STATE OF WISCONSIN CIRCUIT COURT DANE COUNTY

JOHN AND JANE DOE 1, ET AL.,

Plaintiffs,

v. CASE NO. 20-CV- 454

MADISON METROPOLITAN SCHOOL DISTRICT

Defendant.

REBUTTAL EXPERT AFFIDAVIT OF
DR. STEPHEN B. LEVINE, M.D.

Rebuttal Expert Affidavit of Dr. Stephen B. Levine, M.D.

1. I provided an Expert Affidavit dated February 10, 2020. (The "Levine Affidavit".)

2. I have reviewed the Expert Affidavit of Dr. Scott Leibowitz dated August 5, 2020 ("Leibowitz Aff."), and I provide this Rebuttal Affidavit to provide certain observations on assertions that Dr. Leibowitz makes in that report.

A. Dr. Leibowitz's analysis fails to give adequate attention to the long-term health and well-being of the child who struggles with gender identity.

3. Dr. Leibowitz attempts to cast doubt on my experience and expertise with respect to gender identity, gender dysphoria, and treatment of individuals dealing with gender issues. I believe—and other courts have found (Levine Aff. ¶¶ 5-6)—that my more than 45 years of experience working in this area, as detailed in my initial Affidavit and accompanying CV, amply establish my expertise. (Levine Aff. ¶¶ 1-7.) In addition to the experience, positions, and publications listed there, I will observe that within the previous 12 months four child psychiatry fellows from two Cleveland institutions have been under my supervision and instruction in my work setting.

4. Importantly, my work in this area has included directly working with, or consulting concerning, children, adolescents, young adults, and older adults who are suffering from gender dysphoria or struggling with less acute gender issues. My observations as to how life unfolds for these individuals at various stages of life, and over the long run, and my attention to the scientific literature as it concerns gender issues in all ages, inform my professional views in this area. Specifically, my wide experience across multiple stages of the lives of patients has led me to my strongly-held view that the mental health professional treating a young person who is struggling with gender issues must—as a matter of professional ethics—take the "life course" perspective that I have already described, rather than merely aiming to make the patient as happy as possible in the present moment. (See Levine Aff. ¶¶ 128-130.)

5. By contrast, Dr. Leibowitz's CV suggests that he has been working in the area of gender dysphoria for about 10 years, and that his work has been entirely or almost entirely confined to children and adolescents. I am concerned that this narrow perspective at some points permits him to fall into a short-term perspective that fails to give adequate weight to the long-term well-being of the patient. For example, as I have detailed, multiple studies suggest that affirmation of a transgender identity in children or adolescents strongly correlates with persistence in a transgender identity, and that the increased popularity of rapid and wide affirmation of transgender identities in young people is in fact radically reducing the number of children who "desist" from gender dysphoria and achieve comfort with an identity aligned with their biological sex. (Levine

Aff. ¶¶ 60-65.) Given these facts, and given that persistence into adolescence and young adulthood very commonly involves hormonal intervention,[1] I consider Dr. Leibowitz's casual dismissal of consideration of the risks associated with hormone therapy as "irrelevant" to decisions about whether to permit a child to socially transition (including by using a name and pronouns associated with the opposite sex) (Leibowitz Aff. ¶ 35) to be severely misguided, and inconsistent with a responsible analysis of the long-term interests of children who question their gender identity. He ignores the ethical problems inherent in affirmation of the young. (See Levine Aff. ¶¶ 121-139.)

B. It is not true that individuals who live under transgender identities widely experience happy and healthy lives.

6. Dr. Leibowitz heads the first section of his report, "Gender Dysphoria is a naturally occurring variation in the human experience." The statement is uninformative and perhaps misleading: different hair or skin colors are "naturally occurring variations in the human experience"; unfortunately, but so are bipolar disorder, schizophrenia, and cancer. Some naturally occurring variations are positive, some are neutral, some are harmful and pathological, and some affect different individuals in different ways. The question of which natural variations are healthy, and which are pathological, must be evaluated for purposes of scientific mental health care based on outcomes, not ideology.

