UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

JOY BUCHMAN,

Plaintiff,

Case No. 3:23-CV-105

v.

CITY OF LA CROSSE,

Defendant.

PLAINTIFF'S SUPPLEMENTAL PROPOSED FINDINGS OF FACT IN SUPPORT OF SUMMARY JUDGMENT, OR IN THE ALTERNATIVE, IN SUPPORT OF PRELIMINARY INJUNCTION MOTION

I. Gender Identity

1. "Gender identity" refers loosely to some combination of a person's feelings, desires, beliefs, perceptions, and/or assertions about what their gender "really" is. Levine Decl. ¶19.

2. "Gender incongruence" refers broadly to a mismatch between a person's biological sex and their perceived, desired, or felt gender identity. Levine Decl. ¶24; Drescher Dep. 11:7–12:20.

3. "Gender dysphoria" refers to distress related to such a mismatch and is also a diagnosis in the DSM-V. Levine Decl. ¶¶24, 27; Drescher Dep. 10:3–25.

4. Gender dysphoria "is a psychiatric, not a medical, diagnosis." Levine Decl. ¶32.

5. A person's feelings of gender incongruence or gender dysphoria can and do change for many people. Drescher Dep. 72:6–73:9; Levine Decl. Part IV; Rosik Dep. 31:1–4.

6. "There is no medical consensus that transgender identity has any biological basis." Levine Decl. ¶72; ¶¶72–99.

7. Studies to date have been unable to find a biological basis for gender identity, as distinct from biological sex. Levine Decl. ¶¶73–76; Drescher Dep. 12:22–23.

8. The number of minors asserting a transgender identity has dramatically increased in recent years. Levine Decl. ¶¶77–79 (up to "30-fold"); Drescher Dep. 76:5–6; Rosik Dep. 9:4–16.

9. There has also been a "large change in sex ratio"—i.e., significantly more girls currently present with gender incongruence, whereas previously there were more boys. Levine Decl. ¶80; Drescher Dep. 76:6–15.

10. Researchers have observed "clustering" of transgender identities among social groups, particularly adolescent girls. Levine Decl. ¶81.

11. Researchers have recently started documenting "rapid onset gender dysphoria"—i.e., "adolescents seeking care who have not seemingly experienced, expressed, or experienced and expressed gender diversity during their childhood years." Drescher Dep. 77:24–78:15; Levine Decl. ¶¶91, 80–81.

12. Children have high levels of "desistance"—i.e., children who at one time experienced gender incongruence or gender dysphoria, but later revert to comfort and identification with their biological sex. Levine Decl. ¶¶82, 86–90.

13. There are increasing numbers of "detransitioners"—individuals who previously transitioned to a different gender identity (socially, medically, or both), but later "detransition" to an identity consistent with their biological sex. Levine Decl. ¶¶45, 91–99; Drescher Dep. 68:21–69:6.

14. "Social influence" and a variety of other non-biological factors may play a significant role in a child's or adolescent's sense of gender identity. Drescher Dep. 77:12–79:21; Levine Decl. ¶¶14, 61, 79, 80, 81, 82; Rosik Dep. 9:19–10:7.

15. "[T]here's no way to predict who w[ill] desist" and, conversely, who will "persist." Drescher Dep. 73:3–4; 75:18–24; Levine Decl. ¶¶76, 89.

16. For pre-adolescent children in particular, multiple studies (11) across different places and times have shown that *the vast majority* of children (up to 90%) who experience gender incongruence ultimately desist. Levine Decl. ¶¶86–88; Drescher Dep. 74:19–75:14.

17. With respect to adolescents, the rates of persistence and desistance have not been adequately studied. Drescher Dep. 75:25–76:24.

18. "Desistance is increasingly observed among teens and young adults who first manifest [gender dysphoria] during or after adolescence." Levine Decl. ¶¶91–99; Levine Dep. 61:2–62:11.

19. A child's or adolescent's self-report of a transgender identity cannot always be taken as definitive, but instead may be the result of "obsessions and compulsions, special interest in autism, rigid thinking, broad identity problems, parent/child interaction difficulties, severe developmental anxieties (e.g., fear of growing up and pubertal changes unrelated to gender identity trauma), or psychotic thoughts.)." Levine Decl. ¶¶28–29; Levine Dep. 101:18–103:19; Drescher Dep. 80:5–82:5.

