IN THE SUPREME COURT OF MISSOURI

No. SC96683

R.M.A., A MINOR CHILD, BY HIS NEXT FRIEND: RACHELLE APPLEBERRY,

Appellant,

v.

BLUE SPRINGS R-IV SCHOOL DISTRICT AND BLUE SPRINGS SCHOOL DISTRICT BOARD OF EDUCATION,

Respondents.

On Appeal from the Missouri Court of Appeals – Western District

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BRIEF OF *AMICI CURIAE* THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN ACADEMY OF PEDIATRICS, AND NINE OTHER MEDICAL, NURSING, MENTAL HEALTH, AND OTHER HEALTH CARE ORGANIZATIONS IN SUPPORT OF APPELLANT (FILED WITH THE CONSENT OF ALL PARTIES)

LaRue L. Robinson # 67261
JENNER & BLOCK LLP
353 N. Clark Street
Chicago, IL 60654
(312) 222-9350
lrobinson@jenner.com

Scott B. Wilkens
JENNER & BLOCK LLP
1099 New York Ave. NW
Suite 900
Washington, DC 20001
(202) 639-6000
swilkens@jenner.com

(*Additional counsel for Amici Curiae listed on inside cover*)

Benjamin J. Brysacz
JENNER & BLOCK LLP
633 West 5th St.
Suite 3600
Los Angeles, CA 90071
(213) 239-5100
bbrysacz@jenner.com

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

INTEREST OF *AMICI CURIAE*[1]

Amici are eleven leading medical, mental health, and other health care organizations: the American Academy of Child and Adolescent Psychiatry, the American Academy of Nursing, the American Academy of Pediatrics, the American Medical Association, the American Medical Women's Association, the Association of Medical School Pediatric Department Chairs, the American Nurses Association; the Endocrine Society, GLMA: Health Professionals Advancing LGBT Equality, Mental Health America, and the National Association of Social Workers.

Collectively, *amici* represent hundreds of thousands of physicians and mental health professionals, including specialists in pediatrics and adolescent care, family medicine, internal medicine, psychiatry, and endocrinology; and millions of nurses. *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.

[1] *Amici* hereby certify that no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money intended to fund preparation or submission of this brief, and no person other than *amici* and their counsel contributed money intended to fund preparation or submission of the brief. The parties have consented to the filing of this brief.

Amici submit this brief to inform the Court of the consensus among health care professionals regarding what it means to be transgender; the protocols for the treatment of transgender and gender dysphoric people; and the potential 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 health care 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 have a condition called gender dysphoria, which is characterized by clinically significant distress and anxiety resulting from the incongruence between one's gender identity and the sex assigned at birth. The international consensus among health care professionals regarding treatment for transgender and gender dysphoric people is to assist the patient to live in accordance with his or her gender identity, thus alleviating and avoiding 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), hormone therapy, and surgical interventions.

Access to single-sex facilities that correspond to one's gender identity is a critical aspect of social transition and, thus, successful treatment for transgender and gender dysphoric individuals. By contrast, excluding transgender individuals from facilities consistent with their gender identity undermines their treatment; exposes them to stigma and discrimination; potentially harms their physical health by causing them to avoid restroom use; and impairs their social and emotional development. Similarly, transgender students who must 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 Experience 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]

[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

Transgender people differ from cisgender (*i.e.*, non-transgender) individuals, whose gender identity aligns with the sex assigned at birth.[3]

Recent estimates suggest that approximately 1.4 million transgender adults live in the United States, or 0.6 percent of the adult population.[4] That said, "population estimates likely underreport the true number of [transgender] people."[5] People of all different races and ethnicities identify as transgender.[6] They live in every state, serve in our military, and raise children.[7] Gender identity is distinct

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

[4] Andrew R. Flores et al., The Williams Inst., *How Many Adults Identify as Transgender in the United States?* 2 (2016).

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

[6] *See* Halley P. Crissman et al., *Transgender Demographics*: *A Household Probability Sample of US Adults, 2014*, 107 Am. J. Pub. Health 213, 214-15 (2017); Andrew R. Flores et al., The Williams Inst., *Race and Ethnicity of Adults Who Identify as Transgender in the United States* 2 (2016).

[7] Gary J. Gates & Jody L. Herman, The Williams Inst., *Transgender Military Service in the United States* (2014); Sandy E. James et al., Nat'l Center for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 2 (2016); Rebecca L. Stotzer et al., The Williams Inst., *Transgender Parenting: A Review of Existing Research* (2014).

from and does not predict sexual orientation; transgender people, like cisgender people, may identify as heterosexual, gay, lesbian, bisexual, or asexual.[8]

The health care 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."[9] Medical 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.[10]

Much as the health care professions recognize 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 impairment in judgment, stability, reliability, or general social or vocational capabilities."[11]

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[8] 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.