7. Dr. Leibowitz attempts to suggest that modern psychiatry does not view gender dysphoria as pathological. (Leibowitz Aff. ¶ 11) However, I note that despite a name change in DSM-5, the decision was made to retain the condition—and its diagnostic criteria—in this manual, which is the "Diagnostic and Statistical Manual *of Mental Disorders*." The DSM-5 does not contain diagnostic criteria for identifying benign "natural variations" such as, for example, having an extroverted or introverted personality type. Gender dysphoria is accepted by the profession as pathological, and is characterized by "clinically significant distress" and impairment of social, educational, relational or vocational function. It is not a healthy and harmless "variation."

8. Dr. Leibowitz asserts that "transgender people, when supported . . . live highly productive, satisfying, and emotionally-fulfilling lives." (Leibowitz Aff. ¶ 12) Dr. Leibowitz provides no citation for this sweeping assertion. Unfortunately, as I have detailed at length in my initial Affidavit, with extensive citations to peer-reviewed studies by multiple groups of researchers across many years from many different countries, the contrary is true for many individuals. Both adolescents and adults living transgender identities, whether with or without the aid of hormonal or surgical intervention, suffer

[1] For example, in a retrospective study conducted at the gender clinic in Leiden, the Netherlands, T. Brik et al. (2020), *Trajectories of Adolescents Treated with GnRHa for Gender Dysphoria*, ARCHIVES OF SEXUAL BEHAVIOR, doi.org/10.1007/s10508-020-01660-8, reported that of children in their study set who experienced gender dysphoria and persisted in that dysphoria into adolescence, the large majority "subsequently started treatment with gender-affirming hormones."

severely disproportionate mental health problems as compared to the general population. (Levine Aff. ¶¶ 21, 90-91, 95, 105, 114.) A very recent study replicates this same finding.[2] Nowhere in the literature is there any documentation of the rate of "productive, satisfying, and emotionally fulfilling" lives among individuals living in transgender identities nor, more importantly, are there agreed-upon criteria for making these three separate assessments. Instead, Dr. Leibowitz's assertion represents nothing more than a faith-based belief that those who recommend hormones and surgery wish to believe about their interventions.

9. Indeed, I note that Dr. Leibowitz does not dispute the reality and severity of *any* of the risks and costs that I have detailed as associated with adopting and continuing life in a transgender identity. These include adverse impacts on physical and mental health, on social and family relationships, and (where hormonal or surgical change is ultimately pursued) loss of fertility and all that follows from becoming a parent and grandparent. (Levine Aff. ¶¶ 98-120.) Apparently, even though these consequences are reasonably foreseeable, and have demonstrably been experienced by many adult transgender individuals, Dr. Leibowitz considers them "irrelevant" because they are not immediate. I do not consider them irrelevant.

10. Dr. Leibowitz criticizes the often-cited article by Dhejne et al. (2011) that reported high rates of suicide, mortality, cancer, drug use, and psychiatric disorders among post-surgical transgender adults (*see* Levine Aff. ¶ 91) as lacking any "control group." (Leibowitz Aff. ¶ 28.) This is an odd criticism of this study, for multiple reasons. First, this article reports on the most thorough long-term follow-up study ever done of individuals who have undergone sex reassignment surgery, comes from a respected center of transgender medicine and set of authors, and is widely cited in the literature. Second, the authors carefully describe their process for selecting two different "control

[2] In addition to the several articles cited in my initial Affidavit, a recent study found that compared to the general population, after adjustment for sociodemographic factors, "those diagnosed with gender incongruence were about six times as likely to have had a health care visit due to mood or anxiety disorder in 2015, more than three times as likely to have received prescriptions for antidepressant and anxiolytic medication in 2015, and more than six times as likely to have been hospitalized after a suicide attempt." Branstrom & Pachankis, *Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries*, AM. J. PSYCHIATRY, 4: Doi: 10.1176/Appi.Ajp.2019.19010080. More recently, after multiple critiques of their methodology prompted the editor of the Am. J. Psychiatry to request two different statisticians to re-look at the methodology, Branstrom & Pachankis retracted their assertion that gender-affirming surgery improved mental health outcomes, stating that they found "no significant difference" in mood disorders or hospitalization for suicide attempt, and *higher* rates of anxiety disorders, among individuals diagnosed with "gender incongruence" who underwent gender-affirming surgery, as compared to those who did not. Branstrom & Pachankis, *Toward Rigorous Methodologies*, AM. J. PSYCHIATRY 177:8, August 2020.

