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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, by and through her parents and next friends, Penny and Peter Poe; **PENNY POE**; **PETER POE**; **JANE DOE**, by and through her parents and next friends, Joan and John Doe; **JOAN DOE**; **JOHN DOE**,

Plaintiffs,

v.

RAÚL LABRADOR, in his official capacity as Attorney General of the State of Idaho; **JAN M. BENNETTS**, in her official capacity as County Prosecuting Attorney for Ada, Idaho; and the **INDIVIDUAL MEMBERS OF THE IDAHO CODE COMMISSION**, in their official capacities,

Defendants.

Case No. 1:23-cv-00269-CWD

EXPERT DECLARATION OF CHRISTINE BRADY, PhD

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I, Christine Brady, PhD, hereby declare and state as follows:

1. I am over 18 years of age and competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. The opinions expressed herein are my own and do not necessarily express the views or opinions of my employer.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinions.

4. In preparing this declaration, I reviewed Idaho State Legislature House Bill 71 (hereafter "Ban"). My opinions contained in this declaration are based on my training as a psychologist; my clinical experience as a pediatric psychologist, including my experience treating youth and young adults up to age 23 with gender dysphoria; my knowledge of peer reviewed research relevant to the treatment of gender dysphoria; my knowledge of the clinical best practice guidelines set forth by professional organizations for the treatment of gender dysphoria including the World Professional Association for Transgender Health ("WPATH") Standards of Care for the Health of Transgender and Gender Diverse People Version 8 ("SOC 8"), Endocrine Society's the Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline ("Endocrine Society Guideline"), and the American Psychological Association ("APA") Guidelines for Psychological Practice With Transgender and Gender Nonconforming People.

BACKGROUND AND QUALIFICATIONS

5. I am a Clinical Assistant Professor in the Department of Pediatric Endocrinology and Diabetes, and (by courtesy) Psychiatry and Behavioral Sciences at Stanford University School of Medicine. I am the full-time psychologist at the Pediatric and Adolescent Gender

Clinic at Stanford Medicine Children's Health. I provide direct therapeutic service to patients (average of 350 families per year), clinical supervision/training to the psychology graduate program and psychiatry fellowship program, and lectures on gender affirming care to psychology students, residents, and fellows and psychiatry fellows. I also conduct research on cultural considerations related to Asian American Native Hawaii Pacific Islander (AANHPI) gender diverse youth.

6. I received my Bachelor of Science and Master of Arts in Psychology from James Madison University, Harrisonburg, VA. I completed my Ph.D. in Clinical Psychology at Ohio University, Athens, OH in 2014. I completed a year-long Pre-Doctoral Internship at the University of Washington/Seattle Children's Hospital as well as a year-long Post-Doctoral Fellowship at the University of Louisville/Norton Children's Hospital.

7. In 2015, I co-founded and was Co-Director of the Gender Clinic at Hennepin Healthcare in Minneapolis, MN. After a year in Minnesota, I became Co-Director of the Pediatric Gender Clinic at the University of Louisville and was there for three years before coming to Stanford, where I have been working for almost three years. In the eight years I have been working with individuals with gender dysphoria, I have treated over 1,000 youth and families. Currently, 100 percent of my clinical practice are transgender youth. In previous positions, I provided therapy to a wide range of presenting problems including ADHD, depression, anxiety, trauma, and coping with medical illness such as cancer. Thus, I have extensive experience and strong therapeutic skills in working with patients with gender dysphoria as well as other common diagnoses in adolescents and young adults.

8. I am a licensed psychologist in the state of California.

9. I have been a member of WPATH since 2017.

10. Further information about my professional background and experience is outlined in my curriculum vitae, a true and accurate copy of which is attached as **Exhibit A** to this report.

11. I am being compensated at an hourly rate of $250 per hour for preparation of expert declarations and reports, and $400 per hour for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

EXPERT OPINIONS

A. Gender Identity

12. A person's sex is typically assigned at birth based upon the external genitalia observed. A person's assigned or designated sex may or may not align with their gender identity. Transgender or gender diverse individuals have a gender identity that does not align with their assigned sex. Cisgender individuals have a gender identity that does align with their assigned sex.

13. Gender identity is a person's core, internal sense of gender, such as male or female. Every person has a gender identity.

14. Gender identity is not a choice. It is an essential part of one's identity and being. Moreover, gender identity is not something that can be voluntarily changed.