[9] Am. Psychol. Ass'n, *Report of the APA Task Force on Gender Identity and Gender Variance* 26-27 (2008), **[hereinafter "Am. Psychol. Ass'n Task Force Report"]**.

[10] *Id.*; Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* 13, 25 (2015).

[11] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (2012).

A. Gender Identity

"[G]ender identity" refers to a person's internal sense of being male, female, or another gender.[12] Every person has a gender identity,[13] which cannot be altered voluntarily[14] or ascertained immediately after birth.[15] Many children develop stability in their gender identity between ages three and four.[16]

"[G]ender expression refers to the way a person communicates gender identity to others through behavior, clothing, hairstyles, voice, or body characteristics."[17] There are many individuals who depart from stereotypical male and female appearances and roles, but who are not transgender.[18] Indeed, most people who express their gender in a non-stereotypical or non-conforming manner are or become

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[12] Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People, Gender Identity, and Gender Expression* 1 (2014).

[13] *See* Caitlin Ryan, Family Acceptance Project, *Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual, & Transgender Children*, 17 (2009).

[14] Colt Meier & Julie Harris, Am. Psychol. Ass'n, *Fact Sheet: Gender Diversity and Transgender Identity in Children* 1; *see also* Am. Acad. of Pediatrics, *Gender Identity Development in Children* (2015).

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

[16] *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.

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

[18] Ethan C. Cicero & Linda M. Wesp, *Supporting the Health and Well-Being of Transgender Students*, J. Sch. Nursing 1, 6 (2017).

comfortable with the sex they were assigned at birth.[19] In contrast, a transgender boy or transgender girl "consistently, persistently, and insistently" identifies as a gender different than the sex they were assigned at birth.[20]

Psychologists, psychiatrists, and neuroscientists are not certain why some people are transgender. Some research suggests there may be biological influences,[21] including, for example, exposure of natal females to elevated levels of testosterone in the womb.[22] Brain scans and neuroanatomical studies of transgender individuals may also support these biological explanations.[23]

B. Gender Dysphoria

Being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."[24] However, many transgender

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[19] 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) **[hereinafter "WPATH Standards of Care"]**.

[20] *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.

[21] *See* Am. Acad. of Pediatrics, *Gender Non-Conforming & Transgender Children* (2015); Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1895 (2008).

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

[23] *See, e.g.*, Francine Russo, *Is There Something Unique About the Transgender Brain?* Sci. Am. (Jan. 1, 2016).

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

individuals are diagnosed with gender dysphoria, a condition that can be characterized by debilitating distress and anxiety resulting from the incongruence between an individual's gender identity and birth-assigned sex.[25]

1. The Diagnostic Criteria And Seriousness Of Gender Dysphoria

The Diagnostic and Statistical Manual of Mental Disorders 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' 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."[26] 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"; (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.[27] Similarly, the World

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

[26] *Id.*

[27] *Id.* at 452.

Health Organization's International Classification of Diseases recognizes that gender dysphoria is "characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex."[28]

Gender non-conforming children may 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.[29] For instance, a deepening voice for male-assigned individuals or the growth of breasts and the beginning of a menstrual cycle for female-assigned individuals can cause severe distress.

If untreated, gender dysphoria can contribute to debilitating distress, depression, impairment of function, substance use, self-mutilation to alter one's genitals or secondary sex characteristics, other self-injurious behaviors, and

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[28] World Health Organization ("WHO"), International Classification of Diseases-10 F64.2 (2015 ed.). For its upcoming International Statistical Classification of Diseases-11, the WHO has proposed using "gender incongruence" as the name for the gender identity–related diagnoses. 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, 3875 (2017). "Not all individuals with gender incongruence have gender dysphoria or seek treatment." *Id.*

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

suicide.[30] Transgender individuals also are frequently subjected to prejudice and discrimination in multiple areas of their lives, which exacerbates these negative health outcomes.[31]

2. The Accepted Treatment Protocols For Transgender and Gender Dysphoric People

Until the middle of the twentieth century, many mental health practitioners approached individuals with same-sex attractions and individuals who were gender non-conforming as pathological, and unsuccessfully attempted to make patients more gender-conforming.[32] There is no evidence that these methods alleviate gender dysphoria or that they can prevent someone from being transgender.[33] To the contrary, they can "often result in substantial psychological pain by reinforcing

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[30] *See, e.g.,* DSM-5, *supra*, at 455, 458; Stephanie A. Brill & Rachel Pepper, *The Transgender Child: A Handbook for Families and Professionals* 202 (2008) (discussing risk of self-mutilation).