groups," which enabled the authors to compare the health of this population against controls otherwise comparable to the study group in age and sex. Third, Dr. Leibowitz himself consistently asserts as "facts" opinions based on articles reflecting far less rigorous study methodology than that used by Dhejne et al. (2011), and indeed he declares that it would be "unethical" to do a controlled study of the impact of social transition on the gender identity outcome of children. (Leibowitz Aff. ¶ 25.) Dr. Leibowitz demands "controls" to dismiss respected studies that are inconsistent with his preferred theories, but when it comes to defending his own opinions, he flips and dismisses controlled studies as "unethical" and impossible.

C. A child's expression of desire to use names and pronouns associated with the opposite sex is an indicator that calls for evaluation by a mental health professional, not blind affirmation by educators.

11. Dr. Leibowitz observes that a desire to adopt a transgender name and pronouns does not necessarily mean that a child suffers from gender dysphoria as defined in DSM-5. (Leibowitz Aff. ¶ 13, 43.) This is correct. However, such a desire does not reflect normal gender identity formation (Levine Aff. ¶ 10), and as I explained in my initial Affidavit, it is well recognized as a "yellow flag" that calls for evaluation of the child by a knowledgeable MHP. (Levine Aff. ¶¶ 71-79.) For example, "the Endocrine Society guidelines recommend that children and adolescents with gender concerns" should undergo a thorough diagnostic analysis by a MHP with appropriate expertise. (*See* Levine Aff. ¶ 75 n. 25, quoting Shumer & Nokoff (2016).) The time for a thorough evaluation and diagnosis is when *some* signs of potential pathology are detected—not after one is already sure of the diagnosis.

12. Recognizing this desire as a sign that calls for the involvement of a MHP is all the more important given the repeated finding that children and youths who experience gender dysphoria suffer high rates of psychiatric illness and other isolating factors. (Levine Aff. ¶¶ 21, 35.)

13. Dr. Leibowitz suggests that it is harmless and appropriate for school authorities to conceal this "yellow flag" from parents because children or adolescents who suffer from gender dysphoria are likely to exhibit other signs of distress which will adequately warn parents to seek the intervention of a MHP. (Leibowitz Aff. ¶ 45.) This suggestion is irresponsible. Unfortunately, as is regularly observed after a teen suicide, it is too often the case that parents as well as school staff fail to recognize signs of emotional or psychiatric distress in the adolescent . If a teacher or other school authority becomes aware of a potential indicator of mental pathology, he or she cannot safely assume that that some other indicator will come to the parents' attention and prompt them to seek professional help.

14. Dr. Leibowitz asserts that "outside the school setting, it is a well-established clinical practice" when working with minors to keep from parents information that the minor "ask[s] the provider not to share with their family." (Leibowitz

Aff. 50.) This is both irrelevant and inaccurate. First, this is irrelevant because school is not a "clinical" setting or relationship, and teachers and school administrators are not mental health "providers" and are not qualified to make "clinical" decisions. Second, with rare exceptions a "clinical setting" and confidential doctor/patient relationship between a minor and a psychiatrist or psychologist cannot exist without the knowledge and consent of a parent. Third, what Dr. Leibowitz describes is decidedly *not* the practice with regard to younger children. Whether it could be ethical for a MHP to conceal from parents a matter as consequential as an adolescent's wish to adopt a transgender identity (absent general permission from the parents to keep the child's "confidential" disclosures secret from the parents) is doubtful. A MHP has no general authority or duty to keep important information about a minor patient secret from the parent or guardian simply upon the request of the minor.

15. Dr. Leibowitz nowhere disagrees with my opinion that patients who present with gender identity issues "differ widely and must be considered individually." (Levine Aff. Section III, ¶¶ 54-59.) Nor does he anywhere assert that social transition is the right clinical choice for each child who has questions about his or her gender identity. Yet the Madison Policy is inconsistent with this truth, requiring all school staff to use transgender names and pronouns and otherwise "affirm" students of any age in a transgender identity upon the request of the child, without any diagnosis, assessment or therapeutic prescription by any mental health professional.