15. Efforts to try to change a person's gender identity through therapy have been shown to be ineffective and harmful. For example, in a survey of transgender adults, those who reported receiving talk therapy aimed at changing their gender identity to match their sex assigned at birth (sometimes referred to as conversion therapy) indicated a lack of effectiveness

of that treatment, higher psychological distress, and increased odds of suicide attempts.[1] The survey found that conversion efforts in children under the age of 10 correlated with a 4-fold increase in attempted suicides.[2] Major U.S. professional medical organizations have therefore published statements warning against the dangers of conversion therapy and their recommendations that it should not be used with transgender individuals (e.g., American Psychological Association, American Medical Association, and American Academy of Child and Adolescent Psychiatry).[3]

B. Diagnosing Gender Dysphoria

16. Gender dysphoria is a clinical diagnosis given to an individual who is experiencing significant symptoms and impairment of function due to the incongruence between their assigned sex and their gender identity. Gender dysphoria (and past iterations of gender dysphoria) was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) in the 1980s (version 3). The diagnosis and its criteria have changed over time to reflect the most current research regarding the presentation of this diagnosis.

17. The current version of the DSM (DSM-5 published in 2013 and DSM-5-TR published in 2022) define gender dysphoria as a "marked difference between the individual's

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[1] Jack L. Turban et al., *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, 77 JAMA PSYCHIATRY 68, 69 (2019).
[2] *Id*. at 68.
[3] AMERICAN PSYCHOLOGICAL ASSOCIATION, APA RESOLUTION ON GENDER IDENTITY CHANGE EFFORTS 1-2 (2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf; AMERICAN MEDICAL ASSOCIATION & GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, SEXUAL ORIENTATION AND GENDER IDENTITY CHANGE EFFORTS (SO-CALLED "CONVERSION THERAPY") 4 (2022), https://www.ama-assn.org/system/files/conversion-therapy-issue-brief.pdf; American Academy of Child & Adolescent Psychiatry, *Conversion Therapy Policy Statement* (Feb. 2018), https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

expressed/experienced gender and the gender others would assign him or her." Symptoms must be present for at least six months, be verbalized externally, and be causing significant impairment in various domains of functioning such as peer relationships, school, or home life. There are different diagnostic criteria for children than there are for adolescents and adults.

18. For pre-pubertal children, DSM-5 diagnostic criteria are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or insistence that one is the other gender (or some alternative gender different from one's assigned gender).

2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire, or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

3. A strong preference for cross-gender roles in make-believe play or fantasy play.

4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.

5. A strong preference for playmates of the other gender.

6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, game and activities.

7. A strong dislike of one's sexual anatomy.

8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social circles, school, or other important areas of functioning.

19. For adolescents and adults, DSM-5 diagnostic criteria are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

20. For adolescents and adults whose gender identity differs from their sex assigned at birth, it is very unlikely that they will later come to identify with their birth-assigned sex. In my experience with over 900 transgender adolescent patients who met the criteria for gender dysphoria, only 6 have later come to identify with their sex assigned at birth (4 had not engaged in medical interventions; 2 had received puberty delaying medications, stopped those medications, and their endogenous puberty resumed; none expressed regret around their gender exploration or care).

21. There is some research on pre-pubertal children that has been described as showing high rates of "desistance" of transgender identity among pre-pubertal children.[4] Because that research included gender-non-conforming children who did not necessarily identify as a sex different than their birth-assigned sex, it can be misleading when used to talk about desistance of transgender identity. In other words, many of these youth did not identify as transgender, would not meet the criteria of gender dysphoria under the current DSM 5 standards, and would not be included in studies of transgender youth today. A more recent study of pre-pubertal transgender children who had socially transitioned (mean age of 8-years-old) reports 2.5% of participants identified with their designated sex at birth five years later (mean age of 13-years-old at follow-up).[5] Moreover, there is no evidence that transgender adolescents are likely to "desist" at high rates. One study found that only 3.5% of adolescents stopped taking puberty blockers because they no longer wished to have gender affirming treatment.[6]

22. Some patients with gender dysphoria may discontinue gender-affirming medical interventions for a variety of reasons, including having achieved their transition goals (e.g., voice deepening, facial hair growth), barriers to accessing care such as lack of insurance, or family or social pressure. Discontinuing care should not be interpreted to mean that the patient has "detransitioned" in the sense of coming to identify with one's birth-assigned sex[7] and there are