20. Many of the individuals who "transitioned" and then "'detransitioned' or changed back to a gender identity matching their sex" reported that they were previously mistaken about their own gender identity and that their dysphoria was related to other issues. Levine Decl. ¶¶93, 95; Drescher Dep. 70:12–22.

21. Many "detransitioners" also regret not having psychotherapy prior to transitioning. Levine Decl. ¶¶45, 99; Levine Dep. 106:24–107:5.

22. Many mental health professionals believe that the first response should be "counseling or psychotherapy" as a "potential path to eliminat[ing] gender dysphoria by enabling a patient to return to or achieve comfort with the gender identity aligned with his or her biology." Levine Decl. ¶¶68–71 (quoting various professionals).

23. "The distinct trend in western Europe is to make psychotherapy, not affirmation, the first approach to Gender Dysphoria in children and adolescents." Levine Decl. ¶¶50, 157.

24. "At least five European countries" adopt a "start-with-psychotherapy-first" approach. Levine Decl. ¶157.

25. While some professionals recommend immediate "affirmation" of a child's or adolescent's self-asserted gender identity, there is no consensus among mental health professionals—rather, there is substantial disagreement—about the best approach for treating children and adolescents experiencing gender incongruence. Levine Decl. ¶¶36–51 (surveying "four competing models of therapy"); *id*. ¶¶52–71 (surveying various disagreements).

26. Indeed, there is "far too little firm clinical evidence in this field to permit any evidence-based standard of care." *Id*. ¶¶52; Levine Dep. 65:11–66:5, 67:25–68:11.

27. All of the evidence about the various approaches to helping children and adolescents with gender incongruence and gender dysphoria is "very low quality." Levine Decl. ¶¶ 110–25.

28. "[N]o approach to working with [transgender and gender nonconforming children] has been adequately empirically validated."[1] Drescher Dep. 84:11–14 (agreeing "absolutely" with this statement).

29. "[C]onsensus does not exist regarding best practice with prepubertal children." *Supra* n.1; Drescher Dep. 84:15–17 (agreeing "absolutely" with this statement).

[1] American Psychological Association, *Guidelines for Psychological Practice with Transgender & Gender Nonconforming People*, 70(9) American Psychologist 832, 842 (2015), https://www.apa.org/practice/guidelines/transgender.pdf.

30. One of the "approaches" mental health professionals take with gender incongruent children is "encourag[ing] [children] to embrace their given bodies and to align with their assigned gender roles." *Supra* n.1.

31. "Consensus does not exist regarding whether this approach may provide benefit or may cause harm or lead to psychosocial adversities." *Supra* n.1.

32. One practitioner who takes this approach is Dr. Kenneth Zucker, a well-known practitioner in the field of gender dysphoria and someone who Dr. Drescher respects. Drescher Dep. 85:20–86:2.

33. There is no good evidence establishing that talk therapy to help a child or adolescent find comfort with their biological sex, if possible, is harmful. Levine Decl. ¶¶155–169, *id*. ¶168; Levine Dep. 72:24–73:17.

34. "[G]ender identity conversion efforts ha[ve] not been as well studied as SOCE."[2] Drescher Report p. 15, 16.

35. With respect to the Lee study, the only study Dr. Drescher points to as evidence of harm, Drescher Report p.16 & n.26, the authors *themselves* emphasize that its design does not allow drawing any conclusions as to causality. Levine Decl. ¶163.

36. That same study also appeared to "have defined '[gender identity change efforts]' as *coercive* efforts to change gender identity." Levine Decl. ¶¶164–66; Levine Dep. 53:5–54:24; 73:15–75:18.

[2] SOCE stands for "sexual orientation change efforts."

37. What limited evidence there is shows "no durable improvement in mental health after social, hormonal, or surgical transition and affirmation." Levine Decl. ¶¶126–28.

38. What limited evidence there is does not show that transitioning reduces suicide. Levine Decl. ¶¶143–44.

39. There is some evidence that a transition "radically changes outcomes, almost eliminating desistance." Levine Decl. ¶¶103–107; Levine Dep. 113:1–115:3.