D. <u>Use of names and pronouns associated with the opposite sex is a psychotherapeutic intervention that changes gender identity outcomes for many children.</u>

16. Dr. Leibowitz asserts that social transition in the form of using a different name or pronouns "does not constitute a medical treatment." (Leibowitz Aff. ¶ 30.) As I have explained, gender dysphoria is a psychiatric, not a "medical," diagnosis, and is only described and specified in the psychiatric DSM. (Levine Aff. ¶ 24.) With that said, Dr. Leibowitz clearly agrees with my view that use by a child of names and pronouns associated with the opposite sex can constitute, or be part of, an impactful *psychiatric* treatment. For example, Dr. Leibowitz refers to use of transgender name and pronouns as part of social transition, which he describes as "a useful and important tool used by clinicians" in the diagnostic process (Leibowitz Aff. ¶ 22), he opines that assuming a different gender identity "may . . . be helpful" in improving "mental health outcomes" for some children (Leibowitz. Aff. ¶ 25), he asserts that use of a transgender name at school "reduces depressive symptoms, suicidal ideation, and suicidal behavior" (Leibowitz Aff. ¶ 36), and he asserts that use of transgender names and pronouns is "beneficial to [the child's] . . . psychological development." (Leibowitz. Aff. 57.)

17. In other words, Dr. Leibowitz attempts to persuade the Court that a school practice of using transgender names and pronouns upon the request of children and adolescents is important to the psychiatric health of students, while simultaneously

denying that the practice is a component of a psychiatric course of therapy. It is, and as I have explained, there is strong reason to believe that it is an impactful therapy.

18. Dr. Leibowitz accuses me of confusing correlation with causation. (Leibowitz Aff. ¶ 23.) I do not. However, given the fact that the rapid spread of quickly "affirming" therapeutic practices has coincided with an extraordinarily sharp drop in "desistance" from gender dysphoria in children and adolescents (Levine Aff. ¶¶ 60-65), it is reasonable and appropriately cautious for the mental health professional to hypothesize that the adoption of a trans-sex identity by a child does indeed in many cases *cause* children to persist in a transgender identity on into young adulthood at least, rather than desisting. Guss et. al., whom I previously cited, take precisely this view, inquiring into the "*effect* of childhood social role transitioning on later persistence," and speaking of the "possible *impact* of the social transition itself" on the child's "gender identity or persistence." Guss (2013). Other researchers in the field looking at the available data have likewise hypothesized a causal relationship. (Levine Aff. ¶ 65.)

19. Putting on one side the question of causation, I note that Dr. Leibowitz does not dispute the findings of multiple authors, summarized in my Affidavit, that prior to the widespread adoption of "social transition" and "affirmation" as a response to gender dysphoria in children, the overwhelming majority of such children "desisted" prior to adulthood and resolved to comfort with the gender identity consistent with their biological sex. Nor does he dispute the early reports of multiple authors that desistance is rare among children who undergo social transition. (Levine Aff. ¶¶ 60-65.)

E. <u>Multiple considerations and authorities demand family involvement in the decisions and therapy of a child who is dealing with gender issues.</u>

20. I am pleased to see Dr. Leibowitz's description of the extensive diagnostic process that he and his colleagues pursue before deciding on a course of action for an individual child brought to their clinic, including investigation of potential genetic predispositions and in utero exposure to drugs, family dynamics, and indeed the "entire life experience of the child, adolescent, and family" when "assisting in decision-making relating to gender issues." (Leibowitz Aff. ¶¶ 16-17.) I agree that the answers to these questions—and more—are not just relevant, but vitally important to the decision-making process. (Levine Aff. ¶¶ 25, 71-79.)

21. For this very reason, the Madison District policy of assisting children to engage in social transition before and without their parents' knowledge and involvement ("the Madison Policy") is clinically indefensible. A school cannot, to my knowledge, arrange for a child to be systematically assessed and treated by a mental health professional such as Dr. Leibowitz without the child's guardians' knowledge, agreement, and likely assistance. The educators who staff a school are not trained and capable to undertake the kind of diagnostic process that Dr. Leibowitz describes, and the Madison Policy does not appear to call for such a process. And without the involvement of parents (or in some cases guardians) it will of course not be possible to obtain meaningful

information about family dynamics, genetic predispositions, or in utero drug exposure. The child who is "socially transitioned" by use of opposite-sex name and pronouns without prior notice to parents is almost inevitably deprived of the sort of diagnostic process that Dr. Leibowitz practices and praises.