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[4] *See, e.g.*, Madeleine S.C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual Outcome of Gender-Dysphoric Children*, 47 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1413, 1413-23 (2008) (investigating which childhood measures of gender behavior related to "desistance").
[5] Kristina R. Olson et. al., *Gender Identity 5 Years After Social Transition*, 150 PEDIATRICS 1, 3 (2022).
[6] Tessa Brik et al., *Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*, 49 ARCHIVES SEXUAL BEHAV. 2611, 2615 (2020).
[7] Jack L. Turban et al., *Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis*, 8 LGBT HEALTH 273, 273-80 (2021).

no studies that have found that such an experience is common among those who receive gender affirming medical care.

C. The Treatment of Gender Dysphoria

23. Being transgender or gender diverse alone is not pathological; a person's gender identity is not a medical condition or the target of treatment. DSM-5 states that treatments for the diagnosis of gender dysphoria should be focused on alleviating the distress/impairment of function stemming from the incongruence between the patient's gender identity and birth-assigned sex, not trying to change the patient's gender identity.

24. Gender dysphoria can be debilitating and cause significant impairment in function. It is well recognized that transgender adolescents and young adults are a vulnerable population at higher risk for depression/anxiety, suicidal ideation and suicide attempts. The Youth Risk and Behavior Survey (YRBS) is an ongoing study conducted by the Center for Disease Control that obtains data on variables relevant to adolescents in the United States. Data from states that ask about and can analyze variables related to gender identity found that adolescents who are gender diverse, when compared to cisgender peers, had higher rates of consideration of suicide (45% vs 10-20%) and attempted suicide (35% vs. less than 10%).[8]

25. Without treatment, adolescents and young adults with gender dysphoria can experience symptoms that make very basic tasks feel impossible such as showering, eating, attending school, or socializing. Clinically, many of my patients report not participating in class due to discomfort with their voice, avoiding the use of bathrooms throughout the school day,

[8] Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students–19 States and Large Urban School Districts, 2017*, MORBIDITY & MORTALITY WKLY. REP., Jan. 25, 2019, at 67, 69.

avoiding physical activity due to body discomfort, as well as discomfort leaving the house in general. Delays in treatment can exacerbate symptoms, creating more impairment and psychological distress. A recent study of adults showed that longer wait times to establish care at a gender clinic resulted in low mood, worsening suicidal ideation and poorer quality of life.[9]

26. The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People are the most widely adopted clinical practice guidelines for the treatment of transgender and gender diverse individuals. The Standards of Care (SOC) were first published in 1979 and the most recent iteration (SOC 8) was published in 2022.[10] Per the methodology described by WPATH "SOC-8 is based on the best available science and expert professional consensus in transgender health. International professionals and stakeholders were selected to serve on the SOC-8 committee. Recommendation statements were developed based on data derived from independent systematic literature reviews, where available, background reviews and expert opinions."[11] SOC 8 provides detailed guidance for evaluation of gender dysphoria and criteria for medical intervention, as well as procedures for hormone treatment and surgery when indicated.[12]

27. The Endocrine Society has also published a widely adopted clinical practice guideline for the treatment of gender dysphoria (Endocrine Society Guideline) to help guide

[9] N. Henderson et al., *The Impact of Gender Identity Clinic Waiting Times on the Mental Health of Transitioning Individuals*, 65 EUR. PSYCHIATRY S851 (2022)
[10] E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH S1 (2022).
[11] *Id.* at S3.
[12] *Id.*

providers working with gender diverse adolescents and adults.[13] The SOC 8 and Endocrine Society Guideline have a high degree of overlap and consensus regarding best practices.

28. The American Psychological Association (APA) also released guidelines specific to the provision of mental health care to gender diverse individuals.[14] The APA defines gender affirming care to be "care that is respectful, aware, and supportive of the identities and life experiences of [transgender and gender non-conforming] people."[15] Gender affirming care is creating a safe, therapeutic space where individuals can grow, evolve and understand themselves more completely, wherever their path may lead.

29. As stated above, these guidelines are widely accepted in the professional community. They have analyzed all available scientific research, and are widely referenced and endorsed by all major U.S. medical and mental health associations.

