worst, 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 transgender individuals, and only transgender individuals, who are required by these policies to use facilities that are incongruent with their gender identity and how they live and are recognized in the world (or to use separate facilities not used by other students—which likewise calls attention to and raises questions about them). That is particularly so since some children will have transitioned before they arrive in a particular school environment—and thus exclusionary policies may be the only way that they are forcibly "outed" to their peers as transgender.

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[68] James et al., Nat'l Center for Transgender Equality, *Report of the 2015 U.S. Transgender Survey*, *supra*, at 114.

Such compelled disclosure of one's transgender status is harmful for at least two reasons. First, as the American Academy of Pediatrics has recognized, control over the circumstances in which a person may choose to disclose being transgender is fundamental to the development of individuality and autonomy.[69] Exclusionary policies rob transgender individuals of the personal choice regarding whether and when to reveal their transgender status, forcing them to give up their privacy and dignity. Particularly given the hostility that remains in society towards transgender individuals, disclosure of one's status as transgender is often anxiety-inducing and fraught; it is critical to a person's sense of safety to have control over when and how that information is shared.

Second, and relatedly, such compelled disclosure presents a significant safety risk for transgender individuals by exposing them to harassment or abuse because of their transgender status. In a 2013 survey of transgender individuals, fully 68 percent of 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.[70]

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[69] 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/AAPOpposesLegislationAgainst TransgenderChildren.aspx.

[70] 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).

These harms affect youth and adults alike. As the American Psychological Association and the National Association of School Psychologists state, "many gender and sexual orientation diverse children and adolescents experience harassment, bullying, and physical violence in school environments."[71] Because unwanted disclosure may cause such significant harm, the American Academy of Pediatrics' guidance explicitly forbids pediatricians from sharing a patient's transgender status with others.[72] 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."[73]

C. Exclusionary Policies Exacerbate Stigma And Discrimination, Leading To Negative Health Outcomes.

It is well documented that transgender individuals experience widespread prejudice and discrimination in every aspect of life, including employment, education, health care, housing, transportation, places of public accommodation, police protection, courts, and government benefits programs—and that this discrimination frequently takes the form of violence,

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[71] 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).

[72] AAP Technical Report, *supra*, at 305.

[73] Am. Acad. of Pediatrics, *American Academy of Pediatrics Opposes Legislation that Discriminates Against Transgender Children*, *supra*.

harassment, or other abuse.[74] 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.[75]

Exclusionary policies perpetuate such stigma and discrimination, not only by forcing transgender individuals to disclose their status, but by marking transgender individuals as "others" who are unfit to use the restrooms used by everyone else. Indeed, the very existence of exclusionary policies targeting transgender individuals fosters stigma and discrimination. Such policies inherently convey the state's judgment that transgender individuals are different and entitled to inferior treatment than cisgender individuals. This is the essence of stigma. A stigmatized condition or status is one that is negatively valued by a society—a "differentness" manifested in social institutions, including the law, and in individual behaviors.[76] Laws that accord the majority and minority groups different

[74] 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.

[75] 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).

[76] Erving Goffman, *Stigma* 5 (1963); Bruce G. Link & Jo C. Phelan, *Conceptualizing Stigma*, 27 Ann. Rev. Soc. 363 (2001); Jennifer Crocker et al., *Social Stigma, in* 2 *The Handbook of Social Psychology* 504 (Daniel T. Gilbert et al. eds., 4th ed. 1998).

status accentuate the perceived "differentness" of the minority and thereby legitimize prejudicial attitudes and individuals acts against the disfavored group, including ostracism, discrimination, and violence.

It is therefore to be expected that exclusionary policies will result in worse health outcomes for transgender individuals. Research increasingly shows that stigma and discrimination can have deleterious health consequences,[77] including striking effects on the daily functioning and emotional and physical health of transgender persons.[78] 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.[79] Another study concluded that "living in states with discriminatory policies . . . was associated with a statistically significant increase in the number of psychiatric disorder diagnoses."[80] And a third study demonstrated that past school victimization may result in greater risk for post-traumatic stress disorder,

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[77] *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.

[78] *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").

[79] Randi Ettner et al., *Secrecy and the Pathophysiology of Hypertension*, Int'l J. Family Med. (2012).

[80] Bradford et al., *Experiences of Transgender-Related Discrimination and Implications for Health*, *supra*, at 1827.

depression, anxiety, and suicidality.[81] 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."[82] 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 for their health and well-being. In a society in which the vast majority of restroom facilities are segregated by gender, 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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[81] Toomey et al., *Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth*, *supra*, at 1581.