22. Dr. Leibowitz refers repeatedly to the WPATH organization, and remarks that "There are sections in the WPATH Standards of Care that explicitly state how practitioners should approach children and adolescents." (Leibowitz Aff. ¶ 15.) That is true. Dr. Leibowitz does not quote those sections, however. Perhaps this is because even the recommendations of the controversial WPATH Standards of Care ("SOC"), which I have discussed in my initial affidavit (Levine Aff. ¶¶ 45-53), are sharply contrary to the path adopted by the Madison Policy.

23. First, the SOC prescribes the "roles of mental health professionals" in working with "children and adolescents with gender dysphoria." (SOC p. 14.) If a child's gender dysphoria or gender questioning is concealed from the parents, the child is very unlikely to get the aid of an appropriately trained mental health professional. Because the Policy mandates school staff participation in "social transition" of a child without first obtaining input from a mental health professional who has performed a thorough assessment of that particular child, the Madison Policy is inconsistent with the WPATH SOC.

24. Second, the necessity of the involvement of families in both diagnosis and therapeutic decisions is written all over the WPATH SOC. An initial "assessment should include an evaluation of the strengths and weaknesses of family functioning." (SOC p. 15.) The first *action* called for by the WPATH SOC after diagnosis is that the MHP "provide family counseling." (SOC p. 14.) "Families play an important role in the psychological health and well-being of youth." (SOC p. 15.) "Families should be supported in managing . . . anxiety about their child's or adolescent's psychosexual outcomes." (SOC p. 16.) Obviously none of these steps prescribed by the WPATH SOC are possible if the parents are being kept in the dark. Again, the Madison Policy is irreconcilable with the WPATH SOC.

25. Third, the WPATH SOC recognizes that parents legitimately face "difficult decisions regarding the extent to which [children] are *allowed* to express a gender role that is consistent with their gender identity." The word "allowed" unambiguously reflects a recognition that it will not always be appropriate to allow the child to do what he or she wishes. The question of whether the child will use "a name and pronouns congruent with gender identity" is identified as one of the more *profound* forms of "social transition," and is expressly included among these "difficult decisions." (SOC p. 16.) The Madison Policy violates the WPATH SOC by mandating that acquiescence to the child's wish in this regard is required in every case, for every child, and—in cases where the parents are not informed—by taking this "difficult decision" away from the parents in consultation with the child and a mental health professional.

26. Dr. Leibowitz is correct that several medical professional organizations have endorsed policy statements similar to the WPATH SOC with respect to at least some aspects of treatment of children and adolescents who suffer from gender dysphoria. Like many experienced practitioners in the field, I do not agree with all aspects of these statements. However, I would emphasize that to my knowledge, not a single one of these organizations has endorsed encouraging and aiding children to socially transition before or without the involvement of a mental health professional in the life of the specific child. Not a single one has endorsed the idea that adults responsible for the well-being of children during much of the day (that is, school authorities) should conceal from parents the fact that a child or adolescent is struggling with gender identity, or is living under a transgender identity at school.

27. Dr. Leibowitz expresses concern that some families may not be "supportive" of a child's wish to adopt a transgender identity. (Leibowitz Aff. ¶ 51, 53.) As the WPATH guidelines referenced by Dr. Leibowitz recognize, this is within the range of appropriate parental choices, hopefully in consultation with a mental health professional. Given the data concerning desistance rates and the potential impact of social transition on the likelihood of desistance (Levine Aff. ¶¶ 60-65), it may be the wise choice for many families.

28. An unspoken premise of Dr. Leibowitz's opinions is that children and adolescents are competent to make wise choices about decisions that will mold their own maturation and the formation of their gender identity. This is scarcely even arguable with respect to pre-pubertal children. At many points, Dr. Leibowitz discusses the capabilities and desires of adolescents, but of course neither the Madison Policy nor Dr. Leibowitz's ultimate endorsement of that Policy is restricted to adolescents. Even adolescents have very limited ability to understand the importance of sexual relationships, marriage, and gender roles on their future lives and happiness. (Levine Aff. ¶¶ 128-130, 134-139.) And it is well established from many studies that adolescents chronically fail to appropriately balance short-term desires against their longer-term interests as they make decisions. This is all the more true of children who have grown up in the unstable environment of foster care, who are autistic, or who have other psychiatric illness—populations which unfortunately account for a very disproportionate share of young people who claim transgender identities. (Levine Aff. ¶ 21.) It is for all these reasons that the consent of parents or legal guardians is almost invariably required for even minor medical or psychiatric interventions. The child's request is not enough.