40. An early social transition "almost inevitably leads to the administration of puberty blockers … [and] cross-sex hormones." Levine Decl. ¶107.

41. Puberty blockers and cross-sex hormones are a "scientifically unproven course of treatment" with "significant physical, mental health, and relational risks," including "steriliz[ation]" and other "complex medical implications," making the child a "patient for life." Levine Decl. ¶102; Levine Dep. 95:24–97:12.

42. Overall, transgender-identifying individuals face substantially worse mental health outcomes, Levine Decl. ¶¶129–35, and risk of suicide, *id*. ¶¶145–54, than the general population, over the full life span.

II. Sexual Orientation

43. Sexual orientation can and does change for many people. Drescher Dep. 102:22–103:8; 106:22–106:24; Rosik Decl. ¶¶17–31; Rosik Dep. 30:18–19; Levine Dep. 18:24–25, 21:2–7.

44. Fluidity in sexual orientation is "particularly pronounced in the[ ] adolescent early adulthood years." Rosik Dep. 59:21–22.

45. The reasons for sexual orientation change are not always known. Drescher Dep. 106:22–106:24.

46. Sexual orientation is complex and cannot be definitively attributed to any one factor (or set of factors), including immutable characteristics such as genetics or biology, as several studies and the APA have recognized. Rosik Decl. ¶¶9–15; Rosik Dep. 45:25–46:10.

47. Large-scale studies have found "only 'very small' correlations between any genes and same-sex behavior," such that "sexual orientation [is] no more genetically determined than 'a range of characteristics that are not widely considered immutable, such as being divorced, smoking, having low back pain, and feeling body dissatisfaction.'" Rosik Decl. ¶¶11–12 (quoting one study and a review of many studies).

48. "Empirically, the frequency of change in sexual orientation is particularly high among those who experience same-sex attraction and overwhelmingly in the direction of greater heterosexuality." Rosik Decl. ¶20; Rosik Dep. 35:17–36:1.

49. Several studies have shown that, over time, participants who initially report a non-heterosexual orientation predominantly switch to a heterosexual orientation. Rosik Decl. ¶¶24–29.

50. "Many individuals who identify as other than heterosexual believe that they possessed and exercised choice in their sexual orientation." Rosik Decl. ¶13; Drescher Dep. 110:13–18; 111:19–112:3.

51. There is "no definitive or meaningful evidence" that voluntary, conversational counseling with those who "wish to explore possibilities of change in unwanted same-sex attractions and behaviors is harmful to most or even many participants." Rosik Decl. ¶32.

52. In 2009, the APA concluded that the available literature on the "efficacy of SOCE or its harm" was "insufficient to draw any definitive conclusions." Rosik Decl. ¶¶33, 35; Dkt. 9-1; Rosik Dep. 66:15–16.

53. At the same time, the APA also remarked that there is a "dearth of scientifically sound research *on the safety of SOCE*," and that "research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so." Rosik Decl. ¶33 (Emphasis added).

54. More recent research still does not provide a sufficient basis for drawing any definitive conclusions about the benefits and harms of SOCE. Rosik Decl. ¶¶35–37, 42; Rosik Dep. 64:5–11.

55. Moreover, "[t]here is little study of SOCE in minors." Drescher Report p. 9.

56. The evidence "does not support the assertion that SOCE is harmful to most, or even many, of those who have participated in it." Rosik Decl. ¶41.

57. "[T]here is evidence that voluntary counseling *is effective* for at least some individuals who are highly motivated to change sexual attractions and

behaviors." Rosik Decl. ¶65 (emphasis added); *id.* ¶¶66–69 (citing and describing research).

58. By contrast, studies purporting to show that SOCE causes psychological harm contain serious methodological flaws including sampling biases (i.e., recruiting only those who *currently* self-identify as LGB+ inevitably excludes other participants) and "failure to conduct before-and-after comparisons" (i.e., failing to "control" for whether participants suffered from mental health issues or other distress prior to SOCE participation). Rosik Decl. ¶¶42–56; Appendix C.

59. The serious methodological flaws present in the studies purporting to show harm from SOCE cast significant doubt on claims that "SOCE invariably cause[s] harm." Rosik Decl. ¶¶55, 56.

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Respectfully Submitted,

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