[31] 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).

[32] Am. Acad. of Child & Adolescent Psychiatry, *Conversion Therapy* (2018); Am. Psychol. Ass'n Guidelines, *supra*, at 835; Jack Drescher, *Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual*, 39 Arch. Sexual Behav. 427, 436-40 (2010).

[33] Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 26; Jack Drescher, *Controversies in Gender Diagnoses*, 1 LGBT Health 9, 12 (2013).

damaging internalized attitudes,"[34] and can damage family relationships and individual functioning by increasing feelings of shame.[35]

In the last few decades, transgender people and those suffering from gender dysphoria have gained widespread access to gender-affirming psychological and medical support.[36] For over 30 years, the generally-accepted treatment protocols for transgender and gender dysphoric people[37] have aimed at alleviating the distress associated with the incongruence between gender identity and birth-assigned sex.[38] 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

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[34] Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression* (2012).

[35] 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); 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).

[36] Am. Psychol. Ass'n Guidelines, *supra*, at 835; WPATH Standards of Care, *supra*, at 8-9. While amici write here about treatment for transgender people diagnosed with gender dysphoria in accordance with DSM-V, these gender-affirming treatments are also often necessary for transgender people diagnosed with gender incongruence in accordance with the most recent Endocrine Society treatment guidelines. *See, e.g.*, Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3869-72.

[37] 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.

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

World Professional Association for Transgender Health ("WPATH").[39] Many of the major medical and mental health groups in the United States recognize the WPATH Standards of Care as representing the consensus of the medical and mental health community regarding the appropriate treatment for transgender and gender dysphoric people.[40]

The recommended treatment for transgender people and those experiencing 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.[41] Each

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

[40] *See, e.g.*, Am. Psychol. Ass'n Task Force Report, *supra*, at 32; AAP Technical Report, *supra*, at 307-08.

[41] 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), **[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); AAP Technical Report, *supra*, at 307-09. Some clinicians still offer versions of "reparative" or "conversion" therapy based on the idea that being transgender is a mental disorder and that gender identity can be changed. However, all of the leading medical professional organizations that have considered the issue 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); Am. Sch. Counselor Ass'n, *The School Counselor and LGBTQ Youth* (2016); 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*

patient requires an individualized treatment plan that accounts for the patient's specific needs.[42]

Social transition—*i.e.*, living one's life fully in accordance with one's gender identity—is often a critically important part of treatment. 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.[43] Transgender children who have not transitioned report higher levels of anxiety and depression than their non-transgender peers, while studies of transitioned children suggest that they report statistically similar levels of anxiety and depression as their peers.[44]

For some transgender and/or gender dysphoric adults and adolescents, hormone treatment to feminize or masculinize the body may be medically necessary.[45] *Amici curiae* the Endocrine Society and the Pediatric Endocrine Society

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Expression, supra.

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

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

[44] Lily Durwood et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. Child & Adolescent Psychiatry 116 (2017); Kristina R. Olson et al., *Mental Health of Transgender Children Who Are Supported in Their Identities*, 137 Pediatrics 1 (2016).

[45] Am. Med. Ass'n, Policy No. H-185.950, *Removing Financial Barriers to Care for Transgender Patients* (Rev. 2016); Am. Psychol. Ass'n Guidelines, *supra*, at 861,

consider these treatments to be the standard of care for transgender and gender dysphoric individuals.[46] 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; and just as they would in any other boy, these hormones will affect most of his major body systems.[47] 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.[48] For children experiencing the onset of puberty, treatment may include medication to prevent further progression of puberty ("puberty blockers").[49] This fully reversible treatment allows children with gender dysphoria to delay the

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

[46] *See* Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3869-70; *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).

[47] Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3885; *see also* Brill & Pepper, *The Transgender Child*, *supra*, at 217.

[48] Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3888-89 (describing effects on adults).