30. The SOC 8 and Endocrine Society Guideline described above emphasize the importance of mental health assessments and evaluations in the treatment of gender diverse adolescents. Beyond assessing eligibility criteria for medical interventions (puberty-delay, hormones, or surgery), which will be discussed below, mental health providers can facilitate exploration and deepen understanding of an individual's gender, help manage anxiety/depression or other mental health diagnoses related to gender dysphoria, provide support related to social transition (e.g. dressing and using names and pronouns that accord with one's gender identity), provide education to caregivers to increase support and positive communication, and enhance

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[13] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (2017).
[14] American Psychological Association, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, AM. PSYCH. 832 (2015).
[15] *Id.* at 832-33.

coping skills to manage discrimination/minority stress. For some, non-medical interventions such as social transition, creating gender congruent expression, and getting social support of their identity is sufficient to manage gender dysphoria. For many others, medical intervention is clinically indicated.

31. Under the WPATH SOC 8 and the Endocrine Society Guideline, no medical interventions are recommended or indicated for the treatment of gender dysphoria prior to the onset of puberty (otherwise referred to as Tanner Stage 2). Prior to Tanner Stage 2, the recommended care is to help youth in their gender exploration, and provide support to youth and families as described above.

32. Once puberty begins, many adolescents with gender dysphoria will experience great distress related to the changes in their bodies that do not match their gender identity. For some of these youth, medical interventions may be deemed necessary. They may include puberty blockers (GnRH agonists) to pause puberty, hormone therapy in accordance with one's gender identity (e.g. testosterone for transgender boys and estrogen and anti-androgens for transgender girls), and sometimes surgery. Pausing puberty with blockers can help prevent the distress associated with physical changes inconsistent with an adolescent's gender identity and also provide the adolescent more time to understand their gender identity before considering less reversible treatments. Hormone therapy and surgery can alleviate the distress of gender dysphoria by helping align the adolescent's body with their gender identity.

33. The WPATH SOC and the Endocrine Society Guideline outline criteria for eligibility for medical interventions for adolescents with gender dysphoria including a) significant duration of gender incongruity, b) the diagnostic criteria for gender dysphoria are met, c) the adolescent has the emotional and cognitive capacity to provide informed consent

regarding the treatment they are seeking; d) any other mental health conditions do not interfere with diagnostic clarity or ability to consent and e) the patient and their family is fully informed of potential risks and fertility preservation options.

34. To determine if the eligibility criteria are met and if medical interventions are appropriate for an adolescent patient, the SOC 8 and Endocrine Society Guideline recommend a comprehensive psychosocial assessment. Assessment procedures can vary based on the practice setting, discipline of the provider conducting the assessment, presence of neurodiversity, or other individual patient considerations/needs.

35. During the assessment, a thorough history and diagnosis of gender dysphoria (evolution of identity, onset of symptoms, types of symptoms experienced, disclosure of identity, impairment experienced) is obtained. It is important to understand fully how identity has developed over time and how their gender dysphoria manifests. Some patients who are evaluated do not meet the criteria for gender dysphoria (either due to symptom length or lack of symptoms), in which case a treatment plan may include non-medical support and intervention to address symptoms/distress.

36. Evaluation of co-occurring mental health disorders is also obtained. If other conditions are present, it is important to understand how/if other diagnoses are related to gender dysphoria and ensure that other mental health needs are getting adequate support and are addressed. Further assessment or testing may be needed to fully understand more complex presentations (e.g., challenging psychopathology, co-occurring neurodiversity) prior to initiating medical intervention. The presence of co-occurring disorders does not preclude eligibility for medical intervention. Gender dysphoria can contribute to symptoms of depression, anxiety, eating disorder, etc., thus we often cannot expect symptoms to improve or be in remission until

the gender dysphoria is treated. Any co-occurring mental health issue should be managed enough so that it is not interfering in the diagnostic picture or impairing one's judgment or ability to make informed decisions. In some cases, further testing or therapy may be needed to address this criterion prior to recommending medical intervention.

37. The assessment should also include an evaluation of an adolescent's ability to understand the potential risks, benefits, and long-term consequences of treatment. Treatment options should be discussed thoroughly, including changes (both reversible and permanent), timeline for when changes occur, realistic expectations of physical changes, medical risks and side effects, and potential implications for fertility and fertility preservation options. As with all medicine, information should be presented in a developmentally appropriate manner to both the adolescent and caregivers. Information should be presented using the current evidence available. Once an adolescent has been provided all the information necessary to make an informed choice, if they want to proceed with the treatment, they must provide assent and their parent or guardian must provide consent.