[82] 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).

In and of itself, this difficult choice causes transgender individuals to experience heightened anxiety and distress around restroom use, which may make it difficult for them to concentrate or focus at school or at work and potentially cause them to eschew social activities or everyday tasks.[83] 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.[84]

Studies also show that it is common for transgender students to avoid using restrooms.[85] But avoidance of the restroom 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.[86]

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[83] Herman, *Gendered Restrooms and Minority Stress*, *supra*, at 75.

[84] Kristie L. Seelman, *Transgender Adults' Access to College Bathrooms and Housing and the Relationship to Suicidality*, 63 J. Homosexuality 1378, 1388-89 (2016).

[85] Am. Psychol. Ass'n Guidelines, *supra*, at 840.

[86] 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; *see also* Frank Hinman, Jr., *Nonneurogenic Neurogenic Bladder (The Hinman Syndrome)—15 Years Later*, 136 J. Urology 769 (1986); Alon Y. Mass et al., *Taxi Cab Syndrome:*

Some transgender students experiencing fear and anxiety about restroom usage may attempt to dehydrate themselves so that they will need to urinate less frequently.[87] 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.[88]

These negative outcomes are not alleviated by forcing students into separate single-user restrooms. Being forced to use separate facilities creates many of the same harms outlined above, including forced disclosure of one's transgender status and 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 just to find the opportunity to go to the restroom. Separate restrooms thus do not alleviate the anxiety, fear, or negative health consequences that result from exclusionary bathroom policies.

A Review of the Extensive Genitourinary Pathology Experienced by Taxi Cab Drivers and What We Can Do To Help, 16 Rev. Urology 99 (2014); Asnat Groutz et al., *Learned Voiding Dysfunction (Non-Neurogenic, Neurogenic Bladder) Among Adults*, 20 Neurourology & Urodynamics 259 (2001); 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).

[87] Herman, *Gendered Restrooms and Minority Stress*, *supra*, at 75.

[88] Lawrence E. Armstrong, *Challenges of Linking Chronic Dehydration and Fluid Consumption to Health Outcomes*, 70 Nutrition Rev. S121, 122 (2012).

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. When children and adolescents are unable to use facilities consistent with their gender identity, they are more likely to encounter anxiety, distress, stigma, discrimination, harassment, or abuse.

Such discrimination and harassment of children and adolescents in their formative years is particularly harmful because it may have effects that linger long *after* they leave the school environment. Unsurprisingly, unwelcoming school environments produce particularly poor educational outcomes for transgender individuals.[89] Poorer educational outcomes, standing alone, may lead to lower lifetime earnings and an increased likelihood of poorer health outcomes later in life.[90]

Moreover, and as already discussed, exclusionary policies may produce and compound the stigma and discrimination that transgender children and

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[89] *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).

[90] *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.

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—even after students have left school.[91]

Conversely, evidence demonstrates that a safe and welcoming school environment may promote positive social and emotional development and health outcomes. Numerous studies show that safer school environments lead to *reduced* rates of depression, suicidality, or other negative health outcomes.[92]

* * *

With appropriate support, transgender youth can become happy and productive adults who contribute much to our society. Schools can and should be safe, supportive environments in which the growth and development of both transgender and cisgender children is fostered and encouraged. By making schools into places of stress and conflict rather than welcoming spaces, exclusionary policies worsen stigma and

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[91] Toomey et al., *Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth*, *supra*, at 1581; *see also* APA/NASP Resolution, *supra*, at 6.

[92] AAP Technical Report, *supra*, at 301, 302, 304-05; *see, e.g.*, Michelle Birkett et al., *LGB and Questioning Students in Schools: The Moderating Effects of Homophobic Bullying and School Climate on Negative Outcomes*, 38 J. Youth Adolescence 989 (2009); 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).

discrimination against transgender students, causing myriad harms to their health, safety, and overall well-being. Exclusionary policies therefore disserve and endanger transgender students.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge this Court to affirm the judgment below.

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APPENDIX

APPENDIX: ADDITIONAL *AMICI CURIAE*

The **American Academy of Child and Adolescent Psychiatry** ("AACAP") has over 9,200 child and adolescent psychiatrist members and is committed to the advancement of science. AACAP partners with its members in advocacy efforts to improve policies and services for children and adolescents with mental illness.