[49] *Id.* at 3880-83.

development of secondary sex characteristics that do not match their gender identity, giving them additional time to decide whether hormone treatment to feminize or masculinize the body is appropriate.[50]

Surgical interventions may also be an appropriate and medically necessary treatment for some patients. These procedures could include chest reconstruction surgery for transgender men, breast augmentation (*i.e.* implants) for transgender women, or genital surgery.[51] Studies show these procedures are effective in reducing gender dysphoria and improving mental health.[52] Because these surgical procedures are largely irreversible, some are recommended only for transgender individuals who have reached the age of legal majority.[53]

Ultimately—regardless of the particular treatments required for a specific individual and when such treatment begins—the goal is for transgender and/or gender dysphoric individuals to experience "identity integration," where "being

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[50] *Id.* at 3880; Am. Psychol. Ass'n Guidelines, *supra*, at 842; WPATH Standards of Care, *supra*, at 18-20.

[51] Hembree et al., *Endocrine Treatment of Transsexual Persons*, *supra*, at 3893-95; *see also* WPATH Standards of Care, *supra*, at 57-58.

[52] 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); Annelou L.C. de Vries, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014).

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

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.[54]

II. Excluding Transgender Individuals From Facilities Consistent With Their Gender Identity Endangers Their 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.[55] 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. In fact, *amicus curiae* the American Medical Association, whose mission statement requires it to support public health, recently confirmed its support for transgender individuals' accessing public restrooms according to their gender identities.[56] And while schools often provide private restrooms for any student who seeks greater privacy for any reason, forcing transgender students to use

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[54] 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).

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

[56] Am. Med. Ass'n, Policy No. H-65.964, *Access to Human Services for Transgender Individuals* (Rev. June 2017).

those separate facilities sends a stigmatizing 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.[57] 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 11-19, 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.[58] Those risks are already all too serious: in a comprehensive survey of over 27,000 transgender individuals, 40

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

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

percent reported a suicide attempt—a rate *nine times* that reported by the general U.S. population.[59]

B. Exclusionary Policies Expose Transgender Individuals To Harassment And Abuse.

Exclusionary policies expose transgender individuals to harassment and abuse by forcing them to occupy gender-segregated spaces where their presence may be 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 only transgender individuals who must use facilities that are incongruent with their gender identity and how they live and are recognized in the world. Because some youth will have transitioned before they arrive in a particular school, exclusionary policies may be the only way that they are forcibly "outed" to their peers as transgender.

Such compelled disclosure of one's transgender status is harmful for at least two reasons. First, control over the circumstances in which a person may choose to disclose being transgender is fundamental to the development of individuality and

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

autonomy.[60] Exclusionary policies rob transgender individuals of the personal choice regarding whether and when to reveal their transgender status. Disclosure of one's status as transgender is often anxiety-inducing and fraught; it is critical to a person's sense of safety, privacy, and dignity to have control over when and how that information is shared.

Second, such compelled disclosure exposes transgender individuals to the risk of harassment or abuse. In a 2013 survey, 68 percent of transgender 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.[61]

These harms affect youth and adults alike. "[M]any gender and sexual orientation diverse children and adolescents experience harassment, bullying, and physical violence in school environments."[62] Because unwanted disclosure may cause such significant harm, *amicus curiae* the American Academy of Pediatrics' guidance states that care should be confidential, and it is not the role of the

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[60] Am. Acad. of Pediatrics, *American Academy of Pediatrics Opposes Legislation that Discriminates Against Transgender Children* (Apr. 18, 2016).

[61] 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).

[62] 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).

pediatrician to inform parents/guardians about a patient's sexual identity or behavior as doing so could expose the patient to harm.[63] 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."[64]

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

It is well documented that transgender individuals experience widespread prejudice and discrimination, and that this discrimination frequently takes the form of violence, harassment, or other abuse.[65] For example, in a Virginia survey of transgender individuals, half of participants reported that they had experienced discrimination in healthcare, employment, or housing, and many individuals had experienced discrimination in more than one area.[66]

Exclusionary policies perpetuate such stigma and discrimination, both by forcing transgender individuals to disclose their status, and by marking transgender individuals as "others" who are unfit to use the restrooms used by everyone else.

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

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

[65] 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).

[66] 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).

Such policies inherently convey the message that transgender individuals are different and deserve inferior treatment.

Research increasingly shows that stigma and discrimination can have deleterious health consequences,[67] including striking effects on the daily functioning and emotional and physical health of transgender persons.[68] 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.[69] Another study concluded that "living in states with discriminatory policies . . . was associated with a statistically significant increase in the number of psychiatric disorder diagnoses."[70] And a third study demonstrated that past school victimization may result in greater risk for post-traumatic stress disorder, depression, anxiety, and suicidality.[71] As the American Psychological Association has concluded, "the

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[67] *See generally* Am. Psychol. Ass'n, *Stress in America: The Impact of Discrimination* (2016).