D. Efficacy of Medical Treatment for Gender Dysphoria

38. In the years that I have been seeing patients with gender dysphoria, I have clinically seen the life-changing—and sometimes life-saving—benefits of gender-affirming medical interventions. Not only do I see improvements in depression, anxiety, and suicidal ideation, but I have seen significant improvements in overall daily functioning in adolescents after receiving gender-affirming medical care. Adolescents who were previously too anxious to attend school in person are now going to school and thriving academically. They are now able to make friends, date, and work, and do so with confidence. Caregivers have often commented on

the weight that has been lifted from their child or how happy they are to see their child thriving again.

39. Research conducted in this area echoes what I have seen clinically. A substantial body of evidence shows the efficacy of gender affirming medical care. Studies have demonstrated improvements in mental health following gender-affirming medical interventions.[16] Many of these studies demonstrate improvement in depression and anxiety symptoms, quality of life indicators, as well as reductions in suicidal ideation and attempts.

40. Moreover, as I have seen in my experience as a clinician the use of hormone blockers and cross-sex hormone therapy during adolescence can prevent the need for future medical treatments (such as surgeries to remove or alter secondary sex characteristics) and allow for more favorable future outcomes. This, in turn, reduces the gender dysphoria associated with one's body failing to align with one's gender identity.

41. There are no scientific studies demonstrating that non-medical treatments alone (such as therapy only) are effective in the treatment of gender dysphoria.

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[16] *See e.g.*, Diane Chen et al., *Psychological Functioning in Transgender Youth After 2 Years of Hormones*, 388 NEW ENG. J. MED. 240, 245-247 (2023) (demonstrating increased mental health benefits from gender affirming care for transgender people); Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. ADOLESCENT HEALTH 643, 647-48 (2022) (same); Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 PEDIATRICS 1, 3 (2020) (same); 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, 2281-90 (2011) (same); Rosalia Costa et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12 J. SEXUAL MED. 2206, 2212-13 (2015) (same); Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 PEDIATRICS 696, 701-03 (2014) (same).

E. Harm to Transgender Youth if Care is Restricted

42. Withholding or discontinuing widely accepted, effective medical care from adolescents with gender dysphoria will cause serious harm. Having seen the significant distress and limitations on function experienced by adolescent patients with gender dysphoria, and the transformative effects of gender affirming medical treatments, the thought of withholding this care from those who need it is deeply concerning. Doing so will predictably result in adolescents unnecessarily suffering distress, withdrawing from life activities and, for some, hurting themselves. It will deny many adolescents with gender dysphoria the opportunity to be healthy and thrive. In a large survey of transgender adolescents and young adults, those who had access to medical interventions reported lower depression and suicidal ideation compared to adolescents and young adults who sought medical interventions but were not receiving them.[17] Restricting access will increase depression and suicidal ideation within an already vulnerable population.

43. For youth entering puberty, access to puberty blockers prior to the onset of irreversible secondary sex characteristics (e.g., deep voice, chest development) bypasses much of the dysphoria, distress and psychological harm that going through misaligned puberty can cause, as well as prevent more invasive and costly procedures in adolescence and adulthood such as surgery.

44. Clinically, I have had cases where patients are not able to receive gender affirming medical care for various reasons and are forced to wait until they turn 18. While waiting, there is often increased psychological distress impairing their daily life and functioning. For example, individuals may become so dysphoric with their bodies that they are not able to

[17] Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. ADOLESCENT HEALTH 643, 647-48 (2022).

leave the house to attend school, participate in extra-curricular activities, or continue working or obtain employment. Those who are forced to wait can decompensate. I have had several cases where depression related to gender dysphoria increased to such a degree that inpatient hospitalization was needed for stabilization following significant self-harm, suicidal ideation or a suicide attempt. In some cases, adolescent patients become desperate and have explored or obtained hormones online or from other countries. Doing so without appropriate dosing and monitoring places them at risk for physical harm.

45. Our clinic has recently had around ten families come to us from other states where bans on gender-affirming medical care for minors have been enacted. With some families, they come to us every 3-6 months for follow-up. This places significant financial strain on families as well as disrupts daily life every 3-6 months. Some families have made the difficult decision to move to California, leaving a state that they loved and leaving their support systems behind in order to care for their child.

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

Executed on: 7/19/2023

Christine Brady, PhD