29. Importantly, in my experience, families confronted with a child who is dealing with gender dysphoria or less acute gender issues are very likely to seek the aid of a mental health professional whether or not they are "supportive" of social transition adoption of a transgender identity. And that expert involvement is vitally necessary to the emotional development and well-being of the child and of the family as a whole regardless of whether parents are initially "affirming" or not. Thus, the fact that some parents may not be "supportive" of a child's desire to adopt a transgender identity does not justify concealing that desire from the child's parents. On the contrary, for the reason

I have explained, even in those cases concealment is most likely to be harmful to the child, and to the whole family. (Levine Aff. ¶ 82.)

F. Dr. Leibowitz's assertion that the Madison Policy "harms no-one" is baseless and is likely to be false in many cases.

30. Dr. Leibowitz concludes with a sweeping assertion that the Madison Policy "harms no-one." There are multiple reasons to believe that this is false. As the WPATH SOC recognizes, the decision to use transgender names and pronouns is a "difficult" one that may not be right for some children and families. (See ¶¶ 25 above; WPATH SOC p. 16.)

31. Both by its immediate and unquestioning implementation of social transition, and by its concealment of this consequential and experimental (see Levine Aff. ¶¶ 66-69) step from parents, the Madison Policy is indeed likely to harm the child. Secrecy and a "double-life" concealed from family is profoundly unhealthy for a child or adolescent. (Levine Aff. ¶ 82.) By even asking the question, "Do you want to tell your parents?" the Policy encourages the child into dishonest relationships with his or her parents. When the Madison Policy acts to prevent parents from learning of their child's gender issues, it prevents those parents from obtaining expert mental health evaluation and care for their child. When the Madison Policy assists and enables a child to experience social transition that parents in consultation with a MHP would not have consented to, substantial evidence suggests that the social transition of a child greatly reduces the likelihood that that child will "desist" from transgender identification. (Levine Aff. ¶¶ 60-65.) And as I have detailed, individuals who live a transgender identity into adulthood suffer severely disproportionate mental and medical health outcomes. (See ¶¶ 8-10 above.) These individuals also frequently suffer long-term social isolation and loss of family relationships. (Levine Aff. ¶¶ 108.) Loss of peer relationships is also common. Other teens, who are themselves struggling to understand and establish their own identities as sexual, gendered humans, are not uniformly willing or able to maintain close friendship relationships with trans peers. Rejection, isolation, or avoidance at a stage in life when teens passionately desire to have friends and be included does not appear to be a harmless matter. Friendlessness is recognized as a factor that increases suicidal ideation.

32. The policy is also likely to harm other members of the child's family, since family relationships form an interlinked web. The WPATH SOC rightly recognizes that family members of a young person dealing with gender identity issues are likely to experience "uncertainty and anxiety." (SOC p. 16.) For a child or adolescent to live a secret "double life" is not only unhealthy for the child, but is likely to create emotional alienation between parent and child while the secret is kept and also after it is discovered, an alienation that is likely to be harmful to the parents and to siblings as well.

Dated: August 14, 2020

_____
Dr. Stephen B. Levine

Subscribed and sworn before me this
_____ day of August, 2020.

32. The policy is also likely to harm other members of the child's family, since family relationships form an interlinked web. The WPATH SOC rightly recognizes that family members of a young person dealing with gender identity issues are likely to experience "uncertainty and anxiety." (SOC 16.) For a child or adolescent to live a secret "double life" is not only unhealthy for the child, but is likely to create emotional alienation between parent and child while the secret is kept and also after it is discovered, an alienation that is likely to be harmful to the parents and to siblings as well.

Dated: August 14, 2020

Stephen B. Levine MD

Dr. Stephen B. Levine

Subscribed and sworn before me this
14th day of August, 2020.

Christie Baum

CHRISTIE BAUM, NOTARY PUBLIC
COMM. EXP. 1/25/2021
STATE OF OHIO