[68] *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").

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

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

[71] Russell B. Toomey et al., *Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth: School Victimization and Young Adult Psychosocial Adjustment*, 46 Developmental Psychology 1580, 1581 (2010).

notable burden of stigma and discrimination affects minority persons' health and well-being and generates health disparities."[72] There is thus every reason to anticipate that stigmatizing 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. 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 single-user restrooms that no other students are required to use, which undermines their health care needs and risks discrimination or harassment; or (3) attempt not to use the restroom at all.

This difficult choice produces heightened anxiety and distress around restroom use, which may make it difficult for transgender individuals to concentrate or focus at school or work and potentially cause them to eschew social activities or

[72] 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).

everyday tasks.[73] 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.[74]

Studies also show that it is common for transgender students to avoid using restrooms.[75] That avoidance 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.[76]

Some transgender students experiencing fear and anxiety about restroom usage may attempt to dehydrate themselves so that they will need to urinate less frequently.[77] Chronic dehydration has been linked to a variety of conditions,

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

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

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

[76] *See, e.g.*, 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; 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).

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

including urinary tract infections, kidney stones, blood clots, kidney disease, heart disease, and colon and bladder cancer.[78]

These negative outcomes are not alleviated by forcing students into separate single-user restrooms. Being required to use separate facilities may force disclosure of one's transgender status and cause anxiety and fear related to being singled out and separated from peers. Additionally, single-user facilities may be less available and more inconvenient, causing people to further avoid restroom use or disrupt their schedules to go to the restroom. Separate restrooms thus do not alleviate the anxiety, fear, or negative health consequences that result from exclusionary bathroom policies.

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. Discrimination and harassment of children and adolescents in their formative years may have effects that linger long *after* they leave the school environment. Unsurprisingly, unwelcoming school environments produce particularly poor educational outcomes for transgender individuals.[79] Poorer educational outcomes, standing alone, may lead

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

[79] *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).

to lower lifetime earnings and an increased likelihood of poorer health outcomes later in life.[80]

Moreover, and as already discussed, exclusionary policies may produce and compound the stigma and discrimination that transgender children and 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.[81]

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.[82]

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[80] *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).

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

[82] AAP Technical Report, *supra*, at 301, 302, 304-05; *see, e.g.,* 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).

With appropriate support—including safe and supportive schools—transgender youth can become happy and productive adults who contribute much to our society. By making schools into places of stress and conflict rather than welcoming spaces, exclusionary policies worsen stigma and discrimination against transgender students, causing myriad harms to their health, safety, and overall well-being.

CONCLUSION

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

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Respectfully submitted,

JENNER & BLOCK LLP

/s/ LaRue L. Robinson

Scott B. Wilkens
1099 New York Ave. NW
Suite 900
Washington, DC 20001
(202) 639-6000
swilkens@jenner.com

LaRue L. Robinson # 67261
JENNER & BLOCK LLP
353 N. Clark Street
Chicago, IL 60654
(312) 222-9350
lrobinson@jenner.com

Benjamin J. Brysacz
JENNER & BLOCK LLP
633 West 5th St.
Suite 3600
Los Angeles, CA 90071
bbrysacz@jenner.com

Counsel for Amici Curiae

CERTIFICATE OF COMPLIANCE

I hereby certify that I prepared this brief using Microsoft Word 2013 in Times New Roman size 14 font. I further certify that this brief complies with the word limits of Rule 84.06(b) and that this brief contains 5,914 words.

Dated: February 27, 2018

/s/ LaRue L. Robinson

LaRue L. Robinson # 67261
JENNER & BLOCK LLP
353 N. Clark Street
Chicago, IL 60654
(312) 222-9350
lrobinson@jenner.com
Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on February 27, 2018, I electronically filed the foregoing *amici curiae* brief with the Clerk of the Court and service was completed via the Court's electronic filing system on:

Alexander Louis Edelman
4051 Broadway
Suite 4
Kansas City, MO 6411

Counsel for Appellant

Steven Feliciano Coronado
14 West 3rd Street
Suite 200
Kansas City, MO 64105

Counsel for Respondent

Merry M. Tucker
14 West 3rd Street
Suite 200
Kansas City, MO 64105

Co-Counsel for Respondent

Dated: February 27, 2018

/s/ LaRue L. Robinson

LaRue L. Robinson # 67261
JENNER & BLOCK LLP
353 N. Clark Street
Chicago, IL 60654
(312) 222-9350
lrobinson@jenner.com

Counsel for Amici Curiae