The **American Academy of Family Physicians** ("AAFP") is the national medical specialty society representing family physicians and has 124,900 physician and medical student members. The AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and serving the needs of its members.

The **American Academy of Nursing** serves the public and nursing profession by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. The Academy is committed to ensuring dignified and respectful health care for all persons, regardless of sexual orientation or gender identity.

The **American Academy of Physician Assistants** ("AAPA") represents more than 115,500 certified PAs in the United States and provides advocacy and educational benefits on behalf of the profession and the patients served by PAs.

The **American Medical Student Association** ("AMSA") represents nearly 40,000 physicians in training and is the oldest and largest independent association of physicians-in-training in the United States. AMSA is committed to improving health care and health care delivery to all

people; promoting active improvement in medical education; involving its members in the social, moral, and ethical obligations of the profession of medicine; assisting in the improvement and understanding of world health problems; contributing to the welfare of medical students, premedical students, interns, residents, and post-MD/DO trainees; and advancing the profession of medicine.

The **American Medical Women's Association** focuses on the advancement of women within the medical profession and the improvement of women's health. Its members include physicians, medical students, and allied health care professionals.

The **American Nurses Association** ("ANA") represents the interests of the nation's 3.6 million registered nurses. With members in every state, ANA is comprised of state nurses associations and individual nurses. ANA is an advocate for social justice with particular attention to preserving the human rights of vulnerable groups, such as the poor, homeless, elderly, mentally ill, prisoners, refugees, women, children, and socially stigmatized groups.

The **American Psychoanalytic Association** is the oldest and largest national psychoanalytic membership organization, with more than 3,500 members. It believes that bias against individuals based on gender identity or gender expression negatively affects the mental health of those individuals, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice.

The **American Public Health Association** ("APHA") champions the health of all people and all communities and strengthens the profession of public health. APHA represents 25,000 individual members and is the only organization that combines a 140-plus year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

The **Association of Medical School Pediatric Department Chairs** seeks to improve the health and well-being of children through the development of the chairs of academic pediatric departments and support of their clinical, research, education, and advocacy missions. The Academic Pediatric Departments lead in care delivery, research, training, and advocacy in their communities and throughout the world.

The **Endocrine Society** is the oldest and largest global professional membership organization representing the field of endocrinology. Our more than 18,000 members care for patients and are dedicated to advancing hormone research and excellence in the clinical practice of endocrinology, focusing on diabetes, obesity, osteoporosis, infertility, rare cancers and thyroid conditions.

GLMA: Health Professionals Advancing LGBT Equality ("GLMA") is the largest and oldest association of lesbian, gay, bisexual, and transgender (LGBT) healthcare professionals, including physicians, physician assistants, nurses, psychologists, social workers, and other health disciplines. Founded in 1981, GLMA (formerly known as the Gay & Lesbian Medical Association) works to ensure equality in healthcare for LGBT individuals and equality for healthcare

professionals, using the medical and health expertise of GLMA members in public policy and advocacy, professional education, patient education and referrals, and the promotion of research.

Mental Health America ("MHA") is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans. MHA is committed to promoting mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated care, services, and support for those who need it, with recovery as the goal.

The **National Association of Social Workers** ("NASW") is the largest association of professional social workers in the United States, with over 120,000 members. NASW recognizes the considerable diversity in gender expression and identity among our population groups. NASW views discrimination and prejudice directed against any individual on the basis of gender identity or gender expression to be damaging to the social, emotional, psychological, physical, and economic well-being of the affected individual, as well as to society as a whole.

The **Pediatric Endocrine Society** ("PES") is the leading professional society for its specialty in the United States. The PES, with more than 1,300 members, is dedicated to promoting the endocrine health of all children and adolescents, including those that are transgender. PES is a co-sponsor of the Endocrine Society's clinical practice guidelines for transgender

individuals, which promote a gender-affirmative model of care.

The **Society for Adolescent Health and Medicine** is a multidisciplinary organization that promotes optimal health and well-being for all adolescents and young adults through advocacy, clinical care, health promotion, health service delivery, professional development, and research.

The **Society for Physician Assistants in Pediatrics** ("SPAP") has approximately 350 members who share a common interest in pediatric medicine. The mission of SPAP is to improve the health care of children by supporting Physician/PA teams who provide cost effective, quality care to pediatric patients and by promoting a network for communication and education between providers dedicated to the well-